POST HYSTERECTOMY PROLAPSE PER VAGINUM A REVIEW OVER 6 YEARS (1984-89)

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SUMMARY

The following is a study of 15 cases of vaginal prolapse following hysterectomy over 6 years period 1984-1989 at the LTMGH Sion Bombay-22. During this period there were 1304 hysterectomies done; 408 abdominal and 816 vaginal giving an incidence of about 1.15%. An analysis of the patients signs and symptoms, an overview of the operative techniques used and a review of literature complete this study.

INTRODUCTION

Post hysterectomy prolapse is that state in which the vagina is partially or completely turned inside out along with its underlying organs under the stress of the intra-abdominal pressure and is due to weakness in the supports of these particular organs. Prolapse of the vaginal vault following hysterectomy; either abdominal or vaginal represents a troublesome if a good result and a functioning vagina are to be obtained.

MATERIAL AND METHODS

This is a study of post hysterectomy genital prolapse surveying a period of six years (1984-89) at our hospital 15 cases of vault prolapse were detected over the same period giving a percentage incidence of 1.15% (Table 1). Symonds and Sheldon from Mayo Clinic had studied cases of vault prolapse over 10 years i 1965 with an incidence of 1.53%. Out of 153 cases, in 72 cases original hysterectomy operation was done in Mayo Clinic. This gives incidence of occurence for this clinic as 0.72%. In our 15 cases, 3 occured after abdominal hysterectomy and 12 after vaginal hysterectomy (Table 2). Our series gives a percentage relationship of abdominal : vaginal hysterectomy of 1:5 as compared to Mayo Clinic with incidence of 1:2. All 15 cases came with main complaint of something coming out per vaginum. In our series only 4 patients had bladder symptoms with frequency

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of micturition present in 2 ccases, dysuria in one and genuine stress incontinence in one patient who also had a urethrocele. One of our patients with enterocele and rectocele had chronic constipation. One patient had a rectal prolapse in addition. 5 of our patients were distinctly abese and 4 patients complained of leucorrhoea and had atrophic vaginitis.

OBSERVATION AND RESULTS (TABLE 3)

In our series Le Forte's colpocleisis was done for 4 cases. One of them had mild degree of stress incontinence after the operation. In the other cases we had done vaginal repair (Kelly's type) at the time of Le Forte's colpocleisis as a precautionary measure. There were only 2 recurrences in 15 cases, in one combined approach was used while in the second abdominal suspension was done alone.

DISCUSSION

The management of patients with post-hysterectomy vaginal prolapse has been reviewed recently by Kauppila et al (1985) who reported on the results of operation for post-hysterectomy vaginal prolapse in 22 patients between 1973 and 1982. All the corrective operations were done abdominally, with a combination of sacral colpopexy and enterocele resection being the most common procedure used. The abdominal approach to the repair of post-hysterectomy vaginal inversion has also been described by Yates (1975) and Grundsell and Larsson (1984). The procedures used all basically involved anchoring the vaginal vault to the promotory of the sacrum with either mersilene or some alternative artificial mesh, or straps of external oblique aponeurosis (Williams and Richardson 1952). Operative bleeding may be a problem if the vaginal vault is attached to the hollow of the sacrum (Sutton et al 1981) as opposed to the promontory. Transvaginal fixation of the vaginal vault to the sacrospinous ligament has been described (Birnbaum 1973, Randall and Nichols 1971), but this obviously involves 'blind' suturing and an increased risk of damage to the bowel or

TABLE I

INCIDENCE OF POSTHYSTERECTOMY PROLAPSE

Cases Studied At.	No. of Hysterectomies	Duration of Stufy	No. of Cases of Posthysterectomy Prolpase	Incidence
MAYO CLINIC	10,000	10 Yrs.	153	1.53%
OUR HOSPITAL	1,304	6 Yrs.	15	1.15%

TABLE II

DISTRIBUTION OF POST HYSTERECTOMY PROLAPSE

Type of Hysterectomy	Original Hysterectomies Done at Mayo Clinic Vault Prolapse	%	Our Hospital Vault Prolapse	%
Abdominal	21	29.16	3	20.00
Vaginal	51	70.84	12	80.00

TABLE 3

VARIETIES OF OPERATIVE TREATMENT FOR POSTHYSTERECTOMY PROLAPSE USED IN THE PRESENT SERIES

Type of Operation	No. of Cases Operated	No. of Cases Combined Operation Done	results
A) Repair of Vaginal Relaxation			
1) Ant. Colporrhaphy	1	1	Good
2) Post. Colpoperineorrhaphy	4	4	Good
3) (1) + (2)	4	3	2 recurrences
4) Kelly's repair	1	1	Good
5) Graham's operation	1	1	Good
B) Enterocele repair			
1) Vaginal ligation of sac	5	5	Good
2) Moschcowitz operation	1	1	Good
C) Colpocleisis			
Le Forte's type	4	0	Good
D) Abdominal suspension			
I) Anterior Suspension			
a) William Richardon technique	4	2	1 recurrence
b) Ferguson's technique	1	0	Good
II) Posterior suspension			
Kauppila's technique		1	0 Good

ureter. From the most recent reviews of the subject (Kauppila et al 1985, Grundsell and Larsson 1984), fixation of the vaginal vault to the sacrum appears to carry a lower risk of recurrence than anterior fixation of the vaginal vault to the round ligaments - but the members reported in these series as well as the present series are small (Table 3).

CONCLUSION

The study of vault prolapse is thus a fascinating and complicated subject which taxes the ingenuity and resources of the surgeon. A thorough knowledge of anatomy, a keen sense of plastic surgery, instinct together with the knowledge of the physiopathology of the pelvic organs is very necessary for effective cures.

REFERENCES

1. *Birnbaum S.J. : Am J. Obstet. Gynec. 86 : 693; 1973*
2. *Grundsell H, Larsson G : Brit. J. of Obstet. and Gynec. 91 : 808, 1984.*
3. *Kauppila O, Punnonen R, Teisala K : Surgery, Gynec. and Obstet. 161 : 9, 1985.*

   Randall C.L., Nichols D.H. : Brit. J. of Obstet. Gynec. 38 : 327, 1971.
5. *Sutton G.P., Addison W.A., Livengood C.H. III, Hammond C.B. : Am. J. Obstet. Gynec 140 : 836, 1981.*
6. *Symonds R.E. and Sheldon R.S. : Obstet. and Gynec. 25 : 61, 1965.*
7. *Williams G.A., Richardson A.C. : Am J. Obstet. Gynec 64 : 552, 1952.*
8. *Yates J.B., Selby P.L., Peacock M., Brownjohn A.M. : Brit. Med. J. 289 : 41, 1984.*