OPERATIVE SURGERY

Fundamental International Techniques

Gynaecology and Obstetrics

THIRD EDITION

Edited by

D. W. T. Roberts

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OPERATIVE SURGERY

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OPERATIVE SURGERY

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Introduction

For the Third Edition of Operative Surgery, the major part of the volume has been retained as would have been expected. The emphasis has shifted slightly in favour of a longer discussion about each procedure and many of the illustrations have only detail changes.

The chapter on Tuboplasty introduces microsurgical techniques to the gynaecological armamentarium. The results of animal experiments suggest that these techniques will improve the results of operation on patients with damaged fallopian tubes and clinical practice is now showing this improvement.

Even if experienced surgeons disagree with details of the procedures presented here, perhaps this disagreement will encourage them to prove that their own practice is better and the volume will have served as a worthwhile stimulant to all who read it.

My thanks are due to all the authors and artists who have contributed to this volume and also the editorial staff of Butterworths for their constant help and encouragement.

D. W. T. ROBERTS

OPERATIVE SURGERY

Contents of this Volume

Radical Operations for Carcinoma of the Cervix

Dilatation of the Cervix and Uterine Curettage

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PRE-OPERATIVE

Indications

Dilatation of the cervix may be indicated:

(*1*) In some cases of spasmodic dysmenorrhoea; it is performed much less frequently since the treatment of dysmenorrhoea by inhibition of ovulation.

(*2*) In cases of cervical stenosis, some of which may occur after operations such as the Manchester repair.

(*3*) For the drainage of pyometra.

(*4*) For the insertion of intra-uterine radium.

(*5*) As a preliminary to curettage or hystero-salpingography.

Curettage is indicated:

(*1*) In the investigation and treatment of irregular uterine bleeding—endometrium is obtained for pathological investigation and uterine polypi or products of conception may be removed.

(*2*) In cases of bleeding after the menopause.

(*3*) In the investigation of infertility—to establish the occurrence of ovulation and to diagnose unsuspected tuberculous endometritis.

(*4*) In some cases of menorrhagia. It is believed that a number of patients will benefit from curettage although its value has probably been exaggerated.

(*5*) As a preliminary to repair operations, in order to exclude uterine pathology.

Pre-operative preparation

There is no need to subject the patient to any special preparation. A laxative may be given if the patient is constipated.

Shaving of the vulva and mons veneris is unnecessary and unpleasant.

Anaesthesia

General anaesthesia is usually employed and muscle relaxation is required for proper examination of the pelvis. Dilatation of the cervix may be performed with paracervical or a regional block technique if the condition of the patient indicates it.

Position of patient

The patient is placed in the lithotomy position unless there has been some orthopaedic condition necessitating or causing limited movement of the back or hips. Special supports may then be used to produce a modified lithotomy position.

THE OPERATION

The vulva is treated with a suitable antiseptic and sterile towels are applied.

Preliminary catheterization of the bladder is unnecessary and undesirable, unless a full bladder is found to obscure the findings of pelvic examination: this should have been avoided.

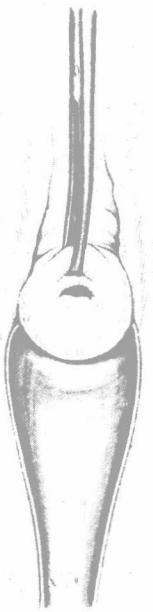
A bimanual examination is made to assess the state of the pelvis and, in particular, to determine the position of the uterus.

1

Insertion of speculum and grasping the cervix

A Sims speculum is inserted, the cervix exposed and its anterior lip grasped with a volsellum forceps. If the dilatation is expected to be difficult, as in some postmenopausal patients or cases of cervical stenosis, a second volsellum is applied. This makes tearing of the cervix less likely.

A polyp, found at the external os, is grasped with sponge-holding forceps and avulsed by twisting.



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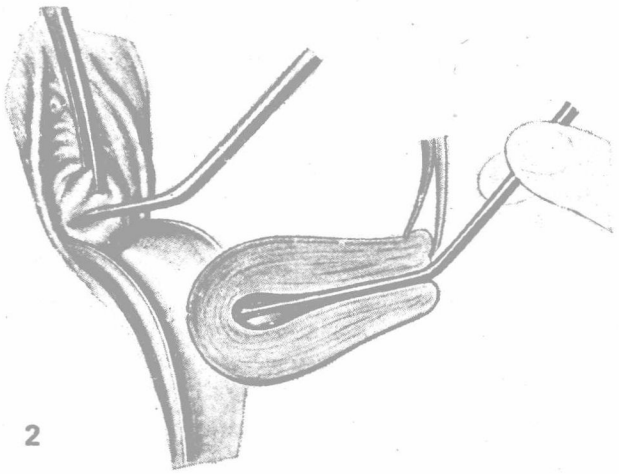

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2

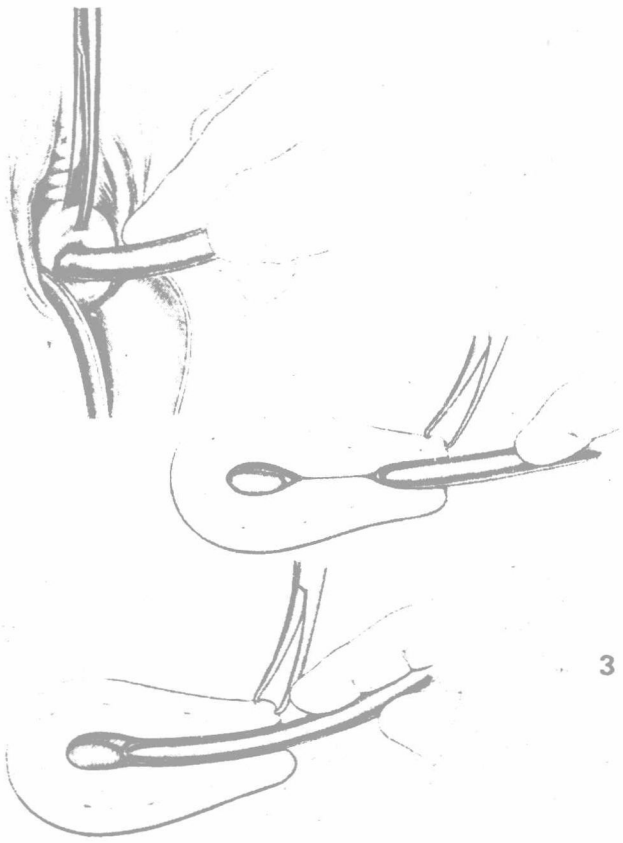
Passage of uterine sound

The sound is passed gently, to measure the length of the uterine cavity (usually about 8·5 cm). The position of the uterus must be remembered and care taken to avoid undue force. Perforation of the uterus or the creation of a false passage through the cervix may occur at this stage.

3

Passage of dilators

A series of graduated dilators is then passed. These should be held lightly so that resistance is felt easily. It is quite unnecessary to dilate the cervix to more than a width of 1 cm (size 12 Hegar). Most injuries are thus avoided.



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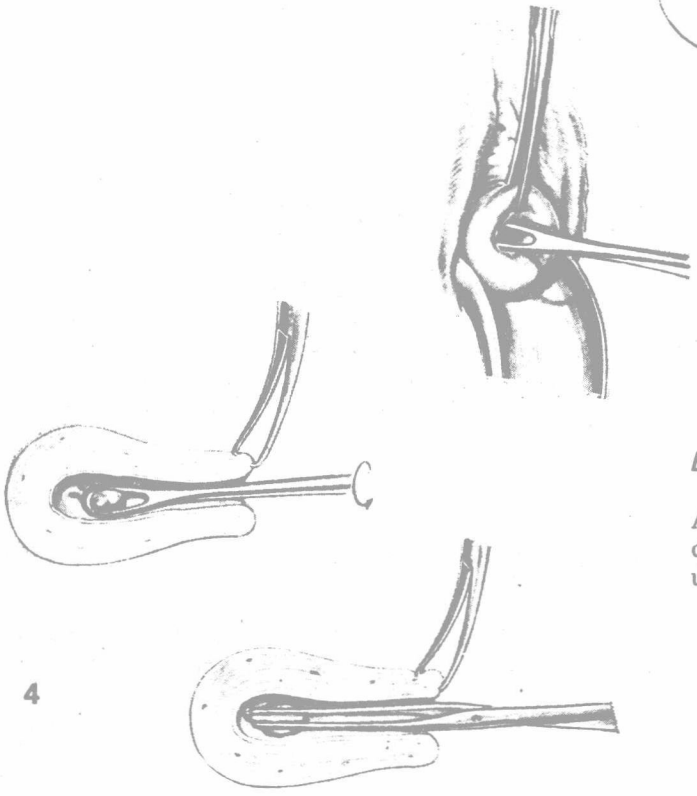

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4

Exploration of the cavity

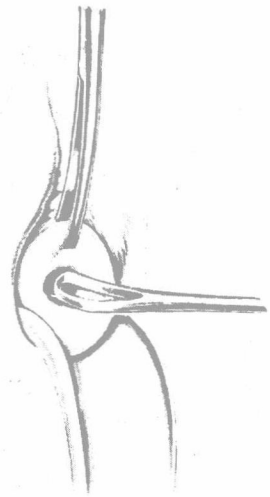
A small intra-uterine forceps (8 mm wide) is introduced to discover and to remove any polypi in the uterine cavity. These may be missed with a curette.

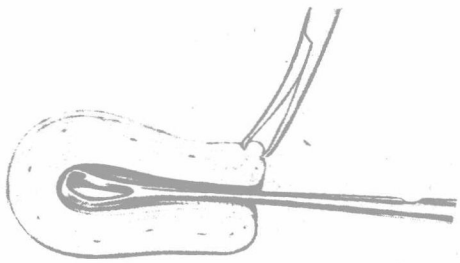
5

Curettage

A sharp curette (9 mm wide) is inserted up to the fundus, held against the uterine wall and withdrawn. This is repeated until all parts of the cavity have been curetted. The tissue removed is collected and kept for examination. When carcinoma is suspected, the endocervix is curetted first so as to try and establish the site of the tumour.

In most cases the operation is uncomplicated and the patient may leave hospital in 24–48 hr. Sometimes patients wish to leave hospital on the same day. This is quite appropriate in suitable cases.





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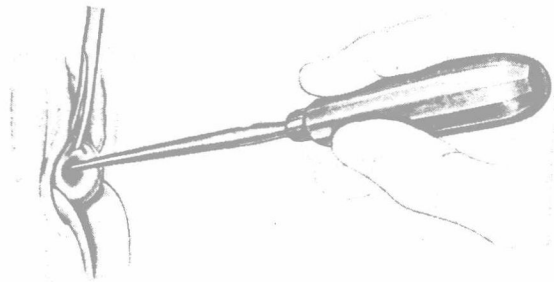

POSTOPERATIVE COMPLICATIONS

Haemorrhage

Bleeding may occur from the cervix if a vessel is punctured by the volsellum; this usually stops on its own. A suture may be required if the cervix is torn by the volsellum.

Excessive dilatation may lead to tearing of the cervix. Bleeding will result and a pack is required occasionally.

Perforation

Perforation may result from the use of excessive force or the passage of an instrument in the wrong direction. It can happen very easily. It should be suspected if an instrument passes further than expected.

No further instrument should be passed, and the patient is returned to the ward for close observation. A rising pulse rate and signs of increasing pain and shock will indicate laparotomy. The perforation may then be repaired or hysterectomy performed as appropriate. In most cases laparotomy is not required.

Sepsis

This should not occur frequently if the operation is carried out properly, but from time to time a patient develops pelvic peritonitis. Appropriate antibiotic treatment is given.

[*The illustrations for this Chapter on Dilatation of the Cervix and Uterine Curettage were drawn by Mr. R. N. Lane.*]

Evacuation of the Uterus

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PRE - OPERATIVE

Indications

(*1*) In cases of incomplete abortion.
(*2*) Following the partial extrusion of a hydatidiform mole.
(*3*) In missed abortion.
(*4*) In cases of secondary postpartum haemorrhage.
(*5*) Cases requiring therapeutic abortion.

Pre-operative preparation

Blood loss in incomplete abortion can be considerable and the patient may require resuscitation before she is fit for anaesthesia. Meanwhile the loss is controlled by the injection of ergometrine, 0·5 mg given intramuscularly.

If the abortion is complicated by the presence of infection, it is preferable to delay the evacuation of the uterus until the sepsis has been controlled by antibiotics. However, in some cases the temperature remains high until the uterus is emptied.

Anaesthesia

General anaesthesia is usually employed. The immediate preparation is as already described in the previous section.

THE OPERATION

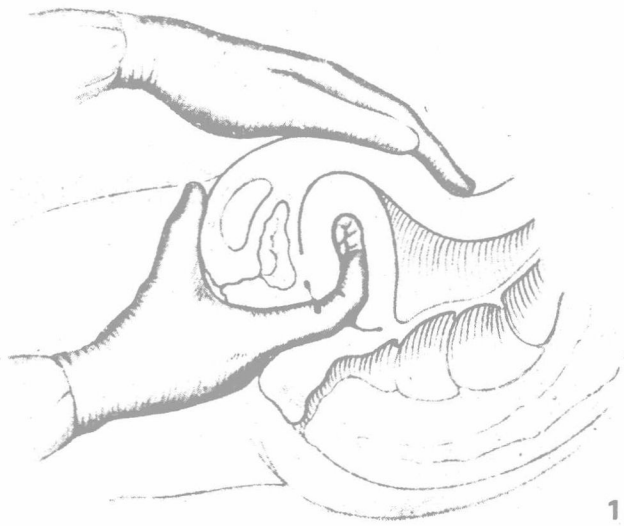
Exposure of the cervix

A Sims speculum is inserted and the blood clot removed from the vagina. Injury to the soft cervix may be minimized by holding it with a sponge-holding forceps rather than a volsellum.

Dilatation of the cervix

In cases of recent incomplete abortion, the cervix may admit a finger; no further dilatation is needed. Otherwise the cervix is dilated as described previously.

When termination of pregnancy is being performed, the cervix may need more dilatation than in the case of diagnostic curettage say to a width of 1·5 cm.



1

1&2

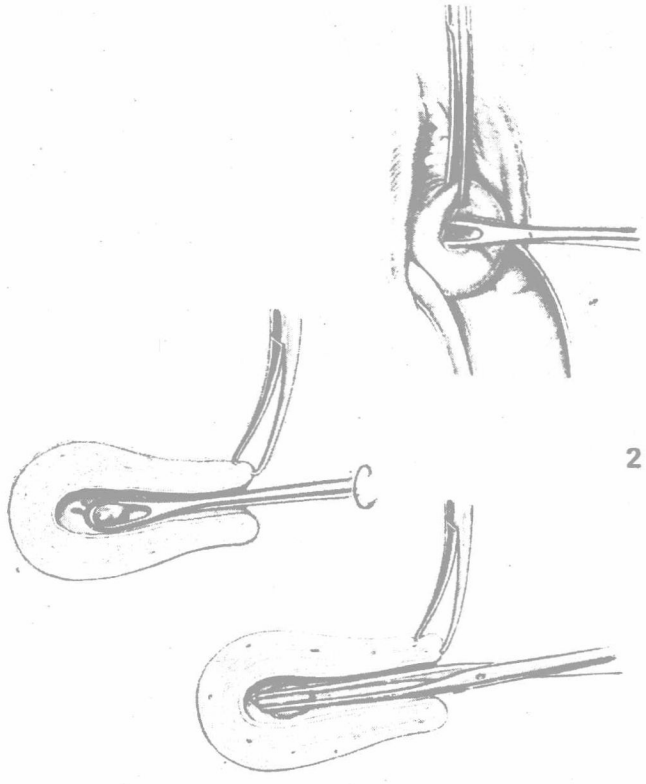
Exploration of the uterus

If the cervix admits the finger, the uterine cavity may be explored digitally, the uterus being guarded by the other hand on the abdomen.

Following instrumental dilatation, the cavity is explored with sponge-holding forceps. These are passed to the fundus, opened and closed, then withdrawn after twisting. The products of conception are thus removed.

Curettage is then performed with a blunt curette. It is not necessary to use a flushing curette. An intravenous injection of ergometrine 0·5 mg encourages contraction of the uterus and makes the curettage safer because the muscle is not so soft.

Bleeding should be minimal after the uterus has been emptied. An intra-uterine pack of 0·5 inch (1·25 cm) ribbon gauze left in for 6 hr is helpful in controlling any excessive loss.



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POSTOPERATIVE COMPLICATIONS

The complications described in the previous chapter may occur. Continued bleeding may be due to incomplete emptying of the uterus and the curettage may have to be repeated.

In septic cases and where criminal abortion is suspected, one should be alert to the possibility of *clostridium welchii* infection and to that of renal damage where certain chemicals have been used.

THE SUCTION CURETTE

Recently, the use of a suction apparatus has been introduced for termination of pregnancy. The instrument is introduced through the dilated cervix and the conceptus removed by the use of controlled suction.

[*The illustrations for this Chapter on Evacuation of the Uterus were drawn by Mr. R. N. Lane.*]