FOLLOW UP STUDY OF MANCHESTER OPERATION FOR GENITAL PROLAPSE

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SUMMARY

Ten years follow up study of Manchester operation on 42 patients shows febrile morbidity in 8, secondary haemorrhage in 4, recurrence of prolapse in 2, recurrence of stress incontinence in 1 and dyspareunia in 6 patients. There is no evidence of cervical malignancy. Authors suggest this operation to be performed in younger patients specially with some benign cervical pathology and preferably after completion of family.

Introduction

Even at the present day, there is definite disagreement among the gynaecologists about best surgical treatment of genital prolapse. In many clinics vaginal hysterectomy with pelvic floor repair is done routinely for all degrees of prolapse, while in others Manchester type of conservative repair operation with or without some modification is thought to be the universal answer.

In evaluating an individual for the type of operation to be performed, various factors will have to be considered e.g.. age of the patient, general condition, degree of descent, presence of cystocele or enterocele, condition of cervix and corpus uteri, desirability of preserving menstrual function and need of further child bearing. Hence, there is definite room for honest difference of opinion. In view of these diversities, present study has been undertaken for evaluation of risk-benefit ratio of this particular operation (Manchester repair) as it is commonly done in this subcontinent.

Material and Methods

During last 10 years period (1975-1984) 42 cases of Manchester operation has been performed in our unit in Eden Hospital, Medical College, Calcutta. These patients have been followed up. Immediate postoperative period was observed directly and later on they were intimated by post for further follow up study. In the follow up clinic they are examined clinically and cytologically after taking cervical smear.

Results and Analysis

Most patients were of younger age group—only 26.3% were at or above 35 years of age during operation (Table II).

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Accepted for publication on 12-3-86.

TABLE I
Type of Operation

Type of operation	No. of patients	Percentage
Only Manchester's Repair	22	52.4
Manchester operation with vaginal Ligation	17	40.5
Manchester operation with repair of Stress Incontinence	3	7.1
Total:	42	100

TABLE II
Age at Operation

Age Group	No. of patients	Percentage
Below 25 years	3	7.1
25-29 years	14	33.3
30-34 years	14	33.3
35 years and above	11	26.3

Interval between operation and follow up varies from 1 to 10 years. It is more than 5 years in 24 patients (57%), between 2-5 years in 10 patients (24%) and less than 2 years in 8 patients (19%). At present 22 patients are above 40 years out of which 7 have already experienced menopause.

In present series 17 out of 42 patients had undergone vaginal ligation along with Manchester Operation.

Besides in another 14 permanent sterilisation measure was already taken. Associated Stress incontinence was repaired by modified Kelley's urethroplasty in 3 patients (7.1%) indicating low incidence of the disease in our country (Table I).

Complications

Eight patients (19%) had got febrile morbidity out of which 4 due to urinary tract infection, 2 due to vaginal infection, 1 due to superficial thrombophlebitis and in 1 case cause could not be established. Post operative vaginal bleeding was noted in 4 patients (9.5%) of which 1 needed blood transfusion. All were of secondary origin and 2 associated with fever. Recurrence of prolapse was found in 2 cases (4.9%). One nullipara showed repeated recurrence of uterine descent along with small cystocele and enterocele. Previously she had Purandare's operation for the same. Probably this is a case of congenital weakness of pelvic supports along with neuromuscular element. Other patient had recurrence of cystocele only (Table III).

TABLE III
Postoperative Complications

	No. of patients	Percentage
Immediate Complications		
Febrile morbidity	8	19
Secondary haemorrhage	4	9.5
Urinary retention	5	12.0
Late Complications		
Recurrence of Prolapse	2	4.9
Recurrence of urinary-symptom (Stress Incontinence)	1	2.4
Dyspareunia	6	14.2

Urinary retention requiring catheterisation was noted in 5 cases (12%). One patient complained of stress urinary in-

continence for few months following operation but demonstration of sign of stress incontinence failed to elicit any such. More likely this is an abnormal variety of urge incontinence. Two out of 3 patients having associated stress incontinence were cured of the symptom by Kelley's urethroplasty and other needed a second operation for persistance of symptom (Table III).

Five patients coming to operation had already discontinued sex relation, another 8 patients have given up after operation possibly in fear. Of the rest 29 patients 23 encountered no problem. Out of 6 patients (14.2%) having dyspareunia, 2 had actual shortening of anterior vaginal wall (Table III).

Condition of cervix—It was irregular in 3 cases. Another 4 patients had menstrual abnormality during follow up. But none of them showed any evidence of malignancy or dysplasia by cytological examination of cervical smear. Cytology report was inconclusive in one patient—which was proved to be absolutely normal on repeat smear. Smear suggestive of deep seated cervical infection was found in 9 cases (Table IV).

TABLE IV
Cervical Smear Cytology Report

Diagnosis	No. of patients
Normal Smear	31
Estrogenic phase	11
Progestogenic phase	13
Atrophic stage (Parabasal Maturation)	7
Infective Smear	9
Endocervical Cell (Erosion)	1
Inconclusive	1
Total	42

Pregnancy following operation—31 patients (74%) had got permanent sterilization done during or before operation. Out of rest 11 patients with further scope of fertility, only 2 (18%) were rewarded—one carried upto term while other ended in mid-trimester abortion.

TABLE V
Other Findings

Menstrual abnormality	4 patients
White discharge	9 ,,
Irregular cervix	3 ,,
Tender Pouch of Douglas	1 ,,
Tubo-Ovarian mass	1 ,,
Short anterior Vaginal wall	3 ,,
Vaginitis	1 ,,

Some other interesting findings—One patient, who complained of dyspareunia, dysmenorrhoea and polymenorrhoea was found to possess left sided tubo-ovarian mass. Hematometra or pyometra due to cervical stenosis was found in none of the patients.

Discussion

In comparison to vaginal hysterectomy with repair complications are rare with Manchester type of conservative repair operation excepting secondary haemorrhage (Shaw, 1933). Post-operative febrile morbidity, reflexion of net complications was encountered in 19% cases, cf. 32.3% vaginal hysterectomy with or without repair (Hawksworth and Roux, 1958).

Stallworthy (1940) reported the recurrence rate of prolapse in 13% cases after Manchester operation. Hawkins and Stallworthy in their earlier series on 1951-54 performed this operation on 66% of all prolapse patients while in a later series done the same on 17% cases only. They are more in favour of radical treatment (Vaginal hysterectomy with repair) to avoid a second operation. Present series shows a recurrence rate of 4.9% and

second operation will be needed in one patient only.

Jeffcoate (1967) pointed out the problem related with pregnancy after Manchester operation. Other than the major problem of infertility it can produce abortion and hazards during delivery and afterwards. Incidence of infertility has been variously reported (Leonard, 1914—80%; Bhaskar Rao, 1962—66.7%; Chakraborty, 1985—66%). Similarly, recurrence of prolapse after a vaginal delivery following this operation is very high—16% by Anjaneyalu (1979), who is in favour of vaginal hysterectomy even in younger patients. In present series, operation was mostly done along with permanent family welfare measure (vaginal ligation) after completion of family (74% cases). Where family had not been completed operation was denied for minor degree prolapse, but performed in second or third degree uterine descent with low amputation of cervix. Present series includes 11 such cases. Subsequent pregnancy occurred in 2 among them. More cases are to be studied before comming to a conclusion regarding the incidence of infertility after this operation.

Bonney (1974) experienced increased incidence of uterine malignancy following Manchester (Fothergill's) operation—45 per 1,00,000. Present series shows no malignancy among 42 patients in 10 years follow up study.

Conclusion

Genital prolapse in young age is very common in our country. Manchester operation is very much suitable for such young patients, preserving menstrual function. Benign cervical pathology like cervical elongation, hypertrophy, chronic cervicitis etc. can be satisfactorily treated without removing uterus. When further child bearing is desired any surgical intervention is honestly denied excepting in major degree uterine descent where this operation should be done with low amputation of crvix.

Recurrence rate can be reduced by (a) Practising Fothergill's technique of Suturing Makenrodt's ligament over front of cervix, (b) Shirodkar's modified technique of suturing utero-sacral ligament over front of cervix in cases of utero-vaginal type of prolapse of young nulliparа patient.

Operation is easy to perform, less time consuming and in expert hand results are extremely satisfactory.

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