GENITAL PROLAPSE IN THE NEW-BORN

(Case report)

by

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Complete prolapse of the uterus at birth is a rare anomaly. Ballantyne (1902), recorded twelve such cases. He observed that true congenital prolapse of uterus was associated with lumbo-sacral spina bifida. Since then Findley (1917), Noyes (1927), and others described the condition. Fraser (1961), and Cottom and Williams (1965), described cases of congenital prolapse that occurred in breech presentation with prolonged labour, which made complete recovery after replacement of the prolapsed uterus. In India, Momin (1958) reported a case of procidentia with other multiple anomalies. The following case is presented because of its association with an obstructed labour in a breech presentation and in addition the baby had other congenital anomalies.

Case Report

Mrs. S. V. K., gravida 2, was admitted as an emergency case in the labour wards of Sassoon General Hospitals, Poona, on 15th Dec. 1966 at 12.30 p.m. Patient gave history of forty weeks of amenorrhoea and was in labour for nine hours. Breech had come out four hours prior to admission and as there was no further progress she was brought to the hospital. She had one full-term normal delivery five years ago.

On examination, the general condition of the patient was fair, temperature was normal, pulse was 90 per minute with good volume and tension. Blood pressure was 110/70 mm of Hg. Cardiovascular and respiratory systems were normal. Abdominal examination showed that the uterus was about 28 weeks' size and it was contracting and relaxing but the lower segment was markedly stretched. On palpation, the head was found to be very big and occupying the entire uterus. Except the head the rest of the body of the baby was found lying outside the vulva. There was a meningocele and a congested oedematous mass was found protruding from the baby's vulva. Vaginal examination revealed a tight cervical rim all round the baby's neck. Head was felt very high up at the brim and was fund to be markedly enlarged. Diagnosis of obstructed labour due to hydrocephalus was made. Tapping of cerebrospinal fluid was tried through the meningocele to reduce the size of the head but it failed. So under general anaesthesia craniotomy of the aftercoming head was done and the baby delivered. Post-operative period was uneventful.

Description of the baby: The baby weighed 2800 gms and showed the following anomalies:

1. Hydrocephalus.
2. Spina bifida with meningocele and
3. Prolapse of the cervix with the uterus.

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Discussion

True congenital prolapse is a rare condition occurring at birth. According to Findley (1917) it may not be apparent at birth in all cases, but becomes obvious during the first few weeks of life.

Ever since Ballantyne's observations of its association with lumbosacral spina bifida occulta, it was believed that spina bifida is the most important aetiological factor. In 9 out of 12 cases reported by Ballantyne and 86% of cases in Findley's series the condition was associated with spina bifida. Noyes (1927) reviewed 24 cases from the literature and showed the importance of spina bifida as an aetiological factor. He stressed that this condition occurs especially when the lower sacral nerve roots are drawn through the lumbar vertebral defect to produce a partial or complete paralysis and weakness of the muscles of pelvic floor and the supporting tissue.

Recent studies have shown that there is no relationship between spina bifida and prolapse. Controlled observations showed that the incidence of spina bifida is as high as in women with prolapse as those without it (Jeffcoate 1962).

Ballantyne suggested that the narrowness of false pelvis, enlargement of pelvic inlet and outlet and defective development of connective tissue of the pelvis are other contributory factors in cases of prolapse, not associated with spina bifida.

Frazer (1961) suggested that the primary cause might be the raised intra-abdominal pressure. In the case described by him the baby was presenting by breech and as the labour was prolonged and the baby showed signs of intra-uterine distress, the patient was delivered by caesarean section. During the operation there was difficulty in freeing the baby from a tight constriction ring. A congested oedematous mass protruded from the baby's vulva. As the mass appeared to become more congested, and the baby appeared increasingly shocked, the mass was replaced digitally. There was no evidence of spina bifida and there was no recurrence after replacement. Had congenital tissue weakness been an important aetiological factor in this case, one would expect a recurrence with the strain of crying and defaecation. Even in the case described by Cottom and Williams the prolapse was present in a case of breech presentation with prolonged labour who was delivered by caesarean section. There was no evidence of an associated lesion and the baby made an apparently complete recovery after replacement of the prolapsed uterus.

Malpas (1955), classified the causes of prolapse into two groups—(a) *Primary*—congenital tissue weakness and obstetric trauma and (b) *Secondary*—raised intra-abdominal pressure. It is possible that both these factors operated in the case we have described above. Not only the baby had spina bifida associated with meningocele, but also the case was one of breech presentation with prolonged and obstructed labour. So, raised intra-abdominal pressure due to abnormal uterine action might have also precipitated prolapse of uterus and cervix in association with spina bifida.

It is important to recognise this anomaly and replace it. It may cause considerable difficulty in diagnosis. Hydrocolpos and neoplasms like sarcoma botryoides may simulate it. In Cottom and William's case the prolapse was associated with ureteric obstruction and azotemia.

The association of hydrocephalus with spina bifida and meningocele and congenital prolapse makes this case more interesting. Failure to tap cerebrospinal fluid through meningocele is probably due to non-communication between the two and so craniotomy had to be done to effect the delivery of the aftercoming head.

Summary

1. A case of procidentia associated with hydrocephalus, spina bifida and meningocele is reported.

2. Baby presented as breech and there was obstructed labour because of hydrocephalus and the delivery was effected by craniotomy.

3. It is possible that the procidentia in this case was due to both congenital weakness of the pelvic floor as a result of spina bifida and also to raised intra-abdominal pressure due to prolonged obstructed labour with a breech presentation.

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