

Cervicoplasty in Severe Cervical stenosis: a Challenging Problem

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Abstract

18 years old patient presented with pain abdomen, whitish discharge, dyspareunia, dysmenorrhoea and delayed menarche was diagnosed as a case of P0+0 with severe cervical stenosis with left sided pyosalpinx. Abdomino perineal approach was done as the surgical procedure. Left sided salpingectomy done, an uterovaginal anastomosis was created keeping malecot's catheter as a stent. She had normal menstruation without dysmenorrhoea after the operation. Malicot's catheter was removed later on. She is now under follow-up. Also we used malicot's catheter as folley's catheter may come out.

Keyword: Cervical Stenosis, Uterovaginal Anastomosis, Malicot's Catheter

Case Report

18 years old married woman presented with pain abdomen, whitish discharge with dyspareunia with delayed menarche. She achieved menarche in 17 years and 4 months of age. Her menstrual cycle was regular with dysmenorrhoea relieved by medication. The pain is cramping in nature. She uses 2 pads per day and menstrual cycle lasts for 2-3 days. Her bowel and bladder habits are normal. The white discharge is not foul smelling and non-itching. No history of fever, vomiting or swelling of lower abdomen. She was married for 1 and half months and husband has left her due to dyspareunia. On general examination, she has no positive finding. On Per abdomen examination Left iliac fossa tenderness was present. On inspection: Vulva appears to be normal. The vagina was blind and only accommodates 4 cm. A small opening of 0.5cm is seen below the urethral meatus. Per Rectal examination revealed mass is felt in right adnexa, tenderness present. Left adnexa were free. Uterus was slightly bulky. During menstruation, blood comes out through the small hole in small amount.

Ultrasound examination revealed a dilated tortuous structure with incomplete septation in left adnexa 2.2 cm seen suggestive of left sided pyosalpinx Uterus and ovaries normal [Fig 1]. Total counts were 17,000/cum and P83 L10 M4 E3, CRP 47 mg/dl. After antibiotic therapy Total counts were 10,000/cu/mm, DLC P72 L16

Manuscript received: 14th Oct 2014
Reviewed: 25th Oct 2014
Author Corrected: 29th Oct 2014
Accepted for Publication: 12th Nov 2014

M7 E6 & CRP 22mg/dl

USG guided pus from Pyosalpinx were sent on 21/7/14 for Culture. It was sterile.

She was diagnosed as a case of P0+0 with severe cervical stenosis with left sided pyosalpinx.

She has received injectable antibiotic before surgery. For surgery Abdomino perineal approach was done. At first we tried to dilate from below, but when it was unsuccessful, we did laparotomy. A left sided pyosalpinx (5x4cm) was seen. Both ovaries were normal. Uterus is of normal size. Right sided tube and ovary were adherent. Left sided salpingectomy was done. Uterus is opened in body with a vertical incision. Cavity of uterus entered. Metal dilator inserted and brought out through artificial vaginal tract after giving in Foley's catheter and safety of bladder is ascertained. We could not go through the small hole. A malicot's catheter is introduced. Uterine cavity is closed in layers by Vicryl sutures. Abdomen is closed in layers after proper haemostasis. Malicot's catheter is cut at the level of vaginal introitus. She was discharged on after 14 days with no complain.

On follow up visit she has normal cycles in between without pain abdomen, fever. Bowel and bladder habits were normal. She is in good health. Malecot's catheter is removed after 6 weeks 3 days under sedation and washed with betadine. We started Azithromycin and Secnidazole. Down wash with betadine were given from time to time

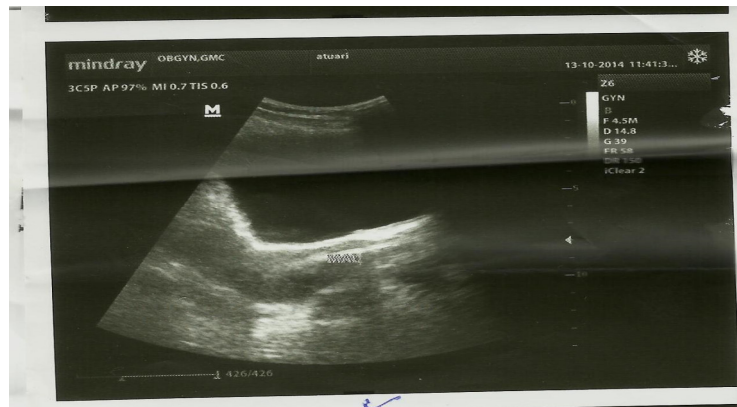
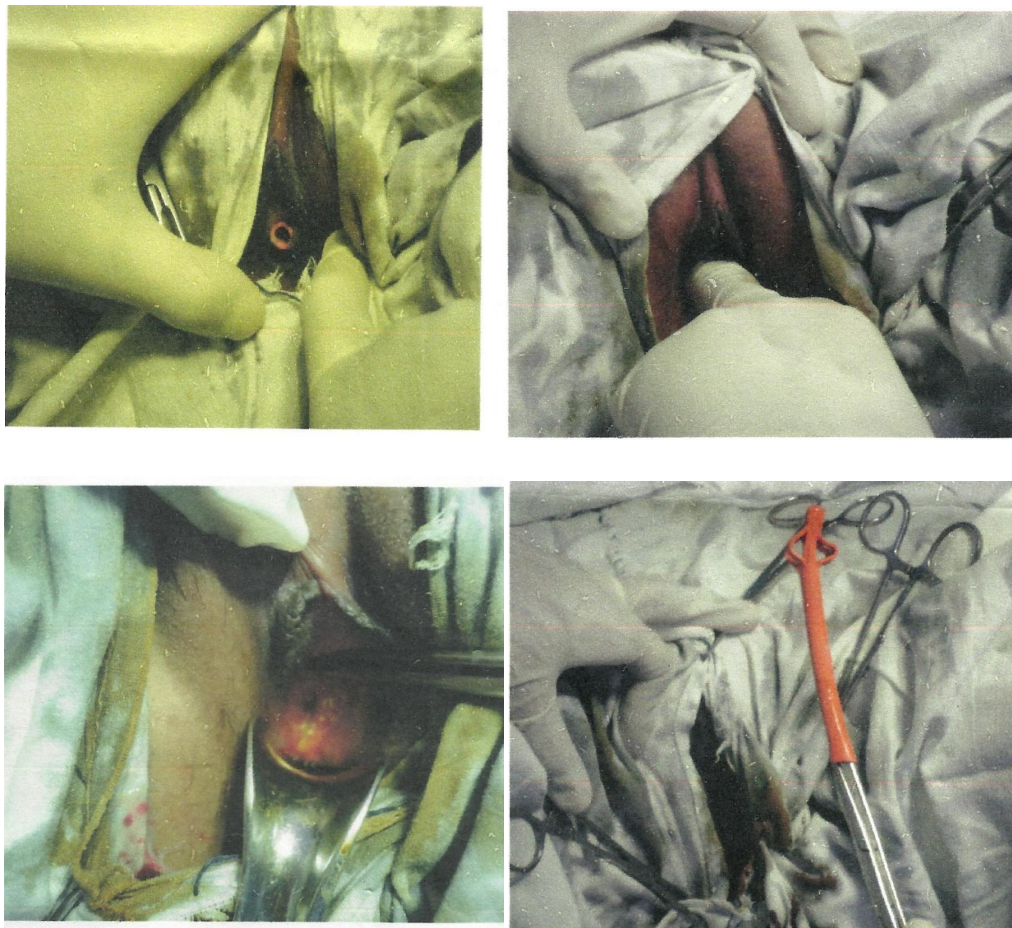


Fig 1: USG showing left sided pyosalpinx

Surgical Procedure



She has 4 cm long vagina without enlarged uterus and normal adenexa. She was asked to come for follow up after next menstruation.

Discussion

Cervical stenosis, an narrow opening of cervix (endocervical canal) is a rare form typical in some cases. In some cases, endocervical canal is completely closed. Symptoms depend on whether there is partial or complete obstruction and patient's menopausal status [1]. Pre-

menopausal women will have hematometra, sporadic bleeding, infertility and endometriosis. The causes are- Birth defect, procedures- colposcopy, cone biopsy, cryosurgery [2] Trauma of cervix, Repeated vaginal infections, Atrophy of cervix after menopause,

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Carcinoma cervix, Radiation, cervical encirclage, endometrial ablation [1-3]. Treatment includes Opening of endocervical canal by dilatation of cervix, laser surgery, hysteroscopy, Shaving of cervical canal [3]. Treatment also includes- Dilatation of cervix and uterovaginal tract with a stent (a tube) may be placed in cervix for 4-6 weeks [4].

Treatment can be dilatation of cervix with catheter in situ for 1-2 weeks [5]. In cervical stenosis, microhysteroscopy can be done [6]. There is a lot of controversy about cervical atresia with functioning uterus. The severe cervical stenosis has similar problem. Some studies advocated hysterectomy in such cases to avoid haematometra leading to dysmenorrhagia, endometriosis, repeated pelvic infection [7]. Caris P.

Robert et al analysed the role of surgical methods in treatment of congenital anomalies of uterine cervix. They have discussed different evidence based issues in this regard. In reproductive endocrinology also favoured hysterectomy in most of such cases. Contrary to it, Deffarge et al [8] published their series of uterovaginal anastomosis. In 10 out of 12 cases attempted pregnancy, 4 were successful, 1 patient had 3 pregnancies delivered by C.S between 36 to 38 weeks, 1 case had cervical encirclage. Fedel et al [9] did 6 cervicovaginal anastomosis successfully. Raudent et al [10] and Mac lock et al [11] also reported such operations.

We have operated similar operations along with vaginoplasty in two cases about 14 yrs old girls with cervical & vaginal atresia alongwith haematometra successfully although few authors suggested hysterectomy in such cases.

Conclusion

In conclusion, with the advanced reproductive technologies, reconsideration of surgical treatment of patients with cervical atresia or severe cervical stenosis needs to be relooked. The recent surgical modifications and broad spectrum antibiotics and successful pregnancy

require such reconsideration so that the patient gets evidence based beneficial treatment.

Funding: Nil, **Conflict of interest:** Nil

Permission from IRB: Yes

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How to cite this article?

Nath JD, Das N. Cervicoplasty in Severe Cervical stenosis: a Challenging Problem. Int J Med Res Rev 2014;2(6):635-637. doi:10.17511/ijmrr.2014.i06.24