

GENITAL PROLAPSE WITH PREGNANCY*

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Introduction

Prolapse of uterus during pregnancy is encountered in India far more often than in the western countries. This is because in our vast countryside the doctor or midwife is not available and the deliveries are conducted by untrained dais. Prophylactic forceps deliveries, timely episiotomies, delivering cases of malpresentations and cephalopelvic disproportion by caesarean section and avoiding difficult and traumatic vaginal deliveries, timely repair of perineal and cervical tears, postnatal exercises, all these have reduced the incidence of prolapse following deliveries in advanced countries. In India women do not get their prolapse corrected by surgical repair after delivery and hence come with this complication during pregnancy far more often.

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Incidence

During the period of six years between 1959 and 1964, there were 16,409 viable confinements at the K.E.M. Hospital, Bombay. In 30 cases the pregnancy was complicated by genital prolapse. This gives an incidence of 0.18%. The largest series ever presented is by Naidu (1961), from Hyderabad, who reports 8 cases among 8,000 deliveries. In the United States this complication is very rare—1:10,000 as given by Vigilante and Bohringer (1956).

The higher incidence in our series may be explained by the larger area that is drained by our hospital, also in our country the majority of deliveries especially in the rural area are conducted by untrained dais.

Age and parity

Considering the age of the patients, 76% were in the age group between 25 to 34; 10% were between 20 and 24 years of age and 14% were of 35 years and above.

Although prolapse of uterus in nulliparous women is a well known entity all cases in this study were in

parous group and none was nulliparous.

Past obstetric career

Out of 30 cases in the present series, 9 patients had abnormal labour or obstetric intervention in the form of forceps or caesarean section; in the remaining 21 cases, who had full-term normal deliveries, prolonged labours resulting in stretching of the tissues might have probably led to the genital prolapse.

Previous repair

Five patients had undergone previous Fothergill's repair, two had previous cervicopexy operations, two had colpoperineorrhaphy and one patient had Shirodkar's modification of Fothergill's operation. These patients had recurrence of prolapse during pregnancy in spite of previous repair operations.

Type and degree of prolapse

These cases of prolapse are classified according to Malpas. This classification is not very satisfactory but there is none better than this. There were 15 cases having second degree and 13 patients had third degree uterovaginal prolapse. In 2 cases there was cystocele, rectocele, enterocele as well as descent of uterus, the cervix being outside the introitus but fundus of uterus still within the pelvis.

Complications during pregnancy and labour

Two patients had prolapse from 32 weeks of pregnancy which was treated conservatively by head low and bed rest.

During labour two patients had oedematous hypertrophic anterior lip which could be pushed over the presenting part. One more patient had transverse lie with cervical dystocia for which lower segment caesarean section was done.

Four babies were lost; 3 due to prematurity, their weights being below 1.2 kg.; one died of asphyxia neonatorum two hours after birth, its weight was 3 kg.

Discussion

In our series the number of cases encountered is more than reported by other authors. This can be explained by the vast majority of deliveries being conducted by untrained dais, where timely episiotomies are not resorted to, and immediate repair of tears not done. These untrained village midwives subject the women to intense bearing down before full dilatation of cervix in the squatting posture. This causes weakness or lengthening of parametrial connective tissue supports. Another factor leading to prolapse uterus is unscientific method of ironing out of the perineum. This method not only enlarges the introitus but also leads to wide separation of levatores ani, while preserving the skin intact, and to permanent weakness of the pelvic floor. This starts prolapse in the puerperium when the pelvic floor is formed mainly by weakened levatores ani and parametrial connective tissue supporting the cervix is weakened. Early resumption of household and manual work by these hospital class of patients act as secondary causes.

During pregnancy the following complications are likely to occur.

The prolapsed cervix is likely to get infected. This infection may reach the uterine cavity and cause abortion.

When there is prolapse with cystocele, retention of urine may develop, although we did not have such a case. Under such conditions the bladder has to be catheterised first followed by reduction of prolapse. Then the patient is given a head low position with rubber ring pessary of appropriate size to support the uterus. The pessary is kept till the sixth month of pregnancy. Later the pelvic brim supports the weight of the gravid uterus. Incompetent os can occur in prolapse uterus with pregnancy but usually it is due to Fothergill's operation with amputation of cervix done for the repair.

Past obstetric history gives an important clue to the aetiology of prolapse. Breech delivery conducted by an untrained person results frequently in the death of a perfectly normal full-term baby, while pulling such a baby through an incompletely dilated cervix will cause weakening of paracervical ligaments. Forceps and caesarean section are not likely to cause future development of prolapse. If undertaken at proper time low forceps operation can act as prophylaxis against prolapse. But application of forceps prior to full dilatation of cervix can cause cervical tears and ligamental weakness.

We had 21 cases who had normal deliveries in the past. Many of them were delivered at home and some in hospitals. The details of the duration of the first stage and especially the second stage were not known except that average sized babies were deli-

vered normally. It would have been interesting to know these points because undue prolongation of the second stage, which could have been cut short by easy low forceps operation, may result in weakening of the pelvic supports.

Management of patients during pregnancy was bed rest with foot end raised and introduction of glycerine acriflavin tampons after reducing prolapse. Though it is said that descent of the gravid uterus is uncommon after the 4th month of pregnancy we have seen two cases which came with utero-vaginal prolapse of the third degree in the seventh month of pregnancy.

Ideally one should hospitalise such patients till term but it is not practicable.

During active labour the line of treatment was reduction of prolapse, if possible, and keeping a close watch on the foetal heart and the progress of labour.

In the two cases where hypertrophic anterior lip was encountered, we were able to slip it easily over the presenting part.

During labour the most difficult part is cervical dilatation. If the cervix dilates rapidly the delivery is uneventful. If the cervix refuses to dilate, then there is danger of uterine rupture because of strong uterine contractions. The only way to avoid this is Dührssen's lateral cervical incisions. Fortunately we had not to resort to these in our cases.

Only one case underwent a lower segment caesarean section, indication being cervical dystocia with transverse lie.

Summary

(1) Incidence of prolapse with pregnancy is high in our series, i.e., 1:547.

(2) The type and degree of prolapse and foetal outcome are analysed.

(3) The management and complications are discussed.

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