REVERSAL TUBOPLASTY FOLLOWING TUBAL STERILISATION

By

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SUMMARY

A two year follow-up study carried out at the Dr. R. N. Cooper Hospital, Bombay entailed a study of 21 cases of reversal tuboplasty following tubal sterilisation. Of these 16 conceived. The surgical technique, post-operative management and follow-up was according to a fixed protocol. The best results were obtained when sterilisation was done at the isthmo-ampullary region.

Material and Methods

Over a two year period 21 patients underwent a reversal tuboplasty for various reasons (Table 1). The surgery was performed by the same surgical unit. Similar protocols were used for all patients. Pre-operative laparoscopy and a hysterosalpingography was done for every patient to determine the site of ligation and the effective future length of tube. Surgery was elective post-menstrual. Intra-operative continuous irrigation was done with Ringer lactate. On table probing of the proximal segment of tube was undertaken to dilate the ostium. Anastomosis was by a three point technique in two layers using Vicryl 5.0 viz. musculo-muscular and sero-muscular effort being made to exclude mucosa as far as possible. Meticulous hemostasis was achieved and intraperitoneal instillation of 300 cc Ringer Lactate was done before closure. Post-operative hydrotubation was done after 72 hours using 100 mg of hydrocortisone, 100,000 units of Crystalline Penicillin in 20 cc of normal saline in the operation theatre. The patient and her husband were encouraged to have planned relations and try for an early pregnancy. If the patient did not conceive within 6 months, an HSG was done followed by ovulation induction.

Results

Referring to Table I, the major requests for Reversal Tuboplasty were due to the death of 1 or more children—a finding reflecting directly on the high perinatal and infant mortality rates. (Hence, the small incidence of Reversal Tuboplasty is expected to follow a natural decline with better health care.) Most women came for surgery after interval of 2 to 4 years seen in Table II primarily due to death of infants in 1-3 years of age group.

TABLE I

Reason for Reversal

Death of 1 or more children	14
Remarriage	5
Desire for more children	2

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TABLE II
Sterilisation—Reversal Interval

Less than 2 years	7
2-4 years	11
More than 4 years	3

Table III shows common methods of sterilisation were Silastic bands and the Pomeroy technique which also had very similar success rates post-anastomosis in terms of pregnancy (Table IV).

TABLE III
Sterilisation Method

(Laparoscopic (Silastic bands)	8
Puerperal (Pomeroy)	7
Interval TL with MTP	2
(Pomeroy)	33

TABLE IV
Outcome Comparison of Type of Sterilisation and Pregnancy Following Reversal

	No.	Pregnancies	Success Rate
Silastic bands	8	6	75%
Pomeroy	13	10	76%

TABLE V
Outcome

FTNDs	7
Twins	1
LSCS	2
Tubal pregnancy	2
Ongoing pregnancy	4

The outcome (Table V) does not show an exceptionally high rate of Tubal pregnancy and operative delivery.

Discussion

As always newer sophisticated implements sweeping onto the medical front are extolled in virtue, so is the operating microscope. Undoubtedly the results are superior, but at high cost. We solved our dilemma by implementing a "microsurgical technique" at macrosurgery. Our results (71%) contrast favouraby from Seigler and Perez (30%). However, the net success rates finally depend on the patients' fertility potential, effective length of tube and tubal function. The 2 tubal abortions had damaged tubes. In our series we had a request for an MTP, on grounds of a twin pregnancy.

Conclusion

Microsurgery is undoubtedly good, but in India centres having the operating microscope and trained doctors are few. By performing macrosurgery on micro-surgical principles it is obvious that there is no substitute for tissue respect and meticulousness for best results. Hence, is the microscope really obligatory? the debate continues.

References

1. Seigler, A. M. and Perez, R. J.: Fertil steril, 26: 383, 1975.