# ABDOMINAL CERVICAL CERCLAGE

## (A Case Report)

by

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*Introduction*

The concept of abdominal cervical cerclage for selected cases of cervical incompetence was introduced by Benson and Durfee (1965). The indications for this operation are rather limited, and no large series has been reported.

**Case Report**

Mr. Y.K., a 22 years old 5th gravida, 1st para presented at K.E.M. Hospital, Bombay. Her last menstrual period had been on 19th January 1981 and her expected date of delivery on 28th October 1981. Her past menstrual cycles had been every 28 days.

She had a full term low forceps delivery 4 years ago following antepartum haemorrhage of unknown etiology. This was followed by a spontaneous abortion at 5 months of gestation, which had started as painless leaking per vaginum. She had another similar abortion at 3½ months of gestation 6 months later. In her next pregnancy Shirodkar's cervical cerclage was performed at 6 months of gestation. Ten days later she aborted through a bucket-handle tear of the cervix. The cerclage was removed but the bucket handle tear was not repaired.

A bimanual pelvic examination showed that the uterus was 10 weeks' size and the fornices were clear. The portio vaginalis was detached from the supravaginal cervix all around except at 9 o'clock position. The internal os was closed.

She was managed conservatively with complete bed rest, oral Isoxsuprine hydrochloride 20 mg 6 hourly and intramuscular 17-alpha hydroxy progesterone acetate 250 mg intramuscularly every week, with a pelvic examination twice a week to assess the opening of the internal os.

The internal os was found to have dilated to 2 cm on 2nd May 1981. An emergency abdominal cervical cerclage was performed on 3rd May 1981 using a mersilene tape on curved taper pointed needles. The tape was placed at the level of the isthmus uteri medial to the uterine vessels after opening the uterovesical pouch of peritoneum and reflecting the bladder away from the uterus. The knot was placed anteriorly, adjusting the tension with a finger in the cervical canal introduced vaginally.

Post-operatively the patient was given Ampicillin 250 mg 6 hourly for 7 days, Isoxsuprine hydrochloride in an infusion form (80 mg/L of 5% dextrose in water) for one day, 20 mg intramuscularly 6 hourly for two days and the same dose orally subsequently.

The patient had an uneventful course to term. An elective caesarean section was performed on 14th October 1981 and a female child weighing 2.9 kg was delivered. The mersilene tape cerclage was found to be undisturbed at the time of the cesarean section.

She had another conception 1 year later and underwent an elective caesarean section on 5th September 1983, when a female child weighing 2.850 kg was delivered. The cervical cerclage was found to be undisturbed at the time of the second caesarean section also.

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*Discussion*

An abdominal cerclage is required when the vaginal procedure is not possible due to loss of portio vaginalis as with cervical amputation, extensive bucket-handle tear of the cervix, or a congenitally short cervix, marked scarring of the cervix as after previously unsuccessful cervical cerclage, deeply notched midline cervical defect, untreated deep forniceal laceration. The technique is much more difficult than a vaginal procedure. The uterine vessels are at risk of injury during the procedure. If the patient goes into an inevitable abortion or uncontrolled preterm labour, an exploratory laparotomy is required to cut the knot. For this purpose it is advisable to place the knot posteriorly as it is better approachable through a posterior colpotomy incision than an anterior one. Another reason is to avoid irritation of the bladder base with an anterior knot. If the patient is discharged from the hospital and fails to report immediately in the event of an inevitable abortion or preterm labour, there is a great risk of rupture of the gravid uterus.

It is mandatory that the patient be explained all these factors before embarking upon the procedure, as it takes as much of the patient's cooperation as the surgeon's judgement and skill to make the operation a success.

*References*

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