HIGH RECTOCELE AFTER PERINEAL REPAIR.*

BY

ROBT. L. DICKINSON, M. D.

Brooklyn, New York.

Gynecologist to Brooklyn Hospital; Consulting Gynecologist to St. Mary's Hospital, Jamaica; Obstetrician-in-Chief to Methodist Episcopal Hospital.

(With Seven Illustrations.)

FULL-SIZE outlines plotted from the ano-rectal canals of living subjects and the charted topography of certain bulging recto-vaginal septa some months subsequent to plastic work on the pelvic floor have served to indicate to the writer some of the reasons for rectocele, and for the percentage of his failures.

The factors in the production of rectocele seem to be:

1. Laceration or lack of tone in the fascia and muscles of the pelvic floor.

2. Injury to the muscular layers of the rectal wall, or defective activity of such layers.

3. Defects in conformation of the rectum, or in the axis of the rectal canal, or of the anal canal, or both.

4. Obstruction from vigor or irritability of the sphincter.

Postmortem observation of the configuration and tonicity of the rectal and anal canals is inconclusive because death effaces many data. Anesthesia, also, relaxes and falsifies. It is only on the living patient that form and direction may be studied fairly, and these are the methods:

(1) The rectum is distended with air and viewed with specula, either in the knee-chest posture or in the lithotomy posture with lowered head; (2) by digital touch; (3) by tracing tape or wire—the resultant measurements and angles being plotted on a full-size sketch.

With loosened waist bands, in the knee-chest posture, a tubular rectal speculum is passed. Say it is five inches long and a scant inch in outside diameter, and bears a mark at every inch. At three inches its tip is seen to impinge on a large valve, whose left edge is just at the left margin of the opening. One makes this mental note. The inner opening of the speculum swings two of its diameters to the right before reaching the lateral

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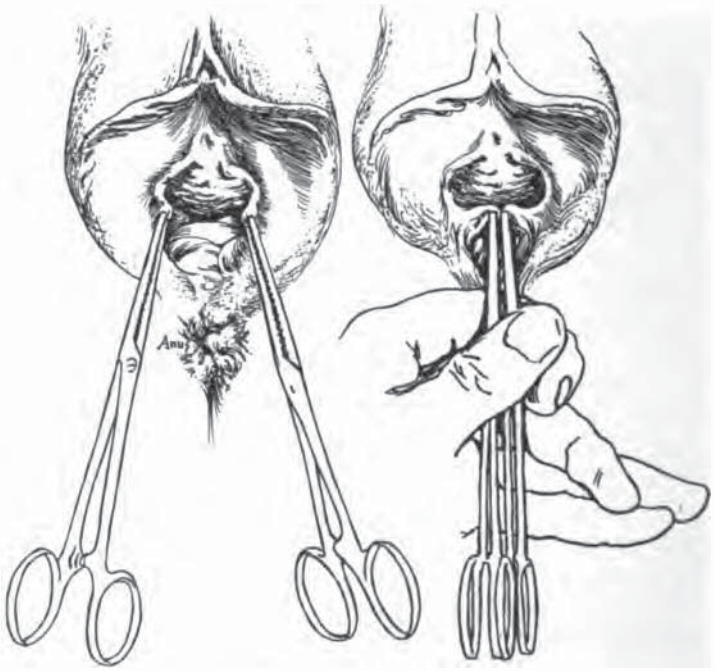
rectal wall. These are two sample measurements. To record them a rectangle 1 x 5 inches is drawn on the history card to represent the speculum tube. Then one enters the two topographical marks noted above, one at the left margin, three inches from the lower end, the other two diameters (two inches) to the right of the right hand line. Five or six points thus determined give a definite outline, lateral and antero-posterior.



FIGS. 1 and 2.

The visual findings are confirmed by the rubber-covered finger, the patient lying on her back. Passed slowly through the anus to study the sphincter, two phalanges are next hooked forward to estimate the position and resistance and thickness of the recto-vaginal septum and perineal pyramid, both quiescent and under strain. Thus the ballooned rectum can be plotted, and an idea obtained of what distention will do to its walls, and where the weak or unsupported points are. Resistance to the tubular speculum on the part of the sphincter calls for a smaller tube, such as the largest Kelly tubular cystoscope.

The ordinary rectal bivalves exhibit little more than anal mucous membrane, and are mostly painful to use.

If one wishes to make a more complete record the lead tape or solder wire is laid along the median contour of the pelvic floor from mons to sacrum. Little slides run on it. These are to be stopped opposite certain points, such as coccyx, anus, fourchette and the crest of the rectocele. A loop is run up into the vagina to determine its axis or follows the curve of the pro-

FIG. 3.

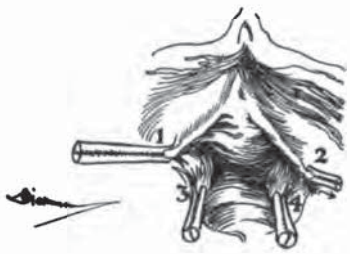


FIG. 4.

truding septum. A tracing from this tape or wire furnishes the basis on which the antero-posterior section is built up from the first two sets of observations. These measurements and methods are chiefly of scientific interest. The practical clinical point of them is that without digital rectal study of the septum no idea can be gained of the extent of the repair required.

PREVENTION OF OCCURRENCE OF HIGH RECTOCELE AFTER OPERATION.

I. Digital rectal examination of septum before anesthesia.

II. Identification of structures at operation, and high apposition.

III. After-care.

I. At the examination in the office or clinic where the pelvic floor injury is recognized (or on the table *before* anesthesia), the conditions of the recto-vaginal septum and the fascial and

muscular conditions must be looked for. It cannot be done after the woman is under ether and all the structures are flabby. Our failures come largely from trying to guess, with a patient's tissues flaccid, what the muscles awake in pelvic floor and rectal wall will do. The gloved hooked forefinger must drive forward on this rectal wall and gain knowledge of its functional activity. Study of individual cases will put an end to some of our discontent with results. I own to being far from a hundred per cent. content with mine.

II. Having determined before giving ether how high up the weak spot on the septum extends, and where the muscle edges

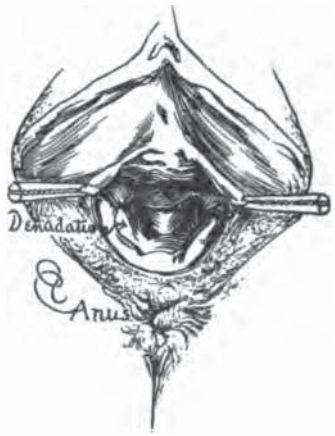
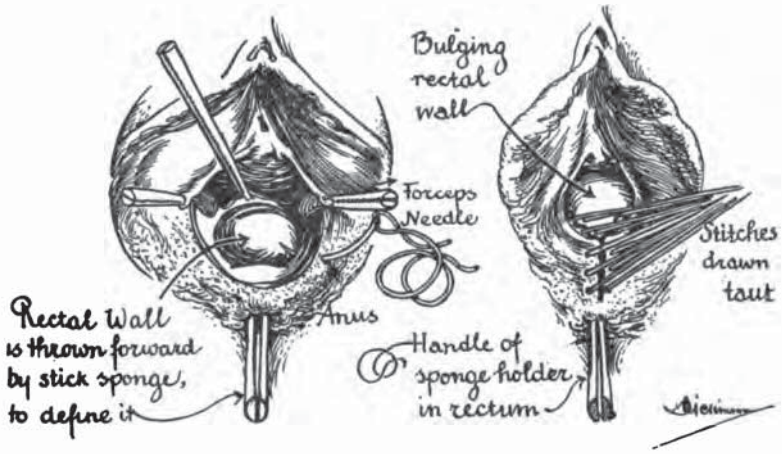


FIG. 5.

are, we must have a handy method, first, to *estimate the amount of denudation required*, and, second, after denudation, to differentiate rectal wall from fascia edge and muscle bundle. To size up the surface to be made raw no method heretofore proposed seems to me to be better than this. A Kocher artery clamp seizes the lowest recognizable end of the hymen on one side; another seizes the other side. The tips of the two are brought together over two fingers laid in the introitus. The seizures are shifted until a snug fit is obtained. The pair of clamps is then dropped, remaining in place. A second pair makes the same two-finger-two-clamp test, seizing the lateral walls of the vagina. A fifth clamp catches the furthest spot on the rectocele, if needed. The knife sketches the outline of the area to be denuded, running from clamp tip to clamp tip, median to the tips. After denuding, the clamps may be removed

or the outer (hymen) clamps may be retained to open up the vulva.

To differentiate fascia edge and muscle bundle from rectal wall the following procedure works well and is safe from contamination, as the guiding finger in the rectum never can be. Also, it gives a more rotund bulge to the rectal wall than the finger-tip. A gauze ball sponge on a sponge holder (usually called "a stick") is passed into the anus and is pressed forward by an assistant in such fashion that the rectal wall bellies forward. Right and left of this hemisphere one searches, as the assistant alternately pushes up and drops back his stick sponge,



FIGS. 6 and 7.

for the exact edge where rectal wall is no longer mere rectal wall, to know the line where the needle must pass. The upper edge of a sound sphincter is readily found, but the lateral structures, withdrawn toward the tuber ischii for years, are shy and elusive. The stitches are placed, clamped long and laid aside. When the upper stitches have been placed, but *before tying any*, the stitches are drawn upon so that the raw surface is closed over. Now comes the real test. The ball sponge in the rectum, simulating the lower end of the fecal column, tries to press past and climb over the obstruction placed by the taut stitches. If it cannot, neither will the battering ram of constipation. If the sponge eludes the upper line and readily pouches thin recto-vaginal septum over the top of the new defenses, we must denude higher.

If the whole barrier yields, no fascia and muscle have been drawn inward,

III. *After-care.*—The woman who is endowed with strong muscle and taut fascia, whose injury is recent, whose peristalsis is trustworthy, and whose trunk girdles are not worn too snug, will need no special warning. Walking in two weeks and working actively in four and intercourse in six will cause no damage. Among four classes, however, a good operation may fail of permanency because of neglect to lay down special regulations and definite dates.

1. Women over fifty, or those of any age whose tissues are over fifty. The old scar yields. Very moderate, repeated strains cause it to give way.

2. Women coming to us with pelvic floors atrophied, whether from severe injuries or long postponement of repair or general flabbiness—these furnish no bulk wherewith to build adequate barriers, or else no rubber quality to give and come back under stain.

3. Those with chronically ballooned rectums.

4. Those with resistance at the anal opening.

The special precautions demanded for pronounced cases of the above groups are as follows:—

(a) Prolonged convalescence; three or four weeks on bed or couch or easy chair.

(b) A daily evacuation, of soft consistency, and without straining; say by means of a four to eight ounce oil enema at bedtime, to be retained until morning.

(c) Low intraabdominal tension, for three months, by avoidance of snug corsets, whether straight-front or other, or health waists, tight bands or heavy skirts, and care in bending or stooping or straining when wearing any waist constriction.

(d) Overcoming of irritability or sensitiveness or undue vigor of the sphincter, and watchfulness against blockade where there is an anal canal at an acute angle to the thrust of the rectal fecal column.

168 CLINTON STREET.