LAPAROSCOPIC STERILISATION WITHOUT VAGINAL MANIPULATION

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In Gujarat last year camps of laparoscopic sterilisation were held. In the beginning there was very good response from public, but it went on decreasing. Few women preferred usual tubectomy instead of laparoscopic sterilisation.

Family Planning Workers and Social Workers were contacted and enquiry was made regarding the same. One of the factors responsible for this was vaginal manipulation which was an unavoidable but most annoying part to the women, especially in presence of many volunteers present in the operation theatre.

There was a demand from Family Planning Workers for alternate procedure of laparoscopic sterilisation without vaginal manipulation. If such procedure was available they promised to motivate many more women.

Otherwise also there are many disadvantages of vaginal manipulation which is necessary in laparoscopic sterilisation. They are:

1. It is very painful procedure and either general anesthesia or heavy sedation is necessary.
2. Volsellum bite on the cervix causes bleeding per vaginum and is sometimes continued for two to three days after operation.
3. Chances of introducing infection by sound passed in uterine cavity.
4. Perforation of uterus.
5. Difficulty of manipulative manover in bulky, pregnant and post purperial uterus.
6. Disturbance of pregnancy in already pregnant women.
7. Violation of decency and modesty of woman due to exposing her in presence of theatre staff.

All these disadvantages can be avoided by adopting technique described for laparoscopic sterilisation without vaginal manipulation.

Technique

Woman is given preoperative dose of 1/1000 gr. of atropin and 100 mg. of pethidiase intra-muscularly before about half an hour of procedure. Trendlenberg's Position is given and knees are kept flexed. Pneumoperitoneum is created with little liberal amount of air e.g. about 3 litres.

Trocar and Canula introduced and after removing trocar scope was advanced. (In the series, scope used was single puncture storz operating laparoscope with 11 m.m. diameter) and quick preliminary inspection of peritoneal cavity done that included looking for presence of adhesions and fullness of bladder etc. after this lady was turned on her left side and given left lateral position. This can be easily achieved with one person at head end and one at foot end and co-operation of woman herself, who is not very heavily

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sedated. After proper left lateral position is achieved, scope in advance in the pelvic cavity and in most of the cases right tube can be seen which can be caught in tongs and fallop ring applied. After right tube is dealt with, scope was retracted and patient was given right lateral position. After right lateral position is achieved surgeon leaning over the woman can advance scope in pelvic easily and visualises left tube and fallop ring is applied.

In case of difficulty

1. Slightly exaggerated right or left lateral position is given.
2. Head end may be lowered further.
3. In more difficult cases, when uterus was retroverted and not in view of scope. Round ligament is identified, which is seen invariably on lateral pelvic wall. Tracing it medially fundus of uterus can be reached. By passing scope behind the fundus it is easy to bring it in anteverted position and then fallopian tube comes in view and can be dealt with.

Advantages of Technique

1. It saves woman from humiliation of vaginal manipulation in presence of theatre staff.
2. Makes ring application easier in post abortal and purperial cases.
3. Skilled person to manipulate uterus is not required.
4. All other disadvantages of vaginal manipulation are avoided.

This technique was used in 184 cases and was successful in 183 of them. One case which required vaginal manipulation had 4th degree prolapse uterus.

Disadvantages: vitrtually there is no disadvantage.

To sum up this technique is a break through in procedure of laparoscopic sterilisation and worth adopting by every laparoscopist performing laparoscopic sterilisation.

See Figs. on Art Paper I