SURGICAL AND PSYCHOLOGICAL SEQUELAE OF STERILIZATION

by

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Introduction

"Obstetricians have assumed a role of greater responsibility for the social welfare of their patients. Limitation of reproduction has taken its place alongside the treatment of infertility as a proper function of the physician. Insurance against conception may be just as important to the fertile woman as the construction of an artificial vagina to the patient born without one in permitting enjoyment of a normal sex life".

Sterilization of either the female or the male with least disturbances of other functions is an effective method of family limitation and control of population. Bilateral tubal occlusion or tubal ligation is usually carried out electively postpartum or after an abortion, with hysterotomy or with caesarean section and in association with gynaecological operations.

Study Design

The patients who are beneficieries must meet certain requirements for the operation:

(a) The age 30 years for women and 35 for men.
(b) At least three living children (minimum 2 sons).
(c) Emotional stability.
(d) A thorough understanding of irreversibility and permanence of the procedure.
(e) Proper motivation.

The technique used for tubal ligation in our series was modified Pomeroy's.

During the last five years 1961-1965 over two thousand sterilizations, 5.2% of the total admissions, have been performed in the Medical College Hospital. A report of seventy cases complaining of untoward reactions carefully followed for over three to five years, operated in our hospital, is submitted.

In the majority of the cases the operations were performed for multiparity and the patients were quite pleased and did not complain for the following simple reasons (Allan Barns).

(a) Improvement in economic condition.
(b) Greater ability to plan for the future.
(c) More time and strength available to invest in the family they already had.
(d) Elimination of constant fear of pregnancy.

Cases were followed up and studied

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within a period of 4 to 6 years after the operation. Most of these patients referred to their symptoms as precipitated by operation. A detailed record of these patients was maintained and symptomatic treatment given. All the same it is imperative to discuss in detail the surgical complications.

TABLE I

Surgical Complications or Sequelae

Symptoms & Signs	No. of cases	Percentage
(1) Menorrhagia	22	31%
(2) Functional uterine bleeding	10	14%
(3) Adenomyosis with progressive dysmenorrhoea	5	7%
(4) Leucorrhoea	4	5%
(5) Fibromyomata	3	4%
(6) Pelvic endometriosis with chocolate cyst	2	2.8%

Table I shows that menorrhagia was the most prominent presenting symptom amongst women between 30 to 40 years and in those young women whose husbands had undergone vasectomy operation. The other sequaelae denote effects of hyperoestrinism.

TABLE II

Psychological Complications

Symptoms	No. of patients	Percentage
(1) Poor work capacity	15	21%
(2) Lowered pain threshold; backache ..	15	21%
(3) Anxiety, palpitation; fear complex ..	10	14%
(4) Dyspareunia	10	14%
(5) Regretted the operation	4	5%
(6) Aversion to coitus (Frigidity) ..	3	4%
(7) Mental depression; suicidal tendencies ..	3	4%
(8) Hiccough, hysterical fits; amnesia ..	3	4%

Table II shows lowering of capacity to work and pain threshold. Majority of the above complaints were exhibited by them and some of them regretted the operation.

Discussion

Multiparity is considered as the prime indication for sterilization in women, which is absolutely voluntary. In our series modified Pomeroy's technique was used; fallopian tubes were crushed at four places and surgical linen thread was used. There were no failures in the 2100 operations done during the last five years. Our personal observation is that in a great majority sterilization in the female and male is satisfactory for the simple fact that they were happy and grateful for the permanent prevention of conception. When these operations are performed in relative-

ly young patients, before the age of thirty years, there is every likelihood that it may produce continuous effects of oestrogens on the uterus uninterrupted by pregnancy for the subsequent period of 20 years. Symptoms like menorrhagia, functional uterine bleeding, adenomyosis, endometriosis compel us ultimately in these women to do hysterectomy. In our series, hysterectomy was performed in 17 cases (0.8%). J. V. Meigs has stated that endometriosis is more common in civilized people who practice contraception or who limit their family early in life. In India, marriages take place early in life and a woman has the desirable number of children by the time she attains the age of twenty-five. She is well motivated to accept this permanent measure of operation of sterilization and at the same time she is ultimately exposed to subsequent sequelae of hyperoestrinism. In our technique there was no development of hydrosalphinx. Sterilization will always have the undesirable psychic effects in apprehensive, morbidly anxious, strongly religious and strongly maternal women, as stated by Savage. Operation must be considered along with many other facets of the patient's personality before it is performed. When the patients were closely interrogated it was observed that, (a) they were not properly motivated (b) operation was forced on them against their desire by husband, (c) mental and physical personality traits were not properly studied by the obstetrician or the family physician, and (d) whether suggestions came from physician obstetrician or the patient volunteered herself was not carefully analysed.

Psychological sequelae were of varied types in our series as stated above.

In some women there was some finality in their thinking; their frigidity and other reactions were a penalty which they were paying for their permanent form of contraception. Patients may be deceptive in their bland acceptance of the procedure only to manifest marked disturbances later, when they are confronted with the final termination of reproduction.

In our series only 3.3 per cent of patients developed post-sterilization surgical and psychological sequelae. The patients complained severely about these which necessitated active treatment. The general consensus of opinion is that certain criteria are to be laid down for sterilization by experience and tradition. A committee consisting of the obstetrician, family physician and psychiatrist should be appointed to formulate the criteria for operation of individual patients so that the incidence of sequelae is reduced to a minimum.

Conclusions

(1) Sterilization of either the female or male is an effective method of family limitation.

(2) Multiparity is the most important indication for sterilization (75%).

(3) Majority of patients were happy and were satisfied with the results of operation.

(4) There was a definite group of patients who regretted the operation.

(5) The surgical sequelae were menorrhagia, adenomyosis, fibro-

myomata. There was no development of hydrosalpinx. The psychological complications were (a) poor work capacity, lowered pain threshold, regret at operation; anxiety neurosis and frigidity.

(6) Proper motivation and study of the personality and age to be taken into consideration by a committee consisting of family physician, obstetrician and psychiatrist to reduce the untoward reactions to a minimum.

Summary

(1) Out of a total cases of 2100 sterilization operations only seventy (3.3%) complained severely that their reactions were related to operation of sterilization.

(2) A detailed study of analytical data of their surgical and psychological sequelae is presented.

(3) To reduce these sequelae to a minimum, ways and means are suggested.

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