

SUCTION EVACUATION OF UTERINE CONTENTS

by

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and

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We have previously reported on the Pilot Study of the use of vacuum aspiration (Rajasekharan and Vijaya, 1971) and we now present the results from a consecutive series of 785 cases.

The technique in current use does not differ from the one we described. As mentioned before we divided our cases into two groups—Group I comprised of 146 cases with the open os and Group II of 622 cases with the closed os. Gr. II was further sub-divided into Gr. IIa 457 cases (uterine size below 10 weeks) and Gr. IIb 165 cases (uterine size between 11—12 weeks). There were 17 vesicular moles.

Results

The rate of failure has remarkably reduced with experience. In our pilot study the failure rate was 32.72, the subsequent failure rate came right down to 7.72. The cause of incomplete suction is still mainly seen in those cases where the products are adherent due to sepsis and infection.

The blood loss proportionately increases with the size of the uterus. In cases with open os the blood loss is negligible. The

average blood loss in Gr. IIa (uterus below 10 weeks) is 9.5 ml. while that in Gr. IIb (uterus between 11—12 weeks) the blood loss is 48 ml. This proportionate increase with the size of the uterus was also seen in our pilot study. We have not experienced a single case of perforation in our whole series, which amply justifies the safety of this procedure.

The suction was applied on 17 cases of vesicular mole with uterine size varying between 14 weeks to 34 weeks. Suction rapidly reduces the size of the uterus within a few minutes. It is less shocking to the patient and it is an effortless procedure on the part of the obstetrician as compared to the conventional method using ovum forceps. There is minimal amount of blood loss during the suction. We did all the suctions with 10 units syntocinon drip flowing. Curettage is not done at the same time, but is carried out a week later. Evacuation was incomplete in one mole. This was discovered at the time when a hysterectomy was done.

With development and research programme being centred on family planning, we encouraged our patients to undergo tubectomy at the same sitting. In our series, 463 patients were sterilised. Tubectomies were first done by, both abdominal and vaginal routes, but as the risk of infection is minimal via the abdominal route, we prefer the abdominal

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Fig. 1
Showing hirsutism.

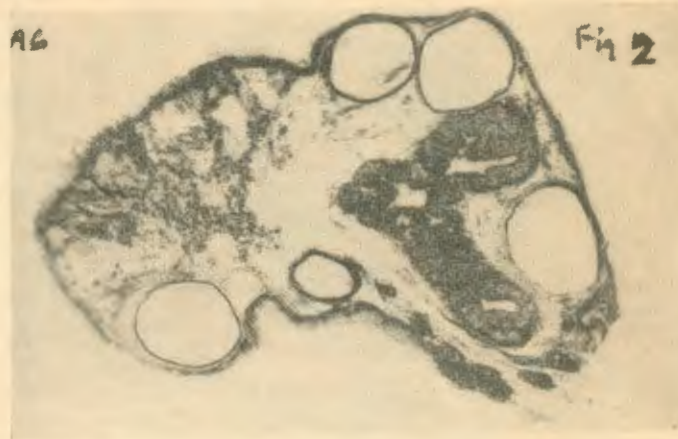


Fig. 2
Section of ovary showing multiple cysts with
normal corpus luteum.



Fig. 3
Section of ovary showing multiple cysts with
stromal hyperplasia.



Section showing
sclerosis a



Fig. 5
Gynaecography showing bilateral enlarged ovaries.

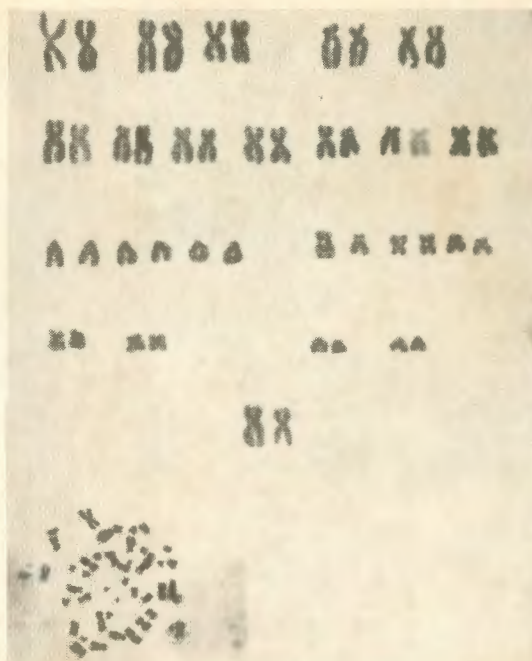


Fig. 1
Karyotype of case No. 8 showing normal pattern (46XX).

Sarcoma of the Uterus—Response to Chemotherapy—Ghosh pp. 88-91

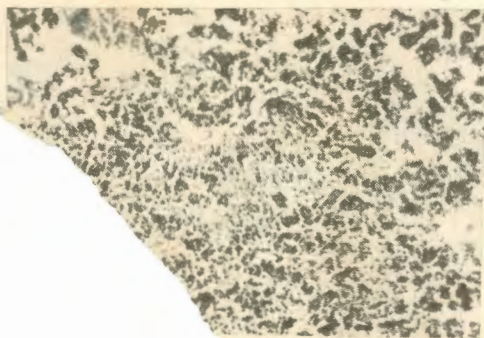


Fig. 1
Sarcoma of the uterus, sarcoma. (X 175).

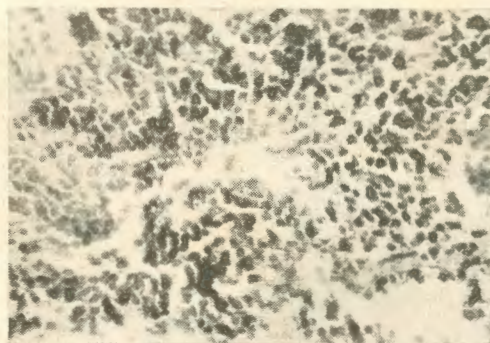


Fig. 2
Microphotograph of sarcoma of the uterus, showing round cell sarcoma (X 350).



Fig. 1

Photograph of gross specimen showing the lesion of the right tube.



Fig. 2

Disected specimen showing the papillary nature of the tumour. The sac was filled with serosanguinous fluid.

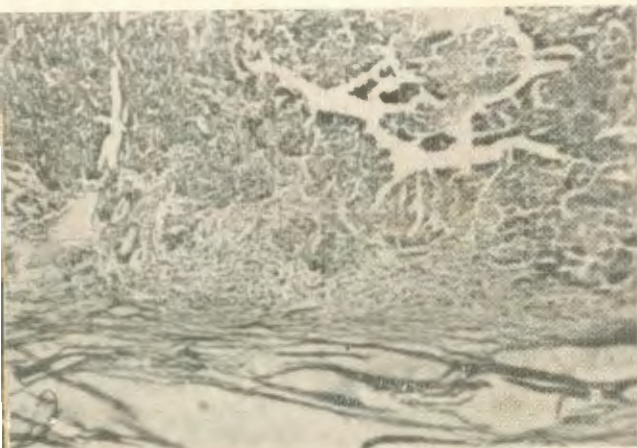


Fig. 3

Photomicrograph showing diffusely arranged hyperchromatic tumour cells. A: places the cells show acinar arrangements H & E X 40.

Carcinoma of the Stomach Complicated by Pregnancy—Tiwari and Wahi pp. 118-120



Fig. 1

X-ray, A.P. view, taken after barium swallow showing the filling defect at the cardio-oesophageal junction.



Fig. 1
External genitalia with hypertrophied clitoris.



Fig. 2
Cut surface of the Teratocarcinomatous tumour.

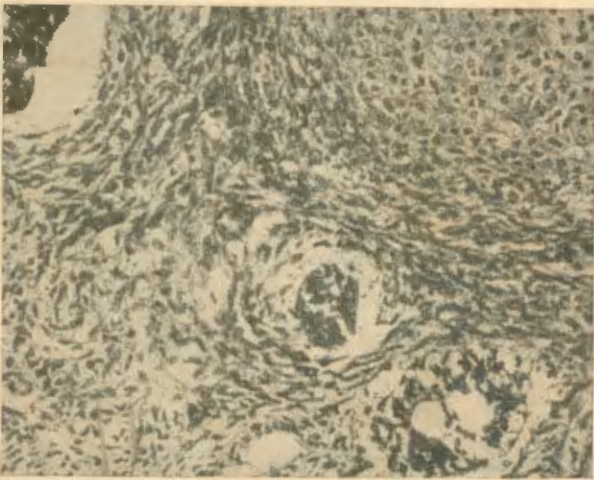


Fig. 3
Microscopic appearance of the tumour showing cartilagenous tissue.

*Birth of a Foetus in a Case of Procidencia—
Narula Et Al pp. 103-105*



Fig. 1
Procidencia with pregnancy when first seen.



Fig. 1

Photograph of gross specimen showing the lesion of the right tube.



Fig. 2

Eisected specimen showing the papillary nature of the tumour. The sac was filled with serous fluid.

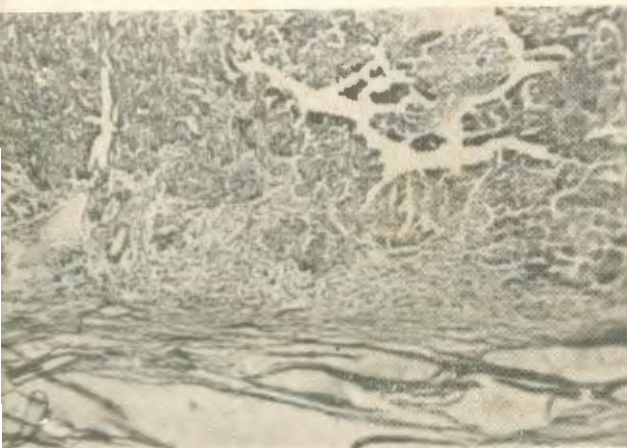


Fig. 3

Photomicrograph showing diffusely arranged hyperchromatic tumour cells. At places the cells show acinar arrangements H & E X 40.

Carcinoma of the Stomach Complicated by Pregnancy—Tiwari and Wahi pp. 118-120



Fig. 1

X-ray, A.P. view, taken after barium swallow showing the filling defect at the cardio-oesophageal junction.



Fig. 2
X-ray of the gravid procidentia.



Fig. 3
Cervix in the process of dilatation with cord prolapse.



Fig. 4
Complete expulsion of foetus and the placenta.



Fig. 5
Procidentia after completion of abortion.

**THE FEDERATION OF OBSTETRIC AND GYNAECOLOGICAL
SOCIETIES OF INDIA**

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**VIIITH WORLD CONGRESS OF OBSTETRICS AND GYNAECOLOGY TO
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It is proposed to organise a Group-Visit to attend the VIIth World Congress of Obstetrics and Gynaecology followed by a tour to some important cities in U.S.S.R. and in Europe. The total duration of this Group-Visit will be about 21 days. Desiring participants should write to the Hon. General Secretary, the Federation of Obstetric and Gynaecological Societies of India before **31st March 1973**, when the details will be supplied. A detailed programme of the Group-Visit with the registration forms and terms and conditions to be complied with is being sent to the Hon. Secretaries of the Memberbodies of Federation very shortly. The minimum number of participants require to form a group will be 15 (fifteen). M/s. Indtravels, the Division of Air-Freight Private Limited is entrusted to work out this International itinery.

21-2-1973.

Dr. C. L. Jhaveri
Dr. N. N. Roychowdhury
Hon. Secretaries.

route and only this approach is used now. We have had no complications after sterilisation.

The follow up of these cases is not very satisfactory. Patients fail to come after the suction to report their wellbeing. Of our total number of cases, 6 came back with a history of bleeding. All 6 were admitted and a curettage was done. In 4 cases placental tissue was removed.

We intend doing suction evacuation under perparacervical block anaesthesia

and also evacuation without cervical dilatation.

In concluding we once again emphasise that suction evacuation of the uterus is an extremely easy procedure, with less blood loss, very low rate of complications and minimal stay in hospital. This would indeed be the most satisfactory method for therapeutic abortion.

Reference

1. Rajasekharan, N.: *The J. Obst. & Gynec. India* 21: 690, 1971.