The place of vaginal hysterectomy in the management of genital prolapse

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INTRODUCTION

IN SPITE of great advances in anatomical knowledge and technical procedures in gynaecologic surgery, there is still a great diversity of opinion as to the principles involved and the best operative technique for the cure of prolapse. The advent of vaginal hysterectomy combined with repair is a comparatively new approach and, I believe, it is an outstanding contribution to gynaecology. The popularity of this procedure is increasing, but there is still considerable disagreement as to its place in the cure of prolapse. A review of the current position is therefore made.

GENERAL CONSIDERATIONS

The repair of genital prolapse has remained a problem, as no single operation has been entirely satisfactory. The age and parity of the patient, the symptoms and the degree of prolapse, the desire for children and the presence or absence of concomitant uterine disease affect the choice and extent of the operation.

Generally, the Manchester operation has been the most successful. Many advocates of this procedure hold that a retention of the cervix is essential for a successful repair, since they believe it forms the "keystone of an arch."

However, this traditional view has been shown to be outmoded. If the cervix were so important, total abdominal hysterectomy would be followed by prolapse. That this was not so was shown long ago by the figures of Read and Bell (1933). In their series of 605 total hysterectomies, there were no cases of prolapse, while 4 occured after 173 subtotal operations. The cervix, therefore, is only the meeting place of the supports of the uterus and its retention is not essential for the cure of prolapse. Thus vaginal hysterectomy in the course of a repair in no way prevents one from performing an effective repair.

INDICATION

Vaginal hysterectomy, combined with repair, is indicated under the following circumstances:

(1) The prolapse is associated with uterine disease or the symptoms of it.

These include menorrhagia and menstrual irregularities. The best that the Manchester repair can do is to repair the prolapse and leave a uterus which has to be dealt with subsequently. In many cases after a vaginal repair, menorrhagia or postmenapausal bleeding necessitates further surgical treatment. This could have been avoided if the uterus had been

removed at the time of repair. Further, if hysterectomy has to be performed after a Manchester repair, there is a chance of damage to the supports of the vault.

(2) The prolapse occurs beyond childbearing years. The removal of the uterus in this age group is an excellent prophylaxis against cervical and uterine cancer.

(3) The prolapse occurs in a group of women who are thought to have an unusual liability to carcinoma body of uterus. This group includes diabetic women and those who have a late menapause.

(4) Third degree prolapse is perhaps the most widely accepted indication for a combined procedure. The Manchester operation on its own is unsatisfactory. In third degree prolapse, it is very difficult to secure a high elevation of the vault by the Manchester technique. The uterine ligaments are grossly elongated and attenuated and it is difficult to replace an atrophic uterus usually with a long hypertrophied cervix lying outside the vagina, inside the pelvis.

On the other hand if a vaginal hysterectomy is performed, the round, cardinal, and utero-sacral ligaments can all be shortened to whatever extent is desired, so that when they are sutured together in re-forming the vault, a high elevation is obtained. Thus vaginal husterectomy is the only procedure which gives good results in third degree prolapse.

Those who believe in preserving a part of the cervix in repair advise that even in major prolapse, there are positive advantages in preserving some part of the cervix. Morris (1965) believes that the addition of vaginal hysterectomy adds nothing to the security of a repair. However, it must be stressed that the repair after vaginal hysterectomy is in no way inferior to that obtained by the Manchester technique. The enthusiasts of the combined procedure feel, as does Williams (1962), who stated that there is nothing that can be achieved by a Manchester repair that cannot be equalled by that repair performed immediately after vaginal hysterectomy, which uses precisely the same tissue to achieve its results. Indeed I would say, in many cases the wider approach and exposure of vaginal hysterectomy offers the opportunity for a superior repair.

CONTRAINDICATIONS:

Vaginal hysterectomy in the course of a repair is contraindicated under the following circumstances:

(1) The young patient desires more children.

(2) Gross pelvic pathology with fixity and distortion of the uterus.

(3) Endometriosis.

(4) Absence of uterine mobility with a high fixed cervix which cannot be drawn down towards the intoitus.

One of the criticisms levelled against vaginal hysterectomy is said to be the development of an enterocele. However, Read (1933) had correctly pointed out that in the vast majority of cases, the so-called post operative recurrent enterocele is not recurrent, but in fact a neglected enterocele. It can be prevented by diligently searching for any actual or potential enterocele and excising it.

RESULTS

Very satisfactory results have been reported from many centres. To quote one, Watson (1963) reviewed 145 patients several years after vaginal hysterectomy and repair and found that in over 90% of cases, there was satisfactory anatomical and functional result.

CONCLUSION

The combined operation of vaginal hysterectomy and repair should have an important place in the management of utero-vaginal prolapse. It is likely to supercede the Manchester operation when the prolapse is associated with uterine disease and when the prolapse occurs in the perimenapausal or postmenapausal woman.

SUMMARY

There is controversy as to the best technique for the repair of genital prolapse. The combined operation of vaginal hysterectomy and repair is a new approach, superior in many cases to the standard Manchester repair. The combined procedure is especially indicated where the prolapse is associated with uterine disease, in peri and postmenapausal women, and in third degree prolapse.

REFERENCES

1. MORRIS, W.I.C. (1 965): *Proc. XVII th. Brit. Congr. Obstet. Gynaec. in J. Obstet. Gynaec. Brit. Cwlth.* 72, 860.
2. READ, C.D. (1951): *Amer. J. Obstet. Gynec.* 62, 756.
3. READ, C.D. and BELL, A.C. (1933): *J. Obstet. Gynaec. Brit. Emp.* 40, 749.
4. WATSON, P.S. (1963): *J. Obtet. Gynaec. Brit. Cwlth.* 70, 29.
5. WILLIAMS, E.A. (1962): *J. Obstet. Gynaec. Brit. Cwlth.* 69, 590.