ERRORS AND EVILS OF EPISIOTOMY

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FOR those conditions in which delivery of the fetus is difficult because of the narrowed or deformed nature of the pelvic bones, cesarean section is used with reservation. Within reason and necessity, it is a life-saving operation to both mother and child. The misfortune of obstetric management is that a more serious operation has become popular in order to cater to the doctor's convenience and showmanship and alleviate the patient's fear.

Some of these advantages, even though false, are secured in a time-saving operation of attack upon the continuity of the pelvic floor. Efforts have been made to warrant its common use by a seemingly harmless name, episiotomy, which means cutting of the pubes or vulva structure outside of the abdominal wall. This is an unfortunate error. The pelvic floor structure which lies between the head in the pelvis and delivery is the caudal musculofascial lower abdominal wall, composed of five layers of fascia and three layers of muscle. The vulva cut if limited to episiotomy has nothing to do with the question. When the musculofascial plates is entirely cut by a side incision, these tissues are cut beyond replacement and injured beyond normal repair.

The vulva and pubes are ornamental structures outside the pelvic floor which impede the head. The plunging of a knife or scissors into this closely constructed musculofascial plate obliquely does damage to each of these structures and puts them beyond rational repair by even a fair surgeon, to say nothing of its universal popularity among untrained men. The author has had opportunities of observing these instances from the beginning of its modern popularization. The weak points have not been confined to the novices. One is not expected to do good work if he does not know the structures which he mutilates, and is not thus true if he is operating nominally entirely outside the so-called pelvic floor in performing an episiotomy while in reality he severs all eight layers of the lower wall of the abdomen.

First, the pelvic floor is seen at times mutilated beyond all repair. Second, the pelvic floor is usually mutilated beyond normal reconstruction in the hands of the performer. Third, the resulting efficiency is decreased from 100 per cent to from 50 to 0 per cent. Fourth, the evils, in addition to these lacks of anatomic and functional faults, are: (1) lack of support; (2) multiple and extensive herniation; (3) infection, scar tissue and fistulas; (4) a high percentage of lack of satisfactory grasp in sexual life, in numerous cases being so unsatisfactory as to threaten a divorce or actually bring it about; proper repair has avoided divorce in the threatened cases; (5) bladder and urethral difficulties have been common and in many cases extensive.

In cases in which a deep oblique incision has been made, leaving that side useless, the author has had the best results by a deep, median and superficial union of the remaining portion of that side of the pelvic floor outside the incision to the deep medium and superficial structures of the untraumatized side. In many cases no structure is found until well out toward the tuberosity on the cut side and on the uncut side the rectum, vaginal commissure and original median perineal region will be found retracted to the uncut side 1 to 1½ inches while this and the paralytic cut side exhibit an expression like Bell's paralysis

which the author has termed the facies perinei.

In the interest of useful repair we are in favor of median pelvic floor section to reach a delayed or an impacted pelvic head. Repair is much more sure. After careful delivery I would pronounce tears more amenable to repair than deep oblique incisions.

Marbury and Goldman, in *The Journal of the American Medical Association*, point out their experience with episiotomy in cases of fistula. Cases of this nature have been met in consultation work and would seem almost inevitable in such blind invasion of the deep and complicated structures of the pelvic floor under the name of episiotomy. Either we do a deep and unmanageable operation and call it by a soft spoken superficial name, or we do what the name signifies when it is entirely unnecessary and inadequate; for episiotomy would not dispose of any smallness of the outlet which might exist.

A real enlargement must attack the pelvic floor; and as such an effort cuts through all of the muscles and fascia of the lower abdominal wall, it would be appropriate to term it "a pelvic floor section" which reaches the head in the pelvic abdomen instead of applying a term which has no proper significance. If the median section leaves the two halves of the pelvic floor similar or alike, it renders it amenable to easy and accurate repair by one who possesses knowledge of surgery and the anatomy of the pelvic floor.

A close study of the purpose of languages reveals the extensive efforts which have been made to provide us a careful study of words, and we are remiss in using the term episiotomy for a procedure which does not correspond at all to the meaning of the word.