MOST CONSERVATIVE TREATMENT OF PROLAPSE: A PRELIMINARY COMMUNICATION

By

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SUMMARY

Very old patient's with inconvenient genital prolapse pose a problem for treatment, when they are medically unfit or poor-risk patients for any operative treatment. Traditional Le Foarte's operation is also accompained by some disadvantages.

A new approach to the problem is suggested in the form of a very simple safe and effective operation. The Operation is based on the principles of Thiersch's stitch taken at the level of introitus. This keeps the prolapsed genitals inside vagina, thus giving complete symptomatic relief. The cervix can be easily inspected any time and the discharges drain freely.

Introduction

Once in a while, a gynaecologist is confronted with a very old, frail, debiliated woman with a major degree of prolapse. Who is unfit to undergo any major surgery like Mayoward's hysterectomy with repair. Functional use of vagina for sexual function is out of consideration in such grand old women, who are often widows.

The traditional answer for this problem has been a Le Forte's operation of partial midline colpocleisis. Though this relatively simple operation performed under local anaesthesia is quite safe and effective, it involves considerable tissue trauma. Infection and non healing of raw areas in opposition pose a serious problem. Stress incontinence often becomes a new inconvenience.

Two separate patients seen in a government hospital gave the author a stimulus for developing a new, more simple, safe and equally effective method for the symptomatic relief in these patients.

(i) A women aged about 80 years presented with a complaint of stress incontinence and leucorrhoea. She gave history of complete prolapse, she had been treated with a ring pessary about 20 years earlier by her family physician. According to her she had been cured of her prolapse permanently. On examination, she was found to have less than a second degree descent, stopping just above a very narrow introitus, which studded with ulcers, infection and a fibrous ring which could hardly admit one finger. On more deeper examination, one could have glimpses of a white polythene ring

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pessary almost completely buried in vaginal wall and covered with fibrous tissue.

(ii) An old woman was posted for Mayoward's operation, who also had a prolapsed rectum. After completion of the gynaecologic operation, the prolapsed rectum was also treated at the same sitting with a Thiersch's stitch in consultation with a proctologist.

Memories of these two cases triggered a synthetic process in the mind of the author and the result was the following operation mhich may be termed as 'Introital tightening' or Dani's Stitch.

The patient is given no pre-operative sedation. She is put in lithotomy position and the parts are cleaned by a dilute savlon or Dettol solution only. The Vagina is cleaned with the same solution and she is draped in the usual way. Lignocaine 1%, without Adrenaline is injected subcutaneously at the posterior forschette (2 cc) and also at a point on the anterior vaginal wall in the midline and about 2-3 cms above external urinary meatus at the sub-urethral sulkus. Two transverse incisions are taken with the knife, about 2 cms in length and deep enough to undercut vaginal wall on either side to make the cut vaginal edges mobile for suturing afterwards.

No. 1 or No. '0' 'situ-pack' long enough for cervical encirclage is taken on a big 3 inch curved cutting needle. The needle enters the posterior incision at the forshchette and is passed sub-cutaneously, at the base of right labium minor so as to bring it out in the anterior sub-urethral incision. The course of the needle follows that of the carunculi myritiformis and is deep enough to include some labial fat. Care must be taken not to pierce the vaginal epithelium and the suture thread should not cut through the vaginal wall when made taut. Special care should be taken at 11 O'clock and 1 O'clock positions so as to avoid a bridge formation in the vaginal fold or recess at these points. The needle is reinserted at the left corner of the anterior incision and a similar course is followed on the left side, so as to bring the needle out in the posterior incision. After taking out the needle, single or double threads are pulled gently so as to tighten the purs-string, tight enough to allow amission of one or two fingers in vagina. 2-3 surgeon's knots are tied, and the ends are cut short enough to allow burging of knots and cut ends in the incision. Both the incisions are closed by a single 'figure of eight' stitch with No-0 chromic catgut.

Healing of vaginal incision may be augmented by administration of oral estrogens. A suitable antibiotic cover may also be given. A beginner may safeguard the urethra by putting a rubber catheter in the bladder during operation. During post-operative period the patient is inspected every day for stress incontinence, infection and hematoma formation in the labia, protrusion of cervix through the purse-string and/or nylon cutting through vaginal wall also should be watched for. Patient can be discharged after seven days and followed-up at suitable intervals.

Advantages of Dani's stitch over Leforte's operation are (1) Less tissue trauma, less or no bleeding; (2) Cervix amenable for inspection or cytology with the use of a smaller speculum; (3) No stress incontinence post-operatively; (4) Free drainage of vaginal discharges.

The author has a limited experience of 11 patients in last 3 years. In the initial 2 patients, the stitches had cut through vaginal wall and had to be removed

within 3 months. In one of them prolapse did not recur. Three patients were lost for follow up. The remaining 6 patients have done well for 4-8 months with no problems. After all, one does not expect them to live very long at the age of 75 to 80 years and above. The treatment is modest and palliative. Though slight post-operative discomfort was experienced by only half of patients, they too got used to the stitch after 1-2 weeks. Stress incontinence was not newly complained by any patient.

Thoughts for the future

(1) A multicentric trial appears warranted to test the efficacy of this operation on really unfit patients.

(2) A possible substitution of 'situ puck' suture by a merceline tape.

(3) A possible routine use of this operation as a substitute to pre-operative packing.

(4) Use of this measure for temporary palliation when prolapse occurs in association of pregnancy is worth considering.