

## PRIMARY VENTRISUSPENSION §

by

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### Introduction

The enthusiasm and the eagerness to correct a retroverted uterus surgically have gradually but decisively regressed in the last 40 years. We have long left behind us the days when retroversion of the uterus was held responsible for every conceivable pelvic symptom and it *per se* was considered a gross pelvic pathology, the universal correction of which was a standard teaching. To-day, with the increase in his knowledge of pathology, the gynaecologist's wisdom has gradually asserted itself to ungrudgingly permit his patient to live merrily with her uterus looking backwards. As a result, the operation of ventrisuspension as a primary surgery is almost boycotted from many teaching hospitals of the world. Most of the suspensions that are now done are done merely as a secondary or incidental procedure in operations for tubo-ovarian masses, endometriosis, fibroids, etc. Primary ventrisuspensions,

where laparotomies are undertaken merely to correct a retroverted mobile uterus, unassociated with any other pelvic pathology, are fast becoming a surgical curiosity. Nevertheless, it is a general impression that primary suspensions are still performed far too liberally in many of the teaching hospitals in Bombay. An analysis and evaluation of the primary suspensions performed at the Petit Hospital during a 3-year period was, therefore, undertaken and the results are presented here.

### Incidence

During the 3 year period of study, from 1st January 1957 to 31st December 1959, 308 uterine suspensions were performed at the Petit Hospital. Of these, 168 were secondary procedures during the course of surgery for some pelvic pathology other than the retroverted uterus. The remaining 140 were primary suspensions. During the same period nearly 15000 patients attended the out-patients' department of the hospital, and 1484 major gynaecological operations were performed. The incidence of primary ventri-suspension thus is 1:107 new patients seen, or 1:10.6 major gynaecological operations.

Table I gives the incidence reported by various authors. Dedman (1953)

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states that the incidence of suspension operations among pelvic laparotomies varies from 15-25% in different hospitals. Dedman (1960) reports an incidence of uterine suspension of 1:200 new patients or 1:40 to 50 instances of retroverted uterus. But 18 out of his 21 patients had additional complicating lesions requiring surgery other than uterine suspension. Thus it can be deduced that the incidence of primary uterine suspension is 1:1400 new patients. In 3000 consecutive new cases in private practice, McFadyen did 32 primary uterine suspensions, an incidence of 1:94 new patients. Youssef says that only 17 primary suspensions were done over a period of 4 years in the busy practice of his large teaching hospital. Both Nash and Craig say that they have not performed any primary suspension for many years past.

TABLE I  
Incidence

Author	Incidence
Dedman	1 : 1400 new patients
McFadyen	1 : 94 new patients
Youssef	17 in 4 years
Nash	None in 10 years
Craig	None in many years
Present series	1 : 107 new patients
Present series	1 : 10.6 major gynaecological operations

It is not possible to make a true comparison between the various incidences mentioned above but it is obvious that our incidence is much higher than that of most other authors.

Out of the 140 cases of primary suspension, complete records could be traced in only 100 cases. Hence, only 100 cases form the basis of this study.

### Indications

TABLE II  
Indications

Indication	No.
Primary sterility	32
Primary sterility + Dysmenorrhoea	18
Secondary sterility	28
Secondary sterility + Dysmenorrhoea	6
Sterility + Dysmenorrhoea + Dyspareunia	2
Sterility + Dyspareunia	4
Dysmenorrhoea	3
Dyspareunia	1
Dysmenorrhoea + Dyspareunia	1
Habitual abortions	3
Backache	2
Total	100

Table II gives the indications for the 100 primary suspensions under consideration. Sterility stands out as by far the most important of the group, being the sole or the main indication in 90 out of 100 cases. No one seriously believes today that a retroverted uterus can cause sterility except in occasional cases. Bravo found that there was no difference in the incidence of retroversion in sterile and fertile women, and that amongst the sterile women with retroverted uterus, in only 1.8% was retroversion the only abnormality present. He concludes that retroversion can only occasionally be the cause of sterility. Plass has shown that retrodisplacement rarely produces symptoms of any moment and is not a common cause of sterility. Sterility does not figure in McFadyen's list of most common complaints by patients with retroverted uterus. It, therefore, is a surprise that 90% of our primary suspensions were done for sterility. It may be added that most of these patients were not thoroughly investi-

gated for their sterility and the coincidental existence of retroversion and sterility was unjustifiably granted a cause and effect relationship and ill-indicated suspensions undertaken.

Thirty patients suffered from dysmenorrhoea. But 26 of these had sterility as their main complaint. In 3 cases dysmenorrhoea was the sole indication for surgery. In no case was a therapeutic pessary test done pre-operatively.

Eight patients had dyspareunia and presented retroverted uterus with prolapsed tender ovaries in the pouch of Douglas. No one would question the justification of suspending the uterus and the ovaries in such patients.

Repeated abortions was the sole indication for suspension in 3 cases, and backache in 2 cases. No one has a genuine faith in mobile retroverted uterus as a cause of abortion. McFadyen has found no difference in the incidence of spontaneous abortions in patients with retroverted and anteverted uterus. As for backache, it needs a lot of imagination to think that a retroverted mobile uterus can cause backache.

Lastly, surgical training of the resident staff is an oft given excuse for submitting innocent women to suspensions they ill-need. Table III shows that only 22% of the suspen-

sions under study were performed by the resident staff and explodes the myth of this excuse.

#### Technique

Uterine suspension was achieved by modified Gilliam's technique in all cases in this series. Youssef advocates correction of retroverted uterus by vaginal route. Dedman (1953) is pleading the use of pubocervical fascia by abdominal route for the surgical correction of retroversion. It is not possible for us to weigh the merits of these and many other methods of suspending a retroverted uterus. We can only say that amongst the countless methods advocated from time to time the modified Gilliam's method has stood the test of time and is the one almost universally used at present.

#### Anaesthesia

Spinal anaesthesia was the choice in most cases and was used in 96 cases. Six of these 96 required a supplementation by intravenous sodium thiopentone either because the spinal anaesthesia had not acted well or because the patients were not properly premedicated. In 4 cases intratracheal inhalation anaesthesia was used.

#### Associated Surgery

TABLE IV  
Associated Surgery

Associated Surgery	No.
Cott's presacral sympathectomy	8
Plication of the ovarian ligaments	15
Extroversion of the ovaries	14
Appendicectomy	36

TABLE III  
Surgeon

Surgeon	No.
Honorary gynaecologist	31
Honorary assistant gynaecologist	47
Registrar	12
House surgeon	10
Total	100

In 8 cases of dysmenorrhoea, Cott's presacral sympathectomy was performed in addition to the uterine suspension. It is not our intension to discuss the place of Cott's operation in the treatment of dysmenorrhoea. We, however, wish to point out that, during the period of study, in not a single instance was Cott's operation done for relief of dysmenorrhoea in a patient with anteverted uterus.

In 15 cases plication of ovarian ligaments was done as the ovaries were prolapsed in the pouch of Douglas with or without any resulting symptoms.

In 14 cases extroversion of the ovaries was carried out for small multiple cysts in the ovaries.

In 36 cases appendicectomy was done as an incidental surgery. In none of these was the appendix grossly pathological. The soundness of the practice of routine appendicectomy at every laparotomy is considered outside the scope of today's discussion.

#### *Morbidity*

There was no mortality in the series. Wound sepsis of minor degree complicated the postoperative period in 8 cases, although penicillin and streptomycin were routinely exhibited. Average postoperative stay in the hospital was 12 days.

#### *Follow-up Study*

Follow-up study was started in July 1961. Thus the minimum interval between surgery and follow-up study is 1½ years while the maximum is 4½ years. Initially patients were called for follow-up study by writing letters. Out of the 100 cases, 50 could not be contacted for follow-up, due to

either imperfect recording of address on the case papers or a change of address. 29 out of the remaining 50, responded promptly. A repeat request by letter was made to the 21 who did not respond to the first letter. This succeeded in 8 cases. Personal contacts by home visits were made in the remaining 13 cases. Thus, in all, 50 patients were followed-up.

(1) *Relief of Symptoms.* Table V gives the relief experienced by the patients from their symptoms.

TABLE V  
*Relief of Symptoms Noted at  
Follow-up Study*

Symptom	Cases followed-up	No. relieved
Sterility	44	9
Dysmenorrhoea	19	12
Dyspareunia	3	2
Habitual abortion	2	2
Backache	2	2

Out of the 44 patients who had sterility, only 9 had conceived. However, this needs further probing. We feel that uterine suspension should be credited with only those conceptions which occur within 1 year of surgery. Judging by this yardstick, only one conception could be credited to uterine suspension. Four conceptions occurred between 1 and 2 years of surgery while 4 conceptions occurred later than 2 years after surgery. Even if all the 5 conceptions that occurred within 2 years of surgery are credited to uterine suspension the result, viz. 11%, should be considered very poor. Of the 19 patients who had dysmenorrhoea (4 had Cott's operation), 12 reported relief (2 had Cott's operation). This result seems better than antici-

pated. Yet let it be mentioned that one patient who emphatically claimed relief from dysmenorrhoea exhibited a retroverted uterus on follow-up examination. Of the 12 patients who had relief from dysmenorrhoea, 8 had relief only following the postoperative delivery. The dysmenorrhoea was relieved not by suspension but by vaginal delivery. Out of the 3 cases of dyspareunia, 2 had benefitted. No cause could be detected to account for the persisting dyspareunia in the remaining patient. Both the patients of repeated abortions had term delivery after the operation. However, in one of them at least, it appears that uterine hypoplasia rather than retroversion was the cause of the repeated abortions as she had 3 abortions of 3, 4, and 5 months preoperatively, while after the operation she had a 7 months' premature delivery, followed by a term pregnancy. Both the patients with backache claimed relief.

Out of the 50 cases, 34 had no relief from any of their symptoms.

The 50 patients who could be followed up were divided into two groups. The first group comprised of the 29 cases who promptly responded to the first letter. The second group consisted of the 21 cases who had to be coaxed for the follow-up. Relief of symptoms was no better in the second group than in the first one. Relief of symptoms was not, therefore, the reason for the reluctance on the part of the patients to turn up for a follow-up study. It is thus unlikely that the patients who could not be followed up had better results than those studied.

(2) *Position of Uterus at Follow-up Examination.* Vaginal examina-

tion at the time of the follow-up study could be carried out on 37 patients only. 30 of these had an anteverted uterus, 5 had a retroverted uterus and 2 had a midposed uterus. None of the patients with retroverted uterus had undergone a pregnancy after the operation. Dedman (1953) found too many recurrences after ventrisuspension of the uterus. Our findings are not in conformity with his. We feel that faulty technique rather than the method of suspension used was responsible for the 5 recurrences even in the absence of a strain of pregnancy.

(3) *Complications.* Complications, like intestinal obstruction, pain and tenderness over the points of fixation of the round ligaments to the abdominal wall, etc., were conspicuous by their absence.

#### *Comments*

Although successive editions of some of our text-books still continue to devote substantial space to ventrisuspension with stimulating descriptions and diagrams of the various methods advocated from time to time, they certainly are more and more guarded in recommending indications for the operation. Current opinion, as judged from the teachings of the text-books and the writings of the various authors, seems to point out that correction of a mobile retroverted uterus *per se* is only occasionally justified. The indications for primary ventrisuspension are fast disappearing. Primary ventrisuspension should not be undertaken unless the malposed uterus is proved beyond doubt to be responsible for the patient's symptoms. A therapeutic pessary test cannot be too strongly recommended

for this purpose. The teaching at our hospital is in conformation with the above statements. The large number of ventrisuspension at our hospital, as found in this study, is, therefore, an unexpected surprise. A ban on the operation of ventrisuspension, except under a strong positive indication, cannot be too strongly pleaded. We all have the knowledge that a retroverted mobile uterus needs no correction. Let us have the courage of our convictions, to desist from suspending a mobile retroverted uterus.

The results of the operation, as noted in the follow-up study, add strength to the plea made by us. Thirty-four of the 50 cases followed up had no relief from any of their symptoms. In other words 68% of the patients were no better in spite of the uterus being held in the so-called normal position. Is an empirical suspension worth undertaking?

In *conclusion*, there seems no justification for the over eager readiness to suspend a retroverted mobile uterus. Proper evaluation of the patient's symptoms by a thorough investigation, inclusive of the pessary test, should be a must before the retroversion can be incriminated for

the patient's discomfort. If proper criteria are insisted upon, primary ventrisuspension will be performed only occasionally.

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