PREGNANCY FOLLOWING REPAIR OPERATIONS FOR GENITAL PROLAPSE**

by

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SUMMARY

Thirty-nine pregnancies following posterior floor repair and Manchester repair have been analysed. In this series of 39 Cases, 17 conceived 5 or more years after repair and 9 conceived between 2 and 5 years after repair.

A study of the literatures revealed varied opinion regarding the incidence and the outcome of pregnancy following repair operations. In view of this diversities, the present study was undertaken to review the current picture of pregnancy following operative corrections for genital prolapse.

Material and Methods

A clinical report of 39 pregnancies out of 38 patients admitted in Eden Hospital, Medical College, Calcutta from January, 1972 to December, 1982 is presented.

Results and Analysis

Out of 39 pregnancy cases, 22 followed Manchester repair and pregnancy occurred between 2 and 5 years in 5 cases and over 5 years in 17 cases. Following other types of repair operation pregnancy followed within 5 years.

This study showed fertility in 20 out of 50 cases studied (40%). Of these out of 38 cases following Manchester repair Operation pregnancy followed in 13 cases (34%).

TABLE I

Operation—Gestation Interval

Nature of Operations	No. of cases	Pregnancy Incidence		
		Within 2 yrs.	2-5 yrs.	Over 5 yrs.
P.F.R.	10	8	2	—
Ant. colporrhaphy with pelvic floor repair	1	1	—	—
Manchester repair	22	—	5	17
Cervicopexy	6	4	2	—

Out of 39 pregnancy cases, 22 followed Manchester repair (in 21 cases). Out of the 22 pregnancies in these 21 cases, 2 ended in abortion. Of the remaining 20 cases in 18 caesarean section was the method of delivery (90%).

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Discussion

Incidence of pregnancy following repair operations have been previously reported as 1 in 368 deliveries (Bhaskar Rao,—1962). The incidence is much lower in our series (1 in 2592—cases). This can be explained by the wide acceptance or family planning procedure in recent years. Moreover, of late more Ward-Mayo's type of operations are undertaken in younger age groups by many gynaecologists (Anjaneyalu, 1979).

In this series of 39 cases, 17 conceived 5 or more years after repair and 9 conceived between 2 and 5 pears after repair.

It is generally recognised that fertility following repair operations specially with amputation of cervix is very considerably reduced (Sen, 1957; Mattingly, 1977). The incidence of infertility has been variously reported (Leonard 1914 80% Lacey 1921 76.7%; Hunter 1958 40%; Bhaskar Rao 1962 66.7%; Gonzalez et al 1967 91.3%). Further, the follow-up study of 50 cases of reproductive age group who had repair operation revealed an almost similar incidence of infertility (60%) (Table II).

The incidence of abortion or premature labour are higher after Manchester repair. There was wide variation in the previously reported incidence as 7% (Bhaskar Rao, 1962) to 50% (Fisher, 1942). Dewhurst (1972) states disturbances in sphincteric mechanisms at the level of internal os causing premature delivery in early third trimester. In this series, out of 39 pregnancies the incidence of abortion and preterm labour was 4 cases in each group (10.3%).

During late pregnancy there may be slight degree of tearing or haematoma in the lower uterine segment above the level of the cervical scar, resulting in antepartum haemmorhage. In this series, in 1 case there was history of A.P.H. at 35

TABLE II

Follow up Study of 50 Cases (20-30 Age Groups) who had Repair Operation Between 1972 to 1976—Fertility Performances

Type of Operation	No. of Cases	Pregnancy followed	Infertile	No Response
P.F.R.	11	6	2	3
Manchester repair	38	13	14	11
Cervicopexy	1	1	—	—

TABLE III

Nature of Pregnancy Events Following Different Repair Operations

Type of Operation	No. of Cases	Pregnancy Events				
		Abortion	Pain	TPH	Prem. Deliv.	Normal
P.F.R.	10	—	—	—	2	8
Ant. colporrhaphy with CPT repair	1	—	—	—	—	1
Manchester operation	22	3 (1 Th. Ab.)	1	1	2	15
Cervicopexy	6	1	4	—	—	1

weeks of pregnancy following Manchester operation. This pregnancy was terminated at 36 weeks and 5 days due to persistant abdominal pain and vaginal bleeding.

Of all the obstetric complications cervical dystocia seems to be the most formidable one. Gordon (1947) cautioned against cervical amputation in patients who are likely to be pregnant.

Cervical scarring may interfere with cervical dilatation. Averill (1957) was of opinon that pregnancies should be terminated by caesarean section. He cautioned that vaginal delivery should not be allowed after amputation of cervix due to the danger of rupture of uterus. In this series, the incidence of caesarean section was 25 out of 35 viable pregnancies (71.4%) and 90 'per cent incidence of sections in pregnancies following Manchester repair (Table IV). All the cases had short trial of vaginal delivery. In all the cases following Manchester repair the cervix failed to dilate and in 2 cases the cervix was on the verge of rupture and in 2 cases tearing took place along the line of scar tissue with serious haemorrhage. In 1 case there was complete obstruction and cervical opening could not be palpated. But out of 10 cases of simple pelvic floor repair without cervical amputation, 8 had vaginal delivery and 2 had caesarean section (20%). Averall (1955) and Hunter (1955) mentioned 23.6% and 18% respectively incidence of caesarean section following P.F.R. operation. In sling operation, 5 out of 6 cases went to term and all had elective caesarean section, since vaginal delilvery is a potent cause of recurrence following these operations (Goswami 1980).

Dewhurst (1972) pointed out that following delivery the repair may be done. Gonazalez (1967) believed that a well assisted delivery does not influence recurrence of prolapse. Bhaskar Rao (1962) mentioned that the incidence of recurrence is less in Manchester repair than with other types of operations. After repeated child birth the uterine supports may again be damaged and recurrence rate may vary from 1 to 16 per cent (Hunter, 1955; Anjaneyalu, 1979).

In this series, a short follow up study revealed 2 cases of recurrence out of the 20 cases attended. These 2 cass had simple pelvic floor repair.

Conclusions

(1) Incidenc eof pregnancy following repair operation for genital prolapse was 1 in 2,592 cases.

(2) Infertility was found to be present

TABLE IV

Method of Delivery in Different Groups of Cases

Type of Operations	No. of Cases	Abortion	Nature of Delivery		
			Normal Vag.	Forceps	C.S.
P.F.R.	10	—	3	5	2
Ant. colporrhaphy with CPT repair	1	—	1	—	—
Manchester repair	22	2	—	2	18
Cervicopexy	6	1	—	—	5

in 66.7% cases following all types of Repair Operations.

(3) Incidence of abortion and premature delivery (Before 37 weeks) was 10.3% in each group.

(4) Following Manchester repair, cervical dystocia was the most important complication and was found in all the cases resulting in 90% incidence of caesarean section. The overall incidence of C.S. was 71.4% in the present series.

(5) There was 1 case of rupture of the cervical scar with haemorrhage during an attempted trial of vaginal delivery.

(6) The perinatal mortality was 4 out of 35 viable pregnancies (11.4%). There was no maternal mortality.

(7) Recurrence of prolapse was noted in 2 cases following confinement. Both the cases had previous P.F.R. Operations.

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