
THE TERMINATION OF PREGNANCY BEFORE THE PERIOD OF VIABILITY
BY ABDOMINAL HYSTEROTOMY THROUGH THE LOWER
UTERINE SEGMENT*

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CIRCUMSTANCES occur when pregnancy has to be terminated before the fetus is viable. Before the end of the third month abortion may be carried out by the usual method of dilating and curetting the uterus. From the commencement of the fourth month and afterwards termination of a pregnancy by vaginal manipulation is accomplished with difficulty, and may be dangerous. The method about to be described is an operation that may be adopted when the pregnancy has advanced to the fourth month and must be terminated, or when sterilization is advisable at the same time as the uterus is emptied.

It is not within the scope of this article to discuss in detail the indications for the termina-

tion of pregnancy before viability, or for the sterilization of the patient. Granted that such an indication exists, abdominal evacuation of the uterus may be carried out by classical hysterotomy or by an incision through the lower segment. The latter method has one distinct advantage. Uterine contractions are not as powerful or as prolonged in the early months of pregnancy as they are at term, so that a mild post-operative leakage is of frequent occurrence. When the incision is through the peritoneal coat of the uterus this oozing is intra-peritoneal. Loops of intestine may become adherent to the clotted area and give rise to intestinal obstruction. The lower segment approach reduces this to a minimum, as the incision in the uterus is extra-peritoneal.

A series of descriptive drawings illustrating the steps of the operation is presented. The

* Read before the Section of Obstetrics and Gynæcology, Academy of Medicine, Toronto, March 7, 1940.

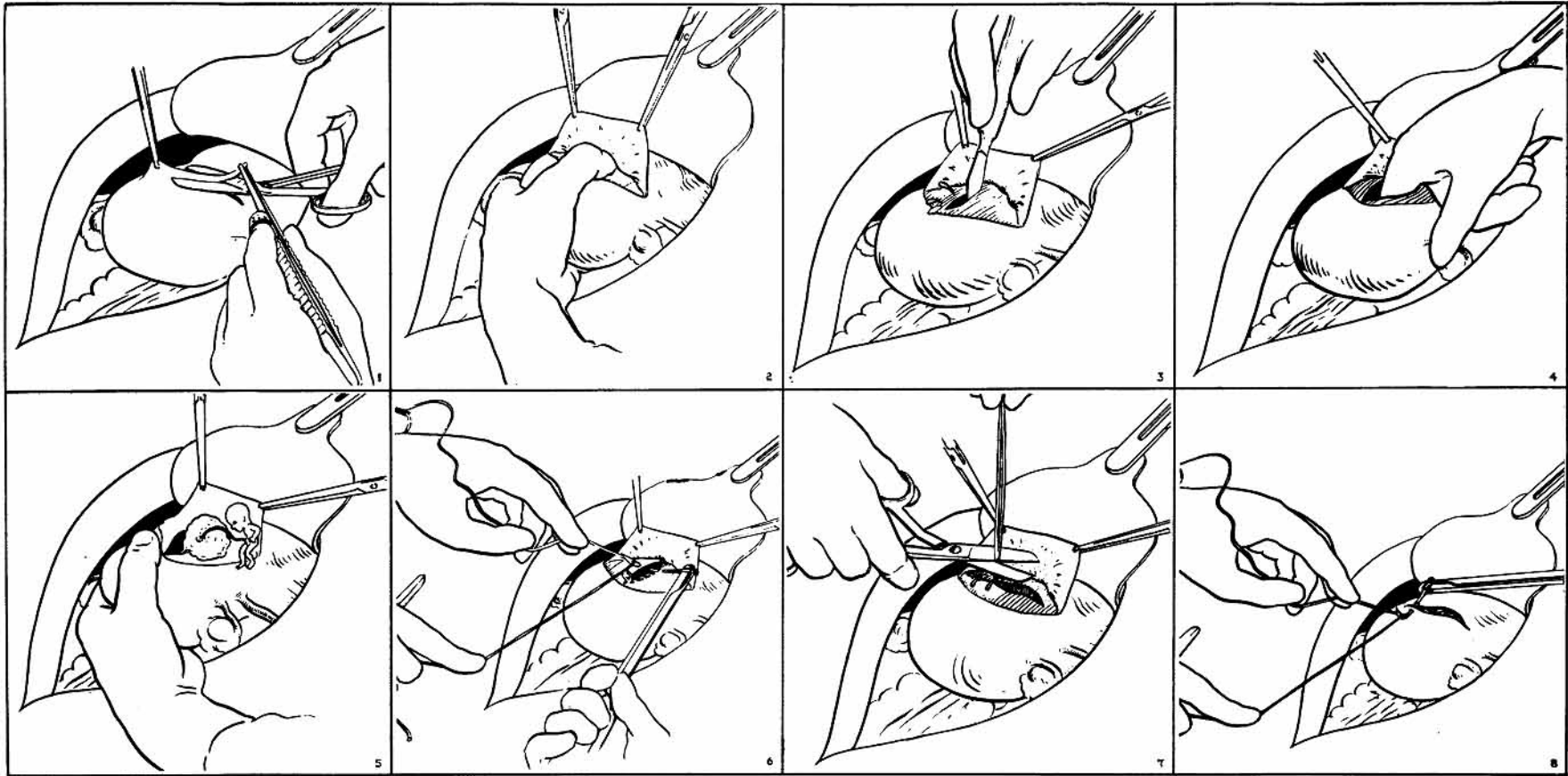


Fig. 1.—The utero-vesical pouch is identified; the peritoneal reflection is put on the stretch, and the intervening area incised. **Fig. 2.**—Dissecting the bladder off the lower uterine segment. Two Kocher forceps are applied to the incised area of peritoneum that is adjacent to the bladder and retracted forwards and outwards. The bladder is gently displaced downwards. Grasping the uterus, as is shown in Fig. 2, allows the surgeon to use his thumb to good advantage in pushing the bladder off the lower uterine segment. In those areas in which the bladder is firmly attached to the uterus and supra-vaginal cervix a few cautious snips of the scissor may be necessary to complete the dissection. **Fig. 3.**—Incising the lower uterine segment. A longitudinal incision is now made in this segment. The initial incision should be bold and direct into the uterine cavity. The hæmorrhage is free—quite free, so that no time should be lost in making the incision. A combined bladder retractor amniotic and blood aspirator, devised by Torpin, will be found useful. Acting as a retractor it also sucks up the blood and keeps the field clear. **Fig. 4.**—Inserting the index finger and freeing the products of conception. The operator inserts the index finger through the uterine incision. It is a comparatively simple matter to free the products of conception from its bed. Once this is accomplished the bleeding practically ceases. **Fig. 5.**—Delivering the fetus

and expressing the placenta. After completing the separation of the placenta and the membranes, as described in Fig. 4 the fundus of the uterus is now firmly grasped with the left hand and the contents expressed. A final digital examination of the interior of the uterus is now carried out. A gauze-covered finger should be used to remove adherent remnants of the placenta and pieces of membranes. This will ensure leaving an empty uterus. **Fig. 6.**—Suturing the uterine incision. The incision is closed in two layers and by continuous sutures. The first suture approximates the endometrial surface of the uterus and the greater part of the muscle; the second suture, the remaining part of the muscle and the pubocervical layer of pelvic fascia that covers the lower uterine segment. I usually reinforce this last suture with two or three interrupted sutures. **Fig. 7.**—An alternative method—the transverse incision. The delivery of the fetus and the expression of the placenta is the same as described in Figs. 4 and 5. The closing of the uterine incision is different. I use a continuous suture for the deep layer, and interrupted sutures for the superficial. The tension is considerable in the transverse incision; so interrupted suturing is preferable and safer. **Fig. 8.**—Closing the flap. The edges are approximated with a running suture, supplemented if necessary with one or two interrupted sutures. The material used throughout is chromic catgut No. 2.

patient is placed in an exaggerated Trendelenburg position. The intestines fall well out of the way, and a minimum amount of packing is necessary. The abdomen is opened through a sub-umbilical incision. The left hand is inserted through the wound, and the uterus "dislocated" from its position in the pelvis. This allows it to be drawn forward with ease.