SOME OBSERVATIONS ON NON-MALIGNANT CONDITIONS OF THE CERVIX

BY

V. N. SHIRODKAR, M.D. (Bom.), F.R.C.S. (Eng.)

Professor of Obstetrics and Gynaecology, Grant Medical College, Bombay.

Many of the non-malignant conditions of the cervix are so well-known to you, and the previous speaekrs have given such detailed and learned information about them, that I will restrict myself to a few personal observations on some of the common conditions met with in daily practice.

The first condition which has not yet found a mention in the text book is a *pseudopolypus of the cervix*. This is the curling in of cervical mucosa due to trauma during labour. Sometimes the cervical epithelium gets detached from the lips of the cervix and curls in. In my early days of gynaecological practice I attempted to cauterize it or remove it only to learn how futile it was to do so. I am sure some of you must have had the same experience. No treatment is necessary.

The second condition is a *complete or partial stenosis of cervix,* following curettage and cervical electro-coagulation. I have very often requested my young colleagues to use a galvanic cautery for cauterizing the cervix, to avoid deep cauterization. With a diathermy electro-coagulation if the point of cautery is kept too long in one place, the burn goes deep into the tissues. I have seen several cases of extreme stenosis with this method of cauterization. Another important point I would like to lay considerable stress upon is the way the after-care of a cauterized cervix is neglected. If one sees a cauterized cervix two days after cauterizing, one finds a large cervical mucus plug containing sloughs and bacteria. This plug may prevent drainage and cause an upward spread of endometritis, giving rise to fever and prolonged bleeding. I call all my patients on the third day, and with a pledget of cotton wool dipped in four per cent copper sulphate solution, I work around the plug and it comes off as a conical piece. Patients are told to keep indoors for three days and take their temperature four hourly. With the rise of temperature they are asked to take procaine penicillin G injections, 400,000 daily, for three days. Patients must be told that there should be no sexual intercourse during the next three weeks following cauterization.

A word about conization of cervix,

Paper read before the Seventh All India Obstetric & Gynaecological Conference at Calcutta on December 21st, 1952.

using a cutting current and a special angular wire electrode, will not be out of place here. There are cases of erosion of the cervix where the glands have penetrated so deeply into the muscle that a superficial cauterization is not enough. It is for such cases that a conization is advised. Conization is bloodless during operation but may cause serious haemorrhage later on. I feel a wedge resection with a knife controlling the haemorrhage on the spot is preferable. This is, however, my personal view.

The third condition is *Hypertrophic elongation of the anterior lip of the cervix.* The hypertrophy may be of such magnitude that you may think of procidentia or extruded submucous fibroid. I have seen one case where the mass was of the size of a cocoanut and had sloughs all over it. The family physician had mistaken it for a large prolapse of the uterus and I too thought it to be so on a casual examination. Under an anaesthetic this proved to be just the anterior lip of the cervix. You may note that it is the anterior lip which gets caught between the foetal head and the pubic arch during labour. This may account for the anterior lip alone being involved in such hypertrophic conditions. Hypertrophic elongation of the cervix is a well known condition and may either occur with prolapse of the uterus or even without it and it occurs sometimes in nullipara. When a nullipara came to us with a hypertrophic elongation of the cervix without a cystocele we did not so far know how to deal with it. I have seen some gynaecologists do an amputation of the cervix and court repeated abortions in their patients. Some try to avoid amputation and do a ventral suspension hoping against hope that the cervix may get drawn up into the vagina.

The operation that I have devised for prolapse of the uterus also solves the problem of the cure of the hypertrophic elongation as you will see in the film which will be shown to you a little later. Majority of the cases can be cured without amputation of the cervix and some may require a partial amputation plus my method of shortening of the uterosacral ligaments.

Other conditions worth mentioning are:—*Lateral cervical tears* and *weak cervical sphincter.* Tears may be slight or extensive, involving the internal os. When the tears involve only the lower half of the vaginal portion of the cervix they are harmless but when they extend upwards and approach the internal os they are definitely pathological. The long cervical sphincter has been provided by nature to resist the rising intrauterine pressure, particularly in the third trimester of pregnancy. Many cases of habitual abortion occur between the fifth and the seventh month and some of them are due to either a torn cervix or a weak cervical sphincter. The tear in the cervix may look quite harmless, as a fold of the vaginal wall covers the real defect higher up. It is well worth your while dissecting this vaginal fold and find that the tear extends really much higher. The repair of this kind of tear by orthodox method of freshening the edges and suturing them together by catgut is to my mind a futile procedure. Very often the union is not strong enough and gives way in the

later months of pregnancy. I would like you to use strips of fascia lata to re-inforce the cervical sphincter. I use almost the same kind of technique to repair a weak cervical sphincter. In these cases I surround the cervix with a strip of fascia lata at the level of the internal os.

The entire technique will be shown to you in a coloured film which I have brought with me today. There are cases of habitual abortions which in the later months of pregnancy show a gradual passive dilatation of the cervix. Membranes can either be felt through the dilated cervix or even a bag of membranes may be projecting into the vagina. There are no labour pains. The condition occurs between four and half to seven months and you may get cases of as many as eight to nine abortions occurring year after year. I have up to now operated upon fifteen such cases, ten of them during the pregnant state. Out of these ten done during pregnancy, seven went to full term and had caesarean section with living children. I propose to do two or more caesareans on them and then tie the tubes. These cases have a weak cervical sphincter which may be due to a congenital defect or due to trauma of a forcible dilatation of cervix in previous labours. One of such cases was due to several induced abortions. Three cases gave history of one or two difficult labours with instrumental deliveries and these were followed by habitual abortions. Out of five cases done in non-pregnant state three have conceived and they are in the fifth, seventh, and eighth months of pregnancy at present. Three out of the ten done during pregnancy aborted within a week of the operation. In two of these I feel that the operation was done a little too late. A slight show of cervical mucus with blood tinge had already started although there were no labour pains. One case who had the operation done in the third month aborted a fortnight after the operation for no definite reason. From the very first day of the conception this patient had severe virus pneumonia with a cough persisting in a harassing manner day and night for the first two months of pregnancy. This might have devitalized the ovum and so it could not grow.

I have done the fascia lata repairs on two cases that had Fothergill operation done on them. One was done during pregnancy and she aborted, but became subsequently pregnant again and has delivered at full term. Kangaroo tendon and catgut was used in this case, but I do not like kangaroo tendon. It looks strong but crumbles up by becoming brittle within a few days of the operation. I recommend fascia lata everytime.

Lastly I would like to describe to you a case of *Congenital absence of the cervix* with a pin-point opening in the vault of the vagina. This woman came at full term for delivery. No opening could be seen from the vagina. I did a caesarean section and succeeded in dilating the pin-point os from above. This I did to ensure a free lochial drainage.