VAGINAL STERILIZATION (STUDY OF 2334 CASES)

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Female sterilization by vaginal route is a well established procedure and has many advantages such as, easy acceptance by the patients, quickness and safety of the procedure, low postoperative complications and short hospital stay.

A detailed study of 2,334 cases of vaginal sterilization was done during the period January 1968 to July 1977 in Jawaharlal Nehru Medical College Hospital, Ajmer and in camps organised in nearby villages. Most of these cases visited Gynaec. O.P.D. for some other complaint and were motivated for sterilization because of multiparity.

Out of the total 7017 sterilizations the incidence of vaginal sterilization was 33.26%. The age, parity, socioeconomical status, education, method of sterilization, anaesthesia, associated surgery, difficulties during operation, immediate and delayed complications were studied.

Great care was observed during the selection of the patients to avoid operative complications and to reduce morbidity.

1. The cases of pelvic infections were avoided or treated adequately.

2. Obese patients with deep pelvis and vagina were avoided, as the approach sometimes becomes difficult.

3. The history of induction of abortion was excluded in abortion cases.

4. The patients with previous operation (abdominal or vaginal) were avoided.

5. By vaginal examination the mobility as well as size of the uterus was assessed. It should not be more than 12 weeks' gestational when associated with Medical termination of pregnancy.

The different indications for which the patients came to the hospital were as follows:

Multiparity	1150	49.27%
Incomplete abortion	281	12.03%
Functional uterine bleeding F.U.B.	109	4.67%
Erosion Cx. and Cervicitis	120	5.14%
Sec. amenorrhoea	53	2.27%
Complete perineal tear	3	0.12%
U.V. prolapse	57	2.44%
I.U.C.D. Menorrhagia	45	1.92%
Missed abortion	9	0.38%
Fibroid polyp	1	0.042%
Medical termination of pregnancy (MTP)	250	21.46%
Ectropion Cx.	3	0 12%
Placental polyp	1	0.042%
Cx. polyp	1	0.042%
	2334	99.82%

Maximum, 49.27% sterilizations were done in cases of multiparity. 2.27% cases had secondary amenorrhoea. 12.03% and 0.38% were cases of incomplete and missed abortion respectively. They refused for abdominal sterilization but readily agreed

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for vaginal sterilization. It shows that the opportunity to evacuate uterus affords a chance to convince women and perform tubal ligation at the same time as uterine evacuation. 21.46% cases wanted medical termination of pregnancy and were motivated for sterilization. Some patients came for some other gynaecological lesions as utero-vaginal prolapse, complete tear, cervical polyp, etc. where associated surgery was done simultaneously with sterilization. Vaginal sterilization was readily accepted by patients undergoing any other associated surgery on perineum or genital tract.

Out of these 2,334 cases, 71.50% were urban and 28.49% were from rural areas, 56.04% were illiterate, 43.95% were literate. (Pr. 34.96%, high School 7.02% and University 1.97%). The maximum, 79.85% were from the age group of 25-39 years, while 5.14% were between 20-24 years. Maximum cases were para 3 and 4 i.e. 51.53% and the grand multiparas were 45.45%. The maximum affinity was shown by the low socioeconomical group of patients i.e. 49.70%, while in the patients with high status the rate of sterilization was found to be minimum i.e. 2.44%.

These data show that sterilization is popular in urban while in the villages people are afraid of the name of sterilization but when they come for M.T.P. they can be readily motivated for sterilization. Most of the women insisted on the M.T.P. alone and refused for sterilization.

It was seen that the illiterate women readily accepted this easy permanent method of family planning but the literate searched for some other method. In highly educated women, the incidence of sterilization is much less as they themselves understand the need for family planning and they use the different conventional methods of birth control.

It was seen that the maximum cases of sterilization were para 3 and 4. The number of grand multiparous women was also significant, 45.45%, this is because that previously at the time of the birth of the last child most of them refused to be sterilised, because of fear of the abdominal stitches and they wanted to hide that they have been undergone sterilization. So they agreed for interval sterilization by vaginal route.

No premedication was given. The anaesthesia used in 80.35% cases was spinal, while in 9.64% cases general anaesthesia was given. Local anaesthesia was not used at all. In 10% where spinal anaesthesia failed and general anaesthesia was given in association.

Vaginal sterilization was done through pouch of Douglas by a transverse incision. In 10 cases longitudinal incision was tried but given up due to danger of rectal injury (one case developed R.V.F.) and lack of proper exposer.

Difficulties during the operation were adhesions in 1.07% cases, short tube in 0.85% cases, where the tube could not be tied vaginally and abdominal sterilization was perfarmed. Retraction of peritoneum occurred in 1.28% cases and was difficult to stich. Bleeding from the incision line occurred in 0.6% cases, while the ovary was injured in 0.17% of cases. Avulsion of fallopian tube occurred in 1 case.

The complications which occurred in the postoperative period, were not much due to surgery but as a result of anaesthesia. Spinal headache occurred in 31% cases, U.T.I. 1.97%, sepsis in 0.21%, pain in abdomen 0.29%, psycosis 0.08% and pyrexia 1.07%, R.V.F. (Rectovaginal fistula) in 0.04% and death ocurred in 0.04% cases.

The average stay in the hospital was 5 days, while the maximum stay was 20

days in the cases where other surgical procedures were stimultaneously done e.g. repair of complete perineal tear and pelvic floor.

Advise given at the time of discharge were:

1. Abstinance for 1½ months.
2. Excessive vaginal discharge may be there—because of cauterizatlon of cervix.
3. Next 3 cycles may be heavy or may come earlier.
4. Should do normal household work.
5. Catgut stiches may come out vaginally after two weeks but she should not afraid that the stiches have given way.
6. To come for check up after 1½ month after the periods.

After one and a half month, pelvic inflammation was found in 3.68%, menstrual disturbances like polymenorrhoea and monorrhagia were observed in 7.7% of cases. Excessive vaginal discharge was complained by 6.42% cases and other miscellaneous general complaints were present in 11.13% of cases, 71.03% cases had no complications.

On long term follow up failure rate was 0.4%, the menstrual irregularities were in 10%, pelvic inflammation in 0.9% and tubo-ovarian masses were found in 3 cases. Out of these, 2 needed laparotomy and came out to be ovarian abscesses. Backache was the complaint in 20% of cases. Fifty had backache without any pelvic pathology and were referred to backache clinic.

This operation has few outstanding advantage.

1. It can be done at any time on non-pregnant women at their convenience, with or without M.T.P. and within 3 months of conception.
2. There is no fright of opening the abdomen and no aftermath of abdominal scar.
3. Convalescence is rapid, smooth and stay in the hospital is less.
4. No chance of incisional hernia.