A REVIEW OF 600 CASES OF GENITAL PROLAPSE TREATED SURGICALLY

BY

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Genital prolapse is one of the most common lesions encountered in gynaecological practice. During the year 1953, out of 1238 patients admitted in the gynaecological wards of the Medical College Hospital, Patna, 225 were cases of prolapse.

The term prolapse includes cystocele, urethrocele, descent of uterus, rectocele and enterocele. Most authors classify prolapse of the uterus as first degree prolapse when the cervix is at the vulva, second degree with the cervix outside the vulva, third degree or procidentia with the entire uterus outside the vulva and the same classification is used in this article.

Large number of operations, both abdominal and vaginal, have been devised for the cure of prolapse. No one operation is suitable for all cases. In determining the method of treatment one has to take into consideration the age, general physical condition, the possibility of future pregnancy and whether there is any coexisting disease. Many women complaining of prolapse have only slight cystocele with the cervix well within the vagina and these do not require any surgical treatment. Where surgical treatment is necessary, the present trend is to perform the repair by the vaginal route.

I find the Manchester operation, devised by Donald and later modified by Fothergill, suitable for most cases of prolapse. The principle of the operation is to strengthen the natural supports from below. The operation is simple to perform and gives good result, cures up to 95% have been reported (Gordon 1946). Even in cases of procidentia the Manchester operation gives good result. Where the uterus alone descends without cystocele this operation often fails and in this type I do ventral fixation of the uterus.

Some gynaecologists object to doing ventral fixation during child bearing age on the ground that it causes difficulty during labour. If the anterior surface of the uterus is fixed as described by Bonney, no difficulty occurs during labour. Six of my cases returned with pregnancy after this operation and all had normal labour. I have done hysterectomy for prolapse only when there are coexisting conditions like bulky uterus, small fibroids, menorrhagia or cervical polyps of the mucus variety.

In very old and debilitated women the LeForte operation is done by many gynaecologists. This has the disadvantage that, if the patient complains of any vaginal bleeding or

discharge after the operation, examination and diagnosis become very difficult. Therefore in some of these cases I passed a steel wire all round the introitus and tightened it so that the introitus admitted only one finger, thus preventing the uterus and vaginal wall from descending outside the introitus, the method used by surgeons for prolapse of the rectum. This was successful only in those cases where the prolapse was mainly a cystocele with extremely atrophied uterus. In other cases the weight of the prolapsed mass against the narrowed introitus made the wire cut out after a few weeks.

During the 10 years, 1943-53, I have treated 645 cases surgically. Detailed notes are not available in 45 cases and these are not included in this review. In 449 cases the operation was performed by me and 151 cases were operated on by my assistants.

Type of prolapse

1. Marked cystocele with hardly any descent of cervix	65
2. Descent of uterus without cystocele or rectocele	56
3. First degree prolapse	161
4. Second degree prolapse	292
5. Complete prolapse (procidentia)	25
6. Rectocele alone	1
Total	600

In 39 cases of second degree prolapse there was a large mass outside the introitus resembling procidentia, but this was mainly due to oedema and hypertrophy of cervix and vagina.

Hernia of the pouch of Douglas was present in 23 cases. Marked rectocele was present in only 20 cases, but relaxation of the perineum was found in all except the nulliparous ones.

There was ulceration of cervix in 124 cases, these were simple ulcers and they healed in a few days when the prolapse was reduced and kept in with large cotton wool tampons soaked in 1/1000 acriflavine.

Eight patients had operation for prolapse elsewhere but had relapsed.

Associated conditions

Hydrosalpinx	1
Ovarian cyst	2
Myoma uterus	2
Cervical polyp, fibroid	2
„ „ mucus	10
Vaginal cyst	1
Labial cyst	2
Complete tear of perineum	2
Vesico-vaginal fistula	1
Diabetes	2
Tubercles on peritoneum of pouch of Douglas removed	1
Chronic bronchitis	several

Anaesthesia used

General	311
Local	202
Spinal	69
Pudendal block	18

Local and pudendal block anaesthesia are of great use when operating on old and debilitated women and also when there are associated diseases like diabetes, bronchitis, tuberculosis, etc., where general anaesthesia, particularly ether, is unsuitable. Local anaesthesia has also the great advantage of minimising blood loss during operation.

With ether there is good deal of bleeding during operation.

The age, parity and type of operation done according to age is given in Table. The youngest was 16 years of age and the oldest 70 years. Most authors of gynaecological text books give multiparity and forceps application during labour as causes of prolapse. In this series 24 cases were in nulliparae and 97 cases occurred after the first childbirth, that is, in more than 1/6th of the cases the cause was not multiparity. Only one patient had forceps applied in the first pregnancy. Weakness of the pelvic floor caused by laceration and stretching, particularly of the levator ani muscle as explained by Pacey, and not multiparity, appear to be the cause in most of these cases.

Manchester operation was the treatment adopted in 443 cases. TeLinde is of opinion that the Manchester operation is a satisfactory procedure only when there is cystocele associated with the first degree prolapse and he has never used it for complete prolapse. In this series there were 25 cases of complete prolapse and 14 of these were treated by Manchester operation, none of these returned with recurrence. It was not possible to follow up the cases owing to want of facilities but as most of these cases came from villages where there are no facilities for operative treatment some at least would have returned if the prolapse had recurred. Of the cases of descent of the uterus without cystocele, 19 had Manchester operation and three of these had ventral fixation later as the prolapse recurred. The remaining 410 Manchester operations were done for first and second degree prolapse and of these 13 returned with recurrence, two were after childbirth, three of these had only enterocele.

Mayo ward hysterectomy was done in 37 cases and two of these cases came back with recurrence, in one three was complete prolapse of the vaginal wall and LeForte operation was done, the other had only slight rectocele and was left alone.

Twelve cases were wired; one of these was done only to keep the uterus in for a few days to get the ulcers healed as she had a complete prolapse with ulcers on cervix and vaginal wall and uterus could not be kept in with tampons. The wire was cut after 10 days, the ulcers had completely healed and she had Manchester operation done. The rest were wired because the patients were considered to be too old and debilitated for any operative treatment. Five of these returned after few weeks to few months as the wire had cut out and in these Manchester operation was carried out under local anaesthesia. In cases of old and debilitated women with cystocele only or cystocele and first degree prolapse wiring appears to make the patient comfortable, but where the prolapse is anything more than the first degree the weight of the uterus caused the wire to cut out and this method is useless.

There were four deaths; one after hysterectomy due to sepsis; three after Manchester operation. One died of sepsis, one of secondary haemorrhage on the 8th day. The third one, an old lady of 68 developed severe attack of diarrhoea and although the

diarrhoea was checked after 2 days she never recovered from its effect and died on the 22nd day after operation. In cases not included in this review there were no deaths.

References:

1. Bonney E.: A Text Book of Gynaecological Surgery 1952, Cassel Company Ltd.
2. Gordon, A. C.: Am. Jour. Obst. & Gynec. 52, 228, 1946.
3. Pacey, K.: Jour. Obst. & Gynaec. Brit. Emp., 56, 1, 1949.
4. TeLinde, R. W.: Operative Gynaecology 1953, Lippincott Company.

AGE, PARITY AND

AGE

Operation	16-20	21-25	26-30	31-35
Manchester operation	17	72	115	52
Ant. and post. colporraphy ..	7	15	9	10
Post. colpo-perineorraphy ..	—	—	1	—
Ventral fixation	8	10	12	2
Mayo hysterectomy	—	—	1	—
LeForte operation	—	—	—	—
Wired	—	—	—	—
Amp. cx., perineorraphy and sub-total hysterectomy	—	—	—	—
	32	97	138	64
Parity Nil	9	7	4	1
1	18	32	28	5
2	5	27	31	7
3	1	15	28	17
4	—	3	20	9
5	—	5	14	7
6	—	—	7	5
7	—	1	3	5
8	—	—	1	2
9	—	—	—	1
10	—	—	—	—
11	—	—	—	—
12	—	—	—	—
13	—	—	—	—
No Note	—	6	4	5

TYPE OF OPERATION.

36-40	41-45	46-50	51-55	56-60	61-65	66-70	Total
56	33	52	25	17	3	1	443
5	6	5	4	3	—	1	65
—	—	—	—	1	—	—	2
4	—	—	—	—	—	—	36
11	3	14	5	3	—	—	37
—	—	—	—	3	1	—	4
—	—	—	3	6	3	—	12
1	—	—	—	—	—	—	1
77	42	71	37	33	7	2	600
—	1	—	—	2	—	—	24
7	2	1	2	1	—	1	97
2	—	3	2	3	—	—	80
11	10	7	2	1	—	—	92
16	2	9	1	2	—	—	62
9	5	9	5	6	2	—	61
5	5	6	5	5	1	—	44
7	3	7	2	2	3	—	33
9	2	5	4	3	4	—	27
5	3	10	1	1	—	—	21
3	3	6	2	1	—	—	15
1	—	—	2	1	—	—	4
—	—	3	—	—	—	1	4
—	1	1	—	2	—	—	4
2	5	4	4	2	—	—	32