COSMETIC SCAR STERILIZATION

By

ARUNA G. RANGNEKAR

SUMMARY

A periumbilical incision for puerperal sterilization hardly presents a scar. The chances of dehiscence of such a small incision are almost negligible and no failures were encountered.

Introduction

Laparoscopic sterilization offers a cosmetic scar but it is difficult to perform laparoscopic sterilization in immediate post-partum period since the large size of the uterus makes it susceptible to injury, moreover many times it is not possible to apply the rings because of the oedematous tubes. A periumbilical incision under such circumstances offers an excellent alternative since it hardly presents any visible scar.

Material and Methods

In one thousand patients demanding puerperal sterilization, the tubes were approached through crescenteric periumbilical incision of 2 to 2.5 cms corresponding to the lower margin of umbilicus.

The procedure was carried out under local analgesia injected along the lower margin of umbilicus. A semilunar incision was made along the line of infiltration cutting through the skin and subcutaneous tissue and exposing the linea alba which was cut in the same line of incision as that of skin in thin patients along with linea alba the peritoneum can also be incised, but in obese patients it had to be dealt with separately to gain access to the peritoneal cavity.

The fallopian tubes were identified and delivered and were ligatured by modified Pomeroy's technique. An absorbable suture was used for ligation. The incision was so small that in all the cases peritoneum and linea alba could be stitched together. In obese patients subcutaneous issue was approximated by plain catgut.

In earlier days, when this incision was introduced the skin incision was closed by a subcuticular stitch, but later on it was left unstitched. The upper edge of incision usually falls on the lower edge like a hinged lid.

No special post-operative care was needed and the patients were discharged from the hospital on second or third post-operative day and were called for a check dressing after one week. The resultant scar simulated a laparoscopic scar and was hardly ever visible.

Results

The average age of patients undergoing sterilization was 24 years. The mean parity was 4. The time taken for sterilization depended on the abdominal thickness and

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laxity and ranged between 8 to 10 minutes. In 3 obese patients it was not possible to get at the tubes because the fundus was broad and the abdominal wall was quite obese. In them the incision had to be extended vertically in the middle by about 1 cm so as to convert the semilunar incision into a crutch shaped one.

In one case since the fundus was broad the tubes were brought under the incision by retracting the uterus towards the surgeon with the help of a Babcock's forceps. This resulted in bleeding from the vascular uterine wall, but it was controlled by applying pressure over the site. In this series no patient required general anaesthesia. The incidence of wound sepsis was not high and in patients who were sterilized by this incision over the last 20 years, the incidence of failure or dehiscence of scar leading to incisional hernia was zero per cent.

Discussion

Abdominal approach to the tubes for sterilization is the oldest of all the methods and despite the alternative like laparoscopy remains the most popular method with Indian women, who would prefer to have operation done in post-natal period as during this period they enjoy the traditional rest of about 6 weeks and are looked after well, even under adverse domestic circumstances. Periumbilical incision apart from offering a cosmetic scar also ensures maximum security against conception unlike laparoscopic sterilization.

Post-partum ligation when performed within 36 hours the fundus and the tubes are situated about 2.5 cms below the umbilical level. It is easy to gain access to the tubes through a small 2 cms incision below the curve of umbilicus with no visible scar. Laxity and thinness of the abdomen adds to the ease of operation. Some authors have reported a slightly increased failure rate because of oedematous tubes during this period, but the failure rate in the present series was zero.

It is not possible to sterilize a patient by this incision if the uterus has started involuting and is more than 5 cms below the umbilicus. A routine vertical incision below the level of fundus should be the right approach under such circumstances.

The shorter hospital stay does not burden the exchequer and helps in the State economy.