

## SHALL WE CUT AND RECONSTRUCT THE PERINEUM FOR EVERY PRIMIPARA?\*

BY

RALPH H. POMEROY, M. D., F. A. C. S.,

Associate Professor of Obstetrics and Gynecology, Long Island College Hospital;  
Visiting Gynecologist and Obstetrician, Brooklyn Hospital,  
Brooklyn, N. Y.

(With five illustrations.)

EVERY primipara incurs a permanent modification of the pelvic floor in the course of delivery of her full-term child. In a disputed but high percentage of first births the acute stage of this modification presents some extent of open lacerated wound and in nearly all of the rest, concealed damage to fascia and levator ani muscles is acknowledged to occur and to be the factor paramount in various degrees of subsequent prolapsus uteri, cystocele and rectocele. We, as gynecologists, have devoted years of thought and much ingenious labor to planning and executing operations for the establishment of tolerable conditions in unhappy women disabled by childbirth; but thus far we, as obstetricians, have not faced and accepted a reasonable responsibility for the discovery of a plan to prevent by sound surgical procedures serious birth divulsion damage to the structures at the pelvic outlet.

Nearly all our obstetric text-books feebly elaborate on the accepted methods of preventing or lessening the extent of visible injuries to the perineum and with apologetic air refer to lateral episiotomy as an expedient positively defensible only as a precaution against laceration into the rectum.

The general attitude toward methods of "saving the perineum" in the second stage is that little can be accomplished beyond en-

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couraging gradual dilatation by the avoidance of precipitate expulsion or too rapid extraction in unfavorable positions. It is to be noted however, that De Lee in his "Principles and Practice of Obstetrics" and Anspach, before this Society, have recently more positively than others advocated a mediolateral perineal incision as a tension release, to hasten termination of the second stage *in the interest of the child*, and with more than usual emphasis on its advantage to the mother in conservation of pelvic integrity.

In 1892 Küstner (Germany), and in 1896 von Ott and Mandelberg (Russia), published favorable discussion of median perineotomy.

In 1895 Stahl of Chicago practised and published advocacy of median perineotomy to the sphincter, stating that "it aids, as no instrument can, in preserving life and body of both fetus and mother."

A contemplation of the underlying thought in the references suggests that we could accept without controversy a hope that there may be developed a standard incision passage through the pelvic floor to release the advancing head. We should wholly concur in the proposition that rending the birth orifice to enlarge its caliber is strictly unsurgical. We have condemned lateral lacerations of the cervix in conditions calling for prompt and large approach to the uterine cavity—we cut and reconstruct symmetrically in the median line. Anterior and posterior hysterotomy are standard—cervix divulsion by hand, "bag," or metal dilators is under fire of criticism.

The natural and usual tear of the perineal structure is asymmetrical in detail, wandering indecisively on one side or other of the median line, beginning and extending at points of least resistance; sacrificing always the fourchette; usually the posterior commissure; and commonly severing the transversus perinei and Luschka's fibers of the levator ani; if the sphincter parts, it is practically never at the midpoint. No precise symmetry of laceration ever results—but the end of tension release creates as near a posterior midline gap as is possible in view of the fascial firmness at the raphe and the muscular density of the posterior column of the vagina. *Spontaneous laceration aims at median symmetry but cannot hit the mark.*

The median incision passes through strong instead of weaker structures, relieves tension symmetrically, and provides ideal conditions for symmetrical reconstruction by suture.

The only assailable point in the claim for superiority for the median incision is the risk of injury to the sphincter ani. The writer claims

that this risk is neutralized by thoroughly stretching and paralyzing this muscle before making the incision. A relaxed sphincter cut in the midline is as accessible and manageable for repair suture as though the perineal body were homogeneous.

Before detailing our technic for perineotomy and reconstruction let us emphasize again the extreme value of the procedure in diminishing danger of death and injury to the first born. A long second stage has destroyed innumerable children by prolonged pressure effects and varying degrees of asphyxia. Why should we consider it other than reckless to allow the child's head to be used as a battering ram wherewith to shatter a resisting outlet? Why not open the gates and close them after the procession has passed?

*Technic of Median Perineotomy.*—In a primipara promising spontaneous delivery and at definite establishment of "crowning"—under brief nitrous oxide gas anesthesia—we dilate the sphincter ani to three or four knuckles with sterile gloved hand—a little officinal tincture of green soap may be used as a lubricant. The labor is allowed to resume (gas or ether analgesia, of course, may proceed intermittently) until fissuring in the vagina, fourchette, or posterior perineum is evidenced on inspection, or on note of trickling blood between pains. Such fissuring when observed prophesies an appreciable laceration of some degree—further delay should mean a firm intention of median incision, as there is disadvantage in lacerations plus incision. With the patient completely under anesthetic and the head in recession, a median incision is made with scissors—the most convenient type is the flat, knee-angled Hanks' uterine scissors—carrying the cut an inch or more up the *columnæ rugarum posterior*, and externally nearly to the rectal mucosa. All tissues are severed to the rectal wall except the sphincter ani, and notably by nibbling snips, rather than as in the classical oblique episiotomies by swift incision under tension. A gloved finger in the rectum is an advantage for a guide. The head is then coaxed out under complete control—the patient still anesthetized—either by fundal pressure by an assistant, or in the grasp of short forceps by the operator. This control of exit is absolutely essential to lessen the risk of extending the incision by sudden extrusion, and perchance through the sphincter up the rectal mucous membrane. A guardian mattress tension suture above the anal margin—suggested by Litzenberg—has proved positively useful.

Paradoxical as it may seem I am practising and advocating complete median incision of the sphincter in cases of doubt as to the relative amplitude of the posterior sagittal diameter. Whether wholly or

partially incised, the conditions of symmetrical median repair with sphincter muscle relaxed and not traumatized are so ideal that I find no practical risk of nonunion. Even in the extreme of extension into the rectum, which very seldom need occur, we

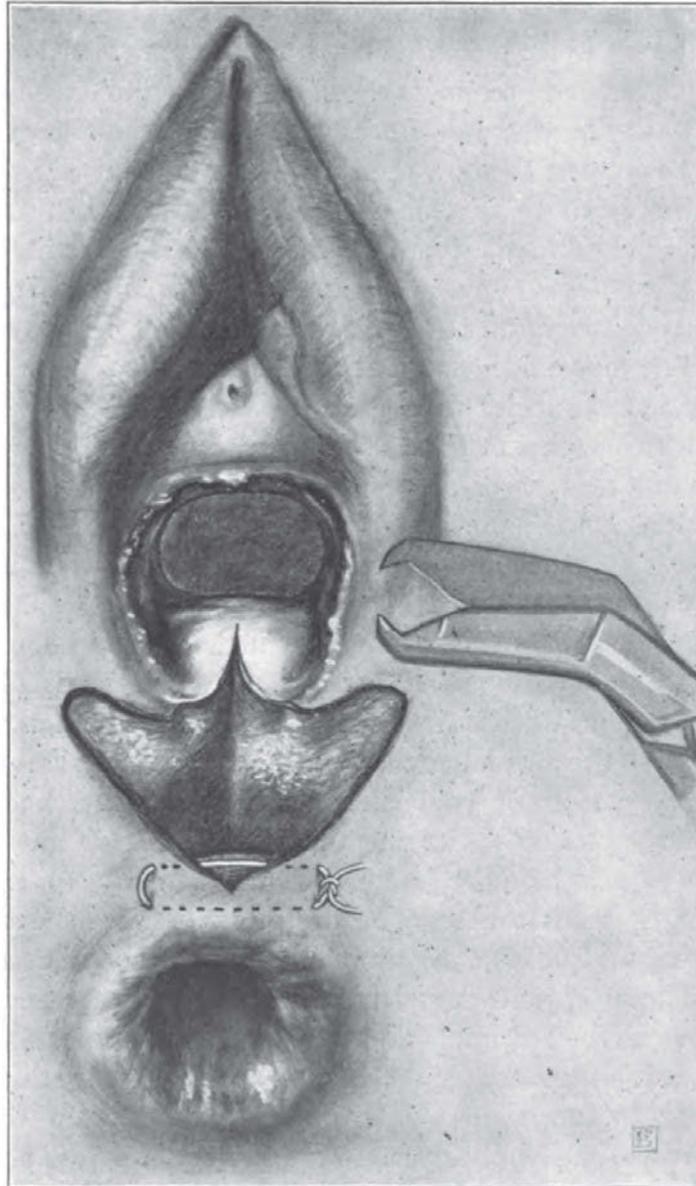


FIG. 1.—Median perinectomy; stretched sphincter; guardian mattress suture.

contend that a temporary capacious cloaca has been created with no damage to the most important and inaccessible fascial anchorages of the pelvic floor. We have all noted the infrequency of prolapsus uteri in association with third degree lacerations of the

perineum. There seems to be here at least presentable evidence that sudden release of tension in the median line tends to save the integrity of the deeper levator attachments and interdependent fascial supports.

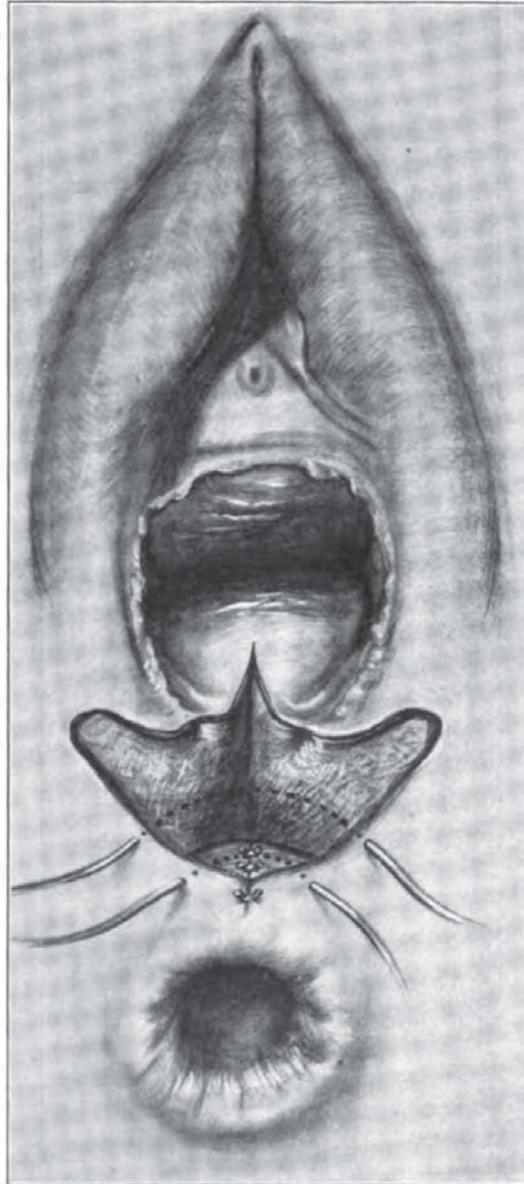


FIG. 2.—Repair sutures for stretched and cut sphincter.

In indicated mid-pelvis forceps extractions and in breech extractions under anesthetics—a judicious stretching of the main sling of the levators can be profitably effected through the rectum while the half hand is dilating the sphincter ani.

The perfect reconstruction of the median perineotomy is so simple as to hardly require description—but a few points of technic have been approved by myself and my associates in Brooklyn.

Chromic catgut No. 1 should be used for all sutures exposed on

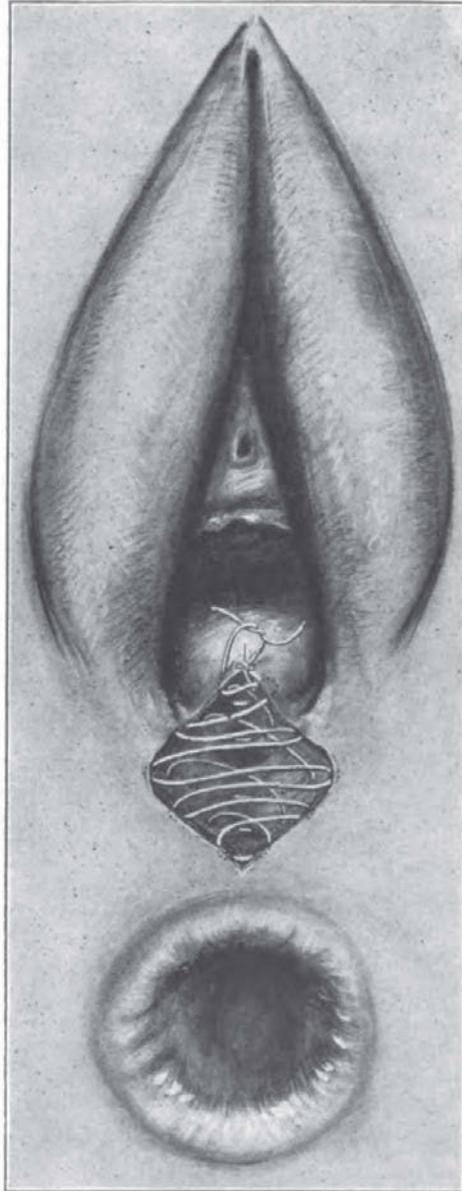


FIG. 3.—Continuous suture for median perineotomy (Dickinson).

skin or mucous membrane and for buried sutures in the sphincter. Plain catgut No. 2 should be used in all fully buried interrupted sutures (except in the sphincter).

In closing the incision in the median column definite care should be exercised to *face up* the vaginal muscle and not merely to close

the mucous membrane edges. Appose the muscles at the median raphé with two or three plain catgut No.1 or No.2 buried sutures. One or two supporting sutures of silkworm-gut may be used as a safety adjunct in sphincter repair.

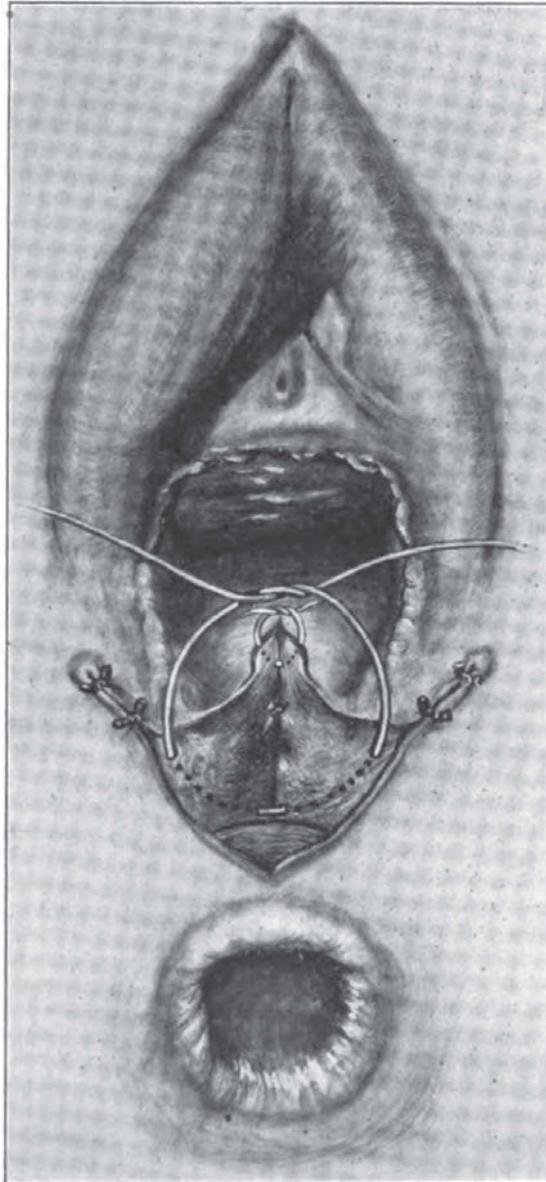


FIG. 4.—Enlarged reconstruction of perinectomy wound.

Dickinson's single strand continuous buried, with return subcuticular stitch, is frequently appropriate.

When healed the conditions reproduce a nullipara. For several years we have carried out this program of incision and repair, with satisfaction.

In the writer's mind, however, runs always a hope to differentiate between the essential risks and typical management of first labor as compared to those of subsequent labors in the same individual. The primipara belongs to the hospital and the expert—the tested

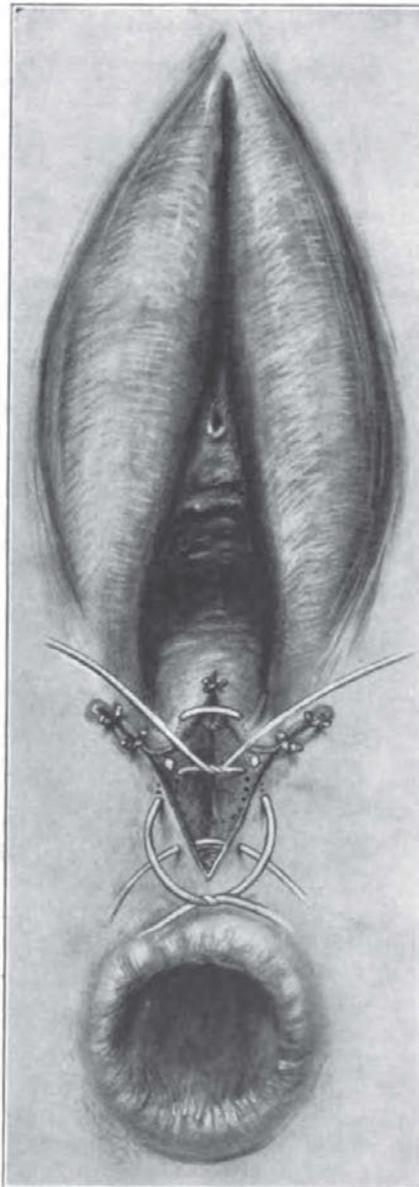


FIG. 5.—Mattress crown-stitch for enlarging perineorrhaphy.

and competent multipara to the home and the conscientious family practitioner.

If we expertly restore the cut perineum of the primipara on the original lines, *has* she been converted into a competent multipara—potentially capable of spontaneous rapid delivery without fresh

wounds? We assume not. Laceration or incision must occur again with the next labor.

Nature's type production of a multipara, in the above sense competent, rests on unrepaired divulsion of the perineum. We must all admit that there are many instances of first or second degree first labor perineal tears, which are not sutured, and which heal partly by contact primary adhesion, and partly by granulation, which do not freshly lacerate at subsequent labors, and yet the patient's disability therefrom is negligible.

Can we by adjustment-suturing of our median perineotomy wound produce uniformly an expanded outlet which will heal *per primam*, prove competent in musculature, and not lacerate at the next delivery? It seems worth experiment.

A tentative suturing technic for a symmetrical expanding perineorrhaphy is shown in the illustrations. We have executed the essential features of this procedure on about thirty cases since January. In the main, primary union has been satisfactory though a small superficial ulcer has persisted in some, when the final mattress purse-string was of chromic catgut. Of late I am using a silk-worm-gut strand for this suture.

It is hoped that this suturing brings together at the raphé the chief muscles severed by incision but that the union will necessarily be less intimate, and that the transverse suturing of the horns of the posterior commissure wounds will eliminate tension bands at the next labor. As sufficient time for labor tests will not accrue for another year or two, I can only offer this proposition as a tentative one, lacking entirely present evidence of favorable "*follow up*" results.

In conclusion I desire to make clear an opinion that the properly executed median perineotomy and repair is advocated at present only for use by the competent gynecological surgeon undertaking the care of a labor case with full operating-room equipment, proper assistants, and an expert anesthetist. Is a primipara ever thoroughly cared for with less provision than this?

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511 NOSTRAND AVE.