INTROITAL TIGHTENING (A NEW CONSERVATIVE OPERATION FOR HUGE PROLAPSE IN GERIOGYNAECOLOGY)

Y. S. NANDANWAR. ● KAMINI DALAL

SUMMARY

Prolapse of uterus with cystorectocele in elderly women who are not fit for anaesthesia and lithotomy position is a challenge for Gynaecologist. Le-Forte operation was an answer in the past with its own problems like, failure, sepsis, and is difficult for unexperienced surgeon. Besides hysterectomy or PAP smear is not easy subsequently.

Our new method is very safe, simple and sure. This can be done by any basic doctor at any primary health centre to help poor, old, socially neglected and helpless senior citizen. There were no complications in our series of 55 patients in last 7 years referred from KEM Hospital Geriatric clinic and other centres.

INTRODUCTION

Prolapse of the uterus with Cystorectocele may be associated with decubitous ulcer and infection and is very much uncomfortable to elderly women. This is not an uncommon problem in elderly in our gyanaecological practice. Use of Vaginal pessary, tampoons and Le-Forte operation one can use with their limitations and complications eg. Pesssary needs cleaning and assistance of tampoons cannot be used for a long term.

Woman who is unfit for prolonged lithotomy and anaesthesia due to her age and geriatric medical and surgical disorders

Dept. of Obs. & Gyn., K.E.M Hospital Mumbai 12.
Accepted for Publication on Jan'97

needs to have safe, simple, short procedure which can be performed by any basic doctor without any special skill and training at a primary health centre level.

This new conservative operation fulfills the criteria and is well accepted in our centre. Dani reported a series of 10 cases in 1989.

Why new approach

Huge prolapse in elderly patients unfit for anaesthesia cannot be left alone because of its own inherent complications like 1. local ulceration and infection 2. Urinary complications. 3. Socio psychological problems due to S.U.I and old age.

Tampoons : Need medical supervision, asepsis and frequent insertion and still can cuase retention of urine and constipation.

Pessaries require regular follow-up, can cause vaginal discharge, ulceration and even vagino-vesical fistulae, impaction, strangulation and urinary incontinence or retention of urine. Le-Forte operation has many disadvantages like

1. Surgeon expertise with good hospital set up.
2. Prolonged lithotomy position at least for 15-25 minutes.
3. Post operative complication.
4. Known recurrance.
5. Injury to the bladder and stress urinary incontinence.
6. Technical difficulty.
7. Hemorrhage.
8. Cervix is not accessible for examination later.
9. PAP smear cannot be taken.
10. Sexual function is not possible.

Considering all these problems a new approach was thought of. Many patients were waiting for surgery when surgerywas getting postponed for one or the other reason, during which time pessary was used as a conservative method for these patients. When they came for follow-up it was found that their prolapse was cured because the pessary had got impacted in the vaginal tissue following infection and fibrosis. This stimulated the thought of introital tightening the principle of which is that of "Theirsch stitch" the surgery done for rectal prolapse.

MATERIAL AND METHODS

We had selected the 55 patients in KEM Hospital over a period of 7 years for this study. All these patients were above 55 years with multiple Geriatric medical and Surgical problems. Most of them were referred from geriatric clinic of KEM Hospital. All these patients were investigated but were found to be unfit for anaesthesia. Complete examination was done after taking a detailed history. The procedure was explained to the patients and their relatives with a clear understanding that this is only a palliative measure In the begining a few cases had cut through of the stitch at 1 O'clock and 10 O'clock positions. Then we started taking deeper stitches. The procedure is very simple done under local anaesthesia using 1% lignocaine injected all around the introitus. 2mm vaginal wall was incised 0.5cms below the urethra and at the posterior fourchette. Any non absorbable material like PDS II No. 1 was taken on a large round body needle

which was inserted through the incision made in the anterior vaginal mucosa passed 0.5cms submucosally andwas brought out through the posterior incision. A similar stitch was taken on the opposite side. And the introitus was tightened to allow a small speculum or two fingers and about 5-6 knots were tied. In order to bury the stitches the vaginal mucosa and the skin were sutured with 1-0 chromic catgut. This procedure took not more than 2 minutes. Post-operative care was not cumbersome. Patients were put on analgesics and oestrogen creams, Local antibiotic cream was applied. Hospitalisation on an average was only for 4 days mainly for other reasons, otherwise it is an OPD procedure.

The advantages of introital tightening are :

1. Cervix is accesible for cytology and examination.
2. Free vaginal drainage is possible.
3. Less trauma with minimal blood loss.
4. Technically easy.
5. Surgical skill is not necessary.
6. No need for indwelling catheter.
7. Stress urinary incontinence was not seen.
8. Prolonged lithotomy position not necessary.
9. Sexual function is possible.
10. Very cost effective.

OBSERVATION AND RESULTS

This is a preliminary study. The procedure can be used temporarily just to give symptomatic relief to poor old ladies who are unfit for anaesthesia and surgery. More elaborate studies are needed to prove the same.

ACKNOWLEDGEMENTS

We are indebted to the Head of the Department of Obstretrics and Gynaecology and the Dean of KEM Hospital for allowing us to publish the above article.

Table I :
SHOWING AGE (n = 55)

Sr. No.	Age	No. of patients	Percentage
1	65-70	07	12.73
2.	70-75	29	52.73
3.	75-80	13	23.64
4.	80 85	06	10.90
5.	>85	-	

Table II
SHOWING RESULT OF OPERATION

Sr No.		No. of pts	Percentage
1	Recurrance, failure and repeated procedure after 8 months	2	3.63
2	Absolutely no complication at geriatric clinic Follow up	51	92.74
3	Stitch cut through and recurrance, fit for anaesthesia and vaginal hysterectomy done after 3 months	2	3.63

Table III
SHOWS DIFFERENT SUTURE MATERIAL USED

Sr No.	Suture material used	Good results	Cut through
1	Sutupak No. 1	10	2
2	Umbilical tape	1	1
3	Ethilon No 1	10	1
4.	Blacks	9	0
5	Vicryl No 1	20	0
6	PDS II	5	0

REFERENCE

Dutt S - J Obstet Gynaec Ind 39 : 725-1989