Anterior Colporrhaphy.

The operative technic of anterior colporrhaphy varies with the object of this operation. In the great majority of cases it is

[1] Charles P. Noble. A Contribution to the Technic for the Cure of Lacerations of the Pelvic Floor in Women. *Amer. Gyn. and Obstet. Journal*, New York, 1897, T. X, p. 413.
[2] Ziegenspeck, *Centr.-Bl. f. Gyn.*, Leipzig, 1899, p. 1251.
[3] P. Duval and R. Proust, Technique de la suture des muscles releveurs de l'anus au cours de la périnéorraphie. *Presse médicale*, Paris, November 22, 1902, p. 1120.
[4] Pierre Delbet, Périnéorraphie par interposition. *Bull. et Mém. de la Soc. de Chir.*, 1902, p. 1092.

done for an anterior colpocele with concomitant cystocele. The following is the operative procedure:

Extensive Anterior Colporrhaphy for Colpo-cystocele.—Commence by exposing and drawing on the anterior vaginal wall by traction forceps. A pair of forceps is placed on the anterior lip

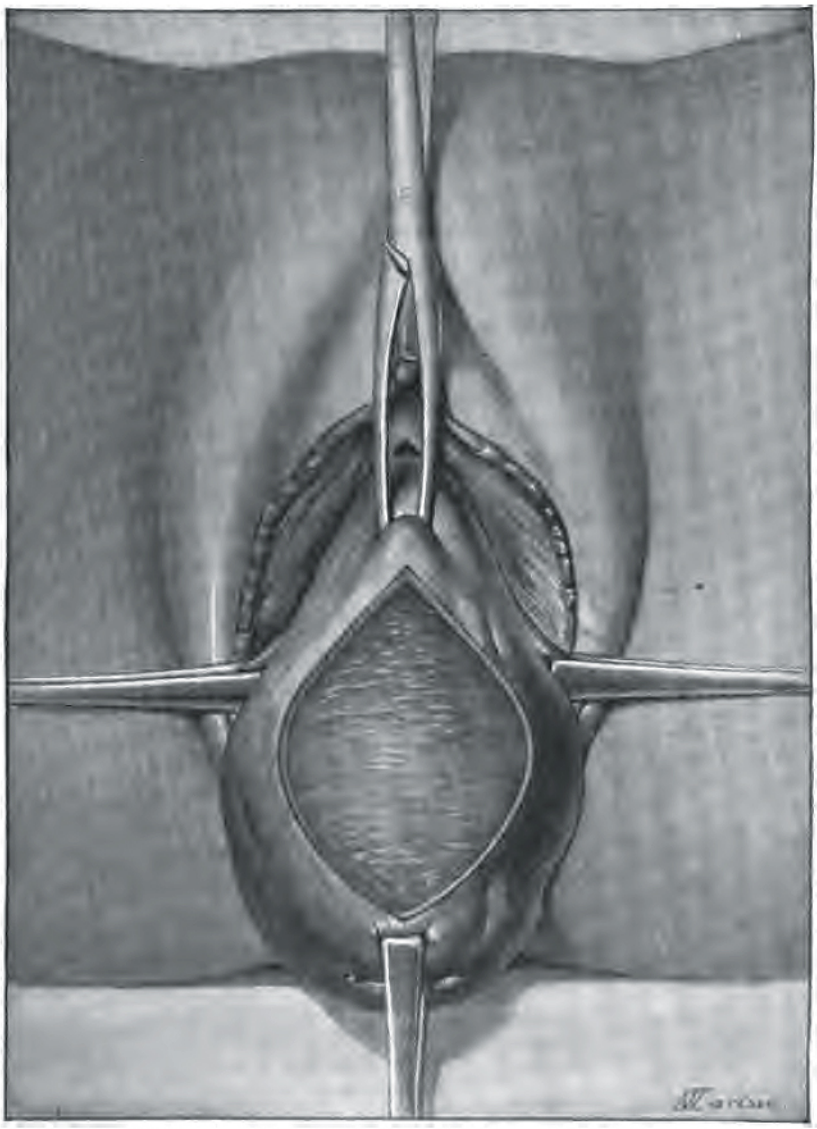

FIG. 130.—Denuded surface in anterior colporrhaphy.

of the cervix, which is drawn down and back toward the fourchette; with a second forceps, median like the first, one seizes the vaginal mucous membrane immediately below the urethral meatus. Finally, two forceps symmetrically placed fix the lateral vaginal wall at equal distance from the upper and lower forceps.

After having *stretched* the anterior *vaginal wall*, trace with a bistoury the elliptical-shaped flap, cutting the whole thickness of the vaginal mucous membrane but not interfering with the vesical wall. Then dissect up the flap, beginning at the anterior angle. The commencement of the dissection at the level of the urethral

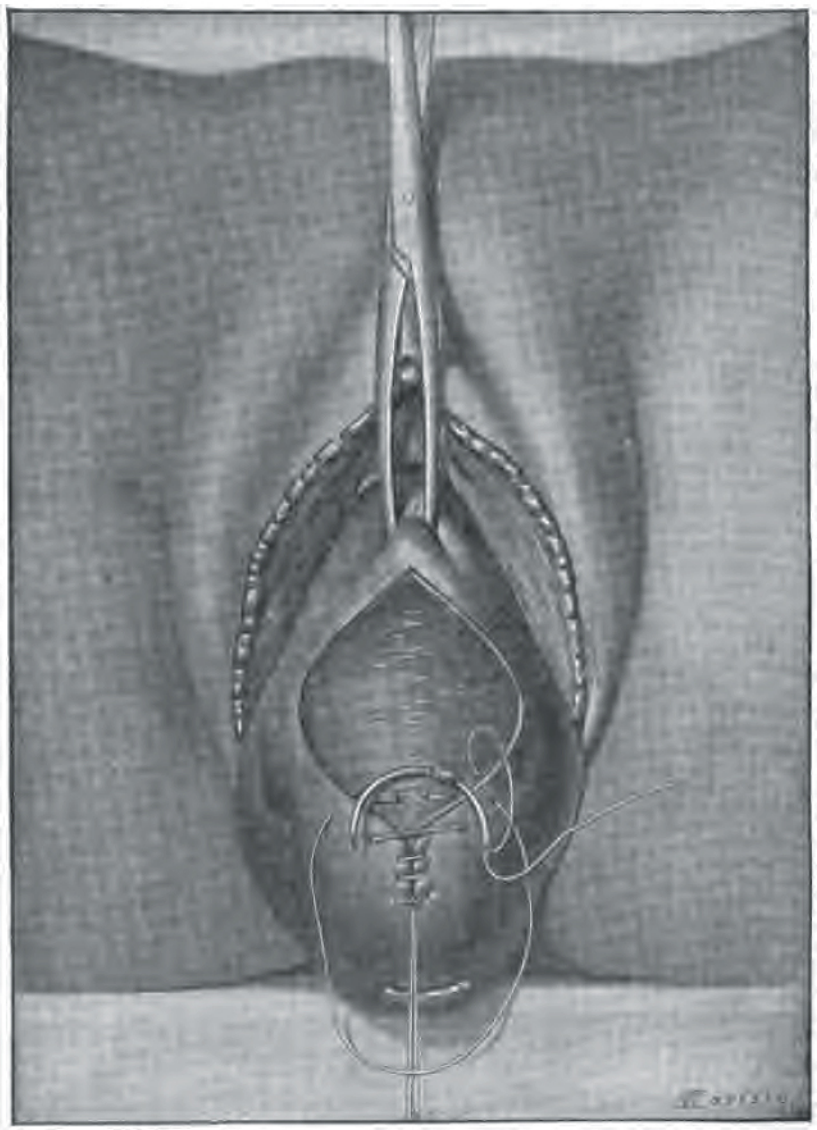

FIG. 131.—The continuous suture commences near the cervix. Hagedorn's needle takes up the denuded surface.

wall is a little delicate because the vaginal mucous membrane is bound to the deeper fibrous tissue. But when one reaches the vesico-vaginal septum, the separation is easy and the bistoury no longer required. It only remains to hook up the free anterior

part of the flap with the index finger and thumb of the left hand and *denude by simply rolling back the parts* which separate easily. The denudation is performed first in the median line and then laterally, until the flap is quite detached. This method is preferable to that of scissors or bistoury. There is less chance of injuring the bladder because one works in a favorable plane of cleavage, and the hemorrhage is less. It is also more rapid which is of importance in anterior colporrhaphy, as generally it is one feature of a more complex operation.

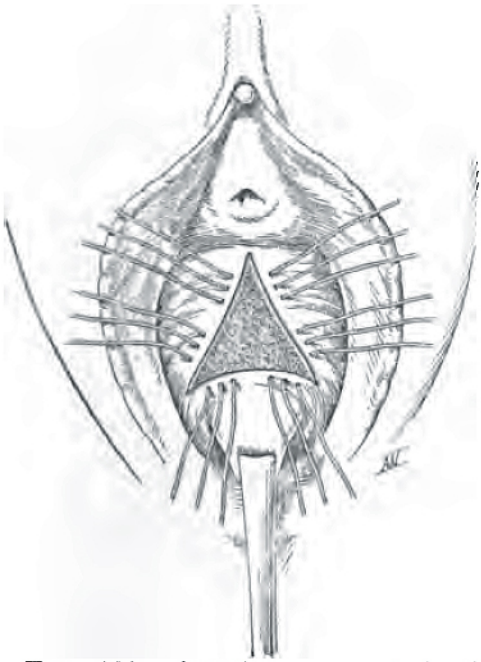

FIG. 132.—Anterior pre-cervical colporrhaphy. Denuded surface, stitches are inserted.

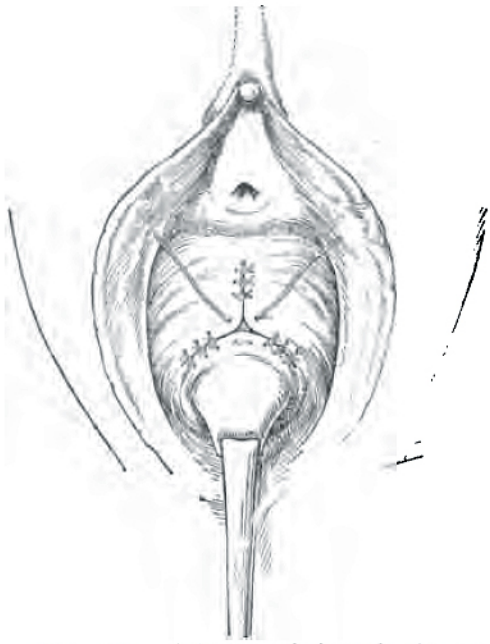

FIG. 133.—Stitches tied with the exception of the last purse-string suture which will close the original center of the three-branched star.

Union is obtained as in all plastic operations. The needle should penetrate below the denuded surface.

We use catgut in place of non-resorbent material such as silkworm gut and silver wire, as removal after contraction is so difficult, seeing that colporrhaphy is so often combined with perineorrhaphy. We prefer the continuous suture which is more rapid. This is done easily with a medium Hagedorn's needle which one can take in the hand. Important to remember is that we commence by the inferior extremity (cervical) and progress to the superior extremity (urethral). The parts are brought together when sutured and the non-sutured portion remains

easily accessible. If, on the contrary, one commences at the urethral extremity, the contraction of the anterior part of the vagina would interfere with the passage of the sutures.

Most often a single suture plane is enough; when the degree of the cystocele has led the operator to do an extensive denudation, the tension of the tissues forces a suture by stages; its execution is easy. Begin with a premier line of stitches which are introduced

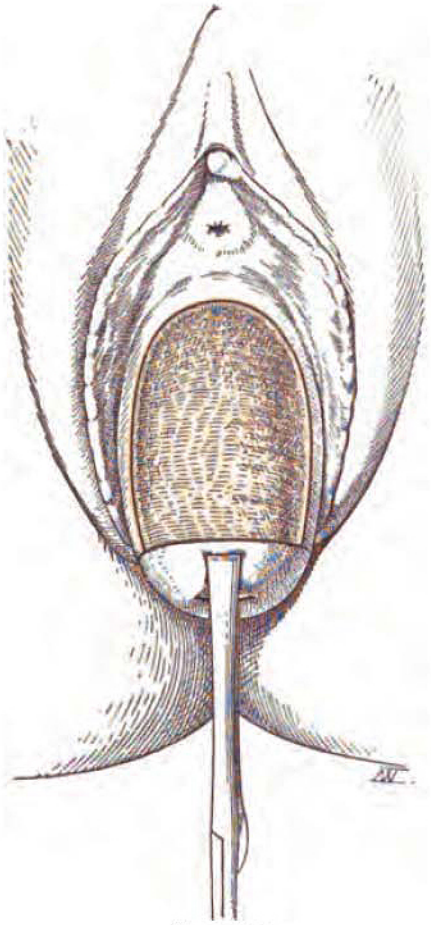

FIG. 134.

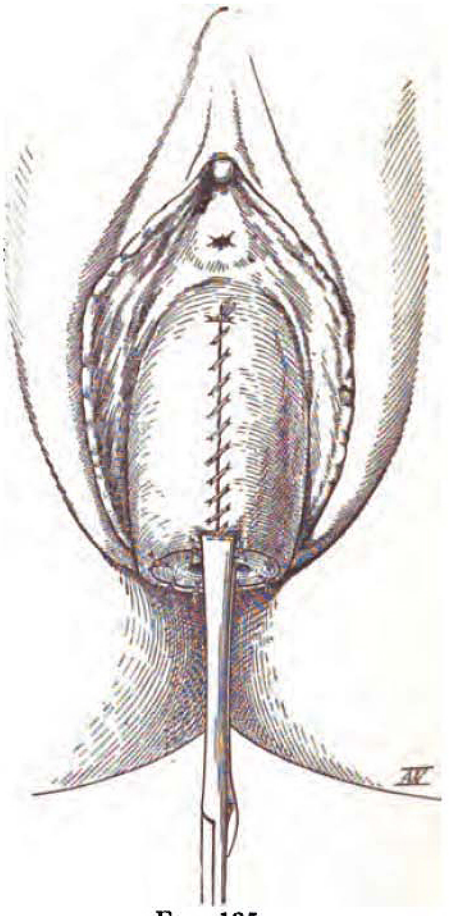

FIG. 135.

and appear in the denuded surface, and thus produce a fold of the vesical wall; then one sutures the non-united parts above this fold, taking up in passage the deep plane to avoid cavities between the two planes.

Various Procedures.—We have described our operation. We ought to add that all sorts[1] of denuded areas have been described and all manner of

[1] See Charles G. Child, in The Review of Cystocele in the Past 100 Years. *Amer. J. Obstet.*, New York, 1906, T. II, p. 514.

sutures. Why go into them? We consider these complicated sutures should give way to the simple continuous suture or that by layers.

Anterior Pre-cervical Colporrhaphy.—In some cases of anteflexion *with collapse of the anterior vaginal wall*, forming at the level of the anterior fornix a prominence, more or less marked, which hides the os. Doléris[1] advises a little anterior pre-cervical colporrhaphy. The denudation is triangular. The base corresponds to the angle of reflexion of the vagina on the cervix and measures 5–6 cm. The sides have the same length and the summit is about the middle of the anterior vaginal column. Unite each of the three angles by two or three separated stitches, thus making a star of

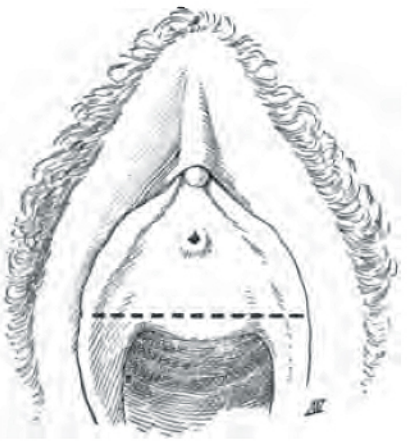

FIG. 136.—Incision for the splitting of the urethro-vaginal septum.

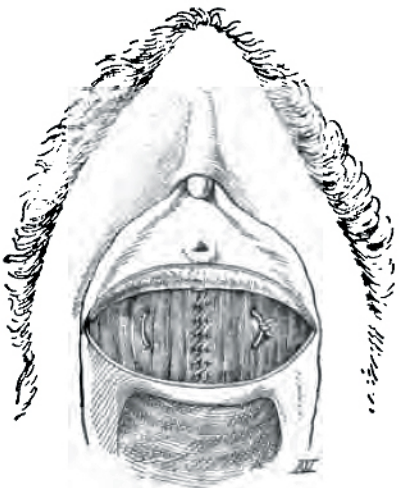

FIG. 137.—Suture of the levators at the level of the splitting of the urethro-vaginal septum.

three branches and the center is closed with a pursestring suture (Figs. 132 and 133).

The vaginal portion of the cervix is thus freed and a solid support is thus made below the bladder and causes it to remain anterior to the uterus, and supports it. It presses the uterus in asense backward and helps to overcome its anterior flexion.

Combination of Anterior Colporrhaphy with Amputation of the Cervix.—Barton Cooke Hirst[2] insists on this fact that the uro-genital diaphragm in prolapse is torn both anterior and posterior to the vaginal orifice. He recommends beginning by *denuding the anterior vaginal grooves* exactly as the posterior are done in colpo-perineorrhaphy. Insert sutures but do not tie them at once. Fix forceps to them and put the forceps on the pubis.

Draw the cervix out of the vulva and make a *large denudation anteriorly*

[1] Doléris, Treatment of Sterility. *Th. de Paris*, 1898–1899.

[2] Barton Cooke Hirst, A Contribution to the Efficiency of Plastic Operations on the Vagina. *Amer. J. of Obstetrics*, New York, 1905, T. II, p. 100.

shaped like a shield with base at the cervix and the top immediately below the urethral orifice. This flap is dissected up and excised (Fig. 134). *The cervix is amputated.* Laterally separate the tissues as far as the uterine ligaments.

A continuous suture in several layers unites the denuded vaginal surface; the stump of the cervix is sutured as in Hegar's operation (Fig. 135), the most lateral sutures taking up the *fibro-muscular tissues of the base of the broad ligaments* in such a manner as to obtain a firm hold of them. The uterus is put back in place and the sutures inserted in the anterior grooves and tied.

Splitting of the Anterior Wall of the Vagina and Suture of the Levators.—The *suture of the levators* commonly practised to-day in colpo-perineorrhaphy was advocated in the treatment of hysterocele by Delanglade,[1] then by Groves[2] and by Chaput.[3] It is done anterior to the vaginal orifice and directly below the bladder. This anterior repair of the muscular pelvic diaphragm has the advantage of placing the bladder on an elastic and normal contractile floor and of pushing back and up the cervix uteri and thus correcting the retro-deviation which accompanies prolapse so often (Figs. 136 and 137).

A finger's breadth behind the meatus make a transverse incision the whole width of the vagina. Separate the bladder and then search for the levators.

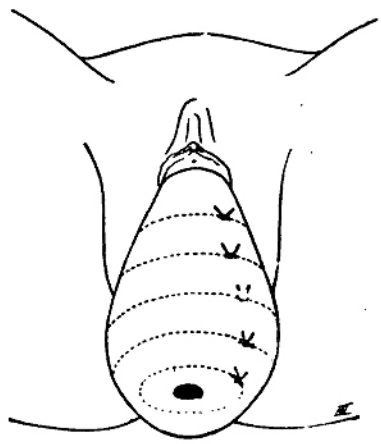

FIG. 138.—Freund's operation.