REVIEW OF CASES OF GENITAL PROLAPSE

by

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Before the middle of the nineteenth century very little attention was directed towards the advancement of knowledge about the anatomical supports of the genital organs or towards the surgical treatment of prolapse.

In 1888, Donald of Manchester introduced his operation of combining amputation of the cervix with anterior colporraphy, this was later improved by Fothergill. Popular by name of "Manchester operation" it is practised widely by British Gynaecologist.

The Mayo Ward operation for uterine and vaginal prolapse was introduced in the beginning of this century and has retained its place in the treatment of uterine and vaginal prolapse.

Material and Methods

For the present study 500 cases of genital prolapse were selected from the indoor of UISE Maternity Hospital of G. S. V. M. Medical College, Kanpur.

Selection of Cases: The selection of cases depends upon the following factors.

Age: The majority of our patients were between 25 to 40 years, only 150 cases were above 45 years and 12 cases were below 25 and 65 cases were between 41 to 45 years of age.

In the UK this operation is performed upon much older patients over 70-80% of patients being about 35. Thus in Hunter series (1950) only 32 out of 330 women subjected to Fothergill's operation were of child bearing age. In Solomon's series (1955) over 65% of all cases were about 40 years.

There is great preponderance of young patients of this series as compared to Fothergill's series (1911) where only 19% were below 30 years.

Table 1 shows the distribution of parity in relation to degree of genital prolapse.

TABLE I

Parity in Relation to Degree of Prolapse

Parity	No. of cases	Degree of uterine prola pse		
		1st	2nd	3rd
0	24	16	8	—
1	85	8	25	52
2	75	24	45	6
3	95	21	54	20
4th para & above	221	65	112	44

It is noted from the above table that majority of the patients developed prolapse after the third delivery. In only 17% of cases did prolapse develop after the first delivery. According to Purandare 25% and Kerkar 14% of all the cases

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developed if after the first vaginal delivery. In our series 24 patients had congenital prolapse.

Degree of Genital Prolapse

One hundred and thirty-four cases had first degree of genital prolapse, 224 cases had 2nd degree of genital prolapse 122 had third degree of genital prolapse.

It is noteworthy that 1 patient developed complete procidentia after the first childbirth and 4 developed after the second child birth.

Douglas peritoneum was removed in 25 cases who had enterocele as well. In 25 cases the colpoperineorrahaphy was not done as there was no rectocele and patients was very young.

In 24 cases who were nulliparous only anterior colporrhaphy along with amputation of cervix was done.

In 141 patients vaginal hysterectomy with repair of pelvic floor was performed. In 10 cases it was performed in first degree of prolapse as they were suffering from functional uterine bleeding. The

TABLE II

Associated Conditions Which Present Along With Genital Prolapse

Conditions		No. of cases	Per cent
Cystocele			
	Mild	198	
	Moderate	150	75.6%
	Severe	30	
Rectocele			
	Mild	282	75.6%
	Moderate	150	
	Severe	21	
Urethrocele		18	3.6%
Vault prolapse		21	4.2%
Decubitus ulcer		210	42%
Stress incontinence		3	0.6%
Supravaginal elongation of cervix		105	21%
Infravaginal elongation of cervix		12	2.4%

Only the important conditions are enumerated which need the operative management. Gross degree of cytocele and rectocele was only present where anterior and posterior vaginal wall together with bladder or rectum protruded outside the vulva on straining.

Types of Operation Performed

Manchester operation was performed on 335 patients. All these cases were below 40 years of age. Ligation of tubes was performed additionally in 56 cases. Buttressing of urethra was performed in 3 cases with good results. The pouch of uterosacral stumps were stitched with the vault routinely, but pouch of Douglas peritoneum was removed in 12 cases where there was vault prolapse.

Comlications

1' *Pyrexia*: One hundred and fifty patients had a rise of temperature above 100° F and in 50 cases there was urinary tract infection.

2. *Haemorrhage*: Eight patients had haemorrhage within 24 hours of the operation and 12 patients had haemorrhage between 9th to 12th postoperative day and it was due to local sepsis in 8

TABLE III

Complications After Operation

Types of complications	Total No. of cases	Vaginal Hysterectomy with repair	Manchester repair
Pyrexia	150	98	52
Haemorrhage	20	8	12
Urinary infection	40	22	18
Dyspareunia	60	20	40
Local sepsis	8	5	3
Stress incontinence	3	1	2

cases and they required intravaginal packing, intra-venous infusion, antibiotics. In 4 patients the haemorrhage was quite profuse and required blood transfusion.

Dyspareunia: Sixty women complained of dyspareunia. In all these cases bimanual examination was not at all painful. Twenty women were afraid of pregnancy and also that the stitches might give way as a result of coitus.

In Hunter's series about 5% of all operated cases complained of dyspareunia. In Solomon's series the coital act was not satisfactory in 14% of cases, but even in these patients there was no actual dyspareunia.

In Kerkar series 7.1% Women complained of dyspareunia.

4. *Strees incontinence*: Three patients developed stress in continence for the first time after the operation which was cured within 6 months. In the present series, 2 patients were having stress incontinence which was cured with Kelly's stitches.

TABLE IV

Relief of Symptoms After the Operation

Presenting symptoms	Total cases	Complete relief	Partial relief	No relief	Worsened	Developed after operation
1. Something coming down	500	450	48	2	—	—
2. Backache	248	212	28	5	3	3
3. Dragging pain in lower abdomen	196	148	40	8	—	—
4. White discharge	396	364	30	2	—	—
5. Stress incontinence	2	2	—	—	—	3
6. Frequency of micturition	235	202	30	—	3	—
7. Burning during micturition	25	21	4	—	—	—
8. Retention of urine	4	4	—	—	—	—
9. Irreducible prolapse	2	2	—	—	—	—
10. Constipation	246	202	8	36	—	—

In Hunter's series 7% of cases were not cured of stress incontinence and 2% developed it after the operation.

Anatomical Correction of Prolapse

The recurrence rate for all cases of uterine prolapse was 2.5%. The recurrence rate for cytocele was 6.2% and for rectocele 2%. In Hunter's series the recurrence rates for cystocele and rectocele were 6.9% and 3%, respectively. Krige (1962), Hawksworth and Roux (1958), Purandare *et al* (1966) recurrence different types of prolapse were of a minor nature and did not need any further operation. In Kerkar's series the recurrence rate for all cases of uterine prolapse was 9.1%. The rates for cytocele and rectocele were 9.2% and 8.1% respectively.

Reproductive function after Fothergill's operation

Within 3 years follow up pregnancy occurred in 125 cases following Manchester repairs, 4 patients aborted between 4-5 months of pregnancy and 105 had vaginal delivery after episiotomy, 30 had outlet forceps and 16 had caesarean section. The incidence of caesarean section is very high in this series. In 8 cases it was done on account of cervical dystocia, in 2 due to placenta praevia, in 2 due to transverse lie, in 3 due to cephalopelvic disproportion and in 1 case of complete procidentia conceived after Manchester repair, caesarean section was done to prevent the recurrence.

Discussion

The following observations were made from the above study. 74% of our cases were below the age of 40 and only 26% of the cases were above the age of 40 years of age. Majority did not have the desired number of children or the women who had more than three full term deliveries had lost one or two children so they were very keen to have a child.

One hundred and thirty cases among 500 were within the parity group 0-2, had second degree of genital prolapse, cytocele and rectocele was present only in 30 and 21 cases respectively.

Vault prolapse was present in 4.2% of the cases. Pathological changes in cervix was present in 40% of the cases.

Stress in continence is very rare and was present only in 2 cases. Vaginal hysterectomy is quite a safe operation even in old frail women. The incidence of postoperative comlications was not higher following vaginal hysterectomy, even in older age group. This operation with pelvic floor repair is the choice of treatment in patients of premenopausal, postmanoausal age, even in patients above 60 years and in complete procidentia. In patients with gross 2nd degree or 3rd degree prolapse and associated uterine pathology Fothergill's operation may be considered safe even up to the age of 35 years.

The operation was successful in 90% with complete relief. In 10.3% there was no relief of symptoms, but anatomical success was 99%.

In Hunter's series 97% of patients had admitted that the operation was worth while and only 3% were doubtful about its success.

The Fothergill's operation does not cause sterility. The chances of conception actually improves in some cases because of removal of the distal unhealthy portion of the cervix.

Summary

(1) A review of 500 cases of genital prolapse is given.

(2) The method of selection of each case, the operative technique and complications are described.

(3) The symptoms suffered by the patients before the operation are analysed and the anatomical and symptomatic success of the operation is assessed.

(4) The effects of the operation on reproductive function are discussed.

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