# THIRD DEGREE UTEROVAGINAL PROLAPSE WITH COMPLETE PERINEAL TEAR

## (A Case Report)

by

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Uterovaginal prolapse with complete perineal tear occurs only infrequently. Authorities like Wilfred Shaw believe that it is almost unknown. He explains that with complete perineal tear, the patient exercises her levator ani muscles continuously and to an extreme degree in order to obtain sphincteric control over the rectum and this way tones up not only the pelvic floor but also the ligamentary supports in the pelvis. Hence, the prolapse in these cases does not occur. Same observation has been made by Jeffcoate and Masani.

*Supports of Uterovaginal Canal*

Main supports of uterovaginal canal are the levator ani muscles, the so-called ligaments which are bands of fibro-muscular tissue, and the endopelvic fascia which surrounds the pelvic organs. Levator ani consists of three parts, ilio-coccygeus, ischio-coccygeus and pubo-coccygeus. Pubo-coccygeus is the most important and this can be divided into pubo-coccygeus proper, pubo-rectalis and pubo-vaginalis. Pubo-coccygeus is inserted into the coccyx and the ano-coccygeal raphe. The pubo-rectalis forms a sling at the ano-rectal junction. Its fibres fuse with the fibres of the external sphincter on all sides of the rectum and thus act as voluntary control of defaecation. The pubo-vaginalis fibres decussate between vagina and rectum and take part in formation of perineal body along with other perineal muscles and the uro-genital diaphragm. It is generally believed that damage to the perineal body is one of the major factors in the causation of prolapse and this acts by widening the hiatus urogenitalis and makes the herniation easy. It is true that majority of cases of prolapse occur in multiparae conforming to the above belief, and yet it is a well-known fact that only rarely prolapse occurs in cases of complete perineal tear. A case with this combination was seen and treated by us and is reported here.

**Case Report**

Patient J.D., R. No. 1346, age 60 years, P 9 + 0, was admitted to the All-India In-

stitute of Medical Sciences Hospital on 29th August, 1959, with the history of a mass coming down per vaginam for last 43 years, since her first child-birth. It was small at first and used to disappear on lying down, but for the last 7-8 years it was constantly out. She was also suffering from urgency of micturition for 40 years, and, at times, she would pass urine on her way to the toilet. She also had occasional pain and burning during micturition. For the past 2 to 3 years she was having slight blood-stained discharge off and on after local trauma to the prolapsed mass.

On leading questions she gave a history of difficulty in controlling defaecation since her first child-birth, and used to have incontinence whenever she had diarrhoea.

She had nine full-term normal deliveries. Three children were alive and well and six died of various ailments in childhood. Her youngest child was 22 years old. She had menopause 22 years back—the periods did not return after her last delivery.

**On Examination**

She was short statured, rather obese and slightly pale. Her blood pressure was 120/80. Temperature was normal. Cardiovascular and respiratory systems were normal.

Examination of genitalia revealed a complete perineal tear with a third degree prolapse, a large cystocele and an enterocele. There was a small trophic ulcer about 1 cm. in diameter on the anterior lip of the cervix and the vaginal mucosa was healthy. On bimanual examination the uterus was found to be retroverted and small. No masses were felt in the fornices (Figs. 1, 2).

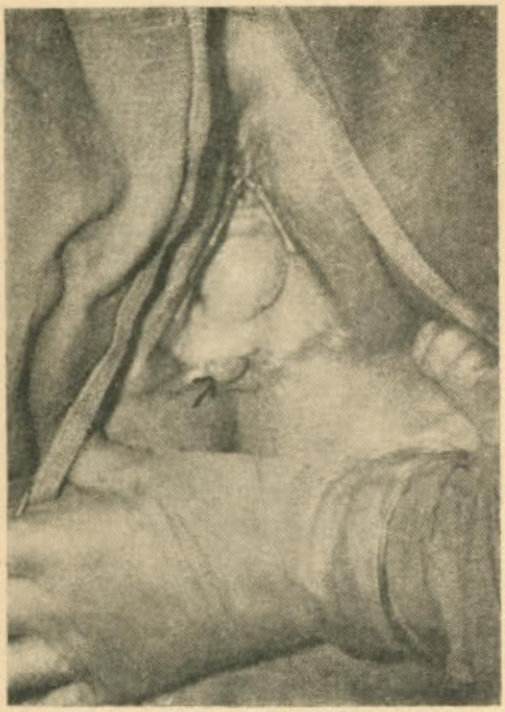

Fig. 1

Complete perineal tear. Prolapse has been reduced to show the tear. Prolapsed rectal mucosa can be seen.

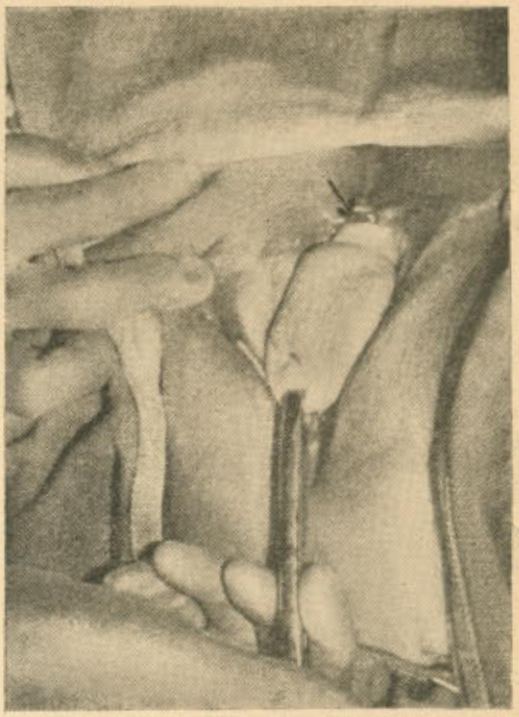

Fig. 2

Third degree prolapse of the cervix. Complete perineal tear is partly covered. Part of prolapsed rectal mucosa can be seen.

Following investigations were done:

Blood-Hb—11 gms. per 100 mils; R.B.Cs, 4.6 millions c.mm.; W.B.Cs. 4600 per c.mm.; Polymorph, 51%; Lymphocyte, 41%; Monocytes, 3%.

E.S.R., 63 mm. (Westergreen).

Stool: Nothing abnormal detected.

Urine: Reaction; acid. Sp. gravity, 1010. Albumin, nil. Sugar, nil. Bile salts, nil. Bile pigments, nil. Microscopic exam. Pus cells not found.

Serum proteins, 5.28 gms./100 mils. Albumin, 2.8 gms./100 mils. Globulin, 2.4 gms./100 mils.

Blood urea: 30 mgms./100 mils. Fasting blood sugar: 75 mgms./100 mils. Chest X-ray: no intra-thoracic lesion seen.

Pre-operatively the patient was given high protein diet, multi-vitamins, iron and bed rest. In a few days the cervical trophic ulcer healed and her general condition improved. She was operated on 10th September, 1959. A modified Fothergill's operation and repair of the complete perineal tear was carried out.

**Procedure**

The bladder was dissected off the cervix as in Fothergill's technique. The pouch of Douglas was opened, the enterocele sac was excised and closed with a purse string suture and the uterosacral ligaments were approximated. Cervix was amputated and reconstructed and the vaginal mucosa repaired as usual. Repair of the complete perineal tear was then carried out as described by Bonney. Post-operatively she was given strepto-penicillin, half gram streptomycin and 4 lacs procaine penicillin, daily and was given low residue diet. She developed allergic rash on the fifth post-operative day, so the strepto-penicillin was discontinued. As low grade pyrexia persisted, she was put on achromycin 250 mgms. 4 hourly which was given for five days. She was originally put on prophylactic strepto-penicillin post-operatively, in view of the fact that her peritoneal cavity was opened in the repair of the enterocele, in the presence of the complete perineal tear.

She had diarrhoea on the fourth post-operative day and this gradually subsided in a week's time. Stool examination was negative.

Post-operative result was good and her sphincter tone was good.

She was seen three months after the operation and was doing well. The control of defaecation was satisfactory. She no longer had urgency of micturition.

*Comments*

It is interesting to note that patient had prolapse for 43 years which started at the same time as the complete perineal tear, though it was aggravated by menopause. Urinary symptoms were present for nearly 40 years. It is wonderful and yet typical of patients like her who continue with their disabilities for so long without seeking medical aid, and come only when the trouble is progressively increasing.

In view of her age and low general health a minimum operative procedure, compatible with good function, was desirable, hence modified Fothergill with repair of enterocele and repair of complete perineal tear was performed. In spite of the diarrhoea, the ultimate result was good.

This case is recorded in view of the scarcity of such case records in literature.

*Summary*

1. A rare case of third degree prolapse with complete perineal tear is reported.

2. The treatment given is described.

3. The literature is reviewed and impressions of some authorities on the subject are given.

*Acknowledgments*

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