CONSIDERATIONS ON THE PROPHYLAXIS OF THE PROLAPSE OF THE VAGINAL STUMP AFTER TOTAL OR SUPRAVAGINAL (SUBTOTAL) HYSTERECTOMY

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After total extirpation of the uterus, the vagina in its arches' region or rather the vaginal stump resulting is bereft of its attachment, till then furnished by the sustaining and supporting apparatus of the uterus. The entire vaginal tube remains connected merely by the paravaginal connective tissue, which, on its part, might favour the depression or the complete prolapse of the vagina subsequently.

The statistical data available on the complication referred to are quite discrepant. Symmonds, Sheldon (1965) have observed 153 patients with prolapse of the vagina (58 after abdominal and 95 after vaginal hysterectomy) without anyway, making reference to the percentage they constitute of the total number of cases operated upon. Richter (1963) reviewed 10 patients with total prolapse of the vagina out of a total number of 1241 hysterectomies, inclusive 776 vaginal, occurring from 6 months to 19 years postoperatively. The same authors place emphasis on the fact that in normal static conditions of the minor pelvis' organs, the extirpation of the uterus does not bring about static changes whatsoever. Gosselin, Ameline, Hugier (1957) report on prolapse of the vagina in 3.2 per cent. According to data submitted by other authors, this percentual ranges between 0.7 and 8.5.

Most of the writers support the opinion that the prolapse of the vaginal stump following total hysterectomy occurs by predilection in cases in which, as early as prior to operation there was present a more or less pronounced degree of descensus of the vagina, which was not given the due attention (Braude, Jmakin, Richter).

Although not so frequent, descensus or prolapse of the stump of the uteral cervix might be also observed subsequent to supravaginal hysterectomy. The conservation of the sacro-uteral and cardinal ligaments in supravaginal amputation of the uterus provides for support of the cervical stump and the vaginal arches under normal conditions in most of the cases. Here too, however, in some cases (mostly in previously existent static changes with more or less manifested descensus of the uterus and vaginal walls) the operation might be complicated by prolapse of the cervical stump or of the entire vagina.

All cases referred to require a new operative approach, which usually is quite difficult and implies great technical difficulties and hazards of a relapse. In most of the patients the operative choice consists in carrying out of an intervention which aims the fixation of the vaginal arch and the cervical stump to the anterior abdominal wall — intervention which is accompanied by the hazards of injuring the neighbouring organs (urinary bladder, ureters and rectum). Doubtlessly, the treatment of these conditions is very

difficult, it requires high surgical skill and by no means precludes a new relapse.

Hence, it is deemed expedient if, in the course of the intervention, measures are provided for which might prevent the eventual descending of the vaginal or cervical stump.

The two cases in our personal experience with prolapse of the vaginal stump after total hysterectomy and one case with prolapse of the cervical

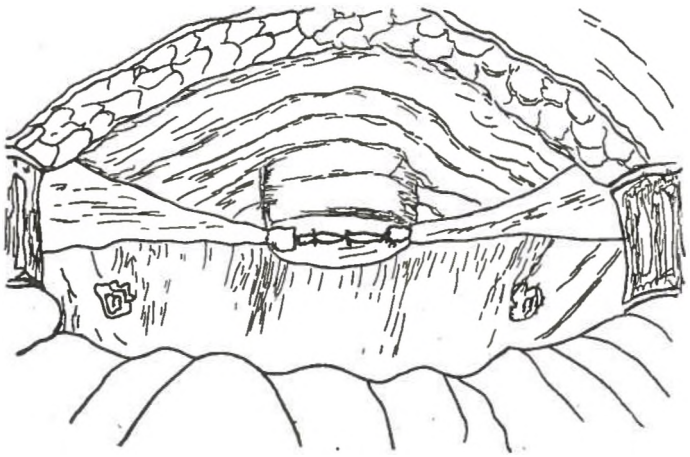

Fig. 1

stump after supravaginal hysterectomy compelled us to resort to prophylactical measures of the kind.

First of all, bearing in mind that the prolapse of the vaginal or cervical stump most frequently occurs in apriori existing propensity towards descensus of the uterus and of the vagina, in case such a finding was met with, we performed simultaneously with the hysterectomy, also the necessary plastic operation of the vaginal walls with strengthening of the pelvic fundus. One should by no means rely, in similar cases, to the measures undertaken for the fixation of the vaginal or cervical stump to the cardinal or round ligaments. In instances of lesion of the pelvic bottom and pronounced tendency towards descensus of the vagina, the listed measures are not invariably sufficing. Later on, atrophy and stretching of these ligaments might occur and thus the creation of conditions favourable for the vaginal descending and prolapse. One of our patients with total hysterectomy on account of initial ovarial carcinoma, in spite of fixing the vaginal stump to the round ligaments, one year after the operation underwent secondary operative intervention for descensus of the vaginal stump and pronounced rectocele (which up to a certain extent was present prior to operation).

The standard technique of the supravaginal hysterectomy was supplemented by the following technical details:

1. The ligatures of the round ligaments of the uterus aiming a greater shortening, especially in instances of longer ligaments, are placed more lateralwise from the uteral horn than usually.

2. The round ligaments, shortened and ligated in the fashion described, are sutured to the cervix uteri with cat gut, following amputation of the uterus and suture of the cervical stump and prior to peritonization (Fig. 1).

The effect of the latter step becomes immediately evident by the stretching and elevation of the cervical stump. Klaus and Snaid from Prague

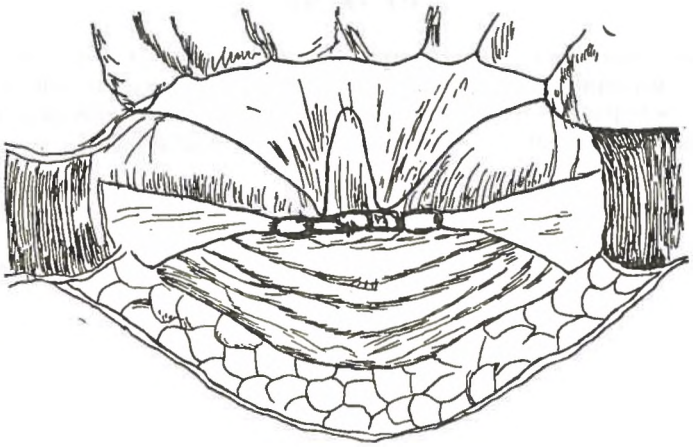

Fig. 2

suture the round ligaments to the respective sacrouterine ligament after performing the peritonization.

In total hysterectomy, the round ligaments are sutured to the midline of the vaginal stump, whereas the stumps of the ligated sacrouterine ligaments — to the posterior vaginal wall and thus the vaginal acrus is reinforced (Fig. 2).

The method herein described was applied over the past three years (1964—1966) in 213 supravaginal and 126 total hysterectomies. The follow up study of the total number of patients disclosed vaginal stump descensus merely in one case, which created considerable difficulties in the ensuing secondary operative intervention.

The good results of the procedure herein described and its simplicity of performence warrant its recommendation for widespread application as a prophylactic measure insofar prolapse of the vaginal and cervical stump after total or supravaginal hysterectomy is concerned.

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К ВОПРОСУ О ПРОФИЛАКТИКЕ ВЫПАДАНИЯ ВЛАГАЛИЩНОЙ КУЛЬТИ ПОСЛЕ СУПРАВАГИНАЛЬНОЙ И ТОТАЛЬНОЙ ЭКСТИРПАЦИИ МАТКИ

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РЕЗЮМЕ

Авторы сообщают о собственных наблюдениях при надвлагалищной и полной экстирпаций матки, при которых они применили фиксацию круглых связок к верхнему концу влагалища. При этом способе профилактики, не наблюдалось ни одного случая выпадания влагалища.