VAGINAL PROLAPSE.

By W. McK. H. McCULLAGH, D.S.O., M.C., F.R.C.S.,
(*Surgeon, Samaritan Hospital for Women;*
Senior Obstetric Surgeon, City of London Maternity Hospital.)

In the last few years there has been a marked increase in the attention paid to the disabilities caused by hernia or prolapse of the vagina in women. Amongst the Samaritan Hospital In-patients I find prolapse operations went up from 90 in 918 cases in 1923 to 186 in 1099 cases in 1933, i.e., almost double. There are few women who have had children who do not complain of some pelvic discomfort as a result of childbirth. I find that over half of the patients attending the out-patient department of the Samaritan Hospital are suffering from this complaint in whole or part.

Ætiology.

Almost the sole cause of prolapse is childbirth. A nulliparous woman can develop prolapse of the uterus even to the stage of complete procidentia as a result of deficient musculature in the perineum and deeper pelvic tissues. Such cases are difficult to cure and are best treated by a combined abdominal and perineal operation.

The parous woman has had the musculature in the anterior and posterior vaginal walls stretched by the passage of a child or children whose anterio-posterior and lateral diameters are at least 3¾ ins. Before this occurred the vagina barely admitted two fingers. The result is that even if the perineum is intact the vagina has been ballooned out to such an extent that the bladder in front drops downwards and backwards, forming a cystocele, and the rectum behind bulges downwards and forwards, causing a rectocele. Should the perineum have suffered a complete tear, there is less danger of a cystocele being present, as the posterior wall has taken the major part of the strain of vaginal dilatation.

It is not necessary for a tear of the perineum to occur to produce vaginal prolapse. The forcible separation in the midline of the right and left levator ani produce the rectocele behind, and of the right and left pubo-cervicalis in the anterior vaginal wall the cystocele in front. It occurs in exactly the same way in these parts as it does in the anterior abdominal wall when the two recti abdominis are separated, leaving a midline protrusion of the abdomen as is sometimes seen in multiparous women of poor muscle tone.

Certain factors in the confinement add to the danger of prolapse occurring, e.g., bearing down efforts in the first stage of labour, not keeping the head well flexed at delivery, using too great downward pressure on the uterus in expressing the placenta, not repairing perineal tears by deep as well as superficial sutures, allowing the mother to get up too soon, and not preventing her from lifting and carrying weights or from playing games for three months after her confinement.

There are certain preventive measures against prolapse which are sometimes adopted. In addition to observation of the above factors, the patient is advised to sleep and lie on her abdomen as much as possible, beginning some 10 days after her confinement and going on for at least three months afterwards. This, with floor-polishing exercises, has a great effect in anteverting the uterus and preventing prolapse symptoms. It is not advisable to insert a pessary until three months have elapsed since the date of the confinement, as the contraction of the vaginal outlet and canal is remarkable and is prevented by the presence of a pessary.

Postgrad Med J: first published as 10.1136/pgmj.11.115.179 on 1 May 1935. Downloaded from http://pmj.bmj.com/ on January 19, 2022 by guest. Protected by copyright.

In cases of complete tear of the perineum where immediate suturing has failed, another operation is of course necessary, but it should be delayed until three months have elapsed, so as to obtain firm union and satisfactory results.

Were it not for the four times greater risk of death to the mother, childbirth by Cæsarean section would be an ideal method of delivery, for in addition to the speed of delivery there would be no subsequent danger of prolapse and a greatly lessened risk of carcinoma cervicis, which kills 3,000 women yearly in England and Wales.

Symptoms.

The symptoms of prolapse are very definite and may be divided into those due to the cystocele, the rectocele, the uterine retroversion if present, the complete tear if present, and the procidentia if present.

The Cystocele causes a heavy dragging pain in the right or left iliac fossa, usually the left, worse towards evening and after exercise. The pain is due to the pull on the peritoneum and the drag on the ovaries, especially the left, which is more subject to pressure on account of the proximity of the pelvic colon. Prolonged standing or exercise causes fatigue and relaxation of the pelvic muscles, which widens the vaginal outlet, and thus increases the descent and pull on the peritoneum and ovaries.

Frequency of micturition by day and a feeling of incompleteness of the act is due to the involvement of the sensitive trigone of the bladder in the base of the cystocele, and the fact that the pouch formed lies below the internal meatus hinders the bladder from being completely emptied. It therefore corresponds to the retroprostatic pouch of urine in a male with an enlarged prostate. Frequency of micturition by night as well as by day is generally due to B.coli infection. Stress incontinence, i.e., passing of urine on coughing or laughing, is due to the weakening of the sphincteric muscles of control by the initial injury at childbirth, or by the drag of the cystocele. Urge incontinence—sudden necessity for rapid evacuation of the bladder—is due to urethral displacement.

The Rectocele causes low backache and a bearing down sensation, also worse after exercise and towards evening. It also is relieved by rest in the recumbent position.

Procidentia, i.e., protrusion of the cervix (partial) or cervix and uterus (complete) causes local vaginal discomfort and discharge. Such cases rarely develop cancer of the uterus, although ulceration is common.

Retroversion when present causes backache, worse just before the periods when the uterus is heavier than usual. It also causes menorrhagia, because of the associated congestion of the uterus, constipation and piles because of the pressure on the rectum, dyspareunia because of the prolapse of the ovaries, and certain ovarian pressure symptoms. These ovarian pressure symptoms are distinctive, but are not generally recognized. They are the same as would occur in the male if the testicles were subject to pressure, e.g., mental depression, irritability, nausea and indigestion, and marital unhappiness. Many of these patients have been treated for gastric ulcer or have already had a curettage or appendicectomy done without any improvement in their symptoms.

Complete Tear of the perineum causes incontinence of flatus and of soft motions. This results in mental reticence and sombreness. Such patients aim at constipation by dietetic means, wash out their lower bowel by an enema each morning, and constantly wear a diaper in case of accidents.

Postgrad Med J: first published as 10.1136/pgmj.11.115.179 on 1 May 1935. Downloaded from http://pmj.bmj.com/ on January 19, 2022 by guest. Protected by copyright.

Treatment.

The treatment of prolapse is palliative or radical.

Palliative. When the patient is young, desires more children, or is not willing for an early operation, a pessary is indicated. A ring pessary of rubber is most commonly used, as it is easier to insert and, if retroversion is not present, generally satisfactory in relieving the symptoms.

It must be replaced by a new pessary every three months and the vagina must be douched daily.

If a retroversion is present which is not, when corrected, kept in position by a ring pessary, then a moulded Hodge pessary is indicated. An appropriately sized Hodge pessary is softened by boiling and the sides are then pulled apart so as to curve outwards. When inserted this support keeps the uterus forward and does not slip out on straining. Should the support prove uncomfortable after a few trials with different sizes, or should the perineum be too weak to support a pessary, the operation is strongly urged.

If the patient is over forty, operation alone should be advised, as allowing a woman to grow old with a prolapse is as bad a practice as to allow a man to grow old with a hernia. The use of a truss or pessary in the old is a nuisance to themselves and a torture to their attendants. Lack of proper attention to a pessary will result in a foul smelling discharge and will predispose to cancer of the cervix.

There are a few cases who are too old or too feeble for operation, and they have to wear a Napier cup and stem pessary, or a tight diaper.

Cases with slight prolapse symptoms associated with pyorrhœa and flatulence can avoid operation by dietetic and dental treatment and calcium therapy.

Radical surgical treatment nowadays is becoming a properly performed Fothergill operation. This consists in an amputation of the cervix, an anterior colporraphy and posterior colpoperineorraphy. When retroversion is associated, the Fothergill operation will correct it unless internal adhesions are present. When this is the case a Gilliam's operation is also performed, especially in the young, whilst in the older a ventrofixation or panhysterectomy may be added.

Most prolapse operations are performed on women over forty and many of these women have associated leucorrhœa, due to an unhealthy cervix, menorrhagia from subinvolution or fibroids and chronic pelvic pain due to diseased adnexa. An excellent operation becoming rapidly popular in such cases is the old-fashioned vaginal hysterectomy, combined with the relatively modern Fothergill operation. There were 43 of these operations performed in the Samaritan Hospital in 1934.

A complete tear only requires a posterior colpoperineorraphy as the anterior vaginal wall is seldom injured. It should not be done until three months at least have passed since the birth of the child. No other operation gives such a wonderful return of mental happiness and physical health as constantly does this comparatively short operation.

Le Forts and the interposition operations are not now favoured by surgeons.

The best time of the year in which to perform these prolapse operations is in the early spring, unless the patient is subject to bronchitis when it is best performed in the late summer.

After treatment is important. For three months the patient must not play games nor do strenuous work. She must rest in the prone position as much as possible, and the best exercise is walking or floor polishing on the hands and knees. It takes over a year to obtain the full benefit of the operation, and then it is found that the patients look and feel better, and that they have regained their physical energy, the loss of which had previously led to an untimely obesity.

Postgrad Med J: first published as 10.1136/pgmj.11.115.179 on 1 May 1935. Downloaded from http://pmj.bmj.com/ on January 19, 2022 by guest. Protected by copyright.