Aspects of Sexual Medicine

Sexual Life after Gynaecological Operations—II*

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British Medical Journal, 1975, 2, 680-681

Vaginal Operations

REPAIR OF PROLAPSE

Of the various factors which influence sexual life after abdominal operations on the pelvic organs surgical method is of relatively minor importance. But this is not true of vaginal procedures, where operative technique may be crucial. Undue narrowing of the introitus and the vagina after a poorly judged or poorly performed repair operation can result in permanent coital disability. In planning and carrying out any vaginal operation allowance has to be made for the patient's age, her wishes with regard to coitus, and the amount of physiological atrophy already present. Preoperative clinical assessment rarely gives a completely accurate picture of the extent of a prolapse, but the more carefully this is done the less likely is the operator to be confronted with an unexpected problem in the theatre which might require a more extensive procedure than had been discussed beforehand. This is particularly true for patients with recurrent prolapse, when a functional vagina may have to be sacrificed in the interests of surgical cure. The patient's views must be sought, and many will be content with the result if they have been forewarned that the vagina is likely to be permanently narrowed, especially if there has been a long history of disability with urinary incontinence.

If the surgeon finds himself operating on a patient in ignorance of her wishes he must assume that a functional vagina is required even in the late middle-aged and elderly. Kinsey[7] found that 97% of a group of women aged 50 had intercourse at least once a week and 80% of 60-year-olds at least once a fortnight. In many cases older women cease sexual activity not by their own inclination but because they lack an interested partner.[5]

Because operative technique is of such great importance in the treatment of prolapse the patient's own doctor is at some disadvantage in offering preliminary advice and in seeing her through the operation and its aftermath, as so much depends on the surgeon's personal judgement and his operative skill. The general practitioner's primary task is to provide as much background information as possible in his referral and to help the patient choose a gynaecologist who will respect her wishes within the limits of achieving a satisfactory surgical result.

Prolapse operations have a poor reputation for preserving sexual function. Francis and Jeffcoate[8 9] found that about 50% of patients stopped intercourse completely or practised it infrequently and with discomfort. In half of these the cause was loss of libido, impotence in the man, advancing years, or deteriorating health in either partner. This left about 20% with apareunia or severe dyspareunia as a direct result of the surgical procedure due either to deliberate tightening or to surgical misjudgement, and the condition was exacerbated by senile contracture and failure to practise coitus. Of the various manoeuvres in the surgery of prolapse posterior colpopeirneorrhaphy carries the highest risk of coital problems.

Vaginal Hysterectomy

Removal of the uterus by the vaginal route as an alternative to abdominal hysterectomy in the parous woman carries no greater likelihood of interfering with sexual activity and may have a less disturbing effect than the abdominal procedure. Such patients tend to be of relatively high parity, so that they usually welcome loss of childbearing. The absence of an abdominal wound, a shorter hospital stay, and a generally quicker recovery all contribute to a more rapid return to normal. These patients therefore form a selected favourable group for the restoration of sexual function.

Anterior Colporrhaphy

The introductory comments on vaginal operations apply particularly to this procedure. It is the most commonly performed prolapse repair and may be carried out alone, as part of a Manchester (Fothergill) operation, or in association with vaginal hysterectomy. Narrowing of the vagina may result from too wide an excision of the vaginal epithelium but is less likely after anterior than posterior repair. Some degree of shortening is almost invariable, especially after amputation of the cervix, but may be minimized by avoiding the use of continuous sutures.

Posterior Repair

Posterior colpoperineorrhaphy is the major cause of vulval and vaginal stenosis after prolapse repair. Traditionally this procedure has been handed down as an essential component of the Manchester operation with little regard to the specific needs of the individual patient. The findings of Francis and Jeffcoate[8 9] have since led to a more cautious and selective use of posterior repair. These authors suggested that colpoperineorrhaphy should be avoided unless the patient has a symptom-producing rectocele. Where the operation is unavoidable the degree of tightening requires very careful judgement, especially in anticipation of continuing post menopausal atrophy. Kinch[10] reminds the surgeon to make allowance for the diminishing sexual capacity of the male partner of advancing age. In all cases it is preferable to err on the side of under- rather than over-correction. In order to preserve a rounded perineum Simmons[11] has devised a simple and sensible modification of technique to avoid the formation of the traditional and useless "skin bridge," which is one of the main causes of postoperative dyspareunia.

When both an anterior and a posterior repair have been performed it is essential to carry out a vaginal examination before discharge from hospital to separate any light adhesions between suture lines before there has been time for scar tissue to organize. Resumption of coitus after six weeks will help to keep postoperative stenosis to a minimum. A longer period of abstinence should be discouraged.

*Part I appeared last week, p. 608

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Br Med J: first published as 10.1136/bmj.2.5972.680 on 21 June 1975. Downloaded from http://www.bmj.com/ on 19 September 2021 by guest. Protected by copyright.

Episiotomy

Episiotomy is the commonest of all perineal operations. The majority are carried out by relatively inexperienced staff in conditions where accuracy of siting and repair may be sacrificed in favour of speed and dispatch. Not surprisingly, temporary dyspareunia is a common postnatal result. Beischer[12] assessed over 200 women three months after delivery with mediolateral episiotomy and found that 39% had dyspareunia, which remained severe and persistent in 6%. In about half of the entire series the anatomical result was unsatisfactory. The lessons to be learnt from this study are self-evident. Careful timing and positioning of the incision, careful repair with fine catgut, and the avoidance of a skin shelf will minimize the poor after effects of this important and universal perineal operation.

Postnatal sexual difficulty is never entirely anatomical and can occur in patients with an intact perineum. Emotional factors are bound to be relevant after childbirth, and loss of libido and coital pain may be a reflection of anxiety over the child or the family situation or about the adequacy of contraception. When contemplating surgical revision of a perineal scar these factors have to be carefully weighed up and sufficient time allowed for their resolution before resorting to operation.

Treatment of Stenosis after Vaginal Operations

Some relief from postoperative contracture may be obtained by the use of dilators and lubricants. Surgical correction of vulval stenosis following perineorrhaphy or episiotomy may be possible by means of a perineotomy (Fenton's operation), but narrowing of the vaginal lumen is usually irreversible and permanent The most typical finding after an ill-judged colporrhaphy is a midvaginal constriction producing a characteristic ridge across the posterior wall. Rankin[13] has described the successful use of a Z-plasty for such cases, but this procedure must have a limited application. Where there is no hope of re-establishing a functional vagina Williams's ingenious operation for vaginal atresia[6] may sometimes provide a solution both for stenosis following vaginal repair and for secondary contracture after irradiation or radical hysterectomy. The operation involves the formation of a coital channel between the sutured labia, so it is applicable only for patients without significant vulval atrophy.

Other Operations

Discussion of every procedure which is likely to affect a woman's sexual life is clearly outside the scope of this article. Attention has been focused on those operations about which patients most often seek advice and reassurance. The comments and recommendations may be applied with modifications to most other circumstances. Complicated procedures such as the repair of fistulae, vulvectomy, and the treatment of congenital atresias are bound to have major implications for sexual function, which should be fully discussed beforehand. Less obvious as a source of anxiety are the everyday minor procedures which are the commonplace of a gynaecological operating list. Few patients undergoing an operation for dilatation and curettage, removal of polyp, or diathermy of the cervix believe that such operations will have permanent ill effects on their sexual life, but equally few seem to be given clear instructions before discharge about such simple matters as the expected amount of bleeding, the use of tampons, and the resumption of intercourse. As a result many women delay their return to normal life far longer than the few days required and magnify a trivial intervention into a major issue. The trend towards day-case surgery must still allow sufficient time for an adequate and unhurried explanation of the purpose and effects of the operation, including the reassurance that any disturbance of function will be transient.

Operations for termination of pregnancy and sterilization have not been included in this review. Because of their greater emotional impact they are in a different category from other gynaecological procedures and would merit a separate study which is not appropriate here. Temporary loss of libido often occurs after therapeutic abortion but is part of the patient's psychological reaction rather than a direct effect of a relatively minor operation. Elective sterilization is less likely to produce disturbance of function, but patients asking about the operation sometimes express the fear that they might lose their sexual drive. They can be firmly reassured that tubal interruption has no adverse effect on libido and, if anything, will probably enhance it. Sexual problems after sterilization are usually the result of poor selection or of inadequate preoperative explanation—an observation which applies to most of the procedures discussed in this article.

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Any Questions?

We publish below a selection of questions and answers of general interest

Intradermal Testing Before Immunization

Can intradermal testing or prick testing with whooping cough vaccine select those babies who will react badly to the initial injections of triple vaccine?

There is no simple intradermal or prick test that will show whether an infant is particularly susceptible to a severe reaction after these injections. Reported severe reactions are probably due to hypersensitivity to various toxic factors in the pertussis component of the vaccine. These include endotoxin, a histamine-sensitizing factor, and a lymphocytosis-promoting factor. Reactions are not believed to be immunologically-mediated and skin sensitivity tests, therefore, would not provide any relevant information.

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