Should cervical dilatation be done in all cases of infertility?

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Summary: **Among the 1260 cases of infertility 375 cases could be properly evaluated and followed up. A routine uterine sounding was done in all cases in the first visit itself. The cases were categorized into two groups as Group I (n=274) with no cervical stenosis and Group II (n=101) with cervical stenosis. Short term infertility was seen in 24(23.7%) so only cervical dilatation was done. Long term infertility was seen in 77(76.7%) and all the 77 cases underwent diagnostic laparoscopy with cervical dilatation. In both groups aggressive management of infertility was done like induction of ovulation & IUI.**

The pregnancy rates were compared in both groups. In group I & group II the pregnancy rates were 66(24%) & 13(12.8%) respectively.

Cervical dilatation is not an absolute necessity in all cases of infertility. Initial sounding of the cervix on first visit itself can select those women requiring dilatation.

Introduction

Infertility is a worldwide problem. About 2-10% of all couples are infertile. A couple who seeks consultation for infertility is already under a lot of stress and the number of tests and visits to the clinic can add a fresh load of anxiety & stress and interfere with the normal lifestyles of the couple. For this reason it is important that the evaluation is well planned, accurate, rapid, cheap, safe & easy to perform. We routinely do semen analysis, transvaginal sonography, patency of tubes etc. But it is equally important to know if cervical stenosis is present or not. D & C for all cases for infertility is a routine practice in many centres but this study emphasises that it is necessary only for cases of cervical stenosis thus avoiding unnecessary anaesthesia.

Materials & Methods

This study has been conducted at the Dept. of OB GYN. K.M.C., Manipal. We have studied 1260 cases of infertility from Nov 1994 to Nov 1996 from which 375 cases could be properly followed up. For all cases coming to our infertility center we have been doing routine tests as TVS, hormonal assay, patency of tubes & a routine sounding is done for all cases in the first visit itself to detect any cervical stenosis.

Table I
Incidence of cervical stenosis

	No.	percentage
Group I (no cervical stenosis)	274	73%
Group II (with cervical stenosis)	101	26.9%

The patients were categorised into 2 groups. Group I (n=274) with no cervical stenosis & group II (n=101) with cervical stenosis.

Results

Table II Shows that long term infertility was seen in 77(76.2%) cases and short term infertility was seen in 24(23.7%) cases. Table III shows that the cervical stenosed patients with short term infertility underwent

Table II
Duration of infertility

	No.	percentage
long term	77	76.2%
short term	24	23.7%
total	101	

Table III
Method of management

Dilatation	short term	long term
Probes & dilators	22	54
Dilators	2	23

Table V
Pregnancy rates

	Group I	Group II
Induction	5	2
AIH	30	7
AID	26	4
spontaneous	5	-
Total	66(24%)	13(12.8%)

ovulation induction, AIH, AID & spontaneously in 12, 42, 15 & 28 cases respectively. Table V shows the comparison of the pregnancy rates in group I & II which were 66(24%) & 13(12.8%) respectively.

Discussion

The above study shows that cervical stenosis is an important cause of female infertility, which we come across in our daily practice & dilatation is required only if stenosis is present. Our study included 101 cases i.e. 26.9% of cervical stenosis. Baggish & Baltoyunis (1987) did a similar study which showed 40% of cervical stenosis while doing hysteroscopies. Dickey et al (1996) & Rosenwaks et al (1994) reported 15% & 40% of cervical stenosis which were managed by various methods.

Table IV
Method of management

	Group I with no cx stenosis (n=274)	Group II with cx stenosis (n=101) short term	Group II with cx stenosis (n=101) long term
Ovulation induction	23	6	12
AIH	191	12	42
AID	48	4	15
Spontaneous	12	2	8

cervical dilatation using probes and dilators in 22 cases & only dilators in 2 cases. In long term infertility group probes and dilators were used in 54 cases & only dilators in 23 cases. Table IV shows group I patients were managed with Induction, AIH, AID & spontaneous in 23, 191, 48 & 12 cases respectively. In group II short term infertility cases were managed with ovulation induction, AIH, AID & spontaneously in 6, 12, 4 & 2 cases respectively. Similarly long term infertility cases were managed with

Conclusion

From our study it may be concluded that cervical dilatation is not an absolute necessity in all cases of infertility unless there is a difficulty in sounding the cervix. Although it may provide options for treatment in selected cases with infertility. The effect of dilatation with other sequelae of obstruction however remains uncertain. Hence an initial routine sounding of the cervix at the first visit can select those women requiring dilatation.

References

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