FALLOPIAN TUBE LIGATION BY THE VAGINAL ROUTE

A New Approach

by

M. R. NARVEKAR,* M.D.

Ligature of the fallopian tubes by the vaginal route is an operation which has firmly established its position in gynaecological surgery. Apart from tube ligations done in the puerperium which have to be by the abdominal route, most other cases can be operated upon per vaginam except for a few well defined exceptions like previous caesarean sections or other major pelvic surgery where adhesions may make the exposure of the fallopian tubes difficult vaginally. A fair degree of familiarity with vaginal surgery is necessary before the operation is undertaken but an average gynaecologist can safely undertake this operation and in skilled hands the procedure need not last more than 10-15 minutes and involve hospitalisation of not more than 4 days.

Non-puerperal tubal ligations have a definite place in our national family planning programme. After a second or third conception a couple may consider it prudent to wait for a couple of years, instead of undergoing a puerperal sterilization, till the last child attains an age where there is no doubt about its physical and mental normality, especially in our country with high perinatal and infant mortality. Again, puerperal sterilization may have been impossible due to various factors such as lack of facilities at the place of confinement, maternal ill-health, absence of the husband at that time to record his consent for the operation or simple indecision on the part of the patient. These are common difficulties encountered in every-day practice and in these patients non-puerperal tube ligation by the vaginal route is an eminently suitable operation.

This operation has been performed by two routes, either by opening the anterior peritoneal pouch after reflecting the bladder, or by opening the posterior pouch. The choice is largely a matter of personal preference, but the posterior approach generally provides a more ample exposure and accessibility to the tubes and is definitely advantageous with a retroverted uterus. I have, however, repeatedly encountered another group of cases where the patient requires repair of an old perineal tear in addition to tube ligation. Sheth and Batliwalla (1968) reported 160 vaginal sterilizations at the K. E. M. Hospital, Bombay, of which 23 required simultaneous peri-

*Hon. Obstetrician & Gynaecologist, K.E.M. Hospital and Hon. Prof. of Obst. and Gynec., Seth G.S. Medical College, Parel, Bombay 12.

Received for publication on 30-1-1970.

neorrhaphy. If the standard methods are employed this would require two separate incisions one in the posterior or anterior fornix for the tube ligation and a second for perineorrhaphy. I want to point out that the two procedures, tube ligation and perineorrhaphy can be carried out through the same perineal incision. The procedure is briefly described below.

An incision is made in the perineum as usual for perineorrhaphy at the junction of the vagina and perineal skin and the vaginal mucosa is separated upwards from the rectum underneath, keeping initially in the midline till the peritoneum of Douglas' pouch is reached. The procedure is very simple and almost bloodless if care is taken to see that the blood vessels are stripped off the undersurface of the vaginal flap and kept attached to the front of the rectum. The peritoneum is opened after proper identification. At this stage wide lateral separation is possible by putting the two index fingers of the two hands in the lateral angles of the incision and stretching firmly laterally, A full view of the pelvic contents is obtained, the uterus, ovaries and tubes easily located, and the tubes ligated by any desired method. The peritoneum is closed. The excess vaginal flaps are excised as usual, the levator ani muscles approximated in the midline and the vaginal and perineal wounds closed as usual. There is no special post-operative treatment except as for perineorrhaphy.

The exposure by this method is very much better than through the anterior or posterior fornix. It is, however, not advocated as a substitute or improvement on the previous methods of approach through the anterior or posterior fornix. By itself this approach through the perineum would involve more dissection, more post-operative discomfort and longer hospitalisation than the other methods. But when a perineorrhaphy is also indicated at the same time, two separate incisions are unnecessary and a much better exposure of the pelvic contents is obtained through the same perineal incision.

Summary

A new method of approach for non-puerperal tubal ligation by the vaginal route is described which has not been previously mentioned in the literature. It is indicated when perineorrhaphy is required with tube ligation.

Reference

1. Sheth, S. S. and Batliwalla, P. R.: J. Obst. & Gynce. India. 18: 274, 1968.

See Figs. on Art Paper V-VI