

TECHNICAL MEMORANDA.

(Under this heading will be published from time to time notes on points of practical interest in regard to methods of treatment, operative and therapeutic, and on the general management of Obstetrical and Gynæcological cases in hospital and private practice.)

On the Technique of Amputation of the Vaginal Cervix.

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THE chief difficulty in amputation of the vaginal cervix is to approximate satisfactorily the mucous membrane covering the vaginal surface to that lining the canal.

The difficulty arises first because of the great difference in the circumference of the edges to be brought into apposition, and secondly because sutures passed through the cut edges of the cervical canal are difficult to insert and when inserted are very prone to cut out.

Schroeder's technique, which is that commonly adopted, and in which two wedges of tissue are excised from the anterior and posterior lips respectively, is faulty because it leaves behind a considerable area of the "erosion" so commonly present in these cases.

For some years I have carried out a procedure which enables the surgeon to attach the mucous membrane of the vaginal surface to that of the cervical canal both accurately and strongly.

The method is as follows:—

Step 1. The cervix is amputated by antero-posterior flaps, as indicated in fig. 1. These flaps at first consist of mucous membrane only, but towards their base include the tissue of the cervix.

Step 2. A chromicised or tanned catgut suture is inserted through the apex of the anterior flap and tied there so that the two free ends are of equal length.

Step 3. The needle still attached to one end is now inserted just within the margin of the cervical canal and passed *through the whole thickness of the cervix* to emerge in front just below the reflection of the bladder. (Fig. 2.)

The other free end of the suture is now threaded onto the needle which is passed similarly but somewhat to one side of the first track.

Step 4. Traction on the two ends of the suture is now made with the result that the flap rolls over until its apex approximates to the anterior margin of the cervical canal. (Fig. 3.) When this result is attained the two ends of the suture are tied together so as to fix the flap in this position.

Step 5. A similar method of suture is now applied to the posterior flap which is rolled in and approximated to the posterior margin of the cervical canal. (Fig. 4.)

Step 6. There now remains a gap on either side of the situation of the new *os externum*. This is closed by interrupted catgut sutures passed deeply through the cut edges of the mucous membrane and the cervical tissue underlying it. (Fig. 5.)

The method is very quickly and easily performed. The only possible accident would be the passage of the needle into the bladder when inserting the anterior approximating suture. This should not happen. Where the cervical tissues are very tough a strong needle is required. Figure 6 shows diagrammatically the principal of the approximating sutures.

DESCRIPTIONS OF FIGURES.

Fig. 1. The line of the incisions for the flaps.

Fig. 2. Passing the anterior approximating suture.

Fig. 3. Traction on the ends of the anterior approximating suture enfolds the anterior flap.

Fig. 4. Traction on the ends of the posterior approximating suture enfolds the posterior flap. The anterior approximating suture is tied.

Fig. 5. The lateral sutures.

Fig. 6. The principal of the approximating sutures shown diagrammatically.

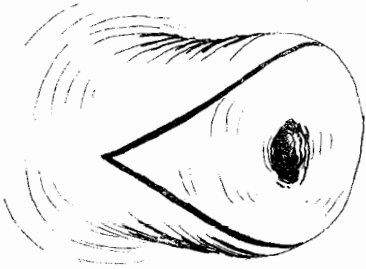


Fig. I.

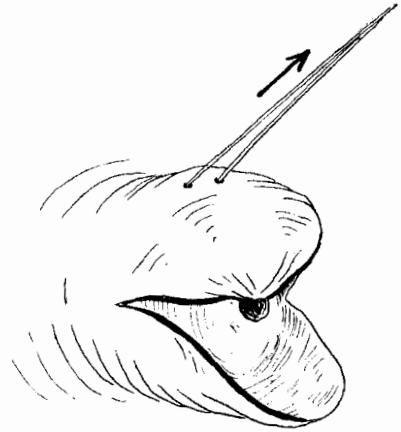


Fig. III.

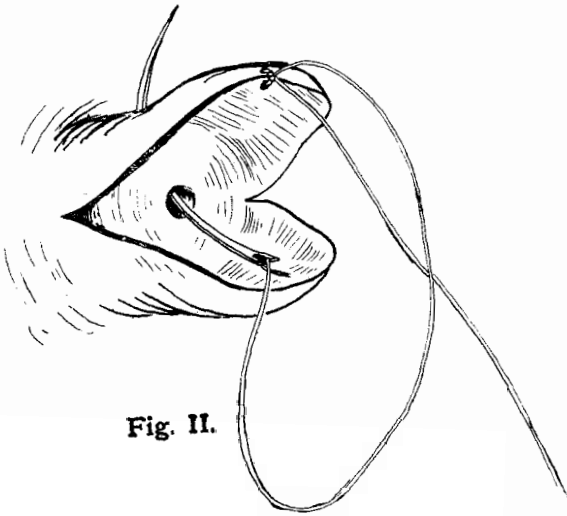


Fig. II.

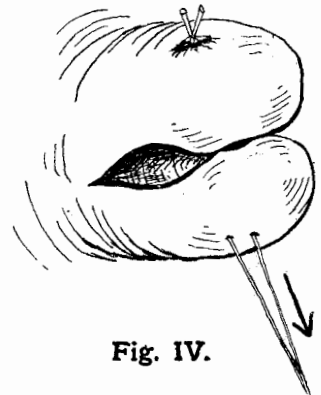


Fig. IV.

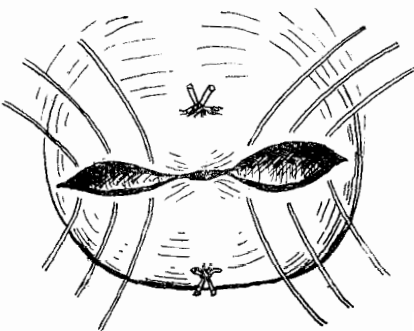


Fig. V.

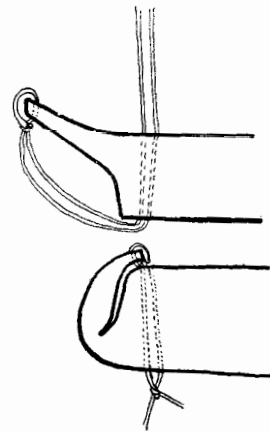


Fig. VI.