

THE CONCEPT OF CONSERVATIVE AND RECONSTRUCTIVE FEMALE PELVIC SURGERY

Pages with reference to book, From 245 To 247

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The appreciation of the delicacy of female pelvic surgery is the need of the day, with its dictum being, “to avoid it if at all possible”.

Once contemplated upon, it is to be considered a complete discipline in itself; demanding avoidance of damage and if encountered, its re-conformation to norm.

With more cognizance it is now fully realised that for achievement of fertility not only structural normality of pelvic organs is required but their superbly synchronized physiological activity is a must too, examples of the latter being appropriately timed ovulation and fimbrial pick up of ova. Tubal motility and endosalpingeal lining with secretory as well as ciliated cells, particularly in the depth of epithelial folds, which are all too important for onward propulsion of the fertilized ovum towards the uterus within specified time for embedding¹.

It is hence no wonder that any infection, be it mixed bacterial gonococcal, clamideal, Koch's or other, can damage the endo as well as peritubal activity by blocks or adhesions of varying grades and shades thus producing infertility, pain and other complications, unless promptly treated.

While the horrifying crude pelvic surgery as was conventionally practised till a decade or so before, with careless rough handling of tissues for speed, thick reactive sutures for strength, packing with rough dry gauze packs for visualisation and above all the superficial joy of a superficially small wound, with tug of war beneath it. No wonder all this also led to adhesions, distortion and of course infertility, the tragedy being that even procedures like myomectomy, wedge resection of ovaries, crude attempts at salpingostomy and conservative endometriotic surgery, all meant to enhance or preserve fertility. Paradoxically contributed to its iatrogenic worsening.

More recently it has been the frequent use of diagnostic laparoscopy in routine infertility work up which has served as a retrospective pointer to such havocs² paving the way for conservative surgery in and around the pelves of young females or those still desirous of further procreation.

Thus also came up the more modern approach of conserving, as much tubal tissue as possible (better over 3 cms) even at emergency tubal ectopic surgery; and as much ovarian tissue as possible at cystectomy for benign ovarian cysts as well as to deplore the combination of pelvic operations with others like appendectomies.

While the present day pelvic re-constructive approaches for such damages are well advanced, as briefly indicated below, would it not be ideal to primarily let them not happen, as Hippocrates even said in 400 B.C. in his age-old oath. “I will use that regimen which, according to my ability and judgement shall be for the welfare of the sick and will refrain from that which shall be injurious’ Fortunately enough the pendulum has now swung towards refined surgery initially on precisely the same principles as for the modern re-constructive one, in various advanced units. However, so much is the general need for it that it has to be necessarily emphasised even during residencies, leave alone being practised by the qualified gynaecologists every where because the picture becomes very gloomy once the adhesions and tubal blocks are actually met with specially in infertile females. Thereafter, the reconstruction of pelvic organs to nearly normal structure and function becomes the job of specially interested precisely trained and fully equipped gynaecological teams. Once it is contemplated upon, careful patient selection becomes a must.

During the operation the surgeon needs to exercise constant sense of judgement. Working through an adequate exposure, the adhesions are to be lysed step by step over spatulas and rods adapted to the use

ofbiocoagulators or., better still, with lasers.¹⁻⁴ This, combined with superb haemostasis and constant irrigation with isotonic solutions, aims at freeing the pelvic organs, specially the peritubal adhesiolysis, with freeing of inferior borders of ovaries (better by mirror reflected lasers), which are essential for free ovulation and ovum pick up. The organs thus freed are then lifted over wet packs or platforms for comfortable working on the chromopertubation localised tubal blocks. Their repair is better performed under some form of magnification (preferably an operating microscope), by tubal fimbriolysis, neosalpingostomies, resection of blocks and re-anastomosis, or reimplantation of tubes. Use of finest atraumatic, non-absorbable sutures of proline or vicryl, are the modern choice.

Meticulous peritonisation of all cracks and rents of peritoneum, even if required with free grafts from anterior abdominal wall or omentum is an absolute must to avoid reformation of adhesions. The immediate results are so beautiful that only seeing can be believing.

Finally pelvic organ fluid floatation, with dextran materials like hyskon and others, along with added heparin and corticosteroids prior to eventual everted parietal peritoneal closure, is currently in vogue⁴. Surgery thus performed with additional post-operative steroid cover and optional prophylactic antibiotic cover (in surroundings like ours), is rewarded with maintenance of free pelvic structures if and when endoscopically reviewed later.

The final measure of success is nothing short of 'fruitful child bearing,' which may reach upto 85% in the hands of experts, even in cases with many adhesions but with minor degrees of tubal damage¹. As the tubal damage-increases, the results drop with preferable resort to IVF & ET in cases of gross tubal destruction.

To sum up, rather than having to launch upon such detailed and exhaustive reconstructive and other specialised plans why NOT conserve

young female's pelvic integrity to start with, be it by prompt management of infections, or by most meticulous and considerate initial pelvic and even lower abdominal operative procedures on them.

To reiterate this is an exercise to be drilled into the minds and hands of all those who are eligible to manipulate internal genital and near-by organs in women yet desirous to procreate, working anywhere however remotely placed or adversely situated. The surgeons' awareness can go a long way in preventing childless disasters in their patients.

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