were hospitalized for a perod of 3 to 7 days. All the patients were under the medication of lsoxsuprine hydrochloride and 17 hydroxy progesterone after the procedure. Black Silk (n 1.0) was the material used for the study and the placement of knot was anterior. The correct timing of cerclage appears to be ranging from 12-18 weeks. A failure rate of 37.5% was noted in cerclage procedures performed after 20 weeks when compared to 7.4% if procedure was done before 20 weeks.

Labour in all cases the stitch was removed at term; normal labour was allowed when no contra indication. Removal of the stitch is simple and in the event of their not attending our clinic clear instruction was given in the discharge summary to the local doctor about the removal of the stitch at term to enable normal delivery. In 3 cases, the stitch was dislodged and had fallen off without being detriment to pregnancy. In 6 cases where the patient delivered at home unattended the stitch simply got displaced without a tear and delivery proceeded normally.

The **end result of the prospective study**- i.e. the effect of cervical cerclage in cervical incompetence is best assessed by *foetal survival*. In comparison with other cerclage procedures the foetal survival rate in srinivasan's stitch is 87.5% where as in other procedures Mc. Donald's 89.59% wurm's 88.88% and modified shirodkar's 66.60%

Table 2 : *Infant salvage Ratio(ISR)*

	Infant survival						
	Before cerclage			After cerclage			
Types of cerclage	Preg-nancies	Survi-vors	%	Preg-nancies	Survi-vors	%	Infant Salvage Ratio
Mc. Donald'd	141	28	19.5	48	43	89.58	4.51
Wurm's	26	9	34.70	9	8	88.88	2.55
Modified Shirodhar's	5	1	20.10	3	2	66.6	3.33
Sreenivasan's	121	30	24.81	40	35	87.50	3.52

. (Table 2)

RECOMENDED READING

1) ***Shirodkar VN*** *– A new method of operative treatment of habitual abortions in the II Trimester of Pregnacy. Anti-Septic 1955. 52-299.*
2) ***Mc. Donald IA :*** *Suture of the cervix for Inevitable reisecarriage Obt. & Gynec. Of the Br. Evep – 1957: 64: 364-350.*
3) ***Hefner J.D., Patow WE, Ludwing T.M.*** *The Wurm Procedure, New Surgical Procedure for the correction of the incompetent cervix during pregnancy., Obst. & Gynec. 1961. 18 616 - 620.*
4) ***Mc. Donald IA:*** *CI. Obst. & Gyn. Cervical Cerclage, 1980, 7 461 -479.*
5) ***Lidegeard O.*** *Cervical Incoverpetercca and Cerclage in Denmark, 1980 – 1990 Acta Obst. & Gynec. Stand. 1994: 73: 35- B.*

PROCEDURE - II

SREENIVASAN'S SLING FOR NULLIPAROUS PROLAPSE

R. J. Sreenivasan, Dhunnanjaya Rao

Department of Obst. & Gyne. , Karnool Medical College & Govt General Hospital, Karnool(Andhra Pradesh) India.

INTRODUCTION

Prolapse of the uterus occurs in 20% of women over 40 years of age. Nulliparous prolapse occurs in 10% of women between 20 years and 30 years age. [1,2]

DEFINITION

Prolapse of the uterus is one form of uterine displacement i.e., downward, the others being lateral, posterior and inversion. ***Nulliparous Prolapse*** is defined as descent of cervix below the ischial spines and later outside introitus without descent of vaginal fornices, bladder of bowel.

ANATOMY OF PRO LAPSE UTERUS

Normally uterus is a pelvic organ – anteverted and anteflexed. It is kept in position by the following support:- ligaments; Fascia; Muscle; Intra abdominal pressure

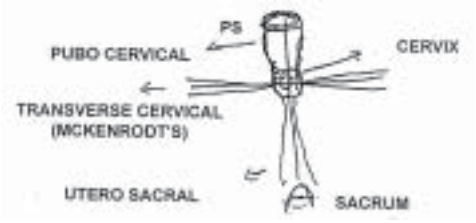
Ligaments:- Sign of the cross+ Three pair of Ligaments:- *Anterior* - Pubo cervical; *Lateral* - Transverse cervical (Mckenrodt's); *Posterior* - Utero sacral

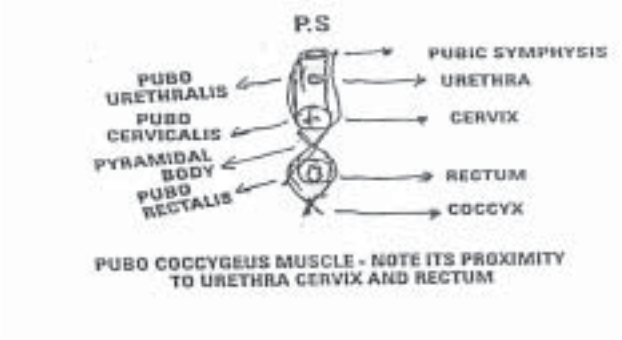
Fascia :- Endo pelvic Fascia – cushoning media consisting of smooth muscle, fat and connective tissue.

Muscle:- Pubo coccygeus – part of levator ani

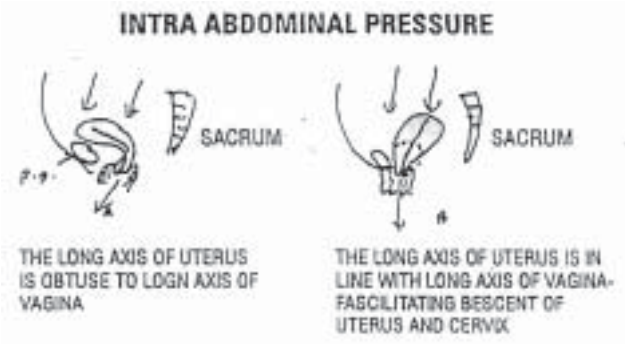
LIGAMENTARY SUPPORTS OF THE UTERUS (SIGN OF THE CROSS)

(Three pairs – Anterior, Lateral and Posterior)





Intra – Abdominal Pressure (IAP):- Any Increase in Intra Abdominal Pressure tends to antevert the uterus futher which impinges on P.S., and prevents descent (See Diagram)



ETIOLOGY OF PROLAPSE

1) Congenital
2) Traumatic – Obstetric Operative
3) Post meno Pausal
4) Chronic Bronchial Asthma
   Tuberculosis
   Constipation
5) Ovarian Tumours, Fibroid Uterus.

DIFFERENTIAL DIAGNOSIS

1) Cystocele, anterior vaginal cysts.
2) Cervical Polyp
3) Inversion uterus
4) Congenital elegation of cervix

SURGICAL TREATMENT

Aim of the Operation is: 1) Preservation of menstrual function.; 2) Preservation of child bearing function; 3) Preservation of sexual function; 4) Relief of symptoms – dragging pain, back ache, uneasiness on walking, dyspareunia; 5) To reposition the uterus in its normal place.

Various sling operations

1) Sacral Hysteropexy (Arthur and Sauage,1957)[3]
2) Posterior Abdominal Cervicopexy (Shirodkar, 1959)[4]
3) Abdominal Sling Operation (Purandare 1966, Chaudhuri 1983)[2,5]
4) Modified Manchester Operation (Currie 1952)
5) Vaginal Sling Operations (Shirodkar, 1959, Chaudhuri, 1979)[4,5]
6) Khanna's Sling Operation.

OPERATIVE PROCEDURE OF SRINIVASAN'S SLING

TECHNIQUE

Steps of Operation

1. Sub – umbilical midline incision.
2. Peritoneal cavity opened
3. General inspection of the pelvis
4. Both round ligaments held with straight artery forceps applied at its medial end
5. U.V. Fold opened – *Photo 2*.
6. Isthmus identified
7. A'Z' shaped stitch applied over the isthmus with No. '1' Black silk with the ends left long – *Photo 3*
8. The ends brought extra peritoneal lateral to the bladder and brought out on either side of medline – *Photo 4*
9. U.V. Fold sutured with 1 'O' chromic catgut *Photo 5*
10. Round ligaments plicate with silk.
11. General peritoneum sutured with 1 'O' chromic catgut.
12. The ends of the silk thread are brought in front of anterior rectus sheath lateral to rectus muscle. *Photo 6*
13. Rectus sheath sutured with No. '1' chromic catgut – *Photo 7*
14. Tension applied to both ends of silk thread till the cervix recedes above the ischial spines and the silk thread is anchored to rectus sheath – on either side of mid line – *Photo 8*
15. Cervix recede into its normal position – *Photo 9*
16. Skin sutured with interrupted sutures using thread.



Fig 1a: Nulli parous prolapse- showing CX outside introitus



Fig 1a: Nulli parous prolapse- showing CX outside introitus



Fig.2:Laparotomy showing uterus opening of utero- vesicle peritoneum



Fig.3: Showing isthmus- "Z" Stitch applied with long ends



Fig.4: Bringing the ends of the sutures extra peritoneally lateral to the rectus sheath 21/2 above public symphysis



Fig.5: Closure of Utero- Uesicle Peritoneum



Fig.6: Bringing the ends of the sutures extra peritoneally lateral to the rectus sheath 21/2 above public symphysis



Fig.7: Closure of rectus sheath