CRYOSURGERY VERSUS ELECTROCAUTERISATION FOR THE TREATMENT OF CERVICAL EROSIONS

by

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SUMMARY

One hundred cases of cervical erosion were studied seventy-five were treated with cryosurgery and 25 with electric cautery. The clinical cure rate with cryosurgery was 97.3% as compared to 32% with electric cautery which is of course a significant difference, besides difference in pain, discomfort and spotting which has also been found to be more with elctric cautery.

Introduction

Electrocauterisation has been since long accepted as the treatment of cervical erosions and chronic cervicitis. Cryosurgery as compared to electric cautery has been found to be extremely safe and more effective. The differences reported from time to time in the relative efficacy of both these modalities of treatment prompted us to undertake this study. Hunter in 1906 first utilised electrocauterisation for chronic cervicities. Beard (1964) reported 39% symptomatic cure rate and 68% clinical cure rate with electrocauterisation of cervical erosions. Weitzer in 1940 first used solid CO_2 as a cryosurgical agent for cervicitis. Since then other gases have also been used. Ostergard *et al* (1969) reported 90% healing with cryosurgery and 33% healing with electric cautery in treatment of cervical erosions.

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Material and Method

One hundred patients of chronic cervicitis or cervical erosion attending the Gynaecological out-patient department of Sahai Hospital, Jaipur were studied. Any associated pelvic infection was ruled out clinically. A wet smear examination was done to rule out vaginitis, and if present treated first. Paps smear was carried out in patients above 35 years of age.

The patients were categorised in two groups:

Group I

Consisted of 75 patients treated within one week of the last menstrual period with cryosurgery as an out patient procedure without an anaesthetic. The apparatus used was Keeler—Amoils ACU 22 cryo unit. It provides four types of interchangeable probes for gynaecological use. The cooling system can be provided either by N_2O or CO_2. For present study

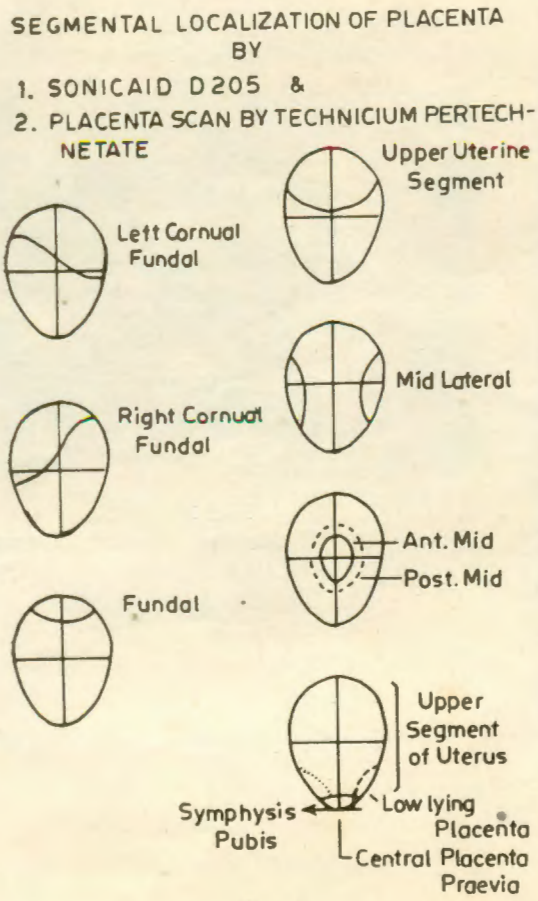

Fig. 1
Showing uterus divided arbitrarily into segments.

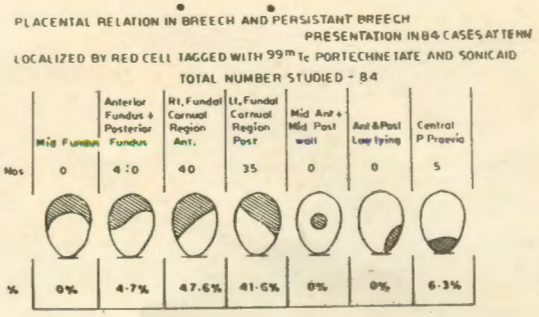

Fig. 2
Segmental localization of placenta by sonicaid D 205 in breech and persistent breech at term gestation.

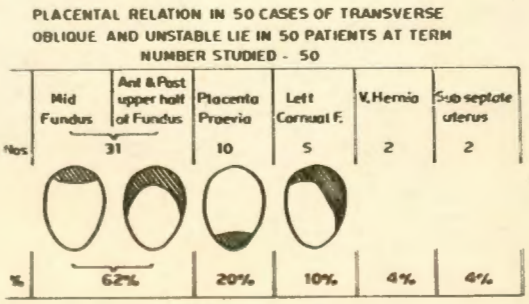

Fig. 3
Segmental localization of placenta using Sonicaid D 205 at term gestation.

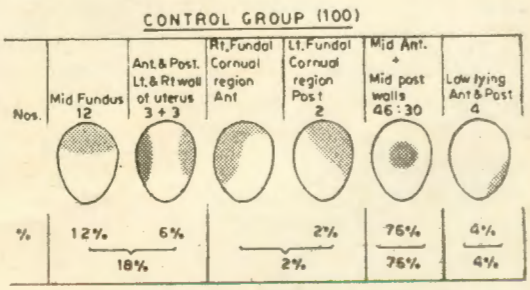

Fig. 4
Segmental localization of placenta in cephalic control group.

tudy of Location of Placenta—Kaul et al.
pp. 78-81

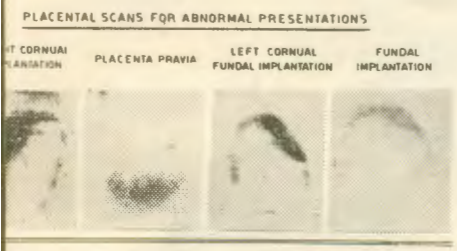

Fig. 5
ental localization of placenta by placental scan in abnormal presentation.

Early Diagnosis of Pre-Invasive Carcinoma of Cervix—Kaur et al. pp. 10-15

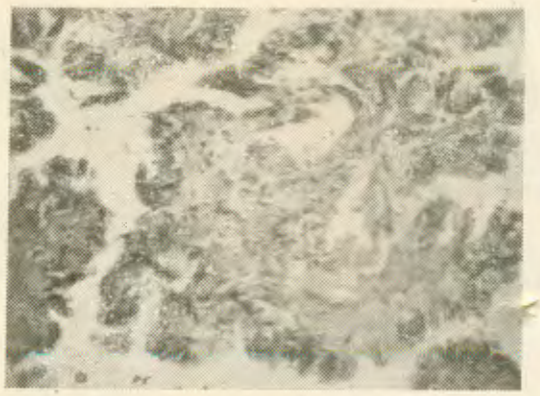

Fig. 1
Microphotograph showing papillary formation and pleomorphism.

Prenatal Sex Determination by Y-Fluorescent Body—Siddiqi et al. pp 24-26

Fig. 1
Y-Fluorescent body positive cells.

Histopathological Changes in Placenta—Kalra et al. pp. 86-90

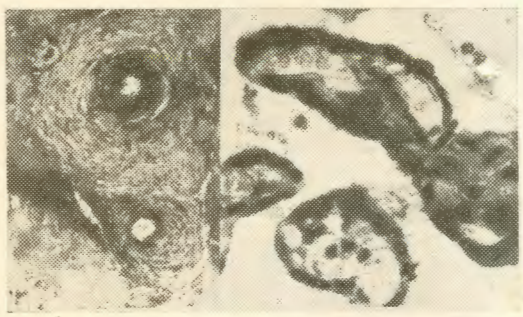

Fig. 1
Microphotograph showing placental villi with increased syncytial knots and vasculo-syncytial membranes on left and blood vessels showing endarteritis obliterans on right (E & E x 80).

Fig. 1
Megaureter and Hydronephrosis.

Fig. 2
Mild hydronephrosis.

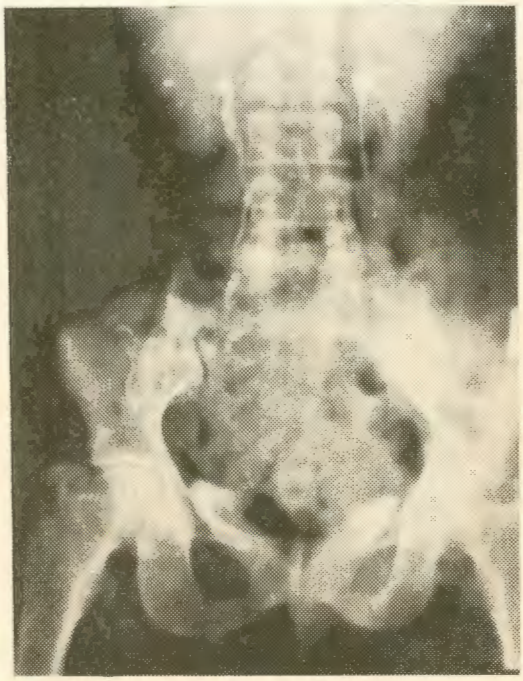

Fig. 3
Showing kinking of ureter.

Rupture of Uterus due to Vesical Calculi—
Pal et al. p. 214

Fig. 1
Phosphate stones as removed by suprapubic cystolithotomy during caesarean hysterectomy.

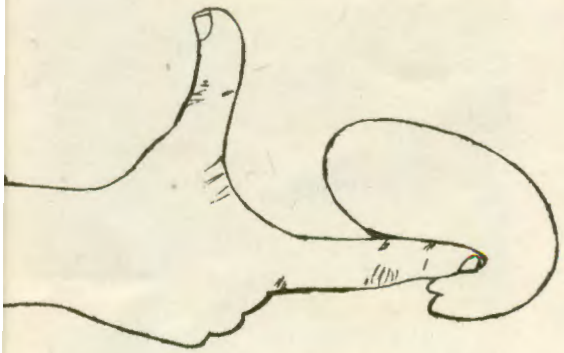

Fig. 1
Digital palpation of the cochleate uterus.

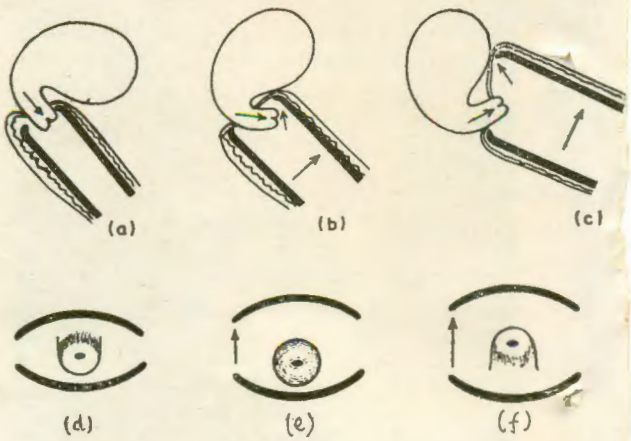

Fig. 2
Showing the mechanism of movement of the cervix in cochleate uterus when Cusco speculum is used (a, b and c). Movement of the cervix as viewed through the Cusco speculum (d, e and f).

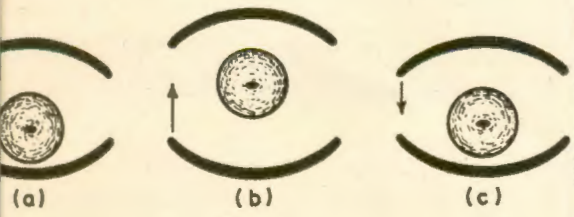

Fig. 3
Showing the movement of the cervix in retroverted and/or retroflexed uterus as viewed through the Cusco speculum (a, b and c).

Low Voltage Electric Stimulation V/s. Valethamate Bromide—Ambiye et al. pp. 48-51

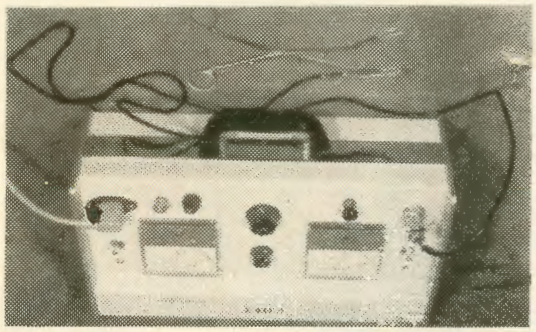

Fig. 1
Cervical ripener or cervilator.