SURGICAL ASPECTS OF STERILIZATION

by

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Family planning, the burning problem of India, has found its greatest rescue in operation of sterilization in women. Planning in the true sense, i.e. to have the desired number of children at desired intervals has not yet materialised. Hence by mere operation of sterilization we prevent further pregnancies in multiparous women. The other side of this problem is that women of younger age group undergo this operation after completing their families without proper spacing. The children at this stage are of about five years and less, susceptible to many diseases incidental to their age. This keeps the parents under constant state of anxiety. Contraceptive measures have not yet gained wide popularity. The recently introduced Lippe's loop seems to be becoming popular. The results are still awaited. Looking to the circumstances our aim still remains to convince women with four and more children to undergo tubectomy.

This report pertains to sterilizations performed at Irwin Group of Hospitals and Shri M. P. Shah Medical College, Jamnagar, during the last five years. Total number of deliveries from 1st & 31st January 1961 to 31st December 1965 were 9783 and the number of sterilizations done during this period was 1022. Hence the incidence of the operation comes to 10.45%. However, during the last year the incidence of sterilizations has come to 18.93%.

Selection of Cases

No patient willing for operation was refused on grounds other than medical. Parity and number of living children was the only merit or demerit for the operation. We did not encourage women with three and less children, minimum one of either sex, to undergo the operation. Majority of our cases had already undergone six deliveries, and it was not unusual to have 10th and 11th paras. We had an occasion to sterilize even a 16th para. Smaller number of earlier parity belonged to the enlightened group, especially of Jamnagar proper. In this group are also included cases where sterilization was done along with caesarean section either for bad obstetric history or for obstructed labour or in a multipara for antepartum haemorrhage. We always sterilize the cases of ruptured uterus when repair is done. Some operations were done on medical grounds

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i.e. heart disease, tuberculosis, etc.

Haemoglobin estimation was done as a routine. Anaemia up to 8 gm% of haemoblobin is never a contraindication to the operation. We have also operated at times on patients with as low as 6 gm.% of haemoglobin. This evidently is the result of patients not seeking antenatal care. We tried persuading anaemic patients to attend postnatal clinics and to undergo vaginal sterilization 3 months after delivery. However, I am sorry to have to state that most of our patients failed to follow our advice and came only with the onset of the next labour pains, with poorer general condition. This led us to operate on patients with greater degree of anaemia. Urine examination was done as a routine. Intrapartum sepsis and severe haemorrhage during labour are other contraindications to the operation.

The patients who delivered elsewhere were not taken up. This being a district hospital we admit cases from outside Jamnagar in their last days of pregnancy so that they can be sterilized after delivery.

Tubectomy is done on the next operation day following delivery, which generally falls within three to four days. We operate even up to the 10th postnatal day. Spinal anaesthesia is the anaesthesia of choice. (Stovaine 2% 1.4 ml.). This gives good relaxation and the retraction of the intestines gives good operating field. General or local anaesthsia is only used when spinal is contraindicated.

Technique

A median or paramedian incision about 5 cms. long extending 1/3 above and 2/3 below the fundus of the uterus is taken. The abdomen is opened. With the help of the long curved retractor (Fig. I) the cornual end of the uterus is brought nearer the incision and simultaneously the tube is caught with the help of Bebcock forceps. This avoids manipulations in the abdomen. Fimbrial end is identified and a loop of the tube, about 2 cms. long is excised after crushing and transfixation. The suturing material used is chromic catgut No. 1. Sterilizations done along with caesarean section or laparotomy need no comments.

Most of the cases who came 3 months after delivery were operated on by the vaginal route. We prefer abdominal route even at this stage if clinically it is observed that the uterine mobility is restricted, the uterus is bulky or there are adhesions.

A large blood vessel in the vicinity of the loop is protected from being crushed or punctured by the needle; this avoids formation of haematoma and its complications.

Difficulties encountered

When the operation is done on the first postnatal day the bulky uterus keeps the cornual end away from the midline and it might be difficult to reach it. The long curved retractor already referred to is quite helpful in such cases. With adequate incision the above difficulty is less common. If the operation is delayed beyond the 8th postnatal day the uterus becomes a pelvic organ and intestines might come in the way of reaching the tubes. Our practice is to pack the

vagina in such cases. This lifts the uterus above the symphysis pubis making the tubes accecible.

Post-operative care

Routine post-operative care as in other abdominal operations is taken. Bladder regains its tone within 6 to 8 hours and catheterization is generally not required. We believe in early ambulation, and looking to the minimum trauma this is not found difficult. The usual post-operative care follows. Sutures are removed on the 6th day and if healed well patient is allowed to go home on the same evening.

Complications

No major complications have been noted up till now. Mild distension or headache was noted in some of the cases and at times we noticed wound sepsis; the latter was more common in obese and anaemic cases. Acriflavin 2% or Ne-ba-sulf powder was used for dressing such wounds. The results were satisfactory.

Late results

No case of failure was reported till to-day. Some of the patients did complain of menorrhagia or scanty periods but we did not attribute this to the operation. Obesity seemed to be due to release of tension. There was no major complication noticed. Cases with backache and palpable adnexa responded to treatment with shortwave diathermy.

Summary

Surgical aspects of sterilization are presented with a background of work done at Irwin Group of Hospitals and Shri M. P. Shah Medical College, Jamnagar.

No failure has been encountered till now.

Post-operative complications were minimum when the abdominal viscera were not disturbed.

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Figs. on Art Paper I