A COMPARATIVE STUDY OF THE OPERATIVE RESULTS IN NULLIPAROUS AND UNIPAROUS PROLAPSE

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SUMMARY

Results of operation in 114 cases Nulliparous and Uniparous prolapse operated by different methods like Fothergill's, Purandare's Shirodkar's abdominal and Shirodkar's vaginal operation at R. G. Kar Medical College, has been studied with special reference to the pregnancy outcome and recurrence of prolapse.

From this analysis it is seen that although Shirodkar's and Purandare's operation has got the advantage of higher pregnancy rate, less abortion and premature delivery, the recurrence of prolapse is not markedly minimised.

Introduction

Treatment of nulliparous prolapse and uniparous prolapse still remains a problem to the gynaecologist because child bearing function in them has to be retained in addition to correction of prolapse. In vagination of the cervix into the vagina has led some to consider the condition as congenital elongation of cervix, leading sometimes to the erroneous belief that its amputation will cure the condition. Moreover, the cellular tissues in them are so fragile that chance of recurrence is also more. Amputation of cervix uteri in young women will have any or all of the three effects upon childbearing.

1. A reduction in the incidence of conception.
2. An increase in the incidence of abortions and premature labours.
3. A marked increase in complications during labour and resultant increase in operative delivery rate.

For these drawbacks, Purandare and Shirodkar have modified the operation without doing amputation. Results of these operations done at R. G. Kar Medical College during last 5 years from January 1975 to December 1980 have been analysed here.

Material and Methods

Out of total 1380 utero-vaginal prolapse cases attending R. G. Kar Medical College during 5 years from January 1975 to December 1980, 114 cases of nulliparous and uniparous prolapse were selected for the present study. These patients were subjected to different types

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of plastic operations like Fothergill's, Shirodkar's abdominal and vaginal and Purandare's operation and were followed up.

TABLE I
Incidence

Total No. of prolapse cases	Nulli-parous prolapse	Uniparous prolapse	Incidence
1380	12	102	8.26%

Discussion

In our institution, we received 12 cases of nulliparous and 102 cases of uniparous prolapse. Problem is really vexed because we have not only to cure the descensus of uterus, bladder and laxity of the perineum, but also to see that the future childbearing, it carried with safety and without recurrence of prolapse.

TABLE II
Different Types of Operations Done

Type of operation	Fothergill's operation	Purandare's operation	Shirodkar's vaginal operation	Shirodkar's abdominal operation
No. of cases	72	25	15	2

TABLE III
Results of Operations in Relation to Pregnancy Outcome

Type of operation	No. of patients conceived	Abortion or pre-mature delivery	Full-term delivery	Not yet delivered	Not yet conceived and/or lost to follow-up
Fothergill's operation	16	8	7 (Vag. 2, C.S. 5)	1	54
Purandare's operation	8	Nil	7 (Vag. 3, C.S. 4)	1	17
Shirodkar's abdominal operation	2	Nil	2 (Vag. 1, C.S. 1)	Nil	Nil
Shirodkar's vaginal operation	6	Nil	4 (Vag. 2, C.S. 2)	2	9

TABLE IV

Recurrence of Prolapse

Type of operation	Recurrence within 6 months of operation	Recurrence after child birth
Fothergill's	3 (Enterocele)	1
Purandare's	1	3
Shirodkar's abdominal	Nil	Nil
Shirodkar's vaginal	1	2

The type of operations performed by us are the following:

1. Fothergill's operation,
2. Purandare's operation,
3. Shirodkar's abdominal operation,
4. Shirodkar's vaginal operation.

Fothergill's operation done in our series has not been met with a rewarding success in all cases. There are cases of abortion, premature delivery and recurrence of prolapse as shown in Tables III and IV.

Shirodkar's modification of Fothergill's operation without amputation of cervix was rewarding in 6 cases. However, recurrence with vaginal operation was much greater (in 4 cases). Argument against this operation that it may entail in the formation of enterocele has not been observed by us because posterior peritoneum of the pouch of Douglas is sutured high up in the cervix. But commendation of this operation without amputation cannot be recommended for recurrence very early in the postoperative period and after child birth.

Shirodkar's abdominal operation though done in 2 cases difficult procedure, sometimes causes adhesion posteriorly with the uterus and cannot be taken as a simple routine technique. In our 2 cases, 1 required caesarean section where posterior part of the uterus was densely adherent with posterior parietal peritoneum and the other had a vaginal delivery. May be it would not have happened with competent surgeon like Shirodkar. However, an operation to be done by majority must have a simple technique.

Purandare's cervicopexy done in our series have given us good results. This is a more simple technique. Post-operative complications are minimum. However, recurrence rate after childbirth is appreciable.

References

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