SURGICAL CORRECTION OF VAGINAL RELAXATION

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SELECTION of patients for any operative procedure must be done with the utmost care. In patients having vaginal relaxations, other than those of marked degree, the indications for vaginal plastic must be particularly painstakingly evaluated. Surgical treatment is for the most part elective and should be done only if definite benefits can be offered to the patient.

The term "vaginal relaxation," as used in this paper, designates the lesions resulting from loss of fascial and muscular support of the anterior and posterior vaginal walls. The most important etiologic factor in the development of those conditions is childbirth trauma with the resultant stretching and laceration of fascial and muscular structures. As a consequence of childbirth trauma, in the anterior vaginal wall the pubo-vesicocervical fascia, the urogenital diaphragm and pubococcygeus muscles are most commonly damaged. In the posterior wall, the prerectal fascia, levator muscles and perineal body bear the brunt of the stresses of childbirth.

Factors contributing to vaginal relaxation include all actions that tend to increase intra-abdominal pressure. Among these are lifting of heavy objects, chronic constipation with forced defecation, and chronic coughing or sneezing. Obesity increases the stress on vaginal musculature; menopausal atrophy of supporting structures also is a contributing factor.

Symptoms

Any degree of pelvic relaxation can exist without causing symptoms. Often, the gradual loss of support allows the patient quite unconsciously to adjust to changing sensations. In perception of discomfort, numerous environmental factors play a major role, such as the patient's personality and marital adjustment.

The lesions do not produce pain, though in advanced stages they may result in discomfort that consists of a definite feeling of loss of support. The sensation often is described by patients as a feeling that "the bottom is falling out," or as a "dragging sensation." Patients sometimes loosely speak of back pain but, on careful questioning, they describe it as the sensation of dragging. When back pain per se exists, it is an incidental symptom; it is extremely unlikely that loss of pelvic support will result in true back pain.

Cystocele and so-called urethrocele (a loss of urethral support) may produce various urinary symptoms. Incomplete emptying of the bladder, secondary to loss of support and tone, frequently results in recurrent urinary-tract infections.

Chronic urethritis, however, should not be overlooked as a common source of these infections. Large cystoceles may require digital replacement by the patient in order to be able to initiate micturition.

Stress incontinence results from loss of urethral support with the result that the stresses from coughing, laughing, and sneezing often precipitate uncontrolled loss of urine. It is of considerable clinical importance to differentiate between *stress* incontinence and *urge* incontinence. Urge incontinence is characterized by an inability to retain urine when the desire to void is present, and it generally indicates presence of a lesion within the urethra or bladder. On the other hand, stress incontinence is not associated with a desire to void and occurs with increased intra-abdominal pressure.

Affections of the posterior vaginal wall include lacerations, rectoceles, and enteroceles. Lacerations of less than third degree are asymptomatic. Rectoceles may interfere with normal rectal dynamics by causing feces to be pocketed during the process of defecation. A marked rectocele may have to be pressed upon in order that defecation may take place. It is important to differentiate between symptoms attributable to rectocele and those secondary to constipation.

An enterocele, a herniation of the pouch of Douglas through the posterior fornix, is an uncommon lesion, and when small it may be overlooked. When marked, this hernia may protrude from the vagina. Symptoms caused by it are almost wholly those of simple loss of support.

The condition of the woman who complains that unsatisfactory sexual relations have resulted from loss of vaginal support should be particularly carefully evaluated. The pathologic condition may indeed be the cause of the complaint, but often the difficulty is more amenable to psychotherapy than to surgical intervention.

Examination

Profound relaxation presents little diagnostic difficulty; it is the less obvious relaxation that easily may be overlooked in examination, which may be a diagnostic problem. The examination of patients in lithotomy position makes relaxations, in general, less apparent. Requesting a patient to bear down may overcome this problem. However, the request may not result in the desired increase in intra-abdominal pressure due to fear of embarrassment on the part of the patient over possible passage of flatus or of urine. Traction exerted on the cervix by means of a tenaculum forceps occasionally helps the patient to bear down and may also reveal an otherwise unsuspected prolapse. The cervix is insensitive and accordingly this is not a painful procedure. If symptoms suggest vaginal relaxation, an examination also may be made of the patient in the upright position.

Panendoscopy which includes examination of the bladder and urethra is a valuable routine procedure, as often it will reveal unsuspected pathologic conditions within the urethra or bladder, such as urethral strictures, pathologic conditions of the bladder neck, polypi, or early carcinomas. Thus, needless or unwise operations can be avoided.

Selection of Patients

Patients having pronounced symptoms of vaginal relaxation generally are very desirous of relief. Any or all of the symptoms mentioned above may constitute indication for surgical treatment; however, symptoms and physical findings should complement each other and be of about equal degree. Symptoms out of proportion to relaxation should be suspect as far as vaginal plastic therapy is concerned.

Surgeons should make an effort to evaluate the socio-economic impact of an operation, for if the physician insists on an elective operation, he may relieve symptoms in the pelvis, only to create new symptoms that will arise from the psychic sphere. It may be wise for the specialist to see the patient several times in an attempt to evaluate her personality better. Fortunate, indeed, is the specialist who has the advantage of close liaison with the patient's family physician and can benefit from his personal knowledge of her problems. Most surgeons have seen technically brilliant operative results too often marred by the subsequent development of true pelvic conversion neuroses.

When surgery is being considered, a pessary may serve to indicate to the patient and to her physician just what symptomatic relief can be expected from the operation. Permanent use of a pessary should be reserved for the poor-risk or aged woman, since results generally are not so satisfactory as those of a well-executed operation.

Repairs should not be performed in a patient who has no symptoms, nor should repairs be performed simply because the loss of support seems likely to become more marked with the passage of time. The decision as to the need for operation in the symptomatic patient generally can be left to the patient herself, although the physician, of course, will play a very significant role in directing her to a choice of treatment. The details of findings at examination, and their implications, should be discussed thoroughly with her. She should be guided toward development of a proper perspective in regard to the symptoms and their importance in terms of future good health and the results to be expected from surgery. We as physicians should be careful not to discourage a patient unduly in regard to operation, so that she deprives herself of the benefits that might accrue from relief of real symptoms.

Operative Procedures

Operative technics are well described in most of the standard textbooks of operative gynecology.[1-3] In considering which operation to use, age and physical condition of the patient are of primary concern. In a premenopausal woman the desirability of childbearing and/or menstrual function should be discussed with the patient. Certainly, where there is any possibility of ablating coital function, it should be discussed with the woman, no matter what her age or marital status. Where operative risk is great, as mentioned before, the value of a pessary should not be overlooked. When a pessary cannot be worn, it often

is possible to perform repairs under local anesthesia; xylocaine is an excellent agent in such a case.

The place of operation in the correction of stress incontinence has not been settled; numerous procedures have been devised and Kegel[4] has proposed exercises as an alternative method of dealing with this problem. This proposal is still being evaluated but information available to date suggests that exercises have a very definite place in the role of preventing the onset of these symptoms, treating mild to moderate degrees of it, and as a preparation for surgery. The decision for operation may often be wisely left to the patient, as she may be the only one who can decide whether her trouble is of sufficient severity to require surgical relief. When operation is contemplated, a vaginal repair should be attempted first and if this fails the various urethral suspension operations[5] may be tried.

The field of vaginal plastic repair constitutes an excellent test of a surgeon's training and skill, since it is necessary to tailor the procedure to the individual situation. A poorly executed repair may be worse than none. Abdominal uterine suspensions for the relief of prolapse and other vaginal relaxations, fortunately, are becoming rare, for they are inadequate and generally useless procedures. The Watkins interposition operation also is becoming less popular than formerly, since the later diagnosis and treatment of an intrauterine pathologic condition is considerably complicated when that operation has been employed.

SUMMARY

Symptoms of vaginal relaxation often can be relieved by vaginal plastic repair. In selecting patients for operation, symptoms, pelvic findings, physical condition, and personality must all receive consideration. Since the operation most often is elective, the patient should be apprised of her condition and be guided by the physician in making the decision for or against surgical relief. Vaginal plastic operations are contraindicated in women who have no symptoms of vaginal relaxation.

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