GOODALL-POWER'S MODIFICATION OF LE FORT'S OPERATION

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ABSTRACT

A significant number of postmenopausal, elderly ladies from low socio-economic group and rural background present with uterine prolapse. Goodall Power's modificaiton of Lefort's operation was done in a selected group of patients with satisfactory results. The operation is considered suitable in such a group and is better alternative to the pessary treatment for uterine prolapse.

(Key word: PROLAPSE UTERUS—CONSERVATIVE MANAGEMENT)

INTRODUCTION

Uterine prolapse is a common problem that a gynaecologist has to manage. The incidence of prolapse in postmenopausal multiparas is relatively high. The congenital weakness of pelvic floor and the effects of obstetric injuries are usually manifested in postmenopausal women when the tissue atrophy sets in due to cessation of ovarian activity.

Goodall Power's (1937) modification of Lefort's operation was tried on seventeen patients over a period of six years-in nine under local anaesthesia supplemented with I.V. calmpose and in remaining eight under regional/general anaesthesia. The results obtained, have been reviewed and the problems faced have been discussed.

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Accepted for Publication on

PROCEDURE

With the patient in lithotomy, traction is made on the cervix (Fig 1). An area of about 3 cms is infiltrated with 10-15 ml of 1% xylocaine all around the cervix. A triangular area of vagina is marked about 2 cms above the cervix, the apex of the triangle covering about 1/3 of the length of the vagina. Sufficient space is left laterally to allow for drainage for cervical secretions. This area of vagina is denuded of mucosa (Fig 2). A

similar triangular area of the same size is marked posteriorly taking care that the bases of both the triangles are at the same level (Fig 3).

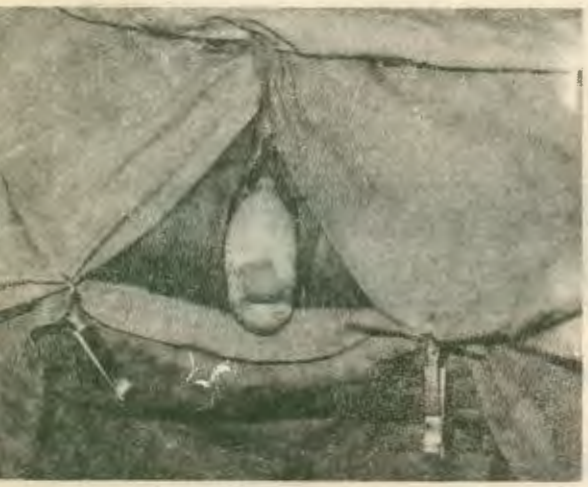

Fig. 1. Cervix exposed

Mucosal edges of the triangle bases are approximated with 'o' chromic catgut. Further closure of the denuded area in done by a series of interrupted sutures with same size of catgut and then placed laterally. The suture picks up the mucosa and some of the adjacent raw surface ensuring that no dead space is left when the sutures are tied. The apex of each of the two triangles is approximated in the same manner.

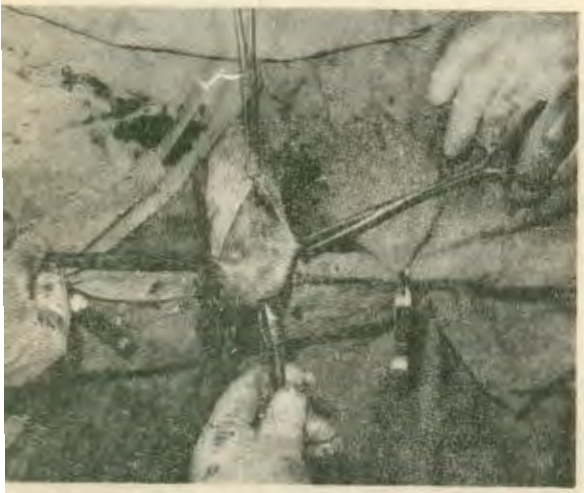

Fig. 2. Unicosal denudation anterior

Fig. 3. Mucosal denudation posterior

Fig. 4. Operation end result

Thus the obliterated vagina forms a kind of a shelf on which the cervix rests, with satisfactory drainage of cervical secretions. The resultant vagina though short is functionally satisfactory (Fig 5).

Patients with cystocele and rectocele require repairs in the usual way. The cystocele repair is done before tying the lateral sutures placed over the denuded area.

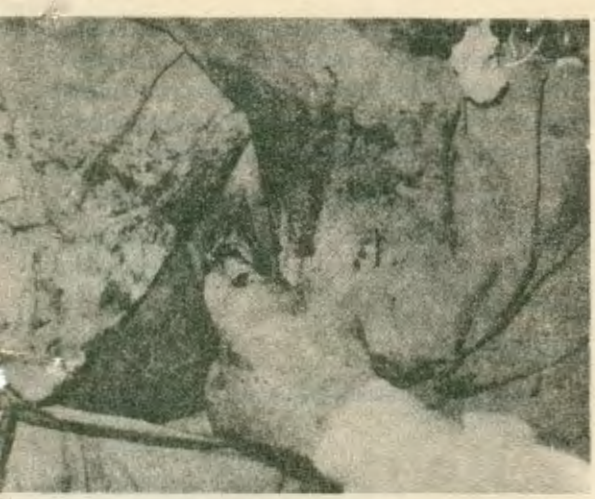

Fig. 5. Depth of Vagina

SELECTION OF CASES

All the seventeen cases were postmenopausal with the average age of 53.05 years the highest being 60 years and the lowest 45 years (Table 1). Eleven of the patients were considered high anaesthetic risks either because of uncontrollabel hypertension, IHD or poor general condition (Table II). One was unwilling for vaginal hysterectomy and repair. Seven patients had cystocele and three had cystocele and rectocele associated with uterine prolapse.

TABLE I:

AGE DISTRIBUTICN

Ser No	Age in years	Number of patients
1.	45-50	6
2.	51-55	8
3.	56-60	3

TABLE II:

ASSOCIATED MEDICAL DISORDERS

Ser No	Medical Disorders	Number
1.	Hypertension	8
2.	I.H.D.	1
3.	COR-Pulmonale	3
4.	Others	5

REVIEW OF RESULTS

All the patients except those in whom cystocele repair was done were ambulatory and on normal diet 6-8 hours after surgery. They complained of minimal discomfort. Fourteen patients were discharged after 7th post operative day.

One patient who underwent cystocele and rectocele repairs alongwith Goodall Power modification developed post operative urinary retention and had secondary haemorrhage from the anterior colporrhaphy sutures. She was managed with tight vaginal packing, continuous bladder drainage and blood transfusion. Post operative morbidity was minimal in rest of the cases. All the patients had a functional vagina (Fig 5). There was no recurrence of prolapse upto 2 years of follow up. Six patients did not report for follow up, hence considered asymptomatic. One patient complained of supposed recurrence which on examination was found to be rectocele, which had been overlooked pre-operatively. The same was repaired during a second sitting.

DISCUSSION

Seventeen postmenopausal cases of uterine prolapse were managed with Goodall Power's modification of Lefort's operation. These were high risk patients. It is a simple procedure, does not require much time and can be carried out under local anaesthesia. It can be carried out by relatively less experienced surgeon with

satisfactory results not only in correction of prolapse but also in leaving a satisfactory length of functional vagina. The patients had minimal morbidity. There is no distortion of the bladder base as a result of the operation. Post opertive I.V.U. was done in the patients who had difficulty in micturition and urethrocystography did not reveal any distortion of the bladder base or any other abnormality.

However, it has the disadvantage of concealing the cervix from view. It is therefore felt that the pocedure may be resorted to only as an laternative to a ring pessary. It is considered superior to pessary as patients with pesary fail to come for review or follow up, particularly so, from the villages. The operation is permanent and does not have the risks and complications following the insertion of a ring pessary.

To conclude, it is a useful procedure in particular circumstances in a very selected group of patients but is not a method of choice for uterovaginal prolapse.

REFERENCE

1. *Goodall JC & Power RMH - A Am. J. Obstet, Gynec.; 34:968, 1937.*