LE FORT'S COLPOCLEISIS

(A Review of 91 Cases)

by

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SUMMARY

Nintyone cases of Le fort's colpocleisis performed by the authors have been presented. The cases were personally followed up over a period of 10 years, follow up ranging from 9 months to 10 years. The special mention is made regarding the modifications made by the authors in the original technique described by Le Fort.

The advantages of this operation are its simplicity of technique, permanent cure, symptomatic relief and minimal surgical risk. In this series excellent results were obtained in approximately 98% of the cases.

Introduction

A severe and complete procidentia is fairly common in old women, and is a cause of discomfort and incapacity. With increase in longevity more and more elderly women consult the gynaecologist for their prolapse. Many of these women are frail, and have additional disabilities like diabetes, hypertension, cardiac problems etc., which make anaesthesia and major surgery hazardous. As a result many of them are condemned to pessary or in spite of the risk subjected to major surgery like vaginal hysterectomy with repair.

In such a situation Le Fort's colpocleisis is a useful alternative as the operation can be performed rapidly, is simple, and can provide lasting satisfactory result. It can also be performed under local anaesthesia.

We are presenting our experience regarding Le Fort's colpocleisis with reference to clinical features, selection of cases for operation, choice of anaesthesia, operative complications, and followup etc. A special mention is also made regarding the modifications made in the original technique.

Material and Methods

A present study comprises of 91 cases of genital prolapse treated by Le Fort's colpocleisis at L.T.M.M. College and Hospital, Sion, Bombay-400 022. All the operations were performed by the senior author personally and the follow-up was also supervised personally over 10 years.

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Observation and Analysis

Age and Parity: The average age in this series was 63 years. The youngest patient was 50 years of age while the eldest was 83 years old. Majority of them (72 i.e. 80%) fall in the age group of 60-70 years.

The average parity was 4.5. All patients were multiparous.

Clinical Features: All patients had usual complaints of something coming out per vaginum, heaviness and pain in lower abdomen, etc. Urinary symptoms like dysuria (50%), burning micturition and urgency (40%) were common. Eight patients had stress urinary incontinence. Other complaints included low backache, difficulty in defecation, discharge per vaginum etc.

Associated medical problems included hypertension (49.5%), diabetes (23%), C.C.F. and left ventricular hypertrophy (6.5%), Cor pulmonale and emphysema (4.3%).

As regards types and degrees of prolapse majority (68) had atrophic uterus and procidentia, with cystocele and rectocele. Three had stump prolapse following subtotal hysterectomy done elsewhere in past. Another had vault prolapse following vaginal hysterectomy one year back. Associated rectal prolapse was observed in one (Table I).

Decubitus ulcers were present in 20, and were treated locally before undertaking the operation.

Criteria for selection

As this operation precludes sexual relations and vaginal examination due to obliteration of the vaginal canal, it was reserved for widows or elderly patients in whom sexual relations are already discontinued.

TABLE I

Types and Degrees of Prolapse in Cases Operated for Le Fort's Colpocleisis

Types and Degrees of prolapse	No. (%)
(1) Procidentia with cystocele and Rectocele	68 (74.72%)
(2) Procidentia with perineal tear	1 (1.09%)
(3) 3rd degree prolapse with Cystocele and Rectocele	17 (18.6%)
(4) Stump prolapse	3 (3.29%)
(5) Vault prolapse	1 (1.09%)
(6) Combined Genital and Rectal prolapse	1 (1.09%)
Total	91 (100%)

Other important criteria included, absence of any pathology in the cervix, uterus and vagina.

As regards the success of the operation is concerned following points were kept in mind before selection of the case for operation. Firstly prolapse should be reducible, and should be of complete variety. The uterus should be outside the vulva when pulled out. Lesser the vault prolapse more difficult is the operation. Secondly the uterus should not be bulky and uterocervical length should be less than three inches, as bulky uterus and cervical elongation are common causes of failure and recurrence of prolapse.

Pre-operative preparation and anaesthesia

Prior to operation routine investigations were carried out as regards anaesthetic fitness viz. haemogram, blood urea and sugar, cardiogram, X-ray chest etc. Pre-operative oestrogen cream locally and stilbesterol orally were given to some of the patients with atrophic vaginitis.

Most of the patients (79) were operated under spinal, (8) under saddle block

anaesthesia. Only 2 were operated under heavy sedation and local infiltration anaesthesia using pentothal, nitrous oxide and oxygen due to marked hypertension which contraindicated spinal anaesthesia.

Technique of operation and modifications

The original Le Fort's operation included making raw surface 4 cms in length and 2 cms in breadth on both anterior and posterior vaginal walls. The raw areas were joined beginning with ends closest to the cervix. The reduction progresses step by step with placing of the sutures and when two surfaces are united throughout reduction is complete.

In our series several modifications in the original technique were made. These included addition of perineoraphy which buttress the posterior vaginal walls and give good support to the septum. Addition of perineoraphy also helps in preventing stress urinary incontinence. The septum was also made stronger by increasing its width and the depth, and the side canals were made correspondingly narrower to prevent the cervix from protruding through them. Another important addition was taking Kelly's stich prophylactically to prevent stress incontinence. In the beginning we observed that out of first 12 cases of Le Fort's colpocleisis in whom Kelly's stich was not taken, 5 developed post operative stress incontinence. To obviate this complaint in later cases, dissection of the urethra from the vagina was carried out and suburethral fascia was plicated by series of Kelly's like sutures, to support the bladder neck and posterior urethral wall. In these cases only 2 post-operatively developed stress incontinence and were advised proper and frequent evacuation of the bladder.

In majority the operation required less than 45 minutes. The minimum time required was 20 minutes and the maximum was 110 minutes.

The post-operative management was routine. The indwelling catheter was kept for 5-8 days after the operation in majority. The perineal sutures were removed on 7th post-operative day and the patients were discharged on 10th-15th day depending on wound healing.

Post-operative complications (Table II)

The post-operative complications included fever, retention of urnie, pulmonary complications, bleeding per vaginum etc. There was no post-operative mortality.

Delayed complications included sepsis and recurrence of prolapse in third week and the examination revealed that entire septum had given way.

TABLE II
Post-operative Complications

Complications	No. (%)
Fever	38 (41.7%)
Pneumonitis	20 (21.9%)
Retention of urine	20 (21.9%)
Vaginal bleeding	1 (1.09%)
Sepsis and dehiscence	2 (2.19%)

Follow-up (Table III)

Out of 91 cases operated, 72 were personally followed up by the authors.

TABLE III

Follow up	Duration 9 months to 10 years
No. of followed up cases	72 (79.1%)
Information by correspondence	8 (8.79%)
Lost for follow up	11 (12.08%)
Recurrence following dehiscence	2 (2.19%)
Anatomical and symptomatic Cure	70 (76.9%)
Total No. of cases	91 (100%)

Eight had intimated by correspondence, their state of health and remarks about the operation.

The duration of follow-up ranged from 9 months to 10 years. The patients were interrogated as regards symptoms, complaints if any and were examined personally.

In 70 results were excellent both anatomically and functionally.

In first 15 cases in whom Kelly's stitch not taken 5 developed stress urinary incontinence. However, in later 76 cases in whom prophylactic Kelly's stich was taken only 2 had minor stress incontinence.

In 2 cases there was recurrence of prolapse. In one it was due to sepsis and giving away of the septum due to overlooking of a small decubitus ulcer around the cervical os (1 cm x 1½ cms) and not awaiting its complete healing before undertaking surgery. In other the uterus was bulky and the uterocervical length was 4½ inches, and the septum had given way at many places. This patient was later treated by Mayoward's hysterectomy.

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