REPRODUCTIVE PERFORMANCE FOLLOWING PREVIOUS FOTHERGILL'S OPERATION FOR GENITAL PROLAPSE

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Certain obstetric and gynaecological complications may arise as a result of repair operations for genital prolapse. The operation may lead to infertility, habitual abortions, repeated preterm deliveries, dystocia and finally recurrance of prolapse.

In our institution, genital prolapse forms 14% of all gynaecological admissions and 38% of these cases belong to reproductive age group. As surgery is inevitable in major degrees of prolapse we are often faced with certain problems when many of them later return pregnant.

We have tried to analyse reproductive performance of 74 patients who had undergone Fothergill's repair for genital prolapse. The study was a retrospective one for a period of 10 years from 1971 through 1980.

Observations

During the period of study there were 27106 deliveries and 140 patients who had undergone some conservative repair operations for genital prolapse giving us the incidence of 1 in 194 deliveries. This brings out one fact that it is not uncommon to see a pregnancy following some repair operation for prolapse. Our socioeconomic and cultural background predisposes the genital prolapse to occur at age and parity much earlier than that reported in Western countries. A large number of our surgically treated cases are therefore interested in child bearing. We are often faced with problems when some of them later return to us pregnant. Of these 140 cases, 50 (35.7%) had undergone Fothergill's repair operation. In addition to this there were 24 cases of Fothergill's repair who were followed up, and had either secondary infertility, abortions or preterm deliveries.

As shown in Table I the incidence of full term normal vaginal delivery following previous Fothergill's repair was 44%. The incidence of caesarean section was 26%. In 2 (4%) of the cases rupture of the uterus was encountered. Assistance of forceps or vacuum was required in 12% and 14% of the cases respectively.

TABLE I

Mode of delivery	No.	(%)
Normal delivery	22	(44)
Forceps delivery	6	(12)
Vacuum delivery	7	(14)
LSCS	13	(26)
Rupture uterus	2	(4)
Total:	50	(100)

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Table II shows indication, for caesarean section in these cases. Most of the cases had caesarean section for indications such as cervical dystocia (53.8%) and inco-ordinate uterine action (23.07%).

TABLE II

Indications for Caesarean	No.	(%)
Cervical dystocia	7	(53.8)
Incoordinate uterine action	3	(23.07)
Placenta previa	1	(7.69)
Premature rupture of membranes	1	(7.69)
Foetal distress	1	(7.69)
Total:	13	(100)

Two cases of rupture uterus were noted following previous Fothergill's repair operation. One of the two was 30 years old IIIrd gravida, who had a history of operation 4 years earlier. On admission 6 hours after the onset of labour, cervix was found as a dimple at the vaginal vault, 8 hours later with moderate pains there was no further dilatation of the cervix and before patient could be taken up for caesarean section rupture occurred. An exploratory laparotomy revealed posterior colporrhexis and total hysterectomy was performed.

The other patient was 28 years old 2nd gravida who had history of operation 2 years ago. On admission, cervix was 2 cms. dilated, and membranes were intact. Since there was no C.P.D., vaginal delivery was decided upon. The patient was observed carefully. After 2 hours patient complained of severe pain and was re-examined. Abdominal examination revealed that the shape of the uterus was irregular, lower segment was stretched and Bandel's ring was palpable, at the level of the umbilicus, F.H.R. was regular. Vaginal examination revealed same findings as before. The patient was taken up for exploration. Laparotomy revealed overstretched lower segment giving away at left lateral end. Caesarean section was performed, the baby was extracted as vertex. The operation and postoperative period was uneventful.

Table III shows nature of the cervix at term and early labour, and its relation with the mode of delivery. Out of 50 cases of previous Fothergill's repair, 1 showed extensive scarring and dimple cervix at the vaginal vault, who had incomplete rupture of the uterus. Rigid non-dilating cervix was seen in 8, of whom 2 had undergone caesarean section for cervical dystocia and 1 had threatened rupture of

TABLE III

Nature of Cervix at Term or Labour and Mode of Delivery

Nature of cervix	No. of cases	No. of LSCS	No. of Rupture uterus	No. of vaginal delivery
1. Scarred and dimpled cervix at vaginal vault	1	—	1	—
2. Scarred but admits one finger	9	3	—	6
3. Regid non-dilating cervix inspite of good pains	8	7	1	—
4. Scarred, sacral cervix persisting in labour	3	3	—	—
5. Minimal scarring	29	—	—	29
Total:	50	13	2	35

the uterus. In 29 cases where cervical scarring was minimal, all had normal vaginal delifery. It is evident that incidence of cervical dystocia was related to the amount of scarring of the cervix.

Recurrence of prolapse following delivery was seen in 4 cases (10.5%), out of 38 followed up cases, remaining 12 cases were lost to follow up after delivery.

Table IV shows the analysis of 74 cases of previous Fothergill's repair as regards fertility. Out of 72 iases, 50 (65.56%) had full term deliveries, 2 (2.7%) had preterm deliveries, 4 (5.4%) had abortions, and 18 (24.32%) had secondary infertility.

TABLE IV

Incidence of Fertility Following Fothergill's Repair: Study of 74 Cases (1971-80)

Total No. of cases	74 (100%)
No. of full term deliveries	50 (67.56%)
No. of preterm deliveries	2 (2.7%)
No. of abortions	4 (5.4%)
Infertility	18 (24.32%)

Discussion

A large number of patients with genital prolapse in our country are interested in childbearing function. And as the surgery is inevitable in major degrees of prolapse we are faced with problems when they later return to us pregnant. The risks are more when amputation of the cervix is spared. After cervical amputation the incidence of infertility is quoted as 90% (Hunter, 1957), 76.3% (Lacey, 1921), 80% (Leonard, 1915). A study of 74 cases of Fothergill's repair operation performed at our institutions during 10 years period showed secondary infertility in 24.32% of cases.

The incidence of abortions and preterm labour is supposed to be higher once cervix is amputated. Its incidence has been reported variously as 68% by Bryn Williams (1942), 50% by Fisher (1941). In Averill's (1915) collected series from 18 contributors the caesarean rate was 23.6% but exact number of cases in whom cervix gave rise to difficulty in labour are not known as about 50% of the Obstetrician favoured elective caesarean at term. Contrary to this Shaw (1933, 1954) in 40 year's of obstetric experience did not have any difficulty in labour in cases on whom he had operated and emphasised that more often the labour is shortened owing to removal of the part of the cervix. In our series of 50 deliveries following previous Fothergill's repair the incidence of cervical dystocia was 53.8%. The cervix was totally scarred in 9, moderately scarred in 12 and minimally scarred in 29 cases. When cervix was totally scarred there was cervical dystocia, inco-ordinate uterine action and all of them resulted in caesarean, including one case of rupture uterus.

Recurrance following delivery in cases of previous repair operations of genital prolapse is a cause of concern to the obstetrician. The incidence of recurrance following Fothergill's repair in our series was 10.5% in followed up cases.

As regards difficulty during L.S.C.S. in cases with previous Fothergill's repair operation pushing down of the bladder was accidentaly opened and was closed in 3 layers later. In 1 case although there was no apperent difficulty in pushing down the bladder patient developed

vesico-cervical fistula on 7th day which healed on its own.

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