Van Lennep (Wm B.)

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A

MODIFICATION IN THE TECHNIQUE OF OPERATIONS

FOR THE

REPAIR OF COMPLETE PERINEAL LACERATIONS.

BY

WM. B. VAN LENNEP, A.M., M.D.,
PHILADELPHIA.

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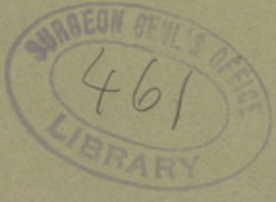

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My experience has been, and I think I reiterate that of most operators, that the principal cause of failure after plastic operations to restore the perineal body when the sphincters and the rectum are torn, is infection through the wound sutures in the gut. If this element of danger could be *positively* eliminated, the operation would be reduced to the correction of an incomplete tear, plus finding and uniting the ends of the sphincters. This danger was impressed upon me very forcibly by a partial failure, a case in which the ends of the sphincter united, but a leak appeared above, producing a sinus which opened on the external surface of the perinæum. Fæcal leakage persisted for a long time, and the integrity of the perineal body was considerably impaired.

With this case fresh in my mind, I was called upon about a year ago to repair a very bad tear, the worst one I have ever met with, which completely destroyed the perineal body, extended up the vagina, almost reaching the cervix, with prolapse of the rectal mucosa at a point well up, and went through both the rectal sphincters and about two inches of the bowel. There was such incontinence of fæces that the patient was unable to walk about without soiling herself, and with this was associated a complete prolapse of the uterus. Remembering the ease with which the rectal mucous membrane can be drawn down after resecting "the pile-bearing inch" in Pratt's operation, it occurred to me that I could use this

as a septum to *positively* shut off any wound infection from the bowel side. The rectal mucous membrane was accordingly loosened by an incision with scissors along the triangle running up the bowel, its edges seized with T-forceps, easily drawn down and held well over the anus by the mere weight of the instruments. There remained then but the ordinary operation for a complete tear *minus* the stitches tied into the rectum. The edges of the rectal triangle were freshened and united by buried sutures of catgut; the torn ends of the sphincter were exposed and brought together in like manner; the oblique cicatrix was dissected out and the gap sutured (posterior colporhaphy), and a new perineal body formed by the flap-splitting method. Of course, the two halves of the flap had to be united in the centre within the vagina.

The perineoraphy completed, the T-forceps were removed, and the drawn-down rectal mucous membrane was allowed to retract and stitched to the anterior or *new* half of the anus. The result has been perfectly satisfactory; the uterus is supported; there is a good, firm perinæum, and the sphincter is completely restored.

I have since had two opportunities of testing this operation with very satisfactory results.