

## RESULTS OF VAGINAL HYSTERECTOMY AND MANCHESTER OPERATION

by

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In the past, although vaginal hysterectomy has been used to achieve sterilization, in many cases, the primary reason given for its use was not to prevent conception, but to correct some forms of pelvic pathology. The purpose of this study is to evaluate vaginal hysterectomy as a method in patients having prolapse and desiring surgical sterilization, and to compare it with Manchester type of operation for prolapse with vaginal sterilization.

### *Material and Method*

From January, 1972 to December, 1976, 230 vaginal hysterectomies were done in cases of genital prolapse without any other pelvic pathology, and during that period 620 Manchester repairs were carried out along with tubal ligation. All the operations were done by the senior author of this paper.

Vaginal hysterectomy was performed in 230 patients and most of them belonged to the age group 36-40 years. Patients had at least 3 living children at the time of operation. During the same period 620 Manchester repairs with sterilization by vaginal route were performed. The major

ity of them were in the age group of 30 to 40 years and had at least 3 living children.

The average blood loss in Manchester type of operations with tubal ligation was between 200 to 400 cc. The blood loss in vaginal hysterectomy was perhaps slightly less as the blood loss from the posterior vaginal wall was more in the Manchester repair. The blood loss occurred particularly at the time when the fallopian tubes were negotiated through the pouch of Douglas.

Immediate postoperative morbidity in both the series are almost similar (Table I).

Average postoperative stay in the hospital was between 10 and 14 days in both the series of cases.

Long term follow-up showed complications like dyspareunia and backache only in 6.5 per cent of vaginal hysterectomies while Manchester operation with ligation had 19.1% of these complications. 14.5 per cent of Manchester operation with ligation presented with dysfunctional uterine haemorrhage. The troublesome complication of dysfunctional uterine haemorrhage was completely eliminated in the vaginal hysterectomy (Table II).

Incidence of abnormal findings like fibromyoma and carcinoma in situ which would have definitely required major

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TABLE I  
Postoperative Morbidity in Both the Series of Cases

Post-operative morbidity	Vaginal hysterectomy		Manchester with ligation	
	Number	Percentage	Number	Percentage
Cystitis	12	8.2	29	4.8
Pyelonephritis	2	0.9	19	2.9
Bladder atony	5	2.1	17	2.6
Cuff haematoma	1	0.5	2	0.3
Cuff cellulitis	5	2.1	10	1.9
Post-operative haemorrhage	1	0.1	6	0.9
Tubo-ovarian abscess	3	1.3	29	4.8
Febrile morbidity	23	10.0	94	15.2

TABLE II  
Long Term Follow-up Sequelae in Both the Series of Cases

Long term follow-up sequelae	Vaginal hysterectomy		Manchester with ligation	
	Number	Percentage	Number	Percentage
Dyspareunia	8	3.5	35	5.9
Backache due to residual pelvic cellulitis	7	3.0	83	13.2
Dysfunctional uterine haemorrhage	—	—	91	14.5
Recurrence	5	2.1	15	2.4

surgery later was completely avoided in vaginal hysterectomy (Table III).

TABLE III  
Associated Findings in the Excised Uterus

Abnormal findings	Vaginal hysterectomy	
	Number	Percentage
Cervicitis	12	5.3
Fibromyoma	9	3.9
Carcinoma in situ	2	0.8
Total	23	10.0

#### Discussion

The increasing use of surgical sterilization necessitates critical analysis of advantages and disadvantages of methods employed.

The major advantage of vaginal hysterectomy over the Manchester operation with ligation is the absence of sequelae of

sterilization in long term follow-up. It has been noted by various authors that menstrual disorders like metrorrhagia, dysmenorrhoea, and menorrhagia, tubo-ovarian masses are fairly common complaints of following any type of sterilization. The interference of blood supply to the ovaries in sterilization lead to cystic degeneration of ovaries and menstrual irregularities (Powel, 1962; Rakshit, 1966, and Chakrabarty, 1966). Soonawala (1973) attributed menorrhagia to pelvic congestion and subclinical adenexal infection. In the recorded cases of our hospital, the menstrual disturbances after tubectomy of any type is nearly 25 per cent. Endometriosis and tubo-ovarian mass formation are another formidable complications following sterilization. Wagh (1966) reported 7 per cent adenomyosis with progressive dysmenorrhoea.



In this study, 230 vaginal hysterectomies and 620 Manchester operations with vaginal ligation have been compared so far as their immediate complications and remote morbidity are concerned.

In this series 14.5 per cent reported with dysfunctional uterine haemorrhage, 13.2 per cent with backache due to residual pelvic cellulitis, and 4.8 per cent of vaginal sterilization with Manchester operation presented with tubo-ovarian abscess.

Vaginal hysterectomy removes the uterus and eliminates a source of future uterine pathology. Haynes and Wolfe (1970) reported the necessity of different types of gynaecological operation in 36.2 per cent of 489 patients after tube-ligation followed for 3 to 5 years or longer. In addition 12.9 per cent required hysterectomy. Williams *et al* (1951) in a follow up study of 200 patients who had tubal sterilization procedure found 24 per cent incidence of significant gynaecological disease and 5 per cent eventually required hysterectomy.

Hysterectomy could be considered as a relatively safe procedure associated with acceptable level of blood loss, postoperative complications, particularly for the intigent and multiparous patients of our country who are most susceptible to the future development of benign or malignant pelvic disease and who probably will not return for adequate follow-up.

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