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EDITORIAL

VAGINAL INCISIONS IN GYNAECOLOGICAL SURGERY

An old proverb goes:"It is the most obvious thing which is least commonly observed." From the very beginning of Mankind the nulliparous woman has delivered her baby of considerable size and weight without difficulty and is still expected to do so. Even today, an obstetrician will deliver a primi-with pride-a big baby either naturally or with instruments, ntilising either a median or medio-lateral episiotomy and would term it as "routine". The use of episiotomy is so much lost in antiquity that no one remembers its originators or those who popularised it. However its use in gynaecological surgery had to wait until the Radical Vaginal Hysterectomy was devised and practised. Schoucardt's contribution of the vagino-perineal incision was mainly to facilitate the dissection and wide excision in his operations of Radical Vaginal Hysterectomy. Unfortunately the popularity of the radical vaginal hysterectomy was limited to central European countries and this incision never became popular in countries like United Kingdom & Commonwealth countries where radical vaginal hysterectomies were not extensively performed. The fact that a vagino-perineal incision can also be used for benign conditions or where the vagina is narrow is often forgotten. Such gynaecologists rather prefer the abdominal approach just on the grounds that patient is not a multipara or does not have uterine proplapse. Prominent gynaecologist from U.K., in his monogram on "V.V.F.Repair Operations" mentions that he has never used Schocardt's incision but admits that he uses midline perineal incision when the vagina is narrow.

The perineo-vaginal incision could be considered of great value when one has to repair a high Vesico-vaginal or Recto-vaginal fistula. Quite commonly the fibrosis accompanying the fistula pulls the region of the fistula either to the left or to the right side of vaginal vault. The perineo-vaginal incision performed on that side with its upper end reaching the edges of the fistula will give the proper mobilisation and space essential for this repair.

The median perineal incision can suitably be used for nulliparous patients or for cases with

uniformly enlarged uterus, and in the post-menoposal patients to facilitate the removal of both ovaries. In today's clinical practice the Caeserean sections, minilap, tubal occlusions and gynaecological laparotomies are increasing in numbers. One often encounters patients with lower abdomen full of operation scars. Occasionally scars of previous hernia repair using artificial prostheses are also encountered, making abdominal incision not only difficult but hazardous to the patient and with a future possibility of recurrence of the hernia. Contrary to the expectations the abdominal approach in these cases is not only more difficult but hazardous too, in producing damage to the bladder, intestines and often the operation has to be abondoned halfway. As against this, the vaginal incisions usually heal promptly, and even if the perineal skin incision opens up, the deeper layers heal well, particularly if synthetic absorbable sutures are used.

The author makes a plea to the gynaecological surgeons not to limit the use of vagino-perineal incisions only in Obstetrics, but utilise them to extend the scope of their gynaecological surgery in their vaginal operations. This will give the patient the advantage of the vaginal approach, thus minimising the post-operative pain, morbidity, and the duration of hospital stay.

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