MEDICAL PRACTICE

*Gynaecology in General Practice***Prolapse—II, Treatment**

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For the purpose of this review the principles of surgical technique are more important than the details in treating prolapse. The surgical details must be learned in the operating theatre. In the first place, as prolapse is due to a mechanical breakdown so its treatment consists of supporting or reconstructing the damaged tissues. It is seldom a lethal condition, though its neglect or injudicious treatment can make it so. If a prolapse is neglected recurrent urinary infection and obstructed renal drainage over a period of years may cause uraemia. In cases of injudicious treatment, as reports of operative and post-operative deaths indicate, the main causes of death are cardiovascular lesions, embolism, uraemia, and infection.

With care in preoperative assessment and preparation and postoperative supervision the mortality and morbidity can be reduced to surprisingly low levels, considering the age groups concerned and the frequent association of such medical hazards as obesity, hypertension, diabetes, chronic urinary infection, and chronic bronchitis. In the years 1951–69 inclusive 6,490 patients had operations for prolapse at Oxford with five postoperative deaths—an incidence of 0.08% (see Table). These

Prolapse Operative Mortality (1951–69)

Operation	Number	Deaths	Cause of Death
Manchester repair ..	2,449	3	{ Pulmonary embolism Coronary occlusion Gastrointestinal haemorrhage on tenth day
Repair with vaginal hysterectomy* ..	4,041	2	
Total ..	6,490	5 (0.08%)	

*By 1 January 1970 the number of vaginal hysterectomies performed was 5,127 with the two deaths reported above

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results confirm that with efficient team work the risk is small and that surgery, when indicated, can be recommended with confidence.

Surgical Treatment

The purpose of operating is not to save life but to restore comfort, and the implications of this are sometimes forgotten. The ideal aim should be to relieve symptoms and give the patient maximum security against developing either recurrent prolapse or other possibly more serious complications. It is important that the operation should leave a functioning vagina, and techniques should be mastered to provide this.

TYPE OF OPERATION

The type of operation must depend on the skill and preference of the surgeon. In the hands of one who is equally experienced with the technique of the Manchester operation and repair combined with vaginal hysterectomy the results as far as treatment of the prolapse is concerned are comparable. Both techniques give good results. Evaluation of the relative merits of the two procedures is outside the scope of this article, but the fact is often overlooked that many unhealthy uteri conserved by the Manchester operation cause trouble later. J. Bonnar *et al.*¹ found unsuspected lesions in 26% of 500 uteri removed at vaginal hysterectomy associated with prolapse repair.

There is, however, a related practical point which deserves mention. When the preoperative assessment of a patient requiring hysterectomy discloses symptoms or signs of prolapse these should not be ignored. To perform a total abdominal hysterectomy with no attention to the pelvic floor can result later in vaginal eversion with cystocele, rectocele, and vault prolapse. This can tax the skill of the most experienced surgeon, and it is also extremely difficult to restore a functioning vagina in those cases. If the hysterectomy is per-

formed vaginally and combined with the necessary repair, even though at this stage no complaint is made of prolapse, the patient can be saved a great deal of trouble.

Vaginal Pessaries

A final reference is necessary to those controversial instruments, vaginal pessaries. Fortunately the days of rubber rings with offensive discharge and frequent changing have gone, but pessaries still have a contribution to make. No woman should wait a year or more in discomfort for an operation when a correctly fitted plastic ring can relieve her symptoms. If she is comfortable and there is no discharge the pessary does not need changing and can remain untouched for a year if necessary. But an appointment should be arranged for its removal. Otherwise some patients—who are completely free of symptoms—will decide against operation and fail to report back until ulceration occurs perhaps some years later. Even a vesicovaginal fistula may develop.

PUERPERAL PROLAPSE

A second indication for the temporary use of a pessary is puerperal prolapse. Operation should not be performed for at

least six months after delivery while involution occurs, and pessary support during this time can relieve symptoms and allow healing to restore the pelvis to normal.

DOUBTFUL CASES

In a third group of doubtful cases it is uncertain that the symptoms complained of can be explained by the minimal amount of demonstrable prolapse. A ring pessary can provide a useful therapeutic test.

With these exceptions the development of safe and effective anaesthetic and surgical techniques has made surgery the treatment of choice. But safety and good results are not achieved without careful and painstaking clinical supervision at every stage of treatment, preoperative and postoperative as well as in the theatre itself. Many thousands of women in Britain continue to live in discomfort from prolapse, with resultant family tensions, because of long waiting lists and inadequate hospital facilities.

Reference

- 1 Bonnar, J., Kraszewski, A., and Davis, W. B., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1970, 77, 1137.

Clinical Problems

Dialysis-associated Hepatitis: Prevention and Control

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Viral hepatitis has seriously hampered the management of renal failure by both dialysis and transplantation in many countries including Great Britain. The death of four staff and seven patients at the Western General Infirmary, Edinburgh, has recently re-emphasized the risks. Dialysis-associated with the unit, such as laboratory staff, hospital nurses, doctors, and technicians and to others less closely associated with the unit, such as laboratory staff, hospital porters, and cleaners. Relatives are susceptible to infection when a patient with hepatitis is dialysed at home.

The initial stages of the Liverpool outbreak were described by Jones *et al.*¹ The present brief account of the later stages of the outbreak at the Sefton General Hospital may be of help both to units that have experienced the disease and to those that have so far been fortunate enough to escape infection.

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Dialysis Unit

Only patients with acute failure were treated in the dialysis unit at the hospital from 1958 until 1965. Initially the Skeggs-Leonards kidney was used, and after 1963 the Birmingham Minicoil. In 1965 two significant changes took place—firstly, a repeated dialysis treatment programme was started, and, secondly the Kiil kidney was introduced.

Because of overcrowding, staff came into contact with all patients, who, irrespective of whether in acute or chronic failure, were treated with the same Kiil dialyser. In the early stages of the outbreak therefore, it was impossible to trace the pathway of infection from person to person. In 1967 the unit was enlarged to allow a dialyser for each patient; however, these were still stripped and reassembled in the same room.

The Outbreak

In March 1966 two nurses and two technicians developed hepatitis, and within six months 15 unit staff and three patients had contracted the infection. Up to January 1967 14 nurses, three technicians, and five patients had developed hepatitis, and by January 1971 55 cases had occurred (see Chart).

Since the introduction of the serum hepatitis (S.H.) test² we have been able to detect hepatitis carriers and therefore use