THE UROLOGIC AND CUTANEOUS REVIEW

VOLUME XVII | JUNE, 1913 | NUMBER 6

INCONTINENCE OF URINE IN WOMEN.

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There is a peculiar form of incontinence of urine in women which either follows childbirth or comes on about middle age, and is not associated with any visible lesion of the urinary tract. Sometimes the most suggestive picture that can be seen by cystoscope is a gaping internal sphincter orifice which closes sluggishly. In the incontinence which comes on at about 40 years or over, the patient usually first notices the occasional escape of a few drops of urine as she makes some unusual exertion. This grows worse until, at last, a little urine runs out whenever she coughs, laughs, sneezes, lifts anything, or steps up high. The condition may finally become so bad that the underclothes are constantly wet and soiled with the malodorous secretions.

For a long time surgeons have tried to relieve this condition by a variety of operations, some of them more or less bizarre, designed to act upon the external urethral orifice by contracting it, or to resect the vagina at the internal orifice, or to kink the urethra, or in one way or another to compress it. These operations rarely succeed. I have seen many patients subjected to them, but none relieved.

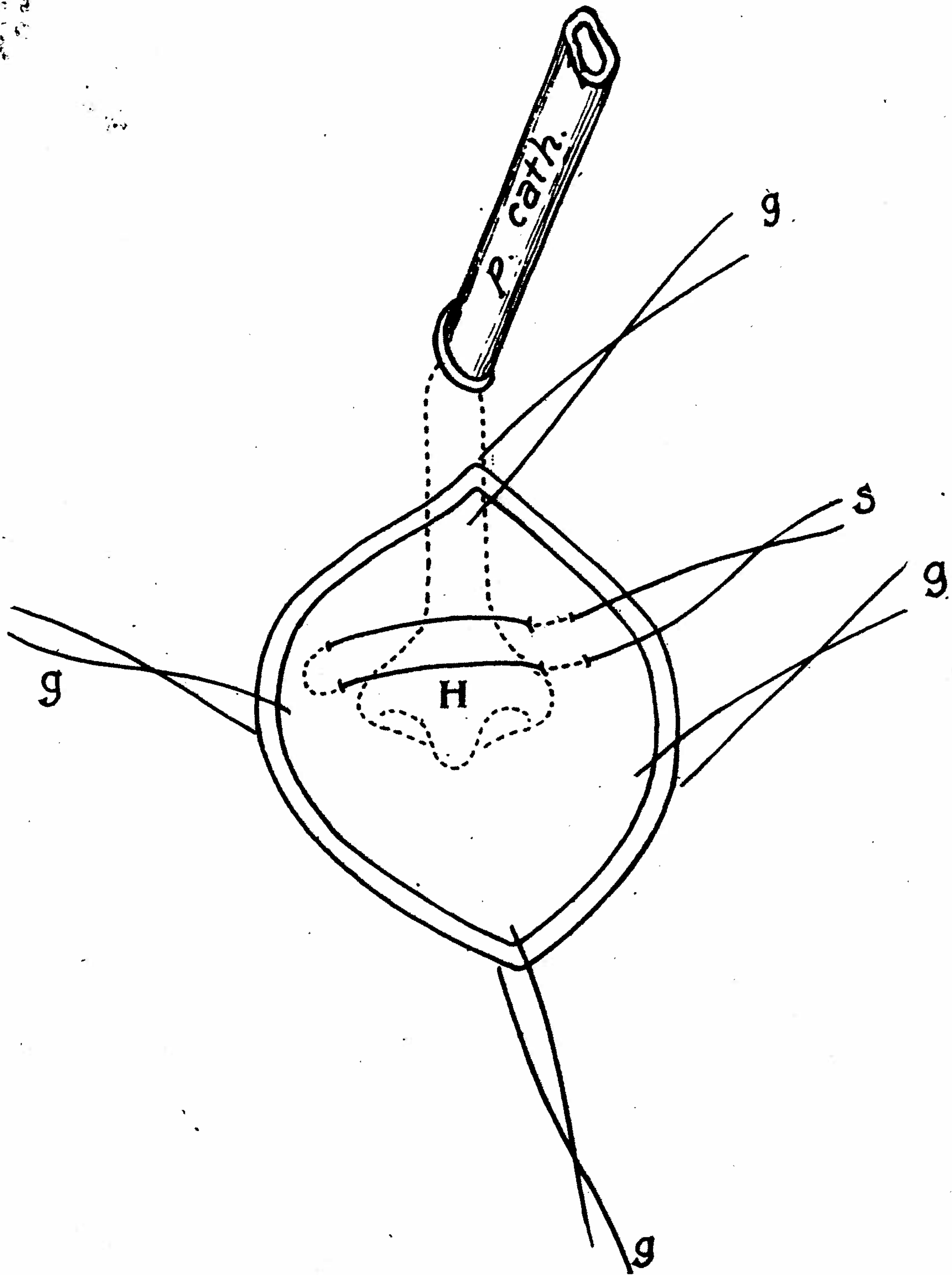
The key to successful treatment lies at the internal orifice of the urethra and in the sphincter muscle which controls the canal at this point. For the past 10 or 12 years I have been operating constantly upon patients suffering from this minor distressing inconvenience and I have succeeded in relieving every case where there had not been a destruction of the tissues at the urethral orifice, that is, where there had been no vesico-vaginal fistula with sloughing.

The operation which I do is as follows: A Pezzer catheter is introduced into the urethra, the tube ought to be small, not over 5 mm. in diameter. With the patient in the lithotomy position, the posterior wall of the vagina is retracted and the area at the neck of the bladder is brought down with either forceps or four guy sutures.

The next step is to slit the vaginal wall down to the urethra and the bladder in the median line for about 1½ or 2 inches. The neck of the bladder should fall at about the center of the incision. The position of the neck is easily determined at all times by moving the catheter to and fro, and feeling its head which presses close up against the urethra. The utmost care should be taken not to cut into the urethra or the bladder at any step of the operation. After making this median incision the vagina is further dissected off on both sides with tissue forceps and dissected away for a distance of 2 to 2½ cm. around the neck of the bladder. This dissection may be made with blunt pointed scissors which push their way into the tissues, separate the bladder from the vaginal walls and then cut the connecting fibrals. The dissection should be deepest at the neck of the bladder.

When the detachment of vagina from the bladder is completed, the finger should be able to grasp at least one-half or two-thirds of the neck of the bladder, including the contiguous urethra. Sometimes the bladder wall is so thin that its mucosa shines through.

The next step is to suture together the torn or relaxed tissues at the neck of the bladder, using 2 or 3 mattress sutures of fine silk or linen passed from side to side. The first suture taking in about 1½ cm. of tissue is tied at once, when the succeeding suture may be passed outside this, further contracting and bringing together the tissues at the neck. This is the principal part of the operation, and when done the mushroom catheter ought to be pulled out, the head of the catheter escaping with a little jump as it clears the tightened recon-



"H" is the head of the catheter marking the neck of the bladder. "GGGG" are the guy sutures holding the wound open. "S" is the suture at the neck of the bladder re-uniting the sphincter muscle.

structed sphincter at the neck of the bladder. The more or less redundant vaginal walls which have been detached in order to expose the sphincter area, are now resected so that the remaining tissues can be snugly brought together from side to side, so as to support the vesical area operated upon and avoid any dead space between bladder and vagina. I prefer to do this suturing with a continuous fine catgut suture in one or two layers.

The after-treatment is simple: No catheterization unless imperative, though sometimes it must be done for several days or even for a week. A Gatch bed and a half-way-up posture from the very first, and then out of bed in a few days.

THE TREATMENT OF PSORIASIS.—A treatment for psoriasis is offered by Bressler (*N. Y. Med. Jour.*) which he looks upon as offering excellent results in this annoying condition. No matter of what location, the parts are first thoroughly washed with spirit of green soap and water; then, for the first variety—a few lesions on any part of the body except face and scalp—paint with:

Chrysarobini..................ʒss to ʒi
Acidi Salicylici...................ʒss
Collodion Flex.....................℥i
M.

Bressler also employs the chrysarobin as an ointment, this being a more active form of treatment for some cases:

Chrysarobini..................ʒii to ʒi
Acidi Salicylici....................ʒss
Petrolati..........................℥i
M.

He continues to use the ointment until scaly lesions drop off, then pushes the ointment a little longer, finally covering the remaining erythematous area with the zinc oxide ointment. In this way a few lesions are usually cured, but we can never guarantee that an outbreak will not occur at any time in some other part of the body.

For the second variety—a moderate number of lesions—the same procedure is adopted, only larger amounts of chrysarobin ointment are used. With the author chrysarobin is the drug of choice. It should be pushed until it produces a slight dermatitis, then covered with zinc oxide ointment. Each night the drug is applied and in the morning a bath is taken. In some individuals it is found that a five per cent. chrysarobin ointment will produce a severe dermatitis, and so we should use only a two or three per cent. ointment. Bressler usually begins with a three per cent. and gradually increases until ten or fifteen per cent. chrysarobin is used. The discoloration of the skin from the drug need not be feared as it soon passes away. Never use chrysarobin on face or scalp. For the scalp use tar, ammoniated mercury or pyrogallol ointment.

Next best result is obtained with an ointment of pyrogallol:

Pyrogallolis..................ʒi to ʒii
Petrolati..........................℥i
M. ft. unguentum.

This drug produces less of a dermatitis than chrysarobin and may be used in large amounts. Tar is a famous and reliable old remedy, especially when combined with mercury. It is especially adapted to face and scalp lesions, but care must be used not to prescribe too large doses of mercury, because of danger of absorption and poisoning. We may prescribe:

Olei Cadini........................ʒi
Hydrarg. Ammoniati...............℈ii
Petrolati..........................℥i
M.

Many other drugs are used, as thymol, oil of turpentine, salicylic acid, etc., but we may confine ourselves to the drugs already mentioned, with very good results.

If the continuous use of chrysarobin ointment does not help, and especially in extensive chronic cases, stop all external treatment and begin a course of internal treatment alone for a period of from two to four months. Use arsenic in the form of Fowler's solution in five to fifteen minim doses three times a day after meals, or the cacodylate of sodium by deep injections, especially in the hospital cases. Bressler continues to use arsenic from two to four months, and in some cases gets very decided cures. Not all cases, however, will respond to internal treatment, and in such we should try the combined internal and external treatment with chrysarobin ointment. A good many patients have been cured by this combined method. The internal administration of potassium iodide has benefited some chronic sases.

The use of the Röntgen rays for chronic obstinate patches has given the author excellent results with almost permanent cures. He exposes the patient's lesions for about two to seven minutes, three times weekly, using a soft tube and placing the parts from six to twelve inches from the target. Treatment is given for two weeks, then suspended for two weeks; then another course is allowed. From four to eight weeks' treatment cures the psoriatic patch.