Analysis of Ain Shams Techniques of Abdominal Sling Operation in the Management of Genital Prolapse

Thesis

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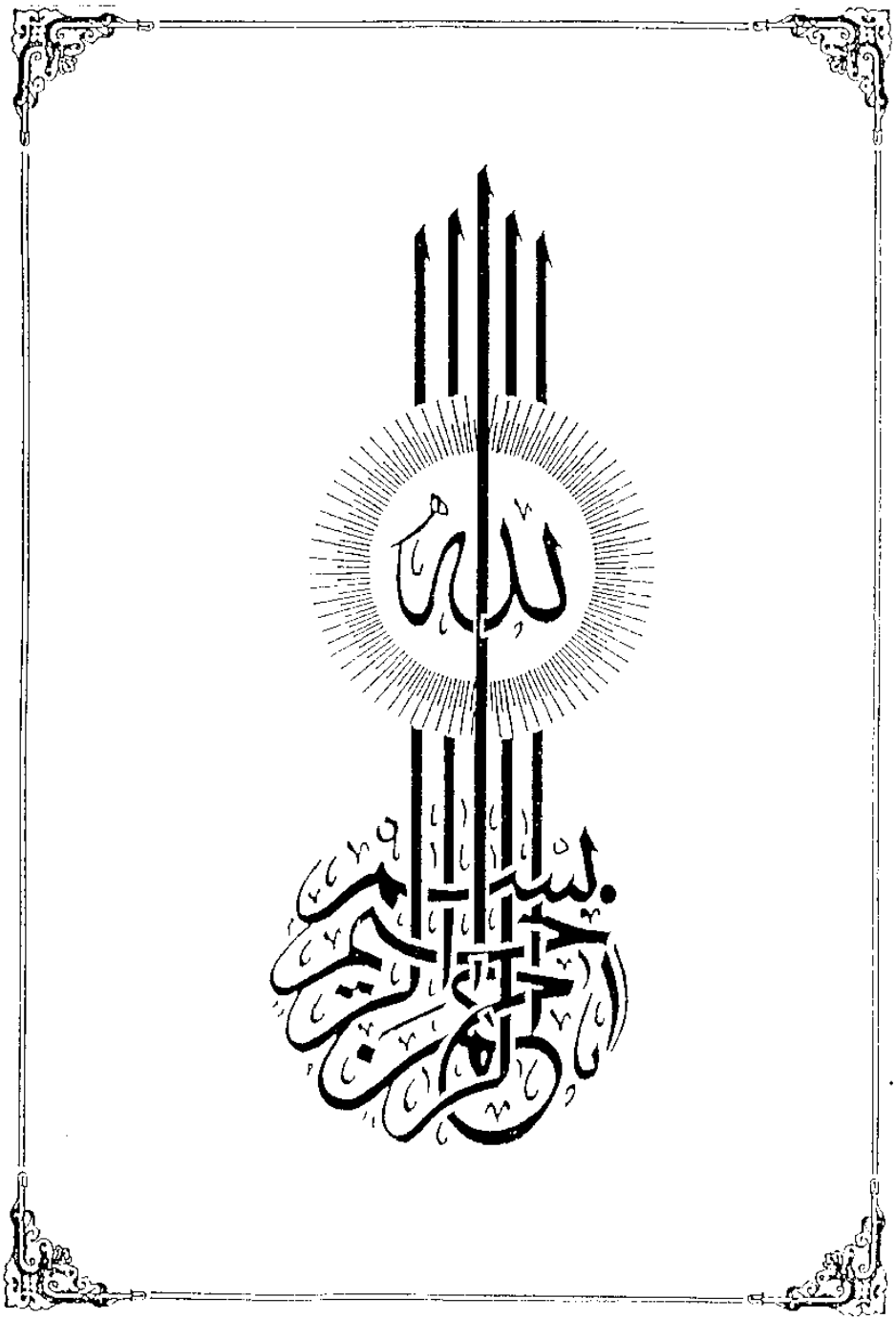

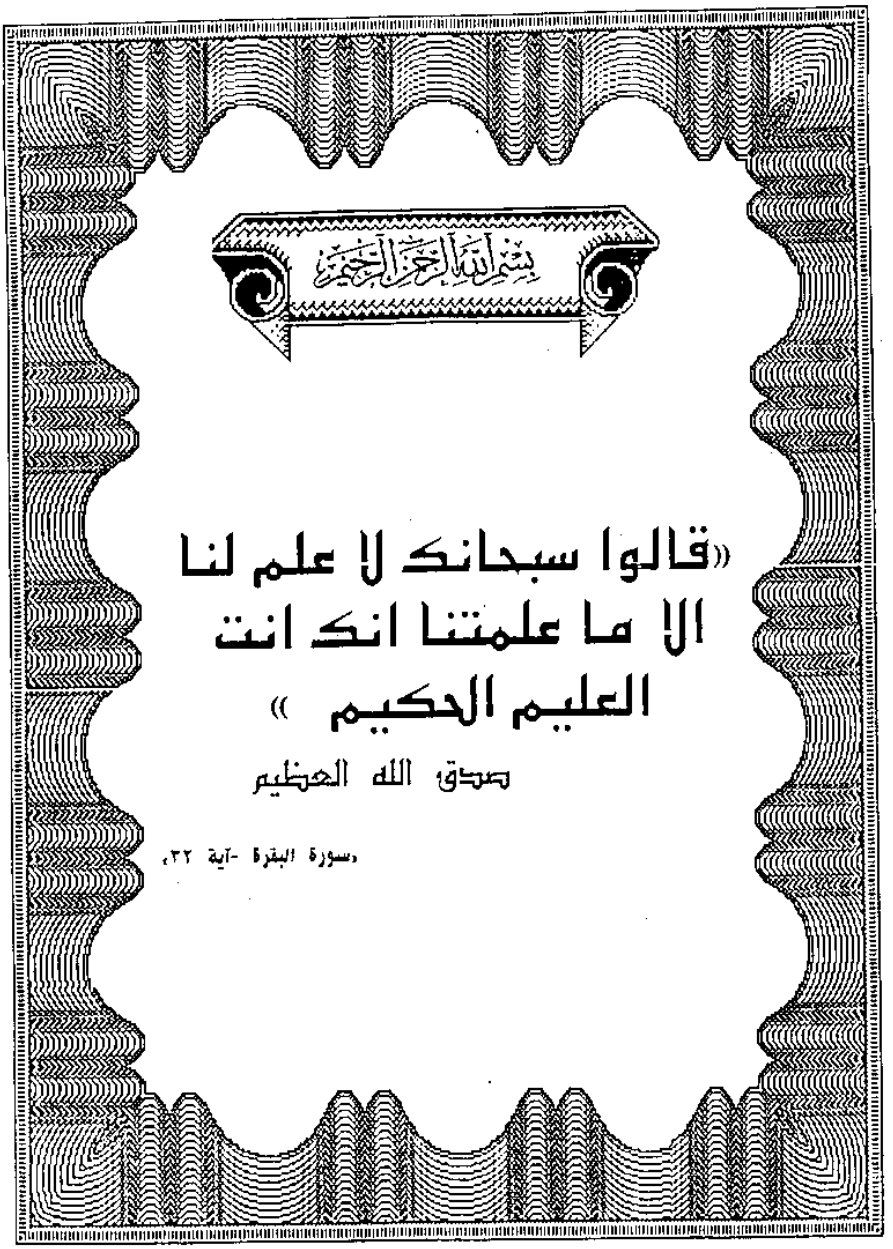

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INTRODUCTION

Prolapse, procidentia (from the latin word procedure, to fall) or downward descent of the vagina and uterus is a common and disabling condition (Tindal, 1987).

Female urogenital organs are supported by :

1- Cardinal and uterosacral ligaments.

2- Pelvic diaphragm and levator ani muscles.

3- Tone of the vagina (Allahbadia and Rambiye et al., 1992).

Uterine prolapse is usually due to weakness of its fascial supports. This may be an inherent or congenital weakness in multiparous as well as in nulliparous patients with prolapse and it is more obviously due to atrophic changes which accompany the menopause (Arthure, 1957).

Prolapse occurs frequently among the white races, the Egyptians and the women in India while the nulliparous prolapse is present in 2% of the women, developing prolapse as there is a congenital defect in the pelvic musculature or innervation (Nichols, 1985).

Due to malnutrition and young age of marriage, cases of congenital prolapse are more common in developing countries and this group includes those who have prolapse after their first delivary. In these women the tendency of prolapse is already present and pregnancy and childbearing bring it to light (Allahbadia and Rambiye et al., 1992) .

Most of the surgical procedures are designed for older women, fertility and uterine preservations are not factors generally considered important. In young age groups, the surgeon must correct the immediate problem of prolapse, preserve a functional vagina yet not diminish the patient's child-bearing potential (Richardson et al.,1989) .

Shirodkar (1958, 1959, 1960) devised an operation for prolapse during the childbearing period where the

Shirodkar (1958, 1959, 1960) devised an operation for prolapse during the childbearing period where the uterosacral and cardinal ligaments are too weak for an extended Manchester operation (Dasture et al., 1967) .

The Shirodkar sling operation consisted of fixing the sling of mersilene tape posterior to the cervix carrying it extraperitoneal from both sides of the rectum and fixing it to the anterior logitudinal ligaments over the sacral promontery. On the left side, the sling had to be looped round a psoas hitch to prevent pressure on the sigmoid colon (Allahbadia and Rambiye et al., 1992).

AIM OF THE WORK