

A NEW METHOD OF INSURING STERILITY FOLLOWING CESAREAN SECTION

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PRESENT methods for preventing pregnancies whenever indicated following cesarean section by operation on the fallopian tubes are three in number and are all open to certain objections.

1. Double ligation of the tube and resection of the intermediate

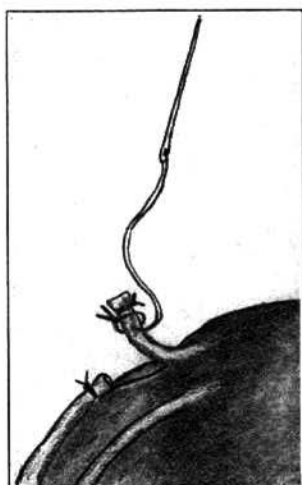


Fig. 1.—The tube is doubly ligated with chromic catgut and divided about $1\frac{1}{2}$ inches from the uterine cornu. The proximal portion is dissected free from its mesosalpinx with a sharp knife, keeping closely to the tube to avoid bleeding. Its free end just proximal to the ligature is transfixed with a long, round-pointed straight needle carrying a double suture of chromic catgut. The knotted loop of this suture is slipped over the free end of the tube and the suture drawn tight.

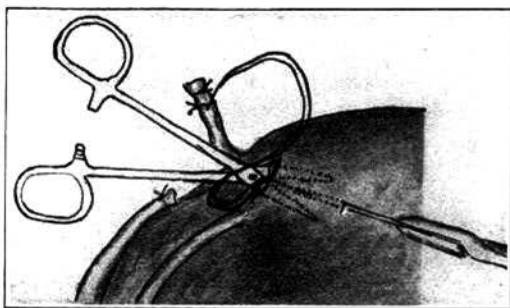


Fig. 2.—A small incision is now made in the serosa of the uterus on its anterior surface just above the insertion of the round ligament. The butt of the needle is grasped with a sharp-pointed hemostatic forceps. The point of the needle is thrust into the incision, through a portion of the muscularis and out again on the surface of the serosa about an inch from the incision. The closed hemostat, still grasping the needle, follows it into the muscularis. The jaws are spread, thus forming a pocket in which lies the traction suture attached to the tube. The hemostat is withdrawn.

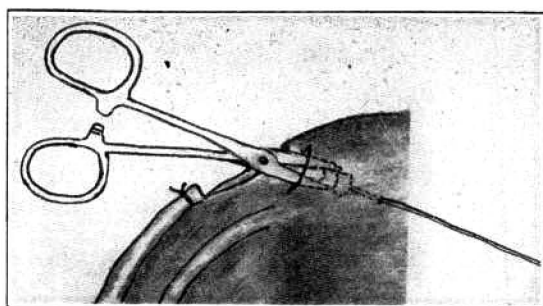


Fig. 3.—The tube end is grasped with the hemostatic forceps and inserted in the small incision. Traction on the suture causes the tube to enter the pocket prepared for it in the muscularis.

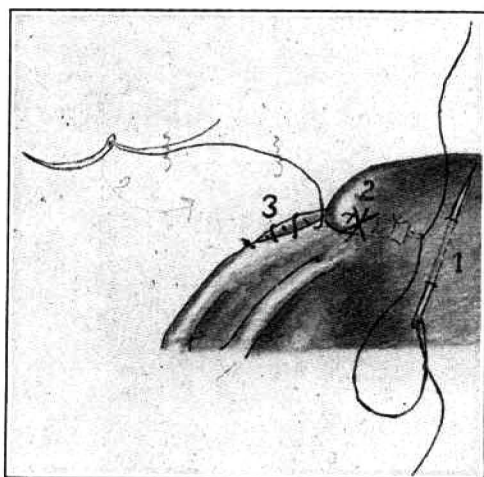


Fig. 4.—The operation is finished in the order shown by the drawing. (1), One strand of the double traction suture is cut and a stitch taken through the uterine surface at right angles to its former direction. The two ends are tied and cut. (2), The small incision in the serosa is closed by a figure of 8 suture which also provides additional anchorage for the tube. (3), The end of the distal portion of the tube is buried between the leaves of the broad ligament.

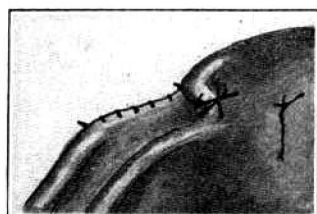


Fig. 5.—The operation is completed and all peritoneal surfaces have been approximated. As the uterus undergoes involution the buried proximal ends of the tubes become more and more compressed and should soon be obliterated. Since no time is wasted in checking hemorrhage the operation can usually be completed more rapidly than by the older method of tubal excision.

portion has occasionally resulted in slipping, premature absorption or cutting-out of the proximal ligature. Patency has thus been re-established and pregnancy has resulted.

2. Burying the infundibulum between the leaves of the broad ligament is open to the objections that the tube is not divided or even ligated and that its fimbriated extremity must necessarily be embedded somewhere near the ovary. Should the sutures used for this purpose fail to hold the wandering ovum might find no great difficulty in entering the distal end of the tube.

3. Resection of the tube with a wedge-shaped excision of its uterine insertion is the most effective method in general use today. Not infrequently, however, removal of the uterine portion is accompanied by free bleeding which may demand considerable time for its control by suture-ligature.

An ideal method should be bloodless, should include division between double ligatures and the burying of both cut ends at as great a distance from each other as possible. With this in mind I have devised the method described in the legends accompanying the following illustrations and I am now using it with complete satisfaction.

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Frederick C. Irving (1883-1957)

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