OUR PRIZE COMPETITION.

FOR WHAT CONDITION IS FOTHERGILL'S OPERATION PERFORMED?

DESCRIBE THE PRE-OPERATIVE AND POST-OPERATIVE TREATMENT OF SUCH A CASE.

The papers submitted by Miss Isobel M. Hutton, B.A., M.B.C.N., Royal British Nurses' Association Club, 194, Queen's Gate, S.W.7, and by Miss Dorothy Dickinson, M.B.C.N., Nurses' Home, Charing Cross Hospital, W.C., in connection with our prize competition this month are both exceptionally excellent, and we have decided to award a prize to each.

MISS HUTTON'S PAPER.

Fothergill's operation is performed in cases of vaginal prolapse which are sufficiently severe for the cervix uteri to have sunk low in the vagina and to be almost protruding from it. The causes of such a condition are usually injury during childbirth and stretching of the tissues during childbirth.

This stretching may be caused by the application of forceps before the cervix is fully dilated thus pulling down the cervix as well as the baby's head, or it may be due to the fœtal head lying too long in the vagina during labour. The supports of the uterus are the trans-cervical and utero-sacral ligaments and the pubo-cervical fascia. It is the weakening of these that allows the uterus to prolapse. Since the anterior vaginal wall is in close connection with the bladder, it follows that, when there is a prolapse, a part of the bladder wall is dragged back also. This forms a sac which is known as a cystocele. In a similar manner part of the rectum may be involved in the prolapse of the posterior vaginal wall, forming a rectocele. When cystocele is present the patient usually comes to the doctor complaining of frequency of micturition and incontinence of urine upon coughing or bending. The condition predisposes to cystitis as there is always a small amount of residual urine which is liable to become infected. If the insertion of a ring pessary does not relieve the symptoms Fothergill's operation or some modification of it is indicated.

Fothergill's operation consists of amputation of the cervix followed by an anterior colporrhaphy. In addition it is often necessary to perform a posterior colporrhaphy and perinæorrhaphy. For anterior colporrhaphy a triangular strip of mucous membrane is removed from the anterior vaginal wall. The bladder is then separated from the supra-vaginal cervix and replaced in its normal position where it is retained by suturing together the pubo-cervical fascia. The triangular incision is closed by means of mattress sutures. In posterior colporrhaphy a triangular area of mucous membrane is excised from the posterior vaginal wall and bundles of fibres of the levator ani muscles are drawn together from either side, thus reforming the pelvic floor.

Patients with prolapse usually suffer from offensive vaginal discharge, therefore they are admitted for treatment with antiseptic douches a few days prior to operation in order that the site of operation may be as clean as possible. One ounce of castor oil or some other aperient is given according to the surgeon's wishes either forty-eight or twenty-four hours before operation and only very light diet is allowed after this. On the eve of operation the patient is given another douche and it is usual for the vagina to be packed with gauze soaked in flavine or some other solution. The easiest way to do the packing is to place the patient on her side and insert a lubricated Sims' speculum. The nurse wears a sterilized rubber glove on her right hand and uses her fingers to pack the vagina, taking care that the fornices are reached. Early the following morning a soap and water enema or a rectal wash-out is given and if the packing has come out it must be renewed. Some surgeons like the packing left in position until the patient is in the theatre, others do not. If the operation is in the morning the patient may be given a cup of tea early, but nothing to eat. Before the pre-operative drug is given a catheter must be passed in order that the bladder may be completely emptied. The operation gown is then put on and the patient told to rest quietly. If Avertin, Nembutal, Sodium Soneryl or any other such drug which produces unconsciousness is ordered it should be given one hour before operation and, of course, the pre-operative treatment must all be done before this. The patient must not be left after Avertin has been given as consciousness is soon lost.

When the patient has gone to the theatre the bed is made. An air ring is placed in readiness and a pillow with waterproof covering to place beneath the knees. A blanket is placed so that it will be next to the patient and hot water bottles or an electric blanket must be used to warm the bed. The patient is placed flat on her back without any pillow and the head is turned to one side. A small cloth, vomit bowl, mouth swabs and sponge holder are in readiness. A dressing has been put on in the theatre and tightly secured by means of a T-bandage. It is a wise precaution to tie the knees of the patient together upon her return to prevent any strain being put upon the stitches if she is restless. The dressing must be examined for signs of bleeding, as hæmorrhage, reactionary as well as secondary, is a complication of this operation. A self-retaining catheter may have been placed in the bladder in the theatre and the urine from this should be released every two hours. If there is no such catheter it will be necessary to catheterize the patient for the first twenty-four hours but after this time it should not be necessary to do so if the patient has been given a sufficient quantity of fluids. The wound should be swabbed with biniodide of mercury in spirit every time the patient micturates and a sterile dressing must be reapplied. It is probable that a mixture of potassium citrate will be ordered. The patient is kept on her back, with only one head pillow, for eight days, then raised gradually by the addition of one pillow at a time. Some surgeons order a mixture of paraffin and phenolphthalein to be given twice daily after the second day and an aperient to be given on the fifth or sixth morning after operation; others prefer the patient to be given an olive oil enema about the sixth day, followed by a soap and water enema given very gently. After defæcation the wound must be irrigated with hydrogen peroxide followed by saline and swabbed with biniodide in spirit. After the bowels have begun to be opened a little solid food is allowed, this being increased gradually from custards

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