CORRECTION OF UTERO-VAGINAL PROLAPSE BY SHIRODKAR'S SLING OPERATION

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SUMMARY

26 young patients with uterovaginal prolapse in the age group 16-30 years were treated by a combined abdominoperineal approach between 1987 and 1990. Shirodkar's sling operation with perineal repair was performed. Two patients have conceived and delivered so far without recurrence of prolapse. This method is an alternative to other repair operations.

INTRODUCTION

Uterovaginal prolapse is a common gynaecological problem. In the elderly patients prolapse is corrected by performing a vaginal hysterectomy with repair. However, this operative procedure is not of any help when one is faced with young patients suffering from III and IV degree prolapses at a very young age.

Various conservative operations have been devised to circumvent this problem such as the Manchester operation. Fothergill's operation and the Cervicopexy operation. But each of these give rise to their own set of problems, such as cervical incompetence, dysmenorrhoea and recurrence of prolapse. Also, Shirodkar's Abdominal Sling operation, which he devised for the treatment of congenital prolapse or prolapse following a single childbirth does not totally correct such a degree of prolapse.

Hence in such young patients we decided to combine the Shirodkar's Sling Operation with vaginal correction of prolapse.

MATERIALS AND METHODS

26 young patients with prolapse were treated by this combined technique of Shirodkar's Sling Operation with vaginal correction of prolapse at the H. B. Municipal General Hospital, Borivili during a period of 3 years from 1987 to 1990.

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OBSERVATIONS

Age and Parity

21(81%) patients were less than 25 years of age and were suffering from prolapse for a period of 1-3 years. 5(19%) patients were between 26-30 years and were suffering from prolapse for a duration of 3-5 years.

5(19%) nulliparous patients had congenital prolapse, 17(65%) patients were primiparas and 4(16%) patients had two children each and wanted further childbearing.

Type of Delivery

17 patients had all their deliveries at home and 9 had hospital deliveries of which 3 patients had prolonged labour and there were 2 operative deliveries.

Degree of Prolapse

7(27%) patients had II degree prolapse, of which two patients had undergone a previous repair operation which had resulted in a recurrence of prolapse. 17(65%) patients had a III degree prolapse and 2(8%) patients had procedentia of which one was a case of congenital prolapse.

Surgery

Standard technique of Shirodkar's Sling Operation was used. Material used was merciline tape which was sutured to the isthmic region posteriorly. In addition round ligament plication was done to maintain the anteversion of the uterus. After completion of the abdominal repair the patient was placed in a lithotomy position and a vaginal correction was done where necessary.

RESULTS

In this series with a follow-up period of 3 years only one patient has had any complaint. She complained of lumbar backache 3 months after the operative procedure. Her X-rays were normal and she had pain relief with symptomatic treatment.

Table I

Degree of Prolapse

II	III	IV
7	17	2

Two patients have conceived so far following the operation. One patient had a III degree prolapse. Following the sling operation she had a full term normal delivery with no recurrence of prolapse and the other patient underwent a full term LSCS for foetal distress with thick meconium stained liquor.

DISCUSSION

This preliminary study brings several interesting points in focus. Firstly, the choice of an operative procedure for correction of prolapse must be made after careful clinical assessment of the patient. Secondly, a single operative procedure is often insufficient for the total correction of the problem and often a combination of procedures must be used. Thirdly, this procedure though technically difficult has given good results in terms of preservation of reproductive function, none or few future obstetric problems and fewer chances of recurrence of prolapse. Fourthly, the decision to do a vaginal repair after the abdominal procedure was taken with the fact kept in mind that if the vaginal repair was done first and then the abdominal procedure, it would result in excessive repair and may interfere with the normal sexual function of the patients.