

## A FOLLOW-UP STUDY OF CASES OF UTERINE PROLAPSE TREATED BY ABDOMINAL CERVIPEXY \*

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For a long time there has been a search for a good operation for cases of uterine prolapse in which future child-bearing is desirable. These cases present a special problem of their own, viz.

(1) The operation should neither hinder future conception nor should it lead to habitual abortion nor dystocia during labour.

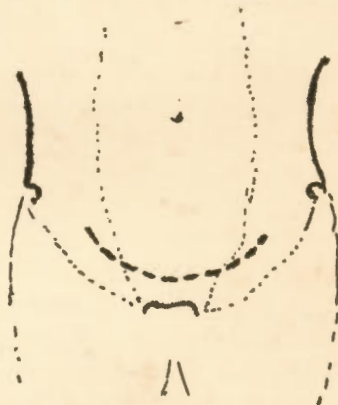
(2) The operation should provide adequate support to the uterus. There should be no recurrence after child-birth. This means that the support should be able to stand the strain of labour.

One of the operations suggested for such cases is abdominal cervicopexy. Two fascial slings are prepared from the aponeurosis of the lateral abdominal muscles which by their tone and contraction pull up the uterus so that when the patient

strains the uterus instead of descending actually rises up.

The essential technical steps of this operation are:—

A transverse curved incision (Fig. 1), about 4 inches long, is made



I - The Incision

Fig. 1

equally on either side of the midline an inch above the symphysis pubis. The rectus sheath is opened in line of skin incision. Peritoneum is opened vertically after separating the rectus muscles. The uterus and the adnexa

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are inspected whereafter a sling is prepared from the rectus sheath on each side extending from the midline to the lateral border of the rectus muscles. The sling is half an inch in width in midline and runs laterally in a fanwise manner. The utero-vesical pouch is opened and bladder is separated from the front of cervix. The slings are brought into the abdomen extraperitoneally by Bonney's round ligament forceps in front of the cervix and transfixed at the level of the internal os. The uterus is brought forwards by advancement of bladder peritoneum and plication of round ligaments.

Care is taken to see (Fig. 4) that

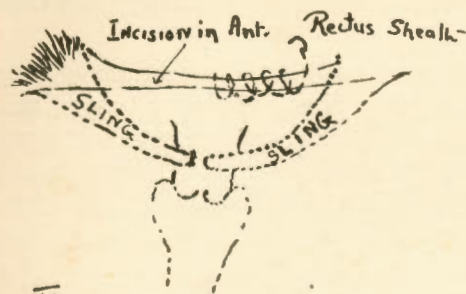


Fig. 4

- (i) the base of the slings is wide enough to maintain the blood supply,
- (ii) while closing the abdomen the lateral angles of rectus sheath should neither be sutured too tightly lest it hinder the blood supply of the sling nor too loose so as to cause a hernia.

The end results of this operation, in our experience, is a uterus (Fig. 2) which is really anteverted and retroflexed so that it gives an impression of a retroposed uterus, the long axes of the vagina and the uterus being in the same direction. The cervix is held up above and a little in front of



II - CERVICOPEXY - End Result

Fig. 2

the posterior superior border of symphysis pubis.

To this original operation, one of us (P. G. B.) has added a modification, viz. vaginopexy (Fig. 3), where-



III - Cervicopexy & Vaginopexy

Fig. 3

in the bladder is further separated from the anterior vaginal wall after which the anterior vaginal wall (in its whole width) is lifted up by means of stitches and sutured to the anterior surface of the body of uterus.

The advantages of this procedure are: (i) it maintains the classical anteverted anteflexed position of the uterus; (ii) it helps to treat a moder-



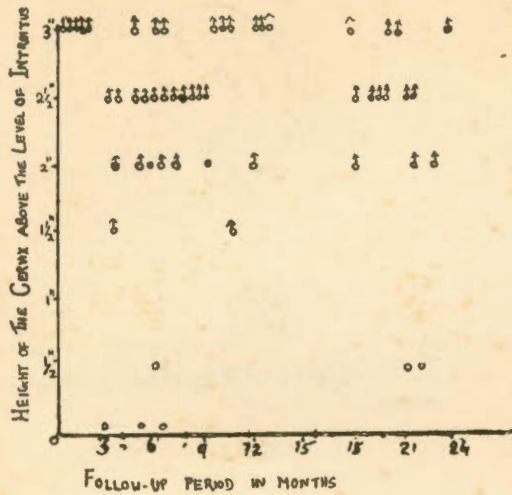


Fig. 5

ate cystocele per abdomen so that a separate procedure is not required per vaginam.

Associated conditions like cystocele, and rectocele, elongated cervix and retroversion are treated at the same time, the vaginal procedure, like anterior colporrhaphy etc., being usually performed prior to the abdominal procedure. Vaginopexy described above obviates the necessity of performing anterior colporrhaphy except in very large cystoceles.

The advantage of cervicopexy is

that it makes use of abdominal muscles which can be strengthened by physiotherapy.

Here we present to you the results of our experience and follow-up study in brief. We, at the Lokmanya Tilak Municipal General Hospital, Sion, started performing this operation since September 1956. In this study we have 53 cases operated within 2 years thereafter for our analysis.

Cases selected are those where future child-bearing is desirable. Cases of procidentia are not thought fit for abdominal cervicopexy.

Table I shows that we performed this operation in 47.74% of cases of prolapse seen by us during the period of two years.

Seven patients have become pregnant after the operation and four have delivered and showed no recurrence after delivery. One case is now pregnant for the second time. Of these cases, only two came with secondary sterility. This shows that this operation does not hinder conception.

In one case at the time of sterilisation we could observe the slings well attached to the cervix. There was no stretching of the slings.

TABLE I  
111 Cases of Uterine Prolapse Treated during September  
1956 to August 1958

Name of operation	No. of operations	Percentage
1. Abdominal cervicopexy .. .. .	53	47.74
2. Mayo-Ward's hysterectomy .. .. .	46	41.44
3. Fothergill's operation .. .. .	4	3.6
4. Amputation of cervix with ventri-suspension ..	3	2.7
5. LeForte's operation .. .. .	2	1.8
6. Anterior colporrhaphy with colpo-perineorrhaphy and ventrisuspension .. .. .	2	1.8
7. Ventrifixation .. .. .	1	0.9

TABLE II  
Summary of Results (Fig. 5)

Follow-up period in months	Level of cervix in inches above introitus	No. of cases	Action of sling	Success	Failure	Total
1. 22-24	3"	2	Good	5		
	Upto 1½"	3	Good			
		2	Poor			
2. 21	3"	2	Good	5	—	7
	Upto 1½"	3	Good			
		1	Good			
3. 18	3"	1	Good	3	—	3
	Upto 1½"	2	Fair			
4. 15	3"	1	Fair	1	—	1
5. 12	3"	5	Good	7	—	7
	Upto 1½"	2	Good			
6. 9	Upto 1½"	5	Good	5		
	Less than 1½"	1	Poor			
7. 6	3"	3	Good	14		
	Upto 1½"	11	Good			
	Less than 1½"	2	Poor			
8. 3 months or less	3"	5	Good	7		
	Upto 1½"	2	Good			
	Less than 1½"	1	Poor			
Total				47	6	53

None of the cases developed post-operative hernia.

Table II shows that our failure rate was 11.32%. Probable causes of failure are: (i) Stretching of the musculo-fascial slings as was seen at the subsequent laparotomy in one of the cases.

(ii) Stitches transfixing the slings to the cervix might have cut through. This can be minimised by avoiding too much tension on the slings and by tying the sutures not too tightly.

(iii) Faulty selection of cases. Third degree prolapse cases are not suitable for this operation.

We do not know whether lower segment caesarean section would be feasible after cervicopexy since (i) the slings are attached to the cervix at about the usual site of incision in the lower segment, (ii) the separa-

tion of the bladder may be difficult, and (iii) the utero-vesical pouch is obliterated.

*Conclusions*

In spite of a few failures, we do not feel discouraged about this operation because if a woman of child-bearing age is relieved of prolapse of the uterus even for sometime by an operation, without interference to her reproductive function, she can subsequently undergo a more radical operation, once she has completed her family, should the prolapse recur. We feel that this operation deserves further trial and a similar systematic follow up.

*Acknowledgment*

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