Practical Observations

ON

"SUPPORTING THE PERINÆUM."

BY

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[Concluded from page 463.]

The Treatment of the Perinæum in Labour.
With a view of arriving at some definite conclusions as to the proper treatment of the perinæum during labour, I have now carefully examined two questions. 1. The effects actually produced by the operation "supporting the perinæum"; and 2. The causes of laceration of the perinæum.

The result obtained by examination of the first of these questions was this: that the only effect which could be said to be produced by "supporting the perinæum" was, retardation of the advance of the head; and that, unless by the exercise of a considerable degree of force, even this effect would not be obtained. Further, it was shewn that other advantages which had been claimed for the operation, had no real existence. And it was also pointed out how retarding the advance of the head was likely to interfere with the mechanism of the natural process by which dilatation is brought about.

The results arrived at by an examination of the second question—the causes of laceration—was, that so far as it was possible to form a conclusive opinion on the matter, unusual rapidity of labour was one of the principal causes of the accident in question. It resulted, from an examination of the subject, that the causes of laceration were, however, very different in different cases; and hence the conclusion, that each particular case must be considered by itself.

What, then, is the practical result of this double inquiry into the value of the remedy—"supporting the perinæum," as applicable to the prevention of the evil—laceration of the perinæum?

It appears to me that the only conclusion we can come to is, that the operation must be rejected. Its object, if that object be limited to retarding the advance of the head, may be in itself good; but this particular method of attempting to gain that object is objectionable. In ordinary cases of labour, as a device for preserving the perinæum from laceration, I believe it to be practically worthless, and there are grave reasons for surmising that in many cases it has led to the very evil it was intended to prevent.

The arguments derived from a careful consideration of the mechanism of the process of dilatation of the perinæum and expulsion of head, all, in fact, lead us to the conclusion that the proper treatment of the perinæum in labour is, under all ordinary circumstances, to abstain from active interference of any kind.

Is the conclusion arrived at by reasoning, countenanced by the results of practice?

In the works of Denman, we find the following:—"When women were delivered without assistance, I have not, in any case, observed any considerable laceration." (Vol. i, page 60.) That the accident

does occur, however, in cases where the delivery occurs unassisted is now well known. The explanation I have already given of this occurrence—that the laceration is due in these cases, not to the absence of assistance, but to the rapidity of the labour—I would now repeat.

Drs. McClintock and Hardy consider medical assistance so necessary, that they endeavour to explain why laceration does *not* occur in cases of unassisted labour, on the theory, "that inasmuch as these females are almost always involuntarily subjected to the deprivation we have mentioned, they habitually use their utmost endeavour to retard the birth of the child when they feel the head in the vagina, in the hope of aid reaching them before the critical moment of delivery; and another reason is that such patients have been spared the ill effects arising from vaginal examinations." (*Report, etc.*, p. 9.) It may, I think, be doubted whether patients do, as a rule, under such circumstances, exercise the kind of control mentioned. The exemption from laceration in such cases appears to be explicable in a very different manner. It is very certain that many deliveries, and rapid ones, do take place in the entire absence of all assistance, and with perfect safety to the mother, so far as the perinæum is concerned. The only conclusion to be drawn from the fact is, that assistance must be of little service in ordinary cases, seeing that no bad result usually ensues in extraordinary ones when it is absent.

We cannot, at this moment, procure any considerable numerical testimony as to the results of the non-interfering system; the practice of supporting the perinæum has been too universally adopted to allow of this being the case; but so far as the evidence procurable goes, it is calculated to give us every confidence in the resources of nature. Dr. West of Alford, and Dr. Swayne of Bristol, both assure us, from the results of a large number of cases, that the plan of "letting the perinæum alone" has with them given very satisfactory results.

Is there, then, nothing to be done to preserve the perinæum from laceration?

There are certain precautions which it is necessary to take, and to which I should be disposed to attach very considerable importance. When the head is passing through the vaginal outlet care must be taken that there be no impediment to its passage forwards. If the thighs of the patient be closed, and if the legs be in a straight line with the body, there may be an impediment of this kind, as in the case of Dr. Hall before alluded to, and the natural result is, that the fourchette is called upon to bear a much greater strain than is necessary. The practice adopted in France, of delivering the woman lying on the back with the legs separated, is the one best calculated to remove this source of danger to the perinæum. So, again, in the delivery of the shoulders, care must be taken to direct the delivery as much forwards as possible. It is very easy to see how infinite mischief may be produced by want of attention to this rule, and it is, in fact, extremely probable that laceration is not seldom due to this cause.

By adopting these simple precautions, I believe that the practitioner will do all that is possible to *prevent laceration* in ordinary cases.

Some other points, in reference to the treatment

and management of the perinæum during labour, must now be considered.

Inunction. It has been recommended that the soft parts should be well and frequently lubricated with oil or lard during the last stage of labour, and with the view of promoting the stretching of the soft parts. It is difficult to see how such lubrication can relax the perinæum, or promote the stretching process; it can do no more than render the surfaces to which it is applied smooth, and so far facilitate the passage of the parts of the child over the same. Like "supporting the perinæum," however, the practice of inunction has had an efficacy imparted to it which it is very far from deserving. There can, however, be no *objection* to using lard or oil, and when the parts are hot and dry, the patient certainly derives satisfaction therefrom.

Dilatation of the vaginal aperture is a procedure which was formerly much in vogue; the fingers being introduced in form of a cone, and the orifice thus dilated. Unless, however, such force were used as would be quite unjustifiable, little could be thus effected. The head of the child is the best dilator.

Dr. Snow Beck believes that, by preventing the perinæum from being pushed down before the head, and "by drawing it backwards and upwards over the protruding part, rupture may sometimes be avoided." (BRIT. MED. JOUR., March 10, 1860.) It is certainly a far more rational proceeding, as I have before shewn, to endeavour to procure dilatation in this manner, than to attempt to do so by pushing the perinæum forwards. The principle of the recommendation is undoubtedly correct, and, as I have before shewn, it was the principle of Røderer and Hamilton; it is possible that the delivery may, in a few cases, be facilitated by the exercise of a slight distensive action in the direction indicated. The exercise of any degree of force would be, however, most objectionable.

In the next place, I would offer a few remarks on the treatment of the perinæum in cases where the labour does not come under the category "ordinary."

Supposing laceration to be impending, what is to be done?

In the first place, what are the signs that laceration is impending? This we must first determine. Now, I have attempted to shew that in what is called "rigidity of the perinæum" the condition present is one which is not calculated to excite apprehensions on this score, and having got rid of these cases, the number remaining is very few. I believe that the presence of *elasticity* of the perinæum is a sign of favourable import in the labour, and one which is indicative that laceration need not be feared. When the head recedes quickly after each pain, this indicates possession of elasticity. When such recession does not occur, when the pains are very violent, when the perinæal tumour has suddenly become much larger, and the parts are evidently very much stretched—if all these conditions are present together in a first labour, the practitioner may, perhaps, reasonably dread the occurrence of laceration. This I believe to be the most ordinary combination of circumstances under which laceration may be said to be imminent, and even these are very few and far between.

In such a case as the one just put, the obvious indication would, at first sight, seem to *retard* the

progress of the head. I believe that any attempt mechanically to retard the progress of the head is objectionable, as well in cases of natural labour as in those cases where laceration is believed to be impending, and for the reasons which have already been stated. The chief of these are—1. That, by retarding the head, we lose the beneficial stretching action of the head on the perinæum; and 2. Because the attempt is not likely to be successful in those cases where it would be supposed to be most required. It appears even probable that, by interposing actual mechanical resistance, the undue force with which the uterus is acting may be increased. In fact, most of the objections (not all) which applied to the operation "supporting the perinæum," apply equally to attempts to retard the progress of the head as a means of saving the perinæum from laceration.

The proper method of retarding the head, supposing it to be resolved to attempt it, would seem to be that recommended by Dr. Leishman; namely, to oppose the fingers inserted within the vagina directly against the head itself. Pressure against the sacrum, also recommended by Dr. Leishman, appears to be useless for the purpose now in view.

A careful survey of the facts on record and the history of the subject generally, have led me to the conclusion that, where laceration is actually threatened, the proper treatment would be to procure additional space by making a slight incision into the stretched and dilated perinæal structures on each side of, and at a short distance from, the fourchette. Experience has shewn that incisions thus made subsequently heal with very great rapidity. The incisions are to be made so as to run no risk of injuring the rectum. Such a procedure as this will, I believe, be called for in an extremely small number of cases; and here I would remark that the *so-called* cases of "rigidity" do not by any means come under the category of cases necessitating such treatment. The congenitally narrow condition of the vaginal outlet would seem to be the one most requiring it.

The subject of the treatment of cases of *rigidity of the perinæum* requires a few words. There may be *real* rigidity constituted by the presence of firm unyielding bands, cicatricial or otherwise, around the outlet of the vagina, or in cases where the vaginal orifice is naturally very small. For these very exceptional and rare cases, when a sufficient time has been allowed to elapse, incision is a proper remedy. I refer now, however, more particularly to the treatment of those cases more commonly met with, and to which I have previously alluded as cases of *so-called* "rigidity," where the perinæum is not dilated, because the force from above required for such dilatation has not been yet exercised; these being cases, not of rigid perinæum, but of imperfectly acting uterus, or of obstruction from certain causes which I need not here again enumerate. We hear of certain remedies having a special power of relaxing the perinæum. I have no faith in the existence of such remedies, and interpret their action in a very different manner. The perinæum must be considered a passive agent in the matter. I believe that the remedies which are said to procure "relaxation," produce this apparent effect chiefly by rousing the uterus to greater activity; the rigidity disappearing be-

cause a greater force is brought to bear on the perineal structures. In cases of the kind now under consideration, the attention of the practitioner will be most profitably employed in ascertaining why it is that the head of the child is not propelled downwards with greater rapidity on the perineum. In many of these cases of so-called rigidity of the perineum, a careful use of the forceps is the best, the proper remedy, the uterine contractions being deficient in power.

The case which I have, in the course of the series of practical observations now brought to a conclusion, argued, is the one of rational *versus* empirical treatment of the perineum during labour. I think there can be little doubt as to the nature of the decision, which will be formed by those who take the pains to consider the question attentively and dispassionately.

36, Berkeley Square, W., April 1861.

Original Communications.

CASE OF DEFERRED LACTATION.

By THOMAS SKINNER, M.D., Obstetrical Physician to the Liverpool Dispensaries.

I WAS lately called to a lady who had just had a severe rigor, and was threatened with inflammation of one or both breasts. The patient, who was the mother of several children, told me that she had had a miscarriage in Scotland about two months before, and that she had every reason to believe she was at the time in the seventh month of pregnancy. At the time of my visit, I detected a little milk in the breasts, and my patient informed me that the week before the occurrence of the "weed", she felt the usual sensation of a "rush of milk" to the breasts, and that milk was then secreted in abundance.

It is interesting to observe, that the date of these latter phenomena corresponds to what would have been the week following the full time of her late gestation. The lady had not been nursing, nor was it known that there was any milk in the breasts from the time of the miscarriage until the week before the rigor.

STRANGULATED OBLIQUE INGUINAL HERNIA IN A FEMALE: OPERATION: SUCCESSFUL RESULT.

By GEORGE LAWSON, F.R.C.S., Surgeon to the Great Northern Hospital, Clinical Assistant to the Royal Ophthalmic Hospital, Moorfields.

THE occurrence of strangulated inguinal hernia in women is so rare, that each case claims for itself a special amount of interest. The following are the particulars of a case which has lately been under my care:

Mary E., aged 56, married, the mother of one child, for the last ten years had suffered from an oblique inguinal hernia of the left side, which, she said, had been in the habit of coming down frequently. For the last three years she had worn a truss; but it fitted her badly, and often, when on, allowed the bowel to descend.

On April 2nd, the hernia came down as low as the left labium at about five o'clock in the afternoon. All her endeavours to return it failed, and she, consequently, applied to Mr. Dickinson, who used the taxis and the other usual remedies, but without success. Abdominal pain of a severe twisting character quickly came on, accompanied by severe vomiting.

At 12.30 A.M., seven hours from the descent of the bowel, and the commencement of the symptoms of strangulation, I saw her. The tumour was then of about the size of a large egg, very tense and tender, and occupied directly the site of the inguinal canal. Failing to return the bowel under the influence of chloroform, I at once operated. It proved to be an oblique inguinal hernia; and, as a division of the external ring gave no relief, and as the sac was much thickened and adherent to the surrounding tissues, I opened it, when the seat of the stricture was found at its neck. The bowel was immediately returned, but the sac was left *in situ*, and the skin closed over it. An opiate was given soon after the operation. The patient progressed most favourably; and, without the use of any purgatives, her bowels were freely opened on the eighth and ninth days after the operation.

April 24. She is now quite well.

Transactions of Branches.

EAST YORK AND NORTH LINCOLN BRANCH.

CANCER OF THE PENIS: AMPUTATION: RECOVERY.

By JOHN MORLEY, Esq., Barton-on-Humber.

[Read September 26th, 1860.]

THE subject of cancer presenting itself so often to our notice in its various forms and in different organs, although not so frequently (according to my limited experience) in the penis as in other parts, and the serious mutilation necessary for its removal, as in the following example, form my apology for bringing before my professional brethren what might at first sight appear to be a very simple case, but upon a correct diagnosis and treatment of which depended the retention or loss of the important organ involved.

I am not aware that I have anything novel to communicate; but, as I have been so ably assisted in the microscopical examination and illustration of the diseased parts by Dr. Munroe, I gladly avail myself of this opportunity of bringing the case before you, as an instance of the benefit to be derived from *association* in the cultivation of everything relating to our noble profession. The readiness with which the required help was rendered, deserves my warmest thanks; and I hope that the recital of the following case will draw forth from other members information on the subject, which will tend to advance our knowledge of the pathology and treatment of cancer in general.

CASE. William Cook, aged 51, a pig-jobber, residing at Barton, married, first consulted me on May 1st, 1858, on account of a tumour situated on the internal aspect of the prepuce, which had latterly caused him a considerable amount of pain. He was the subject of congenital phimosis. He had syphilis about thirty years ago; since which period the inguinal glands had remained slightly enlarged. About five years ago, he observed what appeared to him to be a small wart near the extremity of the prepuce, which was attended with itching and smarting, and gradually enlarged to its present state. The extremity of the penis was inflamed and enlarged; and it was impossible to denude the glans; a hard tumour, however, could be detected by raising the skin between the finger and thumb.

On consultation with my friend Mr. Eddie (who also kindly assisted me at the subsequent operations) it was decided to excise the diseased portion of prepuce, which was done on May 6th. The glans at this time presented a mottled appearance (red and white) on the surface opposed to the preputial tumour. Water dressing was applied at first, until the rapid growth of fungous granu-