TECHNIQUE OF VAGINAL HYSTERECTOMY.[1]

BY

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(With two illustrations.)

BEFORE a society of workers whose constant study is devoted to finding the causes and best means of treating the diseases peculiar to women, it is not necessary to copy from text books and journals the peculiar mode of operation of each surgeon. Suffice it to say that some use the ligature exclusively, some clamps, and others use both ligature and clamps. Some insist on first separating the bladder and ute-

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rus up to the peritoneum, some also enter the peritoneum in front, while others first open into the cul-de-sac. In fact, almost every operator has his own peculiar method.

Still I am certain that no one operates exactly as he described his method one or two or five years ago. We all pick up little points here and there, drop others, and thus within ourselves evolve a method of operation which is adapted to our own mental and muscular condition, all aiming to obtain rapidity of operation with safety and ultimate cure of patient.

I am a follower of the clamp method, and operate as follows: Patient in the lithotomy position, with a wide re-

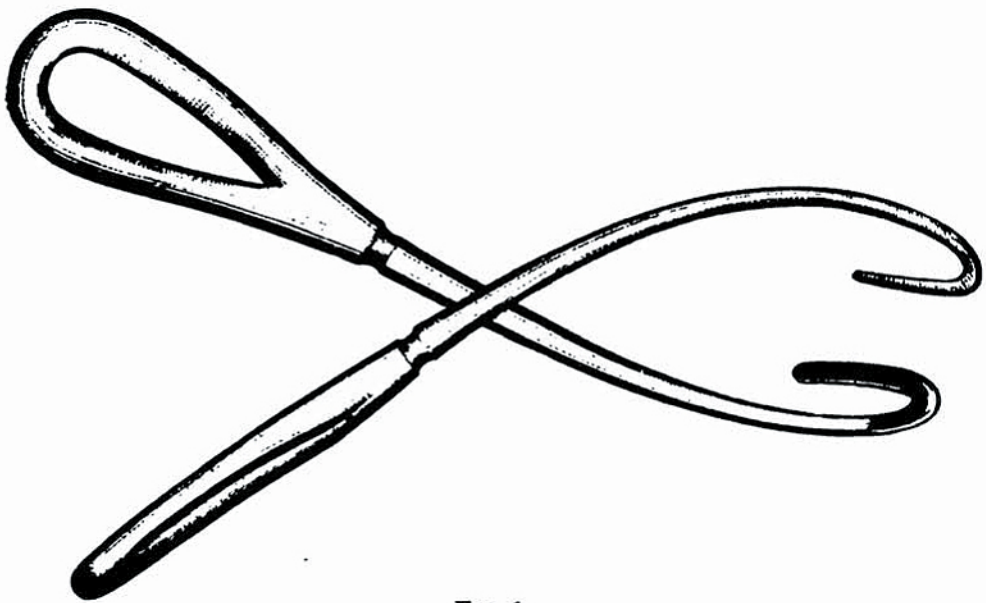

FIG. 1.

tractor expose the uterus; this is grasped with a three-pronged volsella. With a knife I cut through the mucous membrane and submucous tissue encircling the uterus. If only the crescentic cut is made, one in front and one behind, the mucous strip on each side is compressed by the forceps and will cause a great deal of pain. But if it is cut through and shoved back, so that the forceps grasps the ligament only, very little pain is experienced. Then, with your finger and the handle of your knife, you can separate the uterus from the bladder. A cut is then made in the cul-de-sac, and a sponge, attached to a string, introduced above the uterus to keep back the intestines. Then introduce your finger and hook it around the broad ligament, sticking it anteriorly

through the remaining peritoneum. Besides the finger I also use these hooks (Fig. 1), which enable you to use both hands when putting on the clamps. With your finger or hook as a guide you can easily put on the clamp on one side, and then the same on the other side, putting the clamp close up to the uterus, and including, if possible, the ovaries; then the broad ligament on each side is cut between the uterus and the clamp. Some slight attachment to the bladder can be quickly separated. The diseased organ is now removed. By pulling down the sponge we pull down the peritoneum which might have been inverted. Pieces of gauze are placed in the vagina, surrounding the clamps, and on which they

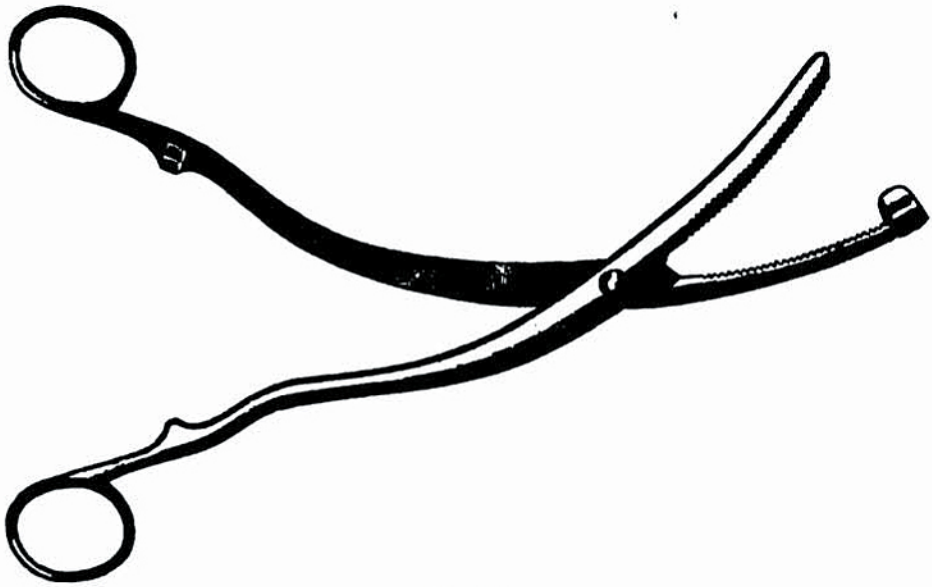

FIG. 2.

rest; this acts as a drainage tube and at the same time prevents injury to the mucosa by the clamps (Fig. 2).

The clamps I remove in from twenty-four to forty-eight hours, and then use douches once or twice a day. If the clamps have not been compressed too tightly there is no sloughing of the stump, and in one week all discharge stops.

I said above, if the ovaries can be reached I remove them also; this, of course, refers to women past the menopause, where senile atrophy has taken place. In such cases I waste no time to remove the ovaries, as little danger exists of future complication. But in young women I always remove the ovaries, as much trouble is often caused by future ovulation in the abdominal cavity, even without a uterus. By pull-

ing the fundus through the cul-de-sac, thus twisting the broad ligaments on themselves, you bring the ovaries down so that they can be readily grasped by the clamps.

By using the knife only to make the cut around the cervix, cutting through the mucous membrane, submucous tissue, and entering the cul-de-sac, and using only the handle and your fingers to *tear* and separate the balance of the tissues, I have been fortunate not to enter the bladder or injure the ureters, nor does much hemorrhage take place. If, however, any arterial branch should cause trouble, I take it up with a catch forceps —in very rare cases two or three catch forceps are required; these I leave in the vagina and remove with the clamps.

In my last case I intended to catheterize the ureters and leave the catheters in place during the operation, so that the ureters could be felt and avoided; but I could not get the proper catheters at the time.

These clamps I have had made similar to many others, but still a little different. They are light, weigh less than three ounces, and can be easily applied.

This operation is easy and can be performed usually in fifteen minutes; result, no shock.

I have seen some of the best operators in this country and Europe use the ligature of silk. The operations would last one and one-half to two hours. The ligature would have to slough off; this will take from three to four weeks.

With the clamps the patient need be kept in bed only ten days, and in two weeks leaves the hospital. Of course the ultimate result is the same.

The advantages of the clamp over the ligatures are: The operation can be quickly done—in fifteen or twenty minutes. The shorter the time the less the shock. Then, as soon as the forceps are removed the patient does not require any after-treatment. There is no danger of septic infection by ligatures, as absolutely no ligatures are needed. I have often remarked that if we could use the buried animal sutures exclusively in this operation I would give up the clamps. If the kangaroo tendon will fill the bill I will use it; but, so far, I have not had enough experience with it. Of course every operation should be done thoroughly, but still quickly, and the shorter time a patient is kept under chloroform the better.