

REPRODUCTIVE PERFORMANCE FOLLOWING PURANDARE'S CERVICOPEXY OPERATION

by

V. R. AMBIYE,* M.D., D.G.O.

and

(Mrs.) C. M. ALWANI,** M.D., D.G.O.

All of us are aware about the peculiar problem of prolapse during the childbearing period among our women. The incidence of prolapse in young girls and nullipara is fairly high in our country as compared to their counterparts in other countries. In addition, a large number of multiparas with prolapse are interested in preserving childbearing function, because of the high perinatal and infant mortality. Cervicopexy, Purandare's operation in cases of prolapse with only some degree of weakness of uterine ligaments, while general built and development of musculo-fascial system is normal. This relatively simple operation, makes use of strips of anterior rectus sheath of the anterior abdominal wall to create support for cervix anteriorly. The purpose of this presentation is to evaluate the childbearing function following Purandare's cervicopexy operation.

Material and Methods

We have tried to analyse the Obstetric performance of 40 patients who had undergone Purandare's cervicopexy

*Reader, Department of Obstetrics and Gynaecology.

**Professor and Head of Obstetrics and Gynaecology.

Department of Obstetrics and Gynaecology, B.Y.L. Nair Charitable Hospital and T.N. Medical College, Bombay-400 008.

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operation. The study was a retrospective one for a period of 10 years' from 1971 through 1980.

Observations

Table I shows the incidence of fertility following cervicopexy operation in a study of 40 cases during 10 years' period from 1971 through 1980. There was a considerably high incidence of infertility (20%). The 4 of them (10%) had secondary infertility and rest were cases of primary infertility. In 4 cases postcoital test did not show any live or dead sperms in the cervical canal, although rest of the male and female investigations including semen examination, tubal factor, cervical factor and other hormonal investigations were normal. In 2 cases, laparoscopy showed cornual block, in 1 male factor was responsible for infertility. In 1 case no cause could be detected inspite of thorough investigations. The incidence of full term deliveries was 67.5%.

TABLE I

Incidence of Fertility Following Cervicopexy

Total No. of cases	40 (100%)
No. of F.T. deliveries	27 (67.5%)
No. of Preterm deliveries	4 (10%)
No. of Abortion	1 (2.5%)
Infertility	8 (20%)

Table II shows type of delivery following cervicopexy operations in a study of 31 deliveries. Of these 4 were preterm deliveries. The incidence of caesarean section was 13%, whereas that of forceps or vacuum was 3.2% each. Twenty-four (77.4%) had normal vaginal delivery. Indications for caesarean section (Table III) were in 2 cases it was cervical dystocia and inco-ordinate uterine action respectively probably due to improper taking up of the anterior lip of the cervix where the strips of the sheath were attached.

TABLE II

Type of Delivery Following Cervicopexy in 31 Cases

	No.	(%)
Normal delivery	24	(77.4)
Forceps	1	(3.2)
Vacuum	1	(3.2)
L.S.C.S.	4	(13.00)
Rupture uterus	1	(3.2)
Total:	31	(100)

TABLE III

Indication for Caesarean Section

Cervical dystocia	1
Inco-ordinate uterine action	1
Foetal distress	1
Placenta previa	1
Total:	4

In a case of rupture uterus following Purandare's Cervicopexy, patient was 22 years primigravida who had history of operation 3 years ago for nulliparous prolapse. On admission, cervix was 2 cms. dilated and membranes were intact. Since there was no C.P.D., vaginal delivery was decided upon. 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 umbilicus, FHS was regular. Vaginal examination revealed the same findings as before. Since abdominal examination was suggestive of obstructed labour, the patient was taken up for caesarean section. Laparotomy revealed overstretched lower segment and was very thinned out and had given way in the midline. Even the strips of the rectus sheath were also thinned out. The lower segment was incised above the level of the fixation of the strips and the baby was extracted as vertex. The lower segment was sutured in 2 layers. The uterovesical pouch of peritoneum was closed and the abdomen was closed in layers. Post operative recovery was uneventful. On follow-up there was no recurrence of prolapse.

As regards the difficulties during caesarean section, the bladder was opened accidentally in 1 case and in other identification of the lower uterine segment was difficult due to adhesions.

All the 31 cases were followed up for a varying length of time after delivery. In only 4 cases the prolapse recurred. In 2 it was only cervical descent, in 1 only vaginal wall prolapse and in 1 both cervical descent and vaginal wall prolapse. Thus the incidence of cervical descent was 9.6% following delivery. (Table IV).

TABLE IV

Recurrence of Prolapse Following Delivery

No. of cases	31
Recurrence of prolapse	4
Cervical descent	2
Vaginal wall prolapse	1
Both cervical and vaginal prolapse	1
	39

Discussion

Certain obstetric and gynaecological complications may arise as a result of repair operations for genital prolapse. The operations may lead to infertility or impaired fertility, habitual abortions, repeated preterm deliveries, dystocia and finally recurrence of prolapse. In our institutions genital prolapse forms approximately 14% of all gynaecological admission and about 38% of these cases belong to reproductive age group. As surgery is inevitable in major degrees of prolapse we are often faced with problems when many of them later return to us pregnant.

There was a high incidence of infertility (20%). The cause of infertility could be pinpointed in 3 cases; in 1 no cause could be detected inspite of thorough investigations, whereas in 4, postcoital test did not reveal live or dead sperms in the cervical canal. In them all other investigation were within normal limits. Probably the strips of the rectus sheath are attached on the anterior aspect of the cervix pull the cervix upwards and the cervix thereby doesn't dip in the seminal pool.

There was also 1 case of obstructed labour following Purandare's cervicopexy which was extremely rare and on review-

ing the available literature we have not come across a single case of obstructed labour which could be attributed to the operation. (Purandare 1966; Baxi 1969).

As regards the difficulty during caesarean section the bladder can be opened up while pushing down or while opening the uterovesical fold of the peritoneum. (Purandare 1966; Baxi 1969). In 1 case the bladder was accidentally opened up mistaking it for uterovesical fold of peritoneum. In all the cases, it was not possible to identify the strips on the lower uterine segment. Also there was no difficulty while opening the lower uterine segment. In 1 case the identification of the lower uterine segment was difficult due to adhesions.

All the cases were followed following delivery in order to find out the recurrence rate of uterovaginal prolapse. The recurrence rate was 9.6%. In 1 case where there was a recurrence of cervical descent upto 3rd degree Shirodkar's sling operation was performed.

References

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