

Episioproctotomy

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THE DELIBERATE INCISION into the rectum at the time of vaginal delivery is a procedure in operative obstetrics which has been recognized for more than a decade. It was described as a "complete perineotomy" by D'Errico and McKeogh in 1951,⁴ by Cunningham and Pilkington in 1953³ and by Fleming in 1960.⁸ These authors, and others,^{1, 2} in the interval which has elapsed since the appearance of their reports, reserve the procedure for use when laceration of the perianal structures or the rectum itself appeared to be inevitable. Recently, Wendt and Wolfgram¹³ have suggested the term "episirectomy" which, while more specific, is derived from both Greek and Latin roots. The hybridization in terminology would not alone justify the existence of still another, and a more cumbersome, designation for what is essentially the same procedure.

"Episioproctotomy," however, besides being etymologically homogenous, refers to the elective median incision of the perineum, the anal sphincters, and the rectovaginal septum, not because involvement of these structures by laceration appears to be inevitable, but, specifically, when the added dimensions of the birth canal thus obtained will limit the extent of injury to the maternal soft tissues in the anterior and lateral segments of the urogenital diaphragm.

With the general acceptance by obstetrical surgeons of prophylactic episiotomy, and with the trend favoring the median incision over the mediolateral,^{7, 12} the increased risk of injury to the rectum has diminished with experience.⁶ The advantages of a clean surgical incision instead of

a laceration are as applicable to the repair of the anus and rectum as to that of the perineum.

MATERIAL AND METHODS

Presented herewith is the experience gained in 939 consecutive deliveries, of which 326 were primiparas and 613 were multiparas.

INCIDENCE. Episiotomy was performed 225 times. Of these, 214 were in primiparas, and 11 were in multiparas.

SUBSEQUENT DELIVERY. A total of 83 deliveries occurred in patients who had had a previous episiotomy. Sixty-one of these were delivered for the second time, 18 for the third time, and four for the fourth time. In three patients episiotomy was done for the second time in an ensuing delivery.

There were no complications in any of these cases.

ANTEPARTUM CARE. Unless contraindicated by premature labor or bleeding, a cleansing enema is given routinely on entry.

ANESTHESIA. Continuous caudal analgesia was used in most cases, with a smaller number of low spinals, and in a few instances general anesthesia. No pudendal block was employed.

TYPE OF DELIVERY. The majority of these deliveries was accomplished by low forceps, or "outlet forceps." Breech extraction was performed in 12 cases. There was one set of twins. Spontaneous delivery over an episiotomy occurred nine times.

Digital exploration of the uterus following delivery was not done routinely. When indicated, however, or when manual extraction of the placenta was required, such measures were undertaken prior to commencing the perineal repair.

POSTPARTUM CARE. No particular modification of routine care during the puerperium is observed, although mineral oil, either plain or as an emulsion, and a stool softener are started within 24 hours after delivery. Usually, spontaneous bowel function is established within 48 to 72 hours. Suppositories and enemas when necessary are deferred until the third postpartum day.

Antibiotics are not used unless specifically indicated.

Hospitalization is not notably prolonged. Primiparas are usually dismissed on the fourth or fifth day after delivery, and multiparas perhaps a day earlier.

RESULTS. In the majority of cases, the postpartum course has been satisfactory, with perineal pain being no greater than that following median episiotomy and less than with the mediolateral incision. In the author's opinion, perineal scarring, vaginal stenosis, and dyspareunia

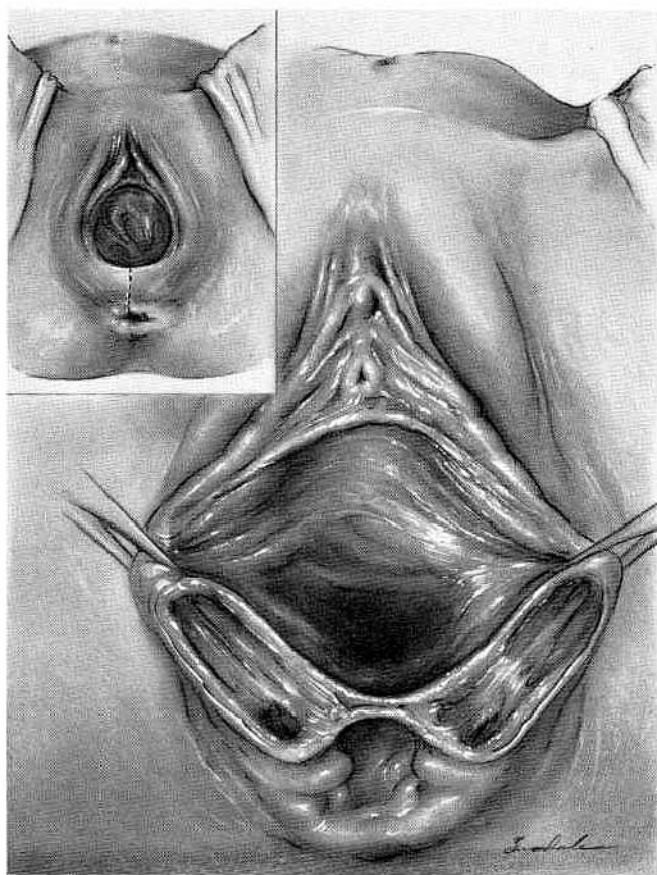


Fig. 1. A median incision is made in the perineum and carried through the anal sphincters and rectovaginal septum.

are less common following episiotomy than after the repair of the customary episiotomy with attendant lacerations.

TECHNIQUE

INCISION. When the patient is ready for delivery, a median incision in the perineum is made with a straight scissors and is carried boldly through the anal sphincters, and approximately 2 to 3 cm. into the rectovaginal septum (Fig. 1). This is done early, preferably before resistance to the delivery of the presenting part is encountered.

REPAIR. The repair is usually done after the delivery of the placenta. A light gauze tampon is placed in the vaginal canal to free the field of bleeding from the uterus. A sponge forceps is applied to each side of the

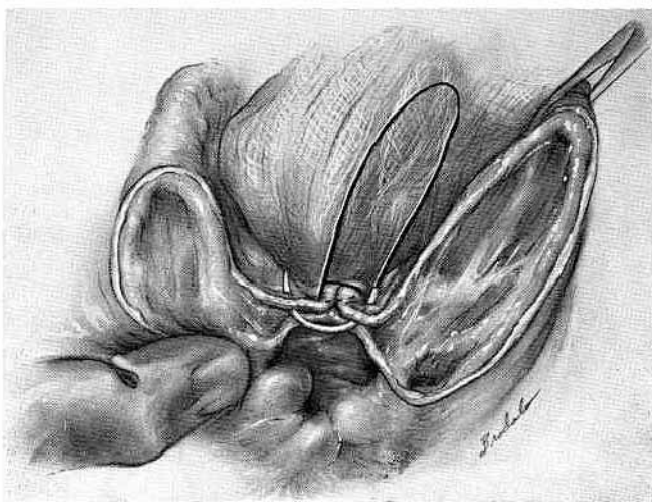


Fig. 2. The first step in the repair is to place a continuous suture through the vaginal mucosa and submucosa, but it does not perforate the rectal mucosa.

perineum and downward traction easily exposes the apex of the recto-vaginal incision. A continuous suture on an atraumatic needle is tied at this point and carried without locking through the vaginal mucosa and submucosa, but not including the rectal mucous membrane, to the level of the hymenal ring (Fig. 2). Thence, it is continued submucosally to the mucocutaneous line in the anal canal, and subcuticularly beneath the perineal skin where it is allowed to remain while the anal and perineal muscles are being approximated. Exposure at the angle of the rectal ampulla just above the anus is important to assure accurate apposition at this juncture, both for the subsequent integrity of the closure and for hemostasis. The retracted ends of the severed sphincters are exposed by traction with Allis forceps and coapted with a figure-of-8 suture which includes the fascial sheaths (Figs. 3; 4, A). Two or three similar sutures are placed in the transverse muscles of the perineum (Fig. 4, B). The continuous suture is then resumed and carried subcutaneously to close the edges of the perineal skin (Fig. 5). At the posterior commissure this serves to complete the repair and the suture is brought out laterally through the perineal skin where it is cut and left untied. Recently, plain catgut has been employed with promising results as described by Shute¹² and in his correspondence with Haufrect⁹ and Whitehouse.¹⁴

COMPLICATIONS

In previous reports no complications followed the elective incision of the anus and rectum.^{3, 4, 8, 13} In this series, however, delayed hemorrhage

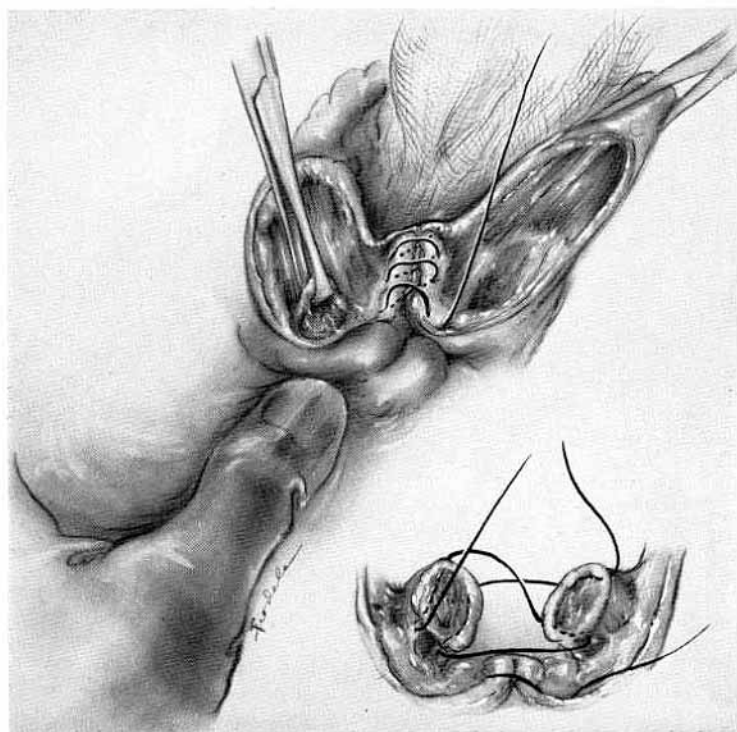


Fig. 3. The severed ends of the sphincters are drawn together with a figure-of-8 suture.

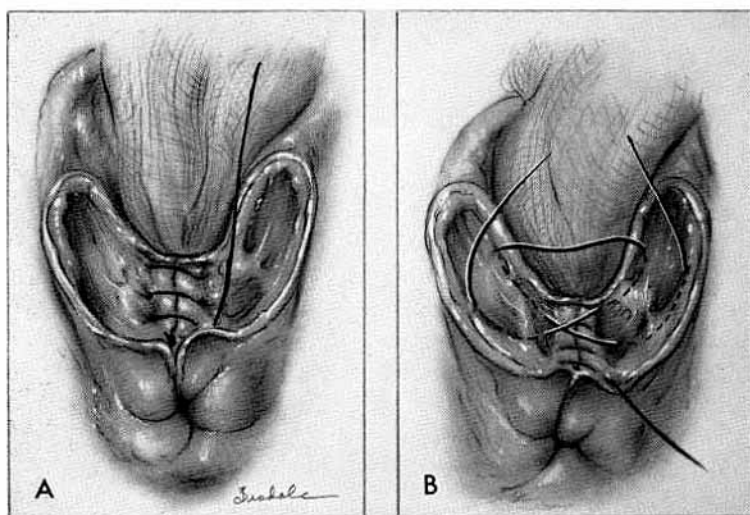


Fig. 4. *A*, The fascial sheaths of the sphincters are approximated. *B*, Figure-of-8 or interrupted sutures are used for the transverse perineal muscles.

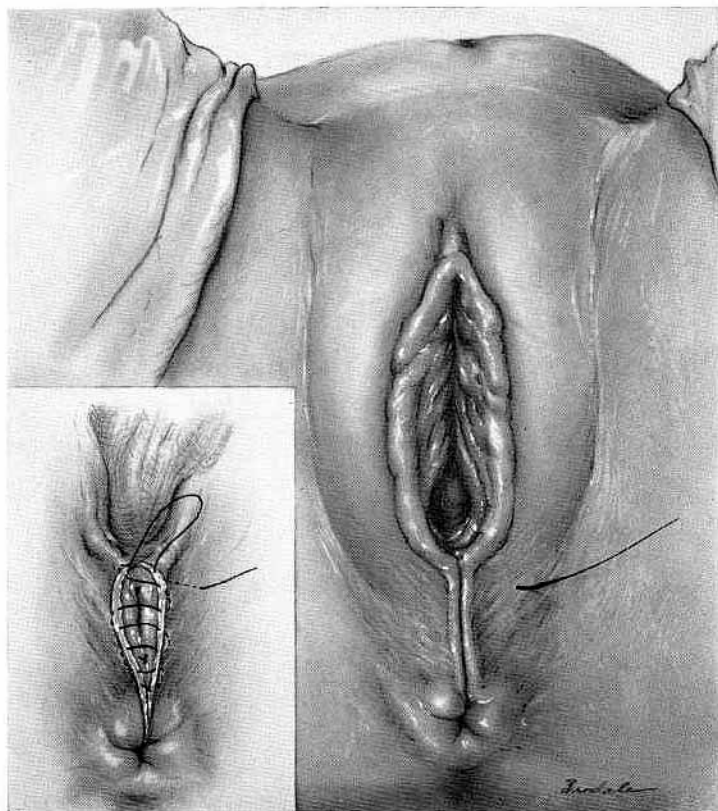


Fig. 5. The continuous submucosal suture is resumed as a subcuticular closure of the skin edges. The end is left untied and protruding from the skin.

from the wound and rectovaginal fistula occurred in a definite number of instances.

HEMORRHAGE. Hemorrhage from the incision occurred 12 times. Secondary suturing was required in seven of these.

FISTULA. Rectovaginal fistula developed in four cases. Each of these will be briefly described since this is the complication which is most feared, and upon which controversy exists. Of the four fistulas, one healed spontaneously, and one appeared three months after delivery as a perineal abscess which drained spontaneously. At present it is a chronic anoperineal fistula. Incontinence of flatus is the only symptom. The patient does not consider that it warrants surgical repair. Fistulectomy with reconstruction of the perineum was required in the other two cases. Results in each of these are satisfactory, although one has a stenotic but competent anal sphincter.

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