The End Results of Vaginal Operations for Genital Prolapse.

By Professor W. E. FOTHERGILL, M.A., B.Sc., M.D.(Edin.),

Honorary Gynæcological Surgeon, Manchester Royal Infirmary; Honorary Surgeon, St. Mary's Hospitals for Women, Manchester.

THIS discussion originated at a meeting of the North of England Society, held at Liverpool in December 1918. Professor H. Briggs described the treatment of a case of procidentia in a patient, aged 18, by a vaginal operation combined with ventro-fixation. W. Blair Bell deprecated ventro-fixation, but advocated a modification of Gilliam's operation. W. F. Shaw deprecated abdominal operations for prolapse, preferring the vaginal methods used in Manchester. Other members urged that the end results of these measures should be ascertained and published, and a collective investigation by the Society was suggested. At subsequent meetings this project was developed and the scope of enquiry came in question. It was proposed to exclude all except cases of complete prolapse, but this was not thought feasible. The term "genital prolapse" has a fairly definite connotation all over the world; and medical men constantly use the word "prolapse" as including both so-called vagino-uterine prolapse and so-called utero-vaginal prolapse. In view of these considerations, it was decided at a Council Meeting of the North of England Society in December 1919, that the enquiry should include "cases of (1) cystocele, (2) rectocele, (3) prolapsus uteri, and (4) elongated cervix protruding from the vulva," namely, in two words, cases of genital prolapse. At an ordinary meeting of the Society in Liverpool in October 1920, F. H. Lacey gave a preliminary report on traced cases operated on at St. Mary's Hospital, Manchester, during the years 1914–15–16. Subsequently it was arranged to defer the further consideration of the subject to this meeting.

I will briefly indicate the steps by which I was led to the technique I now use, and will give a few figures which indicate the nature of the results secured by it after the lapse of years and under the stress of parturition. I saw some vaginal surgery in Edinburgh in the years 1890–95, under the late Sir A. R. Simpson and the late David Berry Hart. Clarence Webster was then assistant to Simpson, and he returned from a visit to Martin, of Berlin, bringing back certain special instruments, which some of you may remember, designed to facilitate the performance of colporrhaphies. The

measures then used in Edinburgh were anterior and posterior colporrhaphies of moderate size, amputation of the cervix and repair of the perineum. These were done as separate operations, and, in some caes, all four were used for one patient. Chromic catgut was the suture material, the immediate results were good; of the end results I know nothing.

When I came to Manchester in 1895 I found that, owing to the initiative of my senior colleague, Professor A. Donald, the surgical treatment of genital prolapse was already highly evolved and most efficient. The anterior colporrhaphy incisions were larger than those I had seen, and the whole thickness of the vaginal wall was removed, not merely a superficial layer. Donald had also brilliantly combined the operation of posterior colporrhaphy and perineorrhaphy in a single operation done from above downwards. This was a great simplification and advance in the treatment of rectocele. For the last thirty years Donald has operated in Hospital four days a week and has cured an enormous number of cases of prolapse by amputation of the cervix, extensive anterior colporrhaphy and his own colpo-perineorrhaphy.

My own contributions to the surgery of prolapse were made at a much later date. Clinical experience gradually taught me that the uterus, vagina and bladder are mainly kept in their places by the lateral combinations of unstriped muscle and connective-tissue known as the parametrium and the paracolpos. Finding that several anatomists had come to the same conclusion, I brought their names and their work before the Royal Society of Medicine in December, 1907. The facts then mentioned have been re-discovered subsequently with surprising frequency in various parts of the world. The practical application of this was that anterior colporrhaphy could best be improved by carrying the incision well up and out on either side of the cervix, fully exposing the paracolpos so that closure of the wound must bring together in front of the cervix structures which were formerly at its sides. This modification of technique I advocated before the Edinburgh Obstetrical Society in 1908. (See *Transactions*, 1907–8.)

Subsequently, I found that by carrying the colporrhaphy incision round behind the cervix instead of in front of it, anterior colporrhapy and amputation of the cervix could be conveniently combined in a single operation instead of being done separately and seriatim. This not only saved time and trouble, but fully exposed the parametrium as well as the paracolpos. When the wound is closed, the stump of the cervix passes upwards and backwards so far that the uterus is left in a position of anteversion. This dispenses with the need for exaggerated narrowing of the vagina, a gain of some importance with a view to subsequent coitus

and parturition. After an extended experimental period, this combined operation was demonstrated to graduates at the Manchester Royal Infirmary in March 1913, and published in the *British Medical Journal* (April 12, 1913). An improved technique was described and figured in the *American Journal of Surgery* (May 1915) and in the *Journal of Obstetrics and Gynæcology of the British Empire* at the same time (March–May 1915).

I cannot say how often I have used these two modifications of technique at St. Mary's Hospitals, at the Manchester Royal Infirmary and in private. But, thanks to F. H. Lacey, I can give some figures relating to my cases treated at St. Mary's in 1914–15–16. Since these operations were done, periods varying from $4\frac{1}{2}$ to $7\frac{1}{2}$ years have elapsed. Whenever rectocele was present Donald's colpo-perineorrhaphy was used, the anterior vaginal wall and cervix being dealt with according to the modified technique I have mentioned.

The number of my patients who replied to Lacey's letter of enquiry is 156. Of these, 150 state without qualification that they are cured, while 6 do not.

(1) Three children since the operation and the womb has come down again.

(2) "The womb is not as it should be." On examination she had no prolapsus. She is at the menopause.

(3) Her doctor reports that this patient has had no chance owing to chronic cough and asthma. This was a case of rectocele only.

(4) Was found on examination to have some vaginal prolapse, the uterus being in good position.

(5) A case of rectocele only; had an instrumental confinement, and was badly torn, with slight recurrence of rectocele later.

(6) "The womb is painful at times." Examination shows no recurrence of prolapse.

Thus two out of the six are found, on examination, to be anatomically free from prolapse. Adding these 2 to the 150 who say they are cured, the result is 152 successful operations out of 156, namely, 97 per cent. As to the ages of the patients, about one-third of these had passed the menopause.

27	were	between	the	ages	of	21	and 30 years.
59	"	"	"	31	"	40	"
41	"	"	"	41	"	50	"
19	"	"	"	51	"	60	"
3	"	"	"	61	"	70	"
149							

The ages of the other seven patients are not recorded. I have operated on several patients over 70 and under 20 but not in this series.

The combined amputation of the cervix with anterior colporrhaphy was performed in 124 cases, the cervix being retained in the remainder, a few of which required no anterior operation but only colpo-perineorrhaphy for rectocele. No case of mere perineal repair is included. An interesting point is that 32 cases were examples of elongated cervix with inversion of the vaginal walls from above downwards. This is the only variety of prolapse which occurred in nulliparous women.

I formerly thought that an operation for prolapse should prevent recurrence even if the patient had one or more subsequent confinements. But we must remember that the arrangements which nature has provided for the support of the pelvic viscera do not by any means always stand the test of pregnancy and labour. To expect from the surgeon arrangements superior to those designed by Almighty Providence, in cases in which these have already failed, is surely asking too much. All we can demand is that the new pelvic floor shall be as good as the original one and a little better if possible. From this point of view the following figures are of interest. Since their operations 21 of the women under 40 and 3 of those over 40 have had children, and 2 others are now pregnant. Thus 26 of the women of reproductive age have conceived subsequently to operation. Of these 26, no less than 23 had the cervix removed by the combined operation. Thus this operation has failed to prevent pregnancy in nearly a quarter of the women of reproductive age.

Thirty children have been born to the 24 patients; of the 30 labours, 23 were natural and 7 were instrumental, but in no case was labour obstructed. Four patients have had two labours each with no recurrence; 17 patients have had one labour each with no recurrence; one patient had one labour, and was badly torn, with recurrence of rectocele not requiring treatment; another had one labour, and says the womb falls slightly when she is tired, but does not require further treatment. Another has had three labours, and there is recurrence which should be treated by another operation. Thus prolapse sufficient to cause inconvenience has only returned in one case out of 24.

I think it must be allowed that vaginal operations afford, for all varieties of prolapse, treatment that is efficient and permanent, that does not prevent pregnancy and that stands the test of parturition in a large proportion of cases.

This being so, it follows that the addition to these vaginal operations of any abdominal intervention is unnecessary and there-

fore undesirable. It involves trouble and loss of time to the operator and adds to the risk and discomfort to which the patient is exposed. I must say with regret that I once, many years ago, lost a patient after a vaginal operation. She died of pneumonia. Others may have had similar experiences, but it cannot be denied that the risk is increased whenever an abdominal section is done in addition to an extensive vaginal operation. To put this in another way, the family medical adviser will not send his cases of prolapse to specialists who cannot cure them without opening their abdomens, when he knows that there are others who cure their cases with monotonous regularity by the vaginal route alone. This is one reason for avoiding abdominal operations in the treatment of prolapse. But there is another and even more serious one. For many men are still using these measures *not in addition to but instead of* vaginal surgery, with inevitable disappointment as the result. It is not to the credit of the profession that women should go home with their cervices still projecting at the vulval cleft after having undergone the risk, discomfort and expense of futile ventrofixations at the hands of those who have never attempted to learn vaginal surgery.