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Modifications and innovations in mc indoe vaginoplasty for better outcomes

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Abstract

Vaginal agenesis is one of the most common female genital disorders. It may be an isolated problem or part of a syndrome. Apart from congenital causes, there are many other indications for vaginal reconstruction.

Diagnosed late and having complex psychological issues, the reconstruction to provide a normal functioning vagina is a challenge. Although numerous techniques are described, there appears to be no consensus on which is the ideal one. Nor is there one opinion on when the reconstruction should be taken up. The McIndoe technique has been used over the ages with success. Many modifications have been described. The present paper describes some modifications with which better results can be achieved consistently with this technique.

Introduction: Creating a functional neo vagina is a challenge, the aim being to provide a vagina of an appropriate length, adequate caliber and with aesthetic acceptance. There are several non surgical and surgical techniques described in literature. The very fact that there are so many described techniques attests to the fact that no single technique is the perfect answer to this complex problem.

The timing of surgery depends on the patient's anatomic configuration and on the presence or absence of functional endometrial tissue. Opinion varies as to when this correction should be taken up.

Aims and objectives: The aim of this article is to present these adaptations and modifications to the McIndoe Vaginoplasty to simplify the procedure so that we can achieve consistently acceptable results.

The important steps include: Creating an adequate space for the neo vagina. | Decreasing the possibility of injury to the bladder and rectum. | Achieving haemostasis to ensure proper resurfacing. | Use of amnion to avoid donor site morbidity. | Using a suitable and easily available mould post operatively and ensuring the stability of graft when the mould is changed for dressing. | Providing sensation at the proximal part of the neo vagina.

Material and methods: This study has been undertaken in 11 cases of vaginal reconstructions from 2005 to 2012 with an average follow up of 5-8 years. All the cases selected were of primary agenesis where no procedure had been tried earlier. None of these patients had functioning endometrial tissue or a normal uterus.

The surgery was done in two stages.

Stage I: Creating a space for the neo vagina. | **Stage II:** Insertion of mould with amniotic membrane graft.

The mould was removed on the fourth day with thighs in abduction and by cutting the labial stitches, softly pulling out the roll gauze followed by the condom and paraffin gauze. In cases where foam splint was used, it was deflated with negative pressure to help in change/removal.

Discussion: Vaginoplasty is considered as the major therapeutic strategy for these patients. The main reason for the creation of a neo vagina in is to make sexual intercourse possible for these patients. Ideally, the creation of a neo vagina should be simple, safe, and most importantly, should allow for satisfactory sexual intercourse. In some cases with a normal uterus it might even be possible to have a child.

The McIndoe technique was first described in 1938 by Bainster and McIndoe. Despite the existence of several alternative methods, there is still no consensus regarding the best option for surgical correction. As with the majority of surgical procedures, the first operation is likely to be the most successful. In a fresh case it is relatively easy to create a proper space and maintain it post operatively with a cooperative patient.

There are limitations in our study. First is the relatively small sample size and the other is the absence of a control group. However, all the included cases are consecutively and contemporarily collected. Second no study was done about the flora of the neo vaginal micro ecology after vaginoplasty. Thirdly no histo pathological samples were taken from the neo vagina for analysis.

Results: A successful surgical intervention is creating a new vagina with adequate length that is functional and sensitive, but not limited only to the length and dimensions. Therefore, successful metaplasia in the membrane also plays an important role in the sensitivity and elasticity of the newly created vagina. The final results were excellent in all the cases with complete graft take, satisfactory dimensions of the neovagina and no stenosis or fistulas.

Biography

Chanjiv Singh Mehta has completed his MCh (Plastic Surgery) in 1991. He has worked for short periods with masters in the field in new delhi, mumbai, agra, trichur, paris, basel, groningen, stoubridge etc. He has numerous publications and he is a reviewer for many journals and on the editorial board of the journal of Punjab chapter of ASI. He is into humanitarian work since long. He is the chair of humanitarian sub-committee of IPRAS, President of MSF-South Asia and director of MSF India. He has worked and organized numerous free camps with international and regional NGOs. He also runs an NGO where the target is women and children receiving treatment and education.

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