

THE MODE OF INCISION IN VAGINAL SECTION.*

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In carrying out operative procedures which involve opening the peritonæal cavity by the vaginal route the most constant difficulty is the smallness of the space in which the manipulations are made. This

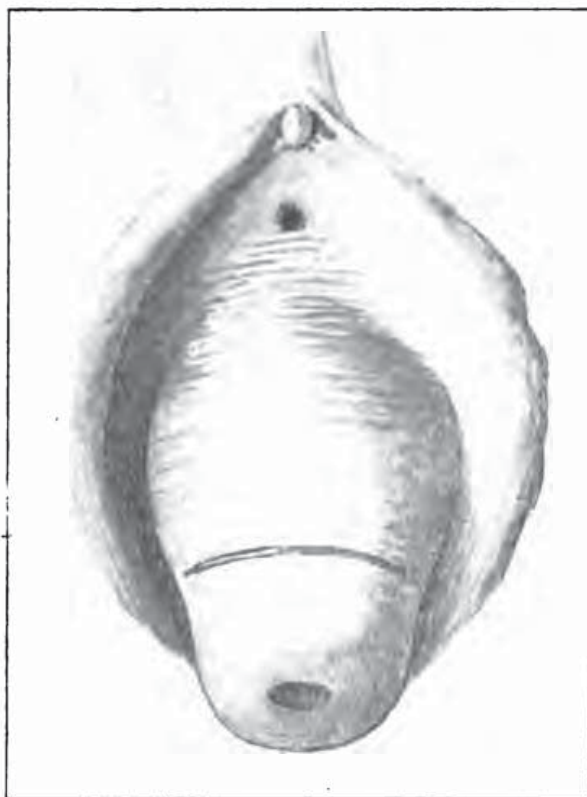


Fig. 1. Anterior Colpotomy Incision of Dührssen and others.

difficulty is particularly aggravating in dealing with ovarian and tubal conditions.

Various forms of incision are employed, the patient in all cases being in the lithotomy position, and the vagina being opened as much as possible by means of retractors.

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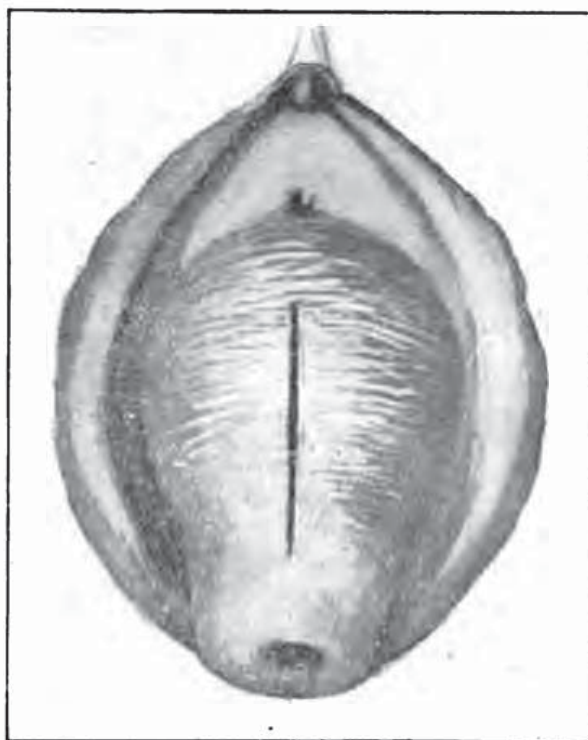


Fig. 2. Anterior Colpotomy Incision of Orthmann and others.

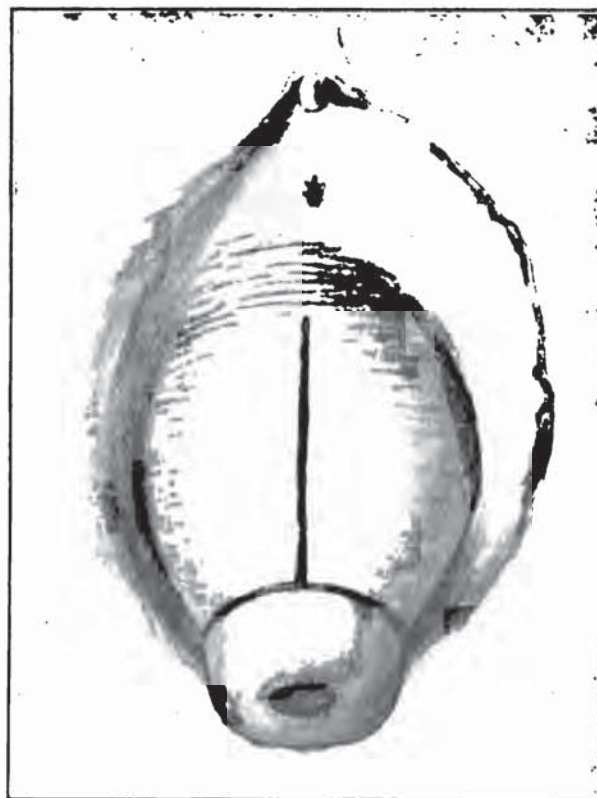


Fig. 3. Anterior Colpotomy Incision of Mackenrodt and others.

1. *Posterior Colpotomy.*—The cervix is drawn downward and forward as much as possible, and a transverse incision, an inch or more in length, made through the posterior fornix, so as to open the lowermost position of the pouch of Douglas. This method is much less employed than anterior colpotomy. It is chiefly used in exploring

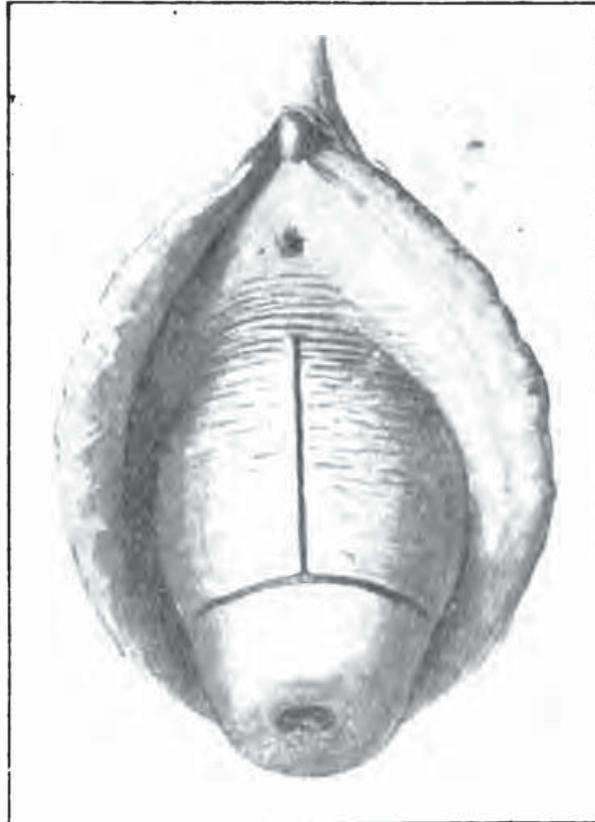


Fig. 4. Webster's Anterior Colpotomy Incision.

the pouch of Douglas, in breaking up posterior adhesions and in opening fluid collections in the pelvis; very rarely for other purposes.

Anterior colpotomy is much more frequently employed for operations on the uterus and appendages. Various forms of incision have been employed.

1. *Transverse.*—Dührssen and others have recommended a transverse incision in the anterior fornix below the junction of the bladder and cervix an inch or more in length. The cervix being pulled down-

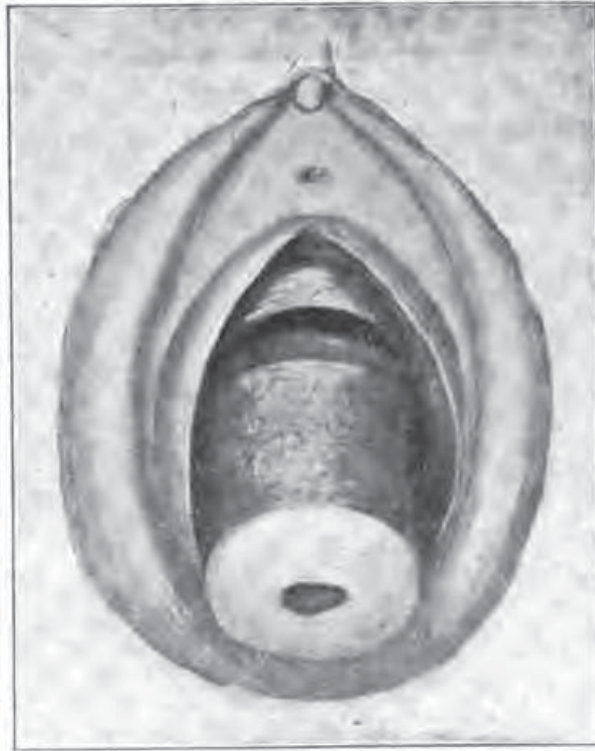


Fig. 5. Webster's Anterior Colpotomy. The Vaginal Wall is dissected from the Cervix and the Utero-vesical Pouch of Peritonæum opened.

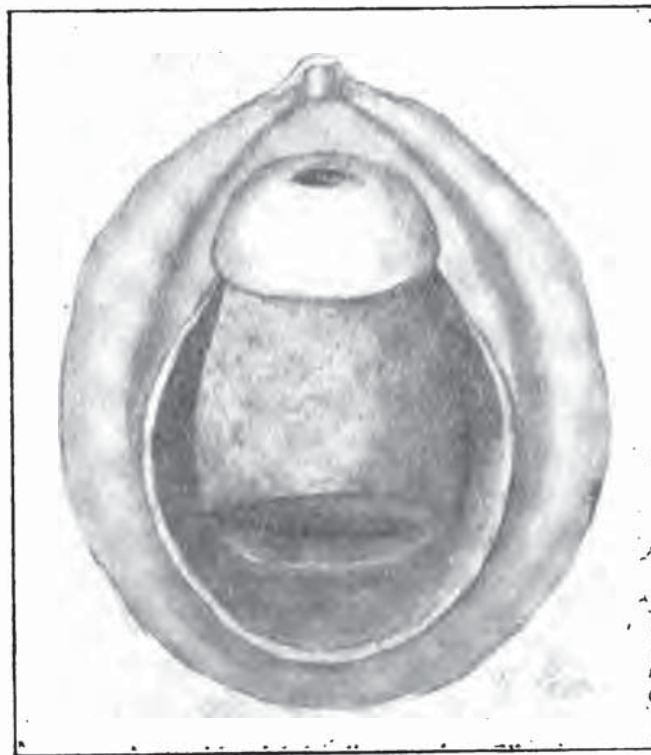


Fig. 6. Webster's Anterior Colpotomy combined with a Posterior Incision. This drawing represents the Vaginal Wall dissected upwards from the Cervix and a Transverse Incision made in the Pouch of Douglas. Digitized by Google

ward and backward, the bladder is stripped from the cervix and anterior vaginal wall through the incision and pushed upward. The utero-vesical pouch of peritonæum is then opened.

2. *Mesial*.—Orthmann and others make a mesial incision through the anterior vaginal wall extending from the junction of the latter with the cervix an inch and a half or more.

3. *T-shaped Incision*.—Mackenrodt makes a transverse incision

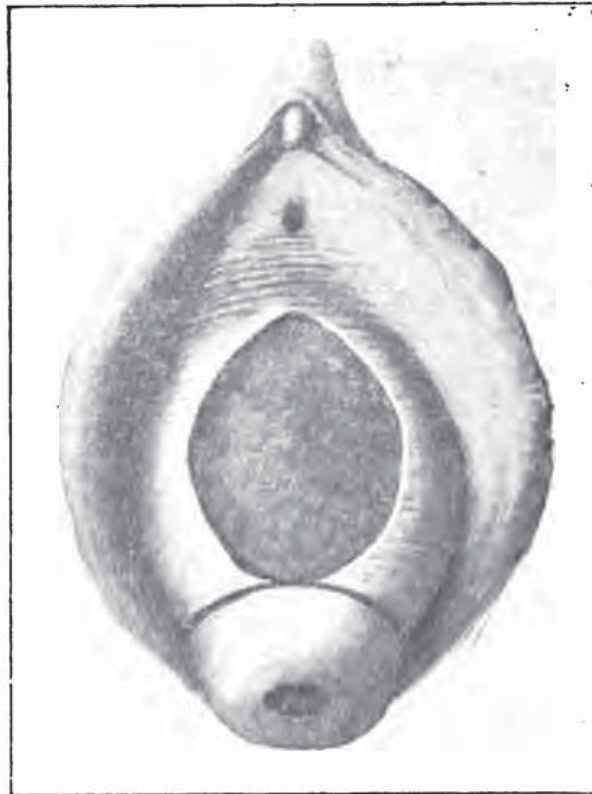


Fig. 7. Webster's Anterior Colpotomy combined with Anterior Colporrhaphy. An Oval Flap of the Anterior Vaginal Wall is removed at the Beginning of the Operation.

like Dührssen's and another mesial one at right angles for an inch and a half or more through the anterior vaginal wall.

4. *Webster's Method*.—The author makes a circular incision around the cervix just below the attachment of the vaginal wall. This is joined by a mesial incision an inch and a half or more in length, dividing the anterior vaginal wall. The cervix being well pulled down, the wall of the vaginal vault is stripped upwards until the anterior peritonæal pouch is reached. The anterior vaginal wall is also



Fig. 8. Webster's Anterior Colpotomy combined with Anterior Colporrhaphy. After the Removal of the Anterior Vaginal Wall Flap, the Rest of the Wall is stripped from the Cervix and the Utero-vesical Pouch of Peritonæum opened.



Fig. 9. Webster's Anterior Colpotomy combined with Anterior Colporrhaphy and Amputation of the Cervix. The Cervix is represented as split prior to Amou-

stripped somewhat from the base of the bladder. The utero-vesical pouch is then opened.

The advantages of this method over the others are that the uterus can be pulled down to a greater extent and that more room is obtained for intra-pelvic manipulations. Sometimes the latter may be facilitated if an additional transverse incision be made through the pouch of Douglas. Frequently when the uterus is considerably enlarged

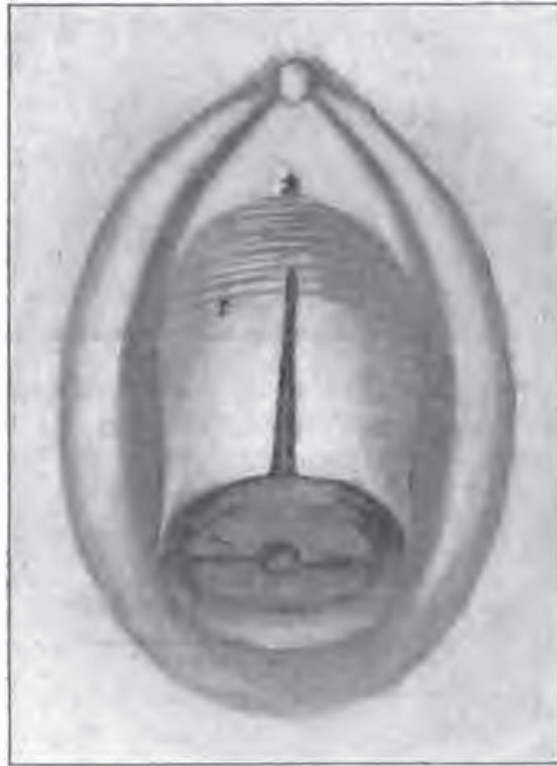


Fig. 10. Webster's Anterior Colpotomy combined with Amputation of the Cervix. The Stump of the Cervix is represented surrounded by the Vaginal Flap.

from chronic metritis it is advisable to ligature one or both uterine arteries (easily exposed in the raw surface already made).

When the enlarged uterus cannot be well brought down its descent may be assisted if the base of one or both broad ligaments be divided internal to the ligatures.

At the end of the operative procedures, the uterus is pushed into place, the peritonæum closed and the original vaginal incisions closed with chromic catgut.

When amputation of the cervix is called for in addition to the colpotomy this procedure is carried out after the closure of the peritonæum and the vaginal flaps are then brought over the stump of the cervix and stretched to the margin of the cervical canal. When, however, the size of the uterus is a hindrance to its descent, amputation should be carried out after the vaginal wall is stripped up.



Fig. 11. Webster's Anterior Colpotomy with Anterior Colporrhaphy and Amputation of the Cervix. The Cervix and Vagina are represented as They appear at the End of the Operation.

Less of the vagina is then occupied by the organ when the body is pulled down and greater access to the pelvis may be obtained. The stump of the cervix in such a case is covered by the vaginal flap at the end of the operation.

When anterior colporrhaphy is required the necessary flap is removed when the first incision is made. The closure of the raw surface thus produced is brought about by means of continuous catgut suture at the end of the entire operative procedure.