

Laparoscopic Repair of Enterocele

Thesis
Submitted for partial fulfillment
of Master Degree in Obstetrics & Gynecology

By
Abeer Abdel Moty Ashry
(M.B.,B.Ch) Ain Shams University

Under Supervision Of

Professor Dr.
Mourad Mohy El-Din El-Said
Professor of Obstetrics & Gynecology
Faculty of Medicine, Ain Shams University

Professor Dr.
Essam Mohamad Khater
Professor of Obstetrics & Gynecology
Faculty of Medicine, Ain Shams University

Dr.
Hatem Saad Shalaby
Assistant Professor of Obstetrics & Gynecology
Faculty of Medicine, Ain Shams University

Cairo, 1999



Acknowledgment

First and foremost, All thanks to my God, the beneficent and the most merciful .

I would like to express my unlimited gratitude to Prof. Dr. Mourad El Said, Professor of Obstetrics and Gynecology, Faculty of Medicine, Ain Shams University, for his supervision, great assistance and encouraging attitude.

I am very deeply indebted to Prof. Dr. Essam Khater, professor of Obstetrics and Gynecology, Faculty of Medicine, Ain Shams University, who has followed with me every thing, step by step till the end. He has offered me a lot of his wide knowledge and precious time and was very meticulous and caring in his supervision. To him I am very grateful.

I am greatly honoured to express my deepest gratitude to Dr. Hatem Shalaby, Assistant professor of Obstetrics and Gynecology, Faculty of Medicine, Ain Shams University, who gave me really a good deal of his valuable time in revising every item in this work. His enthusiasm, persistent encouragement and assistance helped me to finish this work.

I am deeply grateful to every person who helped me to finish his work.

Contents

	Page
Introduction	1
Review of literature	3
I. The development of laparoscopic surgery	3
- History of laparoscopy.....	3
- Modern trends	6
- Instruments for operative laparoscopy.....	8
- Contraindications and complications of laparoscopic surgery.....	16
II. Enterocele.....	24
III. Laparoscopic repair of enterocele.....	50
Patients and methods	61
Results	71
Discussion	101
Summary	112
Conclusion and Recommendations	115
References.....	116
Arabic Summary	v



Introduction

Introduction :

An enterocele is a hernia of small intestine into the vagina. First described in 1736, it is an uncommon but potentially quite symptomatic clinical entity (Holley., 1994).

Incidences of enterocele in various populations of women have not been reported; however, the problem seems to be relatively uncommon. Enteroceles have been reported in as few as 0.1 % and as many as 16 % of women undergoing gynecologic surgical procedures (Austin et al., 1955).

Many enteroceles follow vaginal or abdominal hysterectomy. Various surgical techniques for repair of enterocele include the classical repairs by Ward and Moschowitz (Holley., 1994).

Unfortunately, many enteroceles follow vaginal or abdominal hysterectomy during which inadequate attention is paid to support of the vaginal vault and protection of the cul de sac from the potential ill sequelae of transmission of increased abdominal pressure to the pelvic viscera (Reich et al., 1966).

The repair of an enterocele has classically been via a transvaginal or open abdominal route. With the availability of minimally invasive procedures, they applied an established laparoscopic techniques to enterocele repair (Cadeddu et al., 1996).

There are three essential steps to laparoscopic enterocele repair: Excision of the hernial sac, opening of the recto vaginal septum, approximation of the uterosacral ligaments (Nichols., 1972)

Aim of the work :

The purpose of this study is to evaluate a new minimally invasive laparoscopic techniques procedure for enterocele repair.



*Review
Of
Literature*

Chapter I

THE DEVELOPMENT OF LAPAROSCOPIC SURGERY

An eye in the plevis is better than a thousand pelvic examinations (*Soderstorm, 1978*).

For centuries gynecologists have been concerned by the elusive nature of pelvic pathology and women have undergone unnecessary surgery for medically treatable conditions or have been observed for too long before appropriate treatment was instituted. In the past two decades diagnostic laparoscopy has opened new doorways to the management of infertility and pelvic pain and in more recent years operative laparoscopy has enabled gynecologists to treat a large number of women with pelvic disease without subjecting them to the added problems of open surgery (*Gordon and Magos, 1989*).

History of Laparoscopy :

Early endoscopy :

The first description of endoscopy came from school was led by **Hippocrates** who described the use of a rectal speculum, and the first primitive instruments for gynecological endoscopy date from the same period (*Semm, 1975a*).

Light sources :

Although the earliest sources used to illuminate the body

cavities were mirrors , probably introduced by the Arabs before 1000 AD, the real impetus to endoscopy came with the use of more sophisticated light sources in the middle ages. In 1587 Aranzi described the use of camera obscura' for medical purposes, Aranzi used the sun's rays shining through a hole in a window-shutter into a spherical glass flask filled with water to focus the beam into the nasal cavity. It is generally accepted that it was Bozzini in 1806 who gave the first impetus to modern endoscopy. He developed a complex system which conveyed light from a lamp through a tube into the vagina to illuminate it and allow observation of the cervix through a second channel (*Frangenheim, 1988*).

Lens systems (1890 - 1900) :

The development of telescopes with lenses began in the late nineteenth century when Nitze (1897) working with Reinecke, a Berlin optician and Leiter, a Viennese instrument maker, produced the basis of modern optical instruments. Originally, their light source was an overheated, water cooled platinum wire, but after the invention of the electric light bulb by Edison the later was combined with the cystoscope in the early 1900s (*Gordon and Magos, 1989*).

Modern Laparoscopy :

Laparoscopy (1900 - 1940) :

In the early years of twentieth, the main impetus for