

# Surgical excision's efficacy in perforated inflammation

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## Abstract

**Background** : Although Vaginal Hysterectomy (VH) has largely replaced the Manchester-Fothergill operation (MF), the MF procedure may allow for fertility preservation in many instances of genital prolapse.

**Objective** : The goal is to get pregnant after the MF treatment.

**Materials and Methods** : Four women sought conception through MF.

**Results** : Every patient became pregnant and had a baby close to term.

**Conclusion** : Even though the long-term outcome is comparable to VH, the MF operation should be considered in fertile women.

**Keywords** : Manchester-Fothergill procedure; Fertility Sparing; Pregnancy

## 1. Introduction

The MF operation for surgical repair of genital prolapse is an old technique [1] that has largely been replaced by VH with anterior and posterior colporrhaphy when required. However, the MF operation may maintain the uterus and thus fertility, which is essential not only for fertile women but also for some postmenopausal women who want to avoid hysterectomy. When a pregnancy is wanted, the patient should be informed that the risk of abortion and premature labour is increased, and a caesarean section may be recommended. Furthermore, pregnancy necessitates more controls, and physical stress, such as hefty lifting, must be avoided. We successfully conducted 104 MF operations, but

in this paper, we describe the case of four women who became pregnant following an MF operation.

## 2. Materials and Method

### 2.1. Patients

Between 1998 and 2013, four patients aged 33 to 37 received the MF procedure as uterine sparing surgery for uterine descensus. According to the Baden-Walker modified categorization, two patients had cystocele grade III and uterine prolapse grades II and III, and two patients had rectocele and uterine prolapse grade III. The patients had one prior pregnancy with a normal term delivery. Everyone wanted to save their uterus for a future baby. Every neurologically intact patient was subjected to clinical examinations, and barrier tests were conducted using Simm's speculum and/or pessary to detect the presence of occulted Stress Urinary Incontinence (SUI). The need for urodynamic investigations in cases of genital prolapse without reported SUI is debatable, but we think that in many cases, an accurate basic clinical investigation may prevent the need for urodynamic tests [3]. It was clearly explained to the patients that the procedure increases the likelihood of premature labour and that a caesarean section is also necessary, and informed consent was reached.

### 2.2. Surgery

Every patient underwent the MF procedure, with special attention paid to cervix amputation in order to prevent excessive shortening in the event of a future pregnancy. When required, perineorrhaphy was also performed. The amount of blood lost varied from 100 to 180 cc. The hospital stay was 2-4 days, and there were no problems.

## 3. Results

Patients who received this treatment became pregnant between

8 and 19 months after operation. Every subject received 200 mg of natural progesterone vaginally every night. From 20 weeks of gestation, Progeffik-Effik Italy [4] was carefully advised, as was avoiding any physical stress. Clinical examinations and ultrasounds were done every 15-20 days or more as needed to control the uterine cervix. One patient gave birth naturally at 35 weeks, another at 36 weeks, and two had caesarean sections at 35-37 weeks. The newborns weighed between 2210 and 2685 grammes.

## 4. Conclusions

The surgical treatment of anterior vaginal vault prolapse, as well as almost all, if not all, female pelvic floor dislocation, is still debatable. The success percentage of anterior colporrhaphy varies greatly, ranging from 37 to 100% [5]. However, the results of anterior colporrhaphy are difficult to compare because the success rate is dependent on a variety of factors such as the degree and type of anterior vaginal vault prolapse, central or lateral defects, uterine prolapse, techniques used in conjunction with or without vaginal hysterectomy, and, last but not least, the method used to evaluate the results, subjective or objective. Finally, because of the risks of mesh erosion, the use of grafts as a routine primary repair is not usually advised, and infections, even if future use of biocompatible materials could eliminate these negative impacts. The MF technique allows for the creation of an autologous bladder suspension and the preservation of the uterus even in cases of uterine descensus. This latter point is clearly important in fertile women, though some postmenopausal women may also prefer to avoid hysterectomy whenever feasible. Furthermore, the literature contains numerous accounts comparing the Manchester procedure to Vaginal Hysterectomy (VH) [6-8] and successful pregnancies after MF [9]. Gynaecologists should consider MF surgery not only for fertile women; in fact, the operation time is faster, and complications and morbidity are usually lower when compared to VH [7]. Finally, in many cases of genital prolapse, particularly if fertility is desired, the MF operation should be offered as a viable option to vaginal hysterectomy.

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