PREGNANCY ASSOCIATED WITH UTERINE PROLAPSE

(A review of 22 cases admitted in labour)

by

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Pregnancy happens to occur in women with uterine prolapse, but the association is not so common because uterine prolapse is an obstacle for impregnation to some extent and partly because spontaneous rectification occurs with advancing pregnancy, the uterus rising above the pelvic brim, drags the prolapsed and hypertrophied cervix along with it. Still it is much more commoner in developing countries than developed countries. When pregnancy does occur, complications like abortions, premature delivery, cervical injury are frequently met with. Prolonged labour and interferences may also give rise to intrauterine sepsis leading to maternal and foetal morbidity and mortality.

Material and Methods

Twenty-two cases of pregnancies associated with uterine prolapse were managed in Eden Hospital over a period of one and a half year period from November 1977 to April 1979 among 12,504 confinements.

Analysis

The incidence was 1 in 550 approximately amongst total confinements. Western workers (Keettel, 1941; Piver and Spezia, 1968; Yellen and McNeill 1954; Vigilante and Bohringer, 1956) reported the incidences as 1 in 10,000 to 1 in 13,000 pregnancies, whereas Indian workers (Sen *et al* 1973; Palanichamy, 1976; Naidu, 1961; Dhurandhar *et al* 1967, Kunders, 1967; Kawathekar and Lal, 1973) reported the incidences in between 1 in 102 to 1 in 1038. This shows that pregnancy associated with uterine prolapse is commoner in India. This might be due to malnutrition and multiparity in quick successions. Racial and environmental factors might have some part to play.

Age and Parity

Four were below 20 years, 10 were in between 20 to 30 years, 7 were in between 30-40 years, and 1 was above 40 years. One was a nullipara, 7 were para 1, 9 were para 2 to 4 and 5 were para 5 or above. The highest parity observed was a para 10.

Past History

Eight of these patients gave history of difficulty during their earlier childbirths.

Duration of prolapse

Two were suffering from congenital prolapse, 2 were suffering from this discomfort for last 2 years, 3 were suffering

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from last 3 years and 15 had prolapse in between 3 to 6 years.

Degree of Prolapse

Nine had first degree and 13 second degree of uterine prolapse.

Duration of Pregnancy

Two came with pregnancy below 16 weeks, where spontaneous abortions occurred, 1 at 17th week for M.T.P., and one came at 32 weeks and had premature delivery, remaining 18 came in labour at term.

Duration of Labour

Besides 2 cases of abortions and 1 case of M.T.P. the duration of labour varied in between 8 to 36 hours. In 6 cases it was more than 20 hours.

Complications

There were 2 abortions, 1 premature labour, 1 intrauterine foetal death in this series. This is in conformity with the incidences of abortions and premature labours reported by Kunders (1967), Dhurandhar *et al* (1967) and Kawathekar acd Lal (1973).

Venous obstruction and stasis leads to acute oedema of the protruding cervix. The mechanical trauma to the oedematous cervix causes ulceration and infection. These two factors are said to favour abortions and premature labours.

Oedema of cervix was present in 8 cases in this series, erosion in 3 cases and decubitus ulcer in 2 cases. One case had retention of urine who was admitted twice, once at 26th week and again at 28th week and had to be catheterized. Piver and Spezia (1968) in a review of 33 cases came across 3 cases who had retention of urine, while Kunders (1967), Kawathekar and Lal (1973) came across 2 and 1 cases respectively. Thus urinary retention is not frequent in such cases and usually occurs in earlier months of pregnancy and can be managed by catheterisation.

Gross intrauterine sepsis was present in one case who was in labour for 36 hours and was handled outside before admission. L.U.C.S. wsa undertaken in this case due to obstructed labour for non-dilatation of cervix. The patient died of septicaemia. Piver and Spezia (1968) and Kawathekar and Lal (1973) reported 1 and 3 cases of uterine sepsis respectively, whereas Kunders (1967) and Dhurandhar *et al* (1967) did not observe gross sepsis in any of their cases. Sepsis resulting from prolonged labour and handling by untrained personnel is a dangerous complication and likely to lead to maternal and foetal death. Keettel (1941) reported 9 maternal deaths due to sepsis alone amongst 170 cases of uterine prolapse with pregnancy.

Nature of Confinements

There were 2 spontaneous abortions, I.M.T.P., 1 premature delivery, 1 spontaneous delivery of stillborn at term, 2 L.U.C.S. at term (1 case of congenital prolapse and another case of post caesarean pregnancy), 1 spontaneous delivery following Duhrssen's incision, forcep deliveries in 8 at term (one on aftercoming head of breech) and normal delivery at term in 6. In this series all the cases excepting that of abortions and M.T.P. were admitted in labour. If they were seen in earlier months of pregnancy or at least few days before labour the outcome might have been more favourable after reduction of cervix into the vaginal canal. In this series thus 8 spontaneous vaginal deliveries occurred amongst 22 cases; Kunders (1967) reported spontaneo vaginal deliveries in 7 out of 17 cas

Duhrssen's incision was employed in 1 case who had thick oedematous cervical rim and was in labour for more than 30 hours. This technique of calculated risk has been employed by other workers (Piver and spezia 1 in 33, Kunders 2 in 17, Kawathekar and Lal 4 in 13), yet its place appears to be controversial due to associated risk and haemorrhage, though in this series, no such complications occurred. Two L.U.C.S. were undertaken in this series, though need for sections rarely arises. Piver and Spezia (1968), and Kawathekar (1973) and Lal undertook L.U.C.S. for obstructed labour.

In this series cervical tear occurred in 1 following forcep delivery, adherent placenta was present in 1 and retained placenta with severe P.P.H. in 1 case. Piver and Spezia (1968) also came across all these complications.

Foetal Outcome and Maternal Mortality

Amongst 18 live births (excepting 2 abortions, 1 I.U.D., I.M.T.P.) amongst 22 cases, 3 died in the neonatal period, 1 due to prematurity and 2 due to neonatal asphyxia. Thus foetal loss was 6%. The neonatal death rate of this hospital during 1977 and 1978 were 3.9 and 4.7% (Konar 1978).

There was 1 maternal death, due to sepsis following section. Keettel (1941) reported the incidence as 5%.

Comments

Twenty-two cases of uterine prolapse associated with pregnancy are presented. In 8 of them earlier histories of difficult labours were present. Complications such as abortions, premature delieveries, retained placenta are said to be commoner in such cases, which was also noticed here. Though spontaneous delivery may occur but interferences are also necessary, as observed in the present series, Cervical oedema and obstructed labour are the indications for interference. When these patients were admitted in first stage of labour, they were allowed bed rest with plugging of vagina with roller gauze soaked in glycerine and acreflavine which helped in the dilatation of the cervix and diminished the cervical oedema. When there were maternal or foetal distress and the head was low down with the thin cervical lip over the head, forcep delivery or Duhressen's incision was undertaken. If the head was high with oedamatous tubular non-dilating cervix associated with premature rupture of membranes with or without foetal distress, L.U.C.S. was undertaken. In puerperium rest in bed till cervix recedes on involution was advised to all these patients. Though there was no case of early pregnancy in this series, yet they are usually advised had rest for few weeks. In such cases after 16 weeks, gravid uterus grows out of pelvis and pulls up the cervix.

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