Summary

It is sometimes asked why it is not sufficient to collect a number of pedigrees of mental defectives, and, having analysed them, settle the problem of heredity and mental deficiency once and for all. Both from the clinical and from the biological point of view the problem is a complex one, and a number of considerations are discussed that make it necessary to adopt more complicated lines of approach.

REFERENCES

- ¹ McNeill, C.: *British Medical Journal*, 1934, i, 584.
- ² Pintner, R.: *A Handbook of Child Psychology*, Clark University Press, 1931, p. 615.
- ³ Lewis, E. O.: *Journ. Ment. Sci.*, 1933, lxxix, 298.
- ⁴ British Medical Association, Report of the Mental Deficiency Committee, July, 1932.

REPAIR OF PERINEAL TEARS

A SIMPLE TECHNIQUE

BY

JAMES MELVIN, M.C., M.B., CH.B. ABERD.

Happily, extensive tears of the perineum are seen very infrequently nowadays. Tears involving the vaginal wall are still found in such cases as a primipara with a short quick labour, and in a multipara with much scar tissue, the result of a former tear, at least as often as in cases where forceps have been applied. The rates of maternal mortality are directly influenced by imperfectly repaired tears of the perineum. Sepsis is likely to develop when a tear is stitched in such a manner as to leave pockets and tags, or when a high vaginal or cervical tear is overlooked altogether. The general practitioner need never hesitate to investigate thoroughly, and feel satisfied that he has performed an efficient repair of any tear found if the following simple technique is carried out in all cases.

The Method in Detail

When sterilizing the forceps (whether to be used subsequently or not) there should be included in the sterilizer three rubber gloves, two artery forceps or needle-holders, two large half-curved needles, two small half-curved needles, a few strands of silkworm suture, scissors, a double speculum, and a flat-bladed tongue forceps or a vulsellum. Tubes of sterilized catgut should also be available.

Immediately after the birth and separation of the child (and while the mother is still presumably under anaesthesia) the patient is placed on the left side, with the buttocks over the raised edge of the bed or over a small pillow placed under the accouchement sheet, so that the drawn-up knees are on a lower plane than the buttocks. This position will permit the uterine discharges to flow forwards, downwards, and away from the area to be dealt with. A good light is essential.

The third rubber glove is pulled over the already gloved left hand. The left index finger is gently inserted to its full extent into the rectum. This finger is then swept forwards and downwards through an arc of 90 degrees, bringing practically the whole length of the posterior vaginal wall into the vaginal orifice, and so into full view.

If a tear in the vaginal wall be discovered, this is dealt with by a small needle and a continuous catgut suture, beginning at the uppermost limit of the tear. The edges should be carefully approximated by stitches no more than 1/4 in. apart. The second finger and thumb of the left hand can be utilized to help to tie knots and to retain the strand of catgut while the stitches are applied by the right hand. This suture is tied off on

reaching the lower limit of the tear or on reaching the perineum if the tear extends into that part.

Should the tear be a very deep one, involving the sphincter and part of the rectum, the rectal tear is first repaired by interrupted catgut sutures from above downwards, with the knots tied off in the rectal cavity. The finger is then inserted in the rectum, as described, and a few interrupted catgut sutures applied from above downwards to bring the deeper tissues together. The sphincter is dealt with by applying a catgut suture deeply from one side to the other, taking in the anterior third of the circumference of the anal orifice. The vaginal aspect of the tear is now attended to, as previously described. Elongated tags, such as those caused by bifurcations of the tear, should be snipped off rather than run the risk of a slough later on.

When the perineum remains to be dealt with, or when only the perineum is involved in the tear, the two distal phalanges of the left index finger in the rectum will be found sufficient to make the perineal wound bulge downwards, exposing it in its full extent. A large needle, with silkworm suture, is applied in a deep stitch, taking in the perineal body. The finger in the rectum permits the needle to make a deep and sweeping course from one side to the other without fear of penetrating vagina or rectum. Two such sutures are usually sufficient in tears of the complete perineum. Before tying these sutures the finger is removed from the rectum, the outer glove stripped off the left hand, and the gloved hands swilled in antiseptic solution. The perineal sutures should not be tied tightly. One or two additional interrupted shallow or skin sutures may then be put in to exactly approximate any gaping skin edges of the perineal tear. A loose strip or tag should be snipped off.

After the placenta is expelled (I have never seen a placenta, in its passage down the vagina, break down a repaired tear of vagina or perineum) and the uterus is firmly contracted, the cervix should be examined. With the patient in the same position a speculum is gently inserted along the (repaired or intact) posterior vaginal wall and the cervix viewed by the light of a torch held by the nurse. If a cervical tear be discovered the nurse is asked to kneel on the bed behind the patient's back, and, only if it be well contracted, to press the fundus of the uterus gently down into the pelvis. With this manoeuvre it is surprising how near the vaginal orifice the cervix will present itself. A flat-bladed tongue forceps, in preference to a vulsellum, is made to take a light grip of the cervix, and may be safely handed to the nurse, to be held to one side. The cervical tear is repaired, with a small needle in holder, by catgut suture, beginning distally to the cervical opening.

It is important after this operation to see that the uterus returns to its normal position. This should, owing to the possibility of a retroversion, be confirmed in all confinements by pressing the edge of the right hand deep into the abdominal wall, between the pubes and the body of the uterus, sweeping the latter upwards if necessary.

Anaesthesia is obtained by chloroform in a Junker's outfit, which is tied to the head of the bed or otherwise suspended in full view of the operator and beyond the patient's reach. The mask and bellows are manipulated by the patient, with help from the nurse, under the operator's instructions. The nurse should wear rubber gloves for ease in cleansing, and face masks are worn.

Advantages of the Method

The advantages of applying this technique in all cases are as follows. (1) Its simplicity and possibility of being carried out without assistance other than that of a nurse. (2) No tears are ever missed. (3) Hidden areas are easily

brought into full view and accessibility for efficient treatment. (4) The area to be dealt with is actually within the control of both hands, and deep sutures may be safely and fearlessly applied where required. (5) The choice of time permits the usual hiatus between birth of child and birth of placenta to be usefully filled in. (6) Shorter anaesthesia. (7) Double-gloved left hand obviates fear of contamination from rectum.

This method of dealing with perineal tears may be as old as the hills, but neither in hospital nor in general practice have I seen it in use. Over a period of approximately seven years I have found it not only useful under the peculiar difficulties of labour conduction in general practice, but easy of application and attended by good results.

Clinical Memoranda

Ocular Torticollis or Squint

In an article published in this *Journal* on March 3rd, 1934, I suggested that when the syndrome described by Duane in 1916 arose, of weakness of a superior rectus followed by and associated with hypertrophy and overaction of the complementary inferior rectus in the other eye, the patient was confronted with two alternatives. If the refraction was normal he would probably tilt the head to avoid diplopia: whereas, if the refraction favoured it, he would squint and suppress the offending image.

Many of my colleagues, as well as myself, since our attention has been directed to it, find quite an appreciable number of convergent squints in which, when looked for, overaction of the inferior oblique is a conspicuous feature. I said in my paper that when I should meet with a recently acquired convergent squint with this additional symptom I intended to divide the oblique first, to see if the convergence, which I surmised was merely a protective device, would disappear. I have now met a case which rather lends support to my hypothesis.

A boy, aged 23 months, was brought to my out-patients a few months ago with a left convergent squint of about 40 degrees. This had been noticed for three months, since an attack of pertussis. I sent him for refractive examination. It was found that there were in the right eye two and a half dioptries, and in the left five dioptries, of hypermetropia. Glasses were prescribed, but when he saw me a fortnight later there was no diminution of the squint. On a more careful examination I found great overaction of the left inferior oblique. The left eye "cocked up" strongly on looking up and to the right.

Here was a squint of only three months' duration, with hardly time for amblyopia to have set in, and just the refractive condition which I had postulated for a hypertrophied inferior oblique to produce squint instead of head-tilting. A week later I did a myotomy of the left oblique. I removed a quarter of an inch, and sent him home on the third day. Seen a week after the operation, the convergence had completely disappeared, with or without glasses. Two months later the condition was the same.

It must be emphasized that this squint had only been developed three months, and that, since he had both hypermetropia and anisometropia, to fall into a squint with suppression was the path, for him, of least resistance: a facile Avernine path indeed. Had he had normal and equal refraction he would probably have become a head-tilter.

I am reporting this case not only because it supports the theory that I have sponsored, but because it suggests a new line of thought as regards both aetiology and treatment in a small proportion of convergent squints. Overaction of the inferior oblique should be looked for and

identified or ruled out in all cases of early strabismus. How easy it is to miss may be seen in this case, where both myself and my junior, though each on the look out for such cases, did not discover it on the first examination. This, however, was merely for want of looking.

I need hardly say that if the squint has existed so long that amblyopia is present, such a procedure as myotomy of an inferior oblique, though possibly desirable on other grounds, will not, and could not, be expected to cure the squint. And equally clearly, in such a case as I have outlined above, to attempt to cure the squint by any other operative procedure would be incorrect practice based on a wrong conception of its pathology.

E. TEMPLE SMITH, F.R.C.S.Ed.,

Sydney, N.S.W.

D.O.Oxon.

Delayed Haemorrhage from Ruptured Spleen

The case reported below was seen a few days after Mr. Harold Dodd's article was published in the *British Medical Journal* of December 15th, 1934 (p. 1094). This, and the fact that fewer than fifty similar cases are to be found in the literature, has prompted me to add it to the collection. Incidentally Mr. Dodd's article was of great value as an aid to early diagnosis.

Case History

On December 10th, 1934, a young man, aged 19, was climbing over a fence and fell from it on to his left side, so that the left elbow was forced against the left lower ribs. The degree of violence was comparatively slight. He immediately experienced severe pain in the left side, but was able to cycle home, a distance of two miles. He went to bed, where he remained for six days. The pain in the left side persisted. There was no vomiting, but there were attacks of faintness and cold sweats. During the course of the illness the bowels were opened only once; this was on the fourth day after the accident.

On December 17th, a week after the fall, the patient got up, although he felt no better. While he was sitting at the breakfast table he suddenly became very faint. The pain rapidly grew worse, and spread across the upper abdomen, round to the back, and up to both shoulders, particularly the right. There was some shortness of breath, and the pain was increased by coughing or by taking a deep breath.

Two hours later the patient was admitted to hospital. The temperature was then 97°, pulse rate 92, and respirations 20. He looked pale and sallow. The skin was cold and moist, and the tongue was furred. Examination of the abdomen revealed generalized muscular rigidity and a marked diminution of abdominal respiratory movements. There was also generalized tenderness, most marked (1) in left hypochondrium, (2) in right hypochondrium, (3) in right iliac fossa. There was no distension. There was some dullness in the flanks, but particularly on the left side. Liver dullness was normal, but splenic dullness was diffusely increased.

The patient was kept under observation for a few hours, during which the temperature gradually rose to 100.6°, the pulse rate to 120, and the respirations to 28. The pain was constant. The abdomen was then opened through a left paramedian incision, and found to contain a considerable quantity of blood. There were masses of blood clot in the neighbourhood of the spleen. The organ showed a long laceration in the long axis of its lateral surface, and was removed. A blood transfusion was given immediately, and repeated the next day. The patient made a good recovery.

This case illustrates well some of the points quoted in Mr. Dodd's article, but pain was more marked in the right shoulder than in the left. There was no diarrhoea, and the caecal distension was absent.

I am indebted to Dr. J. F. Hackwood, Medical Superintendent of Farnborough Hospital, where the case occurred, for permission to publish it.

Hendon.

ROBERT GARDINER, M.B., F.R.C.S.Ed.