

Female Sterilisation Through Vaginal Tubectomy

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Introduction

To strike a balance between food grain production and population growth in Nepal various agencies both governmental and voluntary are striving hard in unison goal. This herculean task is being tackled through multipronged attacks both by surgical and non-surgical means. But, inspite of these attempts the disparity between rate of food production and to-be-fed is widening day by day and with the present rate of growth of 2.6% the present population will take a mere 30 years to double in contrast to the present position which had taken 60 years to do so. The situation is indeed very bleak, if we visualise the energy situation, housing condition and the arable land available at present.

Methodology

Of the various surgical procedures aimed at female sterilisation and lately laparoscopy and mini-lap tubal sterilisation, Vaginal Tubectomy was performed in Gandaki Zonal Hospital, Pokhara. All together 22 cases of vaginal tubectomy were performed under spinal anaesthesia using 1.6 to 2ml of 4% xylocain.

Operative Technique: Under aseptic conditions and with anaesthetic rituals, 1.5 ml of 4% xylocain was injected in the subarachnoid space between L3 - L4 in the left lateral

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position. The client is put in the lithotomy position, part prepared with savlon, taking due care to scrub the vaginal canal meticulously. The bladder is evacuated invariably by metal catheterisation and patient slightly tilted to head down position so that coils of small intestine fall back out of the pelvic cavity.

If the uterus is in anteverted position it is made retroverted by bi-manual palpation. Soonwala weighted self-retaining speculum with short and broad blade positioned in the vaginal canal. Anterior (Ant.) cervical lip caught by cervix (Cx.) holding forceps and so is the post-cervical lip. Ant. cx. lip holding forceps removed and placed at the isthmus of Cx. at the ant. extremity of douglas pouch. The posterior cervical lip holding forceps similarly removed to posterior (post) end of douglas pouch. Now both forceps are held taut to cause tenting of posterior fornix. With sharp and bold sniping a hole is made in the vaginal fornix and pelvic peritoneum, the opening being widened by spreading the blades of scissors with occasional hissing sound due to air being sucked in peritoneal cavity. The sharp and long blade of speculum is introduced inside the pelvis. The uterus, if not already manipulated, is retroverted so that the tubes come into view. A gauge swab held in an angled Babcock's forceps is gently introduced in the vicinity of the tubes and if lucky, fimbrial and adherents to the swab pop out.

The fimbrial caught in a long haemostat is tied with chromic catgut no. 2 and fimbriectomy performed on both the sides. The pelvic pouch of peritoneum is swabbed of the blood clot. The lateral ends of the fornicial incision caught in haemostat; vaginal vault and pelvic peritoneum are sutured in a single layer with chromic catgut no. 2.

Post-operative period: Each patient stayed over-night in the hospital and next morning she was discharged with the advice to continue antibiotics and analgesics for at least seven days and refrain from sexual co-habitation for at least four weeks.

Complications, difficulty and result:

1. Operative technical difficulty was encountered in one case. The introitus was too small in lithotomy position due to post-burn scarring.
2. One case developed bouts of vomiting and headache perhaps due to spinal anaesthesia.
3. There was no incidence of sepsis in any of the cases.
4. Dysparunia:- Vaginal tubectomy is disreputed as being invariably linked with dysperunia and in one small series of 22 cases no such reporting was done. Perhaps the patient felt too shy to complain of that (?)
5. No mortality has been noted so far.
6. And so also no failure.

Advantages -

1. This is a "scarless" female sterilisation procedure as none of spouses can visualise the scar.
2. The integrity of ant. abdominal wall, wrathed by repeated unplanned and frugal pregnancies is not jeopardised.
3. Every operative step is undertaken under naked - eye vision and digital palpation.

Disadvantages

1. Hospitalisation for even a single night is undoubtedly eroding the financial resources.
2. All the operations were done under spinal anaesthesia with its inherent hazards and needing an anaesthetist experienced in spinal anaesthesia.

Conclusion

Various surgical procedures are devised, developed and practiced in Nepal especially in the field of female sterilisation. In terms of number of operations performed so far "Laparoscopy" technique heads the list but in terms of simplicity both technological and operative, Mini-lap is the A - one operation in the least developed country like Nepal.

However, vaginal tubectomy should not be relegated to oblivion and family planning agencies should be capable of serving the "dish" to some "vegetarian" in its "cafeteria" because this perhaps, is done without much mutilation to mother nature's flora.

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