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Part First.

ORIGINAL COMMUNICATIONS.

ARTICLE I.—*Perineal Fistula left by the Transit of the Infant through the Perineum.* By J. Y. SIMPSON, M.D., F.R.S.E., Professor of Midwifery in the University of Edinburgh, etc., etc.

THE length of the perineum in the adult virgin female is usually stated by anatomists to vary from one inch to one inch and a half; but it is very frequently found shortened in women who have borne a family, from the liability of its anterior portion to become more or less fissured and lacerated during the passage of the child's head and shoulders.¹

In consequence of the natural shortness of the perineum, it looks *a priori* almost impossible that the child and its appendages should ever be propelled directly *through* it during labour, while the orifices of the vulva and anus were left entire. The state, however, of the perineum is very different in the stage of labour immediately preceding the expulsion of the child, from what it is in the non-parturient condition. By the time the child's head at last fully dilates the external parts in labour, the perineum is so stretched, that it has become thin and lacerable, while, at the same time, it is enormously increased and expanded in all its superficial dimension. The perineum when thus distended by the child's head has been found to measure six inches in breadth, or across from one tuberosity of the ischium to the other; and in length, three inches, or more, from the

¹ See Remarks on the Frequency of its Rupture, in "Obstetric Memoirs and Contributions," vol. i. p. 367.

posterior commissure of the vaginal orifice, backward to the anterior commissure of the dilated and elongated orifice of the rectum, or as much, sometimes, as seven inches from the fourchette to the point of the coccyx. When the perineum is thus attenuated and expanded, like a thin cap placed upon the head of the child previously to its expulsion, it is easy to conceive that a fissure occurring in the centre of the stretched perineal structures, would readily enough tear and extend under the strong expulsive efforts of parturition, so as to allow the head of the foetus to pass through the accidental opening; and if the resulting lacerations assume, however irregularly, the forms of X, Y, or V, with their diverging lines passing somewhat on either side of, but without rupturing into, the orifices of the rectum behind, or the vulva in front, we may have the infant, cord, and placenta, traversing the perineum, while the rectal and vaginal canals remain entire and intact.

Instances in which the infant and its appendages were thus born and expelled through a central aperture in the perineum, have been published by Nedeý, Coutouly, Merriman, and various other accoucheurs; and references to most of the recorded cases of this singular lesion, are to be found in the writings of Moreau,¹ Duparcque,² and Dr Churchill,³ upon the subject.

None of these authors specially allude to any examples of a fistulous opening remaining subsequently in the perineum, as a result and a proof of the perforation of it in the process of parturition. Such a result, indeed, appears to be very rare, in consequence of the edges of the lacerated wound almost always perfectly uniting, under common surgical care and treatment, subsequently to delivery. A preparation in the Obstetric Museum of the University of Edinburgh presents, however, an exception to this general rule, and is a well-marked instance of that rare lesion, viz., perineal fistula in the female.

CASE I.—The patient was attended during her first labour by a practitioner in the west of Scotland. The labour—as he subsequently informed me—was tedious, particularly during the advance of the hand through the lower part of the pelvis. After the perineum had become much stretched and distended by the child's head, and when the artificial support of it by the hand happened to be for a short time withdrawn, a very strong expulsive effort supervened, and the practitioner was recalled to the patient in consequence of her loud cries. To his surprise he found the head passing, or in fact, already nearly entirely passed through a rent in the perineum; and the next pain expelled the body of the child through the same opening. Through this same perineal perforation, the cord and placenta were delivered. The sphincter ani and the anterior edge, or fourchette, of the perineum remained untouched. The sides of the laceration did not entirely unite. A year subsequently to her delivery I saw her, along with the late Dr Dawson of Bathgate, under whose care she

¹ *Revue Medicale* for June 1830; or Moreau's *Traité des Accouchemens*, vol. ii., p. 462, etc.

² *Histoire des Ruptures de l'Uterus*, p. 368, etc.

³ *Diseases of Pregnancy and Childbed*, p. 403.

had come with symptoms of phthisis. The perineal fistula still remained, and, as we found on a *post-mortem* examination, some months subsequently, it was about the size of the barrel of a goose-quill. The opening was situated about half an inch behind the posterior commissure of the vulva. The perineum was very thin at the site of the fistula, and converging lines of old cicatrices were still visible on its mucous surface. But its anterior edge, or fourchette, was strong and dense, and placed unusually far forwards over the vaginal orifice.



SKETCH OF THE PREPARATION.

I have only been able to find on record two other cases, in any way analogous, of perineal fistula originating in perineal perforation

during labour. They are described by Marter of Kœnigsberg,¹ and Halmagrand² of Paris.

CASE II.—In a primiparous woman, to whose assistance Marter was summoned by a midwife, he found the head of the child already passing through a central laceration in the perineum. The child was speedily pushed, by the strong pains that were present, through the abnormal aperture, and the placenta afterwards followed through the same crucial-shaped laceration. Inflammation of the lips of the wound subsequently occurred, and, despite of the use of ligatures, a perineal fistula remained, by which the menses escaped during the two subsequent years. She then again became pregnant; and this second child was born naturally by the vulva.

CASE III.—In 1838, a patient applied to Halmagrand, sometime after delivery, with a perineal perforation not yet cicatrized, and forming a communication with the vagina. He cut the anterior bridle of the perineum, which was slender, made raw the edges of the fistula, and brought them together by the apposition of the thighs alone. Reunion and cicatrization took place in a few days. The patient was subsequently confined without any renewal of the perineal lesion.

To the preceding remarks let me merely add, that, as a means of preventing central-perineal laceration, and the chance; consequently, of perineal fistula as a result, we have to trust to—1st. The common methodic manual support of the perineum, so as to save excess of pressure upon it, while at the same time we push the head forward to the vaginal opening—a means which, in the practice of Denman and Lachapelle, succeeded in preventing the child's head from passing through the perineum, after its central structures were actually burst; 2d. Delivery of the head, and its proper guidance through the vulva by the forceps, as has been effected by Doutrepont, Hüter, and Braun, in cases in which this accident was impending; and, 3dly. Lateral incisions, if absolutely necessary, of the anterior edge of the perineum; for in this, as in the more common longitudinal forms of ruptured perineum, it is, I believe, better practice to make one or two slight cuts on either side of the fourchette, so as to regulate the site and direction of the lacerations that must occur, rather than leave their form and their character to mere chance alone. It is always an infinitely more important matter to save the sphincter of the anus than the sphincter of the vagina.
