OBSERVATION ON BIRTH OF A FOETUS IN A CASE OF PROCIDENTIA

by

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Coexistence of genital prolapse with pregnancy is not an uncommon clinical entity. From time to time such cases are reported but a good number remain unnoticed. In India, incidence of genital prolapse is higher as a result of poorer antenatal, natal and postnatal care.

Review of literature has revealed mention of more thn 200 cases of this entity. Kibel in 1944 gave a resume of 170 cases reported in literature till then and incidence in his series was 1:15676, whereas Kaettal (1941) mentioned an incidence of 1:13000. Later reports on one to five cases observed by Klawans and Kantar (1949), Israel and Waber (1950), Yellen and McNeil (1954) and London (1954) have appeared in the literature.

Genital prolapse as such causes relative infertility in women due to obvious reasons. As the prolapse advances it becomes more and more difficult for a woman to conceive and even if she conceives, to have an uneventful childbirth. Vigilante and Behringer (1956) have stated, "Case of procidentia in which the entire uterus is outside the vulva, has never been reported, nor can it seem possible that this condition might eventuate a normal birth." However, Naidu (1961) from India, described 8 cases of genital prolapse with pregnancy and has mentioned a case of procidentia associated with pregnancy in this series. The patient had a spontaneous abortion at 5 months. The incidence in her series (1 in 1000) was more than ten times the frequency in western countries.

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Case Report

A. D., 40 years old married housewife, para 2, gravida 3, came to the gynaecology out patient department of All India Institute of Medical Sciences Hospital on 24th November 1969 with a history of a mass coming out per vaginam for the past 15 years and amenorrhoea for 4 months. For one month she had symptoms of pain in the mass, backache, frequency of micturition, pain and difficulty in micturition and defaecation. From the beginning of this pregnancy she noticed a sudden increase in the size of the mass which became irreducible. This caused difficulty in sitting and walking.

Menstrual History—Menarche at the age of 14 years. Periods were regular with cycles of 26-28 days and moderate flow lasting for 4-5 days. Her last menstrual period was in July 1969. There was no history of vaginal discharge.

Obstetric History—She had two full term normal deliveries conducted at home by a midwife. Last childbirth was 18 years ago.

Examination—General physical and systemic examination revealed nothing abnormal except moderate anaemia. Uterus was not palpable per abdomen. On pelvic examination a large mass was seen outside the vulva. Cervix could be recognized with

some difficulty as it was markedly hypertrophied and the overlying mucosa was oedematous with areas of ulceration (Fig. 1). Anus was stretched and was transverse. Skin around it was oedematous. Uterus, outside the introitus. The circumference of the mass was 39 cm. and the external os was 20 cms. outside the introitus. Foetal movements could be felt on palpation.

Blood examination showed haemoglobin 6.2 gm% and P.C.V. 19% and blood urea 39 mgm%. Urine examination showed no albumin, sugar or pus cells.

X-ray chest was normal. X-ray of the mass outside the introitus revealed foetus of 16 weeks gestation lying entirely outside the vulva (Fig. 2). I.V.P. was done but bladder, ureters or kidneys could not be visualised.

Treatment—The foot end of the bed was elevated. Local application of glycerine magnesium sulphate solution was repeated four hourly. As she was anaemic, 350 ml. of cross matched blood transfusior. was administered. Some improvement in her general as well as local condition occurred, oedema subsided but the mass remained irreducible. The pain did not subside, hence it was decided to terminate the pregnancy. On 1st December 1969, 20 ml. of glycerine acriflavine (1:10000) was introduced into the uterine cavity with a rubber catheter. On 2nd December glycerine acriflavine instillation was repeated in the same way. After 6 hours of this instillation, patient started having labour like pains with slight bleeding from the external os. No uterine contractions were felt. However, external os appeared to be slightly dilated (Fig. 3). At that stage it was decided to accelerate the process of dilatation with Syntocinon drip. Intravenous infusion of 5% glucose with 5 units of Syntocinon was started. Uterine contractions were not visible but they could be just felt on palpation. However, progressive dilatation of cervix could be observed till there was cord prolapse after 4 hours. Within next half hour, the foetus was expelled followed by the placenta without any difficulty (Fig. 4). There was immediate relief in her pain and reduction in dimensions of the mass (Fig. 5) the circumference of the mass reduced to 30 cm. She had no postabortal complication. The procidentia was 20 cm. in circumference 14 days after the abortion. She was discharged from the hospital on 15th December 1969, with an advise to come for surgical treatment for procidentia.

Discussion

Incidence of prolapse with pregnancy in India is more than ten times the incidence reported from western countries. This may be attributed to multiparity, malnutrition and inadequate obstetric care. Many women suffering from genital prolapse do not get any treatment till there is some complication. Pregnancy with prolapse may be associated with many possible complications e.g. acute retention of urine, abortion, infection and cervical dystocia.

As far as treatment is concerned, minor degrees of uterovaginal prolapse with pregnancy are given conservative treatment. Prolapse is reduced and pessary may be put in. The patient may go to term and have an uneventful delivery.

In cases where pregnancy is associated with procidentia, it may not be possible to reduce the entire prolapsed gravid uterus. In such a situation it is very unlikely that pregnancy would go to term. In this case, the cervix was markedly oedematous and before deciding on the method of induction of abortion, it was decided to introduce glycerine acriflavine (1:10000) in the uterus to reduce the oedema. As the pregnant uterus was entirely outside the introitus, serial observations could be very easily made. The oedema of the cervix was seen to be gradually decreasing and later on the cervix dilated. After two instillations of intrauterine glycerine, syntocinon drip was started (5 units in 5% glucose). In 10 hours she aborted. The foetus and placenta were expelled complete. Careful selection of method of induction was re-

sponsible for uneventful termination of pregnancy and recovery.

How long the pregnancy would have continued had it not been interrupted is difficult to ascertain.

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See Figs. on Art Paper IV-V