REVIEW OF 30 CASES OF GENITAL PROLAPSE ASSOCIATED WITH PREGNANCY

by

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Co-existence of genital prolapse with pregnancy is not an uncommon clinical entity. From time to time such cases are reported. In India, incidence of genital prolapse is higher as a result of poor antenatal, natal and post natal cares.

Material and Methods

For the present study 30 cases of genital prolapse were selected during 3 years' period from the indoor of U.I.S.E. Maternity Hospital, Kanpur. During this period there were 5512 deliveries giving an incidence of 1: 183.

Besides these, reports on 1-5 cases observed by Klawans and Kantar (1949), Israel and Waber (1950), Yellen and McNeill (1954), and London *et al*, 1954 have appeared in the literature.

Salient features

All the 30 cases had genital prolapse before conception, but in 2 cases it was exaggerated during pregnancy.

Four patients were between 20-25 years of age, 12 were between 26-30 years of age and 14 were above 30 years of age. One case was nullipara and 29 were parous and parity varied between 1-12, but the majority were para 4 and 5.

There was no suggestive history in 24 cases, 2 gave the history of prolonged labour, 3 gave the history of difficult forceps delivery and 1 had congenital elongation of cervix, but all these 29 cases developed genital prolapse after the confinement. Twenty patients were having the genital prolapse for the last

TABLE I

Incidence of Genital Prolapse as Reported by Various Authors

Authors	Fear	Total No. of deliveries	No. of patients	Incidence
Keetal	1941	—	170	1:13000
Kibel	1944	—	170	1:15676
Fellen & McNeill	1954	—	—	1:10000
Vigilanta & Bohvinger	1956	—	—	1:10000
Naidu P	1961	8000	8	1:1000
Dhurandhar	1964	16409	30	1:541
Kunders	1967	9343	9	1:1038
Present series	1970-1972	5512	30	1:183

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3-6 years, while 10 patients developed it within last three years.

Thirteen patients came to the hospital for the first time during the 2nd trimester of pregnancy, 2 among them came with retention of urine which was relieved with catheterization and rest in bed. Piver *et al,* (1968) came across 3 cases of retention of urine among 33 cases of uterine prolapse. Kunders (1967) has reported 2 cases among 17, Dhurandhar had not a single case among his 30 cases. Twelve patients came to the antenatal clinic at full term, 4 came in labour and 1 patient came with rupture of uterus due to non-dilatation of cervix.

Complications

Abortion and Premature Labour

In the present study there were 2 cases of abortion and 1 of premature labour. The abortion figure is slightly higher than the figures reported by Kunders (1967) and Dhurandhar *et al* (1967) while premature labour is slightly on the lower side.

Third Stage Complications

There was no case of postpartum haemorrhage or cervical tear, but one case had retained placenta. Piver *et al* (1968) reported 7 cases of cervical tear and 1 case of retained placenta among 33 cases.

Sepsis

In the present study there were 4 cases of sepsis. Three cases were in labour for 16-24 hours, while 1 case was in labour for 30-36 hours. Among the 3 cases, in 2 caesarean section was performed for

TABLE II

Nature of Confinement, its Relation of Labour, the Associated Maternal Complications and the Foetal Outcome

Nature of delivery	No. of cases	Duration of labour in Hours	Type of prolapse: IInd degree	Type of prolapse: IIIrd degree	Retention of urine	APH	Retained placenta	Sepsis	Abortion	Live baby	Still birth	Neonatal death
Spontaneous (FT)	16	8–12	1	15	–	–	1	–	–	16	–	–
Spontaneous premature	1	16–24	–	1	–	–	–	–	–	1	–	–
Forceps delivery (FT)	6	16–24	2	4	–	1	–	1	–	6	–	–
Caesarean section (FT)	4	16–24	1	3.	–	–	–	2	–	3	–	1
Hysterectomy (Rupture uterus at term)	1	30–36	–	1	–	–	–	1	–	–	1	–
Abortion	2	—	–	2	2	–	–	–	2	–	–	–

obstructed labour and in 1 forceps was applied for uterine inertia. One case who developed sepsis was in labour for 30-36 hours and came with rupture uterus; hysterectomy was performed on her. Piver *et al* (1968) reported 1 case of sepsis, while Kunders (1967) and Dhurandhar *et al* (1967) did not observe gross sepsis even in single case. Keetal (1941) has reported a maternal death in a review of 170 cases. In the present series, there was 1 maternal death due to pulmonary embolism in a case of rupture uterus

Foetal Outcome

In the present series there was 1 stillbirth and 1 neonatal death.

Duration of Labour and Confinement

Except 16 cases of spontaneous labour and 2 abortions, the duration of labour was prolonged in 11 cases for 16-24 hours. Thirteen cases among the 16 were admitted in the hospital during the second trimester of pregnancy and were treated on bed rest and reduction of prolapse by tampon soaked with acriflavin glycerine for a variable period of time and then ring pessary was inserted till the cervix receded back in the vagina. Twelve cases came to the antenatal clinic at full term and were hospitalized and above treatment was given except the ring pessary. Four patients came in labour with signs of obstructed labour and cervical dystocia on whom caesarean section was performed. One case came with rupture uterus with signs of shock and collapse.

Of the 17 cases reported by Kunders (1967) 7 had spontaneous vaginal delivery at term and in 2 of them the prolapse was reduced as late as 2 weeks before the onset of labour. Klawson and Kanter have reported 4 cases treated with pessary and bed rest in early pregnancy. All these cases delivered spontaneously. There is no doubt about the beneficial effect of bed rest and replacement of the cervix in early pregnancy. Piver *et al* (1968) reported 1 case of caesarean section due to obstructed labour. Cervical dystocia is another indication for caesarean section (Dhurandhar *et al*, 1967).

Discussion

Incidence of prolapse with pregnancy in India is more common than 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 like retention of urine, abortion, infection and cervical dystocia.

As far as treatment is concerned cases of uterovaginal prolapse with pregnancy are given conservative line of treatment. Prolapse is reduced and pessary may be put in. The patient may go to term and have spontaneous delivery. The usual advice which was given to the patients was rest in bed with the foot end of bed elevated to reduce the oedema and to facilitate its replacement. The reduction was further maintained by acriflavin glycerine tampon till the prolapse was reduced and then pessary was inserted till the pregnancy advanced and the cervix receded within the vaginal canal. Moir (1964) has suggested a simple form of a mere closure of the vaginal intriotus by suturing the labia majora leaving a small space for drainage. He experienced

no difficulty in reopening the intriotus at the time of delivery. The replacement of cervix is very important from the point of view of complications of labour as tardy dilatation of cervix which leads to prolonged labour with associated risks of maternal exhaustion, premature rupture of membranes, intrauterine sepsis, intrauterine foetal death and rarely maternal death. Spontaneous vaginal delivery is the usual outcome. At times, caesarean section may be a safe procedure when the head remains high and signs of obstructed labour supervene.

Prolapse associated with pregnancy exposes the woman to additional risks, hence prevention is very important as far as possible. The most important contributory factor is multiparity which must be controlled by proper family planning methods. Early ambulation during puerperium, high protein diet and perineal exercises are very important.

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