MEDIAN EPISIOTOMY IN PRIMIPAROUS LABORS.*

BY

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It is a continuous marvel not only to the tyro in obstetrics but even as one's experience grows, that a baby is ever born without more serious damage to the lower birth canal. The tissues of the levator ani muscle and of the more superficial urogenital septum are physiologically capable of remarkable stretching, if it occurs slowly, intermittently, and with sufficient surface lubrication. Without proper lubrication not only are the superficial epithelial tissues abraded, but a glacier-like pulling on the deeper structures is produced, rending this union between the layers. Notwithstanding the established efficiency of dilatation in these parts, we are compelled to recognize the fact that the more closely we inspect the birth canal after delivery, the more constantly shall we find more or less damage to the soft tissues. Definite lacerations of the lower birth canal requiring repair, in the experience of the New York Lying-in Hospital, occur in about 44 per cent. of all primiparous labors, and in about 10 per cent. of all multiparous labors.

Undoubtedly in certain primiparæ in whom on careful examination no surface laceration exists, some break in the continuity of the deeper structures may take place; this may involve fascia, muscles, and their attachments. It also must be admitted that a good percentage of primiparæ come through their normal labors with vaginæ that are intact for all functional and mechanical purposes.

Would a neater end-result be obtained in the latter cases by doing an episiotomy before they were stretched to their full capacity? In the ones that do tear, would a better union with less scar tissue be assured by episiotomy? There is much conflict of opinion on the entire subject. Good authorities claim that it is not possible to foretell a laceration and that lacerations heal as readily, and are as easily repaired, as an incision. Equally good authorities, with perhaps sounder surgical grounds, maintain the opposite. There is also some difference of view as to whether the incision should be in the median raphe or placed laterally.

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Some operators, in their eagerness to avoid a tear, consider that as long as the fetal heart remains of good quality an indefinite time can be allowed for the termination of the second stage. I am a firm believer in taking things slowly, to avoid laceration of the soft parts, as long as an appreciable advance of the presenting part continues. But the welfare of the baby must constantly be kept in mind. The head cannot be permitted to pound ineffectually on a too resistant vulvar barrier. Every now and then a baby comes to autopsy with a large cerebral hemorrhage, or the small punctate hemorrhages of asphyxia in the brain, liver, and other organs generally, in mute evidence of too long delay in the latter part of the second stage. We should not, to use a sporting phrase, play the baby's heart against the perineum. The odds are not even, or proper. In many such instances, a properly timed episiotomy would have saved a baby's life. Laceration or incision, and the head, that may have been delayed on the perineum for over an hour despite good contractions, slips through with the next pain. Episiotomy thus not infrequently will obviate the indication for the low forceps operation.

There is no question as to the difficulty in deciding when a laceration is inevitable; and, unfortunately, judgment here does not always come with experience. Other things being equal, however, and granting the absence of such conditions as a narrow pubic arch, disproportion of the presenting part and passage, edema, or inflammatory conditions of the vulva, all of which usually presage a tear of the perineum, a sign that has been of real assistance to the writer is the inclination of the vulva as bulging begins. The more nearly vertical the vulva is as it begins to gape, when the woman is lying on her back, the less a perineal laceration is to be feared. But when the perineum shows pronounced distention near the anus, and the anus dilates early, while the tissues about the vulva lie flat, laceration is likely to occur. The glistening appearance of the perineum stretched to the utmost, described by the text-books, also is never to be disregarded.

It is somewhat of a contradiction of terms to say that the obstetrician avoids a laceration by doing an episiotomy. Nor should we argue that we avoid a deep laceration by making a superficial cut. The serious subsurface lacerations of the levator ani and those of the vaginal wall running up to the fornix, of course, will not be prevented by an inch-long episitomy of the fourchette, whether performed early or late. The more extensive vaginal lacerations usually occur during forceps operation, craniotomy, or a rough breech

extraction. Before we approach any of these, in my opinion, we should make a careful, prolonged, and thorough manual dilatation of the levator, remembering that it is important to dilate gradually, intermittently, and with liberal lubrication. Green soap is the best for this purpose. In certain cases, on account of a narrow, bony outlet, great rigidity of the soft parts, disproportion or emergency, it may be advisable to make deep vaginal wall incisions in the levator ani, going up in one or both of the vaginal sulci. This incision should be preceded by a median incision of the raphe, going down to the sphincter ani, then swerving to one side and continuing up the lateral sulcus in the manner about to be described.

The median incision of the raphe anterior to the sphincter cuts chiefly the central points of insertion of the superficial group of muscles constituting the urogenital septum. Of the levator ani, it cuts only the so-called Lushka fibers, those few fibers running across between the sphincter ani and vagina. I have used both the lateral and the median incisions in the perineum, and it has been my experience that a better union is obtained with less rugged scar tissue and with better preservation of function, with the median incision than by severing laterally the transversus perineii and bulbocavernosi muscles across the continuity of their chief muscular portions. What we gain by episiotomy is this: if laceration of the perineum impends, we avoid a jagged or transverse splitting, or butterfly tear, by making a single straight clean-cut incision. We turn the lower end of the incision away from the anus and avoid injury to the sphincter ani. If the vulva is holding the head on the perineum, despite good pains, a properly timed episiotomy will prevent serious asphyxia of the child from prolonged pressure on the head with its attendant cerebral hemorrhage.

The simple median episiotomy is employed only during the perineal stage of labor. Use ordinary light blunt-pointed cervical scissors curved on the flat. Place the forefinger in the vagina during a pain. About half an inch inside the distended margin of the perineum will be felt a tense band, corresponding to about the location of the hymenal ring. With the middle finger and thumb press the anus to one side and introduce the scissors with the curve pointing in the opposite direction. Start the incision in the midline severing the tissues of the urogenital septum in the median raphe for about three-quarters of an inch. It is desirable to have the incision extend farther on the vaginal, than on the skin surface of the perineum. As the scissors close, the incision will curve slightly away from the anus. This swerve at the lower end of the incision will meet the chief objec-

tion to median episiotomy of the lateral incision enthusiasts, who have much to say on the danger of the median cut extending into the sphincter ani. If more room is required, or if the levator ani is not well dilated, and it is necessary to make an emergency delivery notwithstanding, continue the incision, vaginally, in the line of what will be the vaginal sulcus aside of the rectum. The incision is best made with successive snips rather than with one bold cut.

The repair can be made satisfactorily with a few buried sutures of twenty-day chromic gut, and the margins of the wound may be brought together with interrupted or continuous subcuticular sutures of the same material. Except in the smallest incisions, it is best to do the repair after the completion of the third stage.

By careful observation episiotomy will be found to be of avail in about one-third of all primiparæ. I have never regretted the procedure in any case in which I felt the necessity of doing it.

There is nothing very new in this operation. Michaelis wrote about it in the eighteenth century, recommending a median incision in the raphe, and calling it episiotomy. Of recent years Anspach of Philadelphia and Pomeroy of Brooklyn, have advocated its extensive use, and the effort of this present discussion is to emphasize it as a simple and resourceful help in delivery, to be more frequently used in delay in the perineal stage of labor.

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OBSERVATIONS ON THE PROBLEM OF HEMORRHAGE IN OBSTETRICAL CASES.*

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The object of this paper is to call attention to a very few points relative to hemorrhage associated with obstetrical cases and to make certain suggestions for measures which are, for the most part, prophylactic in their nature. I am prompted by a realization that the maternal mortality has been unnecessarily high in cases of antepartum hemorrhage, including placenta prævia and complete separation of the normally situated placenta; and that postpartum hemorrhage is unnecessarily frequent, though, to be sure, not commonly fatal. In both of these varieties of hemorrhage it is possible,

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