

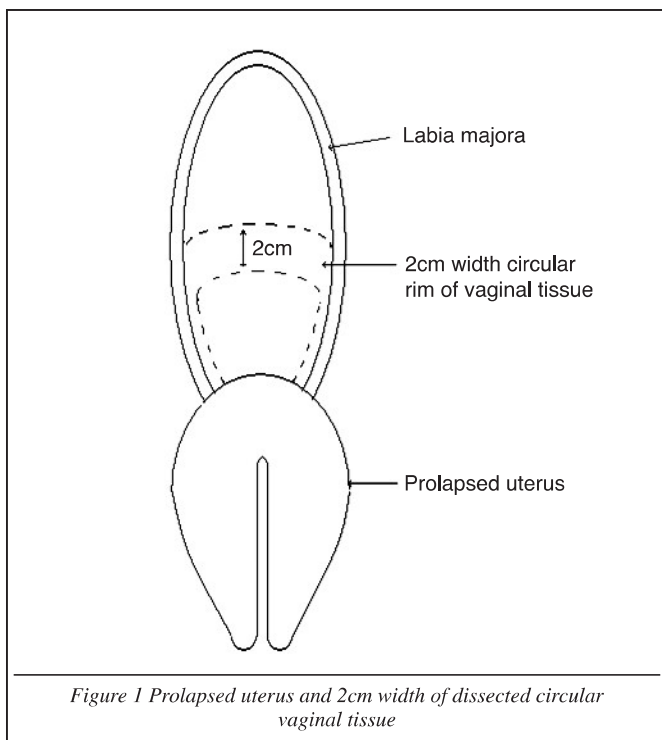
COLPOCLEISIS FOR PROCIDENTIA

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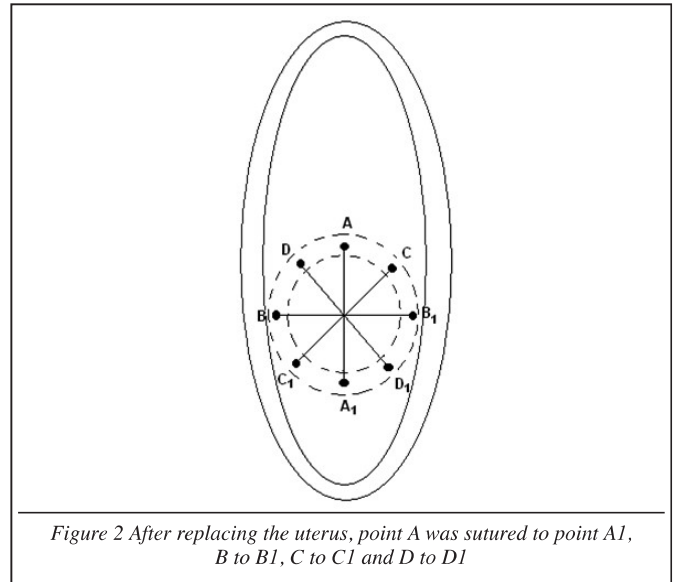
CASE REPORT

A 92-year-old lady was referred from the orthopaedic department with a history of uterine prolapse. She was under their care for Colles' fracture of the right wrist. There was also a history of recurrent rectal prolapse and she was being co-managed by the general surgeons. The urinary or bowel symptoms could not be elicited since the patient was in a confused state. A history of hypertension and cerebrovascular accident was noted in the medical records.

Vaginal examination revealed procidentia with a mild cystocele and rectocele. Rectal examination showed complete rectal prolapse with an oedematous and inflamed mucosa. In view of her medical history, a conservative approach with vaginal ring pessaries was undertaken. Various sizes of ring pessaries were inserted but were not retained. The rectal prolapse was repeatedly reduced manually. After consultation with the general surgeon we agreed on a synchronous combined procedure to repair both prolapsed organs.



The colpocleisis and Delormes procedure were performed under general anaesthesia. The colpocleisis was performed by dissecting a circular rim of 2cm width of vaginal tissue from above the fundus of the uterus. This was followed by plication of the circular area using 0 Vicryl after pushing the uterus and cervix above the incised area. A few external sutures were placed to secure the purse string suture. The Delormes procedure was carried out after infiltrating adrenaline into the submucosa. The rectal mucosa was then dissected from 2cm above the dentate line and a 15cm long



sleeve of rectal mucosa was excised. The rectal muscle was plicated by apposing the mucosa with vicryl. Postoperative recovery was uneventful.

DISCUSSION

Colpocleisis is an operation obliterating the lumen of the vagina. It was first performed in 1877 by Leon Le Fort. It is an effective method of treating uterine prolapse in elderly women who are not sexually active or medically fit for major reconstructive surgery. This is an alternative to hysterectomy with its inherent complications of organ damage and haemorrhage requiring blood transfusion. Advantages include short procedure, minimal bleeding, reduced hospital stay and it may be done under local anaesthesia.⁽¹⁾ There is more than one approach to achieving colpocleisis. The Le Fort operation involves replacing the prolapsed organ in its original position and preventing further prolapse by joining the tissue of the anterior and posterior walls of the vagina.⁽²⁾ Another technique is the inversion of the vagina using purse string sutures after the removal of vaginal mucosa. This is similar to the purse string technique used in our case report. Another method is performing an anterior and posterior repair, suturing them together and strengthening with perineorrhaphy.⁽³⁾

In women less than 64 years, endometrial biopsy and cervical smear should be a part of the preoperative investigations since the uterus and cervix would be inaccessible postoperatively.⁽⁴⁾ Early complications are haematoma, infection and injury to the bladder or rectum. Longterm complications include urinary stress incontinence, which can be as high as 30%, and recurrent prolapse in 2-5% of patients. The results have been good with low failure rates. It has been reported that more than 95% of women had attained symptomatic relief.^(5,6)

CONCLUSION

Colpocleisis is a beneficial procedure in women unfit for major surgery and not sexually active. More research is needed to determine which method of colpocleisis is most suitable, provides the greatest benefit and has the least complications. The incidence of colpocleisis is low, which makes it very difficult to undertake randomised trials. To attain optimal patient outcomes training is essential but opportunities for this are limited.

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AFTER THE GASMAN

John Findlater was interested to read of Sandy Kilpatrick's experience in the Far East (*MBMJ*, Spring 2008). John's basic RAF training, shortly before Sandy's, was extended to take in a variety of roles. At Changi Hospital he acted as assistant to the Medical Specialist, while working also as paediatrician, dermatologist and venereologist. He administered anaesthetics also. As if this wasn't enough, he acted as RAF Embarkation MO at Singapore Harbour where he diagnosed two RAF pilots with polio, and a case of diphtheria that required an emergency tracheotomy.

Infantry training, something he had undertaken at school and university, resulted in the young Dr Findlater gaining proficiency certificates in rifle, Bren gun, anti-tank rifle and grenades, although like Sandy, whose expertise was rather more limited, he doesn't let on



whether he ever used them in anger. He did, however, get a view immediately behind the front line during the Malayan emergency, when the sight of loaded warplanes made an impression.

John arrived back in the UK in 1950. His varied experiences had prepared him for a life in general practice, but it was the variety of his first few days on call – two home deliveries, and new presentations of thyrotoxicosis, diabetes and tuberculosis – that persuaded him. John calls himself a 'Jack of all trades' but such a sobriquet does not do justice to the skills required.

John retired from Ash Trees Surgery, Carnforth in April 1985.

