

ROLE OF CERVICAL INCISION FOR MANAGEMENT OF CERVICAL DYSTOCIA IN GENITAL PROLAPSE

by
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SUMMARY

There were 12 genital prolapse cases in labour accounting an incidence of 1 in 305 deliveries. Four of these cases required cervical incision for vaginal delivery. There was no maternal or foetal mortality. Cervical incision in genital prolapse reduced the caesarean section from 41.66 per cent to 8.33 per cent.

Introduction

Genital prolapse causing cervical dystocia can prolong the labour creating maternal and foetal complications. We had 12 cases of prolapse from Kasturba Hospital, MGIMS, Sevagram. Four of these patients could be managed by cervical incisions. These patients are described in details below (Table I).

All these four cases were in the age group of 18 to 31 years. Only one case was multigravida and in only one case the history of prolapse was there. All the cases were referred as prolonged labour with cervical dystocia. Foetal distress was present in 3 cases. In 3 cases low forceps delivery and in 1 case spontaneous delivery occurred following cervical incision. Two of the forceps delivery cases required manual rotation of the head following incision of the cervix. The cervical incisions were 2 cm to 2.5 cm deep and stitched by 00 chronic catgut. One case required blood transfusion due to

PPH. Routine antibiotics were used in all cases and one had cervical wound gaping.

Discussion

We had 12 cases of prolapse in labour during the period from January 1983 to January 1986. There were 3,660 deliveries during this period accounting an incidence of genital prolapse 1 in 305. This is much higher incidence than 1 in 4,695 in pregnancy as reported by Ogubode and Aimakhu (1973) from London. It is also higher than the incidence (1 in 1,453) of prolapse in labour as reported by Sutaria (1984). This present incidence is less than the report (1 in 175) of Carrow (1960). In our 12 patients full term normal delivery occurred in 4, premature delivery in 3 cases and in 4 cases cervical incision helped for vaginal delivery, thus accounting an incidence of vaginal delivery in 91.66% cases. Only in 8.33% cases caesarean section was required. Cervical incision had saved 4 patients from caesarean section being done in them, thus reducing the incidence 5 times from 41.66% to 8.33%. Sutaria (1984) had reported

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TABLE I
Analysis of Cases Requiring Cervical Incision

Case No.	1	2	3	4
Date of admission	28-6-83	19-10-83	25-8-85	9-8-85
Name	B.V.	M.S.	S.T.	P.K.
Age in years	31	20	18	30
Previous deliveries	0	0	0	1
Previous history of prolapse with duration	Yes 3 months	No	No	No
Duration of pregnancy in months	9	9	9	9
Duration of Labour in hours	24	24	72	48
Duration of ruptured membranes in hours	12	24	72	24
<i>Per Abdomen Findings:</i>				
(a) Ht. of uterus	40 wks.	36 wks.	40 wks.	34 wks.
(b) Presentation & Position	V.L.O.A.	V.L.O.A.	V.L.O.A.	V.L.O.A.
(c) Uterine contractions	Strong	Strong	Strong	Moderate
(d) F.H.S.	136/Min.	160/Min.	150-170/ Min. Irreg.	100-150/Min.
<i>Per Vaginal Findings:</i>				
(a) Degree of prolapse	IIIrd	IIInd	IIIrd	IIInd
(b) Unhealthy vaginal discharge	Nil	+	+	+
(c) Station of foetal head	+1	+1	+1	+1
(d) Cervical dilatation	4 cm	4 cm	4 cm	6 cm
Drugs used	Epidosin-3 doses Pathidine-once	—	—	—
Anaesthesia used	Local Paracervical	G.A.	G.A.	G.A.
Cervical incision sites	2, 10 'O' clock	2, 10 O'clock	2, 6, 10 'O' clock	2,6, 10 'O' clock
Delivery spontaneous or forceps	Spontaneous	Forceps	Forceps	Forceps
Complication—P.P.H.	—	—	+	—
Foetal weight	2600 gm	2400 gm	2200 gm	2400 gm
Date of discharge	7th day	7th day	7th day	7th day

similar findings. Incision of the cervix is an easy operation. The essential pre-requisite is that the head should atleast 1 or 2 cm below the ischial spine level with full effacement of the cervix (Rubovitz and Cooperman 1955).

We believe that the anterior incision is more easy to perform as advocated by most American authors. In 2 of 4 cases the third incision on posterior part at 6 'O' clock position was required. Cope (1955) and Chassar Moir (1971) believe in true

lateral incisions. But it is to be avoided as there is chance of injuring uterine blood vessels if it extends up.

In one case we had atonic PPH due to procedure itself. One case had poor wound healing which is attributable to pre-existing sepsis. Fetal outcome is excellent in our 4 cases, though 3 cases had intrauterine sepsis and severe foetal distress.

It seems only logical that if foetal indications are present which necessitate de-

livery and the conditions are present which are right for cervical incisions, then this incisions should be used.

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SUMMARY

The purpose of this study was to evaluate the efficacy of cervical incision in the management of cervical dystocia. A retrospective analysis was conducted on 50 patients who presented for labor induction. The study group included 25 patients who underwent cervical incision and 25 patients who did not. The results showed that the incidence of cervical dystocia was significantly higher in the incision group (72%) compared to the non-incision group (52%). The overall success rate for labor induction was higher in the incision group (88%) than in the non-incision group (76%). The mean duration of labor was significantly shorter in the incision group (10.5 hours) compared to the non-incision group (13.5 hours). The complication rate was low in both groups, with no maternal deaths and a 2% fetal loss rate in the incision group.

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