

LABOUR FOLLOWING REPAIR OPERATIONS FOR GENITAL PROLAPSE†

(A Study of 89 Deliveries)

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Genital prolapse is one of the most frequent disorders met in our day to-day practice. Our socioeconomic and cultural background predisposes this condition to occur at an age and parity earlier than that reported in western countries. A large number of patients with genital prolapse are therefore interested in preserving menstrual and childbearing function. Hence it is essential for the obstetrician to know the effects of various plastic repairs for prolapse on pregnancy and labour.

Material and Methods

The present study was carried out at T.N. Medical College and B. Y. L. Nair Charitable Hospital, Bombay-400 008 for a period of 8 years from January 1971 to December 1978, to find out the effect of plastic surgery for genital prolapse on pregnancy and labour.

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Observations

From 1971 through 1978 there were 89 deliveries in patients who had undergone operations for genital prolapse. During the same period there were 22604 deliveries—an incidence of 1 in 284.

As shown in Table I, majority of the

TABLE I
Nature of Previous Operation and Number of Deliveries

Previous Operation	No. of Deliveries (%)
Shirodkar's uterosacral advancement	40 (44.9%)
Fothergill's repair	22 (24.7%)
A. P. Repair	13 (14.6%)
Purandare's Cervicopexy	10 (11.2%)
Shirodkar's Sling Operation	4 (4.5%)
Total	89 (100%)

deliveries were following Shirodkar's uterosacral advancement viz. 40 (44.9%). In 22, it followed forthergill's repair. The other operations included A.P. repair, Purandare's cervicopexy, and Shirodkar's abdominal sling operation.

The mode of delivery in different groups is as shown in Table II. The over-

TABLE II
Mode of Delivery and Previous Operation

Previous Operation	Mode of delivery				
	N. Vaginal	Forceps	Vaccum	LSCS	Rupture
Shirodkar's Ute. Sac.					
Adv.	29	4	3	4	-
Fothergill's	12	1	-	8	1
A.P. Repair	10	1	-	2	-
Cervicopexy	7	1	-	2	-
Shirodkar's Sling	4	-	-	-	-
Total	62 (69.7%)	7 (7.9%)	3 (3.4%)	16 (17.9)	1 (1.1%)
89 (100%)					

all incidence of caesarean was 17.9%. Normal vaginal deliveries occurred in 69.7% of the cases, whereas assistance of forceps and vaccum was required in 7.9% and 3.4% of the cases respectively.

When seen in relation to the nature of the previous operation it was seen that Fothergill's repair had the highest incidence of caesarean (36.36%). The caesarean rate following Shirodkar's uterosacral advancement and Purandare's cervicopexy was 10% and 20% respectively.

Table III shows indications for caesarean and the type of previous operation. The commonest indications for caesarean were cervical dystocia and incoordinate uterine action in 43.8% and 25% of the

cases respectively. The higher incidence of cervical dystocia and incoordinate action was seen in cases who had undergone Fothergill's repair.

Only 1 case of rupture uterus was seen in a 30 year old IIIrd gravida, who had the Fothergill's repair 4 years earlier. The prolonged labour and cicatrization of the cervix were probably responsible for the rupture. An exploratory laparotomy showed posterolateral colporrhexis for which total hysterectomy was performed. In 2 cases, Shirodkar's Encirclage operation was performed. Both the cases had previous Fothergill's repair done 2 and 3½ years before. The incidence of premature rupture of membranes was 10% following

TABLE III
Type of Operation and Indication for Caesarean

Previous Operation	Indications for I.S.C.S.			
	Cervical dystocia	Incoordinate Ut. Action	Foetal distress	Placenta Previa
Fothergill's	4	3	1	-
Shirodkar's				
Uterosac. Adv.	2	1	1	-
Cervicopexy	1	-	-	1
A.P. Repair	-	-	1	1
Total	7 (43.8%)	4 (25%)	3 (18.7%)	2 (12.5%)
16 (100%)				

Shirodkar's uterosacral advancement and 22.7% following Fothergill's repair.

Discussion

Although Fothergill (1921) and Shaw (1933, 1954) did not elaborate much on cervical dystocia following cervical amputation, Hunter (1939, 1955) had repeatedly pointed out that cervical dystocia is a much dreaded complication following Fothergill's repair. His caesarean rate was 10% and 5% of it was for "failed trial labour for cervical dystocia. In Averill's (1955) collected series of 156 deliveries; the caesarean rate was 22.6%, but the exact incidence of cervical dystocia was not known as in 50% of the cases elective section was performed.

In our series, overall caesarean rate was 17.9%, while that following previous Fothergill's repair was 36.36% of which 18.18% were following cervical dystocia. Rupture of uterus as a result of cervical dystocia due to cervical amputation has been reported (Brandt, 1933; Hunter, 1957). We had 1 case of posterolateral colporrhexis who required total hysterectomy. The incidence of cervical dystocia in other repairs for prolapse was considerably less, probably because the cervix is spared. As regards the difficulties during caesarean, the pushing down of the bladder was a problem, especially in 3 cases of previous Fothergill's, 1 case of previous uterosacral advancement and 1 case of previous cervicopexy. In a case of previous Purandare's cervicopexy bladder was accidentally opened, mistaking it for peritoneal reflection.

Purandare (1966) has mentioned difficulties in performing caesarean due to adhesions and advancement of bladder. Two cases of obstructed labour following

cervicopexy have also been reported (Domadia and Lele, 1973). We had only 1 case of cervical dystocia, out of 10 deliveries following previous cervicopexy.

Cervical incompetence following Fothergill's repair is well known (Lash, 1960). We had only 2 cases of cervical incompetence following Fothergill's repair (9.09%). In both these cases Shirodkar's Encirclage operation was performed.

Higher incidence of P.R.O.M. was noted especially following Fothergill's repair.

Conclusions

(1) During 8 years, 1971 through 1978, at B.Y.L. Nair Ch. Hospital, Bombay there were 89 deliveries following plastic operations for prolapse. Its incidence was 1 in 254.

(2) 44.9% were following Shirodkar's uterosacral advancement and 24.7% were following previous Fothergill's repair.

(3) Overall incidence of Normal vaginal deliveries was 69.7% and that of caesarean was 17.9%. Higher incidence of caesarean was noted in cases with previous Fothergill's repair (36.36%).

(4) Cervical dystocia was the most important complication and was noticed in 43.8% of the cases who underwent caesarean. Higher incidence of cervical dystocia and incoordinate uterine action was seen following Fothergill's repair, viz. 18.18% and 13.63% respectively.

(5) Incidence of P.R.O.M. was 10% following Shirodkar's uterosacral advancement and 22.7% following Fothergill's repair.

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