GENITAL PROLAPSE ASSOCIATED WITH PREGNANCY

(An Appraisal of 40 Cases)

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Genital prolapse is one of the most frequent disorders met in our day to day practice. Our social and cultural background predisposes this condition to occur at an age and parity, earlier than that reported in Western Countries. Therefore, co-existence of genital prolapse with pregnancy is not an uncommon clinical entity especially in our country.

Material and Methods

Forty cases of pregnancy associated with genital prolapse were studied during 8 year period from January 1973 to December 1980, at T.N. Medical College and B.Y.L. Nair Ch. Hospital, Bombay 400 008, with special reference to incidence, clinical features, duration of pregnancy and labour, complications, foetal outcome etc.

Observations

Incidence: The incidence was 1 in 565 confinements. A comparison of the incidence of prolapse as reported by Western Authors (Kettle; 1941. Yellen and Macneill; 1954; Piver and Spezia, 1968) as 1 in 10,000 to 1 in 15,000 and that by Authors in India (Naidu 1461; Dhurandkar *et al* 1964; Mitra 1975). This difference shows that prolapse with pregnancy is not uncommon in India. This is due to poor socio-economic conditions, malnutrition unrestricted multiparity and inadequete obstetric care.

Age and Parity: As shown in Table I, the majority of the cases were in the age group of 31-40 (47%) and parity group of 3 and 7 (55%).

TABLE I

Age and Parity

Age in years	No. (%)	Parity	No. (%)
Less than 20	5(12.5)	Nullipara	2(5)
20-30	15(37.5)	1 & 2	8(20)
31-40	19(47.5)	3 & 4	22(55)
41 and above	1(2.5)	5 & above	8(20)
Total	40(100%)	Total	40(100%)

Past History: There was no suggestive history in 27 cases, 6 gave history of

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Accepted for publication on 15-4-81.

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prolonged labour, 5 gave history of difficult forceps delivery and 2 had congenital elongation of cervix.

Duration of Prolapse: Twenty-four were having the genital prolapse for last 4-6 years, 10 for last 2-4 years, 4 for last 2 years, and 2 had congenital enlogation of cervix. Except these 2 cases of congenital elongation of cervix, rest 38 had developed prolapse after at least one confinement.

Types and Degrees of Prolapse

TABLE II
Degrees and Types of Prolapse

Degree of prolapse	No. (%)	Types of prolapse	No. (%)
1st degree	6(15)	Cystocele	18(45)
2nd degree	28(70)	Rectocele	11(5)
3rd degree	6(15)	Enterocele	2(5)

As shown in Table II, 70% of the cases had second degree prolapse. Forty-five per cent of the cases had associated cystocele. Only 9 (22.5%) did not have either cystocele, rectocele or enterocele.

Duration of Pregnancy: Six cases had come in first trimester, 2 (5%) with spontaneous abortion and 4 (10%) with retention of urine. Two had come at 16 and 18 weeks respectively for second trimester termination of pregnancy. Twenty-four cases had come to antenatal clinic during 20-30 weeks of pregnancy, while only 8 had come during labour.

Complications: There were 2 spontaneous abortions and 3 premature deliveries in the present study. There were 4 cases with acute retention of urine which could be managed by catheterisation and reduction of prolapse. There were 3 cases with third stage complications viz. 2 with cervical tear and 1 with retained placenta. Not a single case of gross sepsis was noted in the present series. There was no maternal mortality.

Nature and Duration of Labour: (Table III)

TABLE III
Nature, Duration of Labour and Complications

Nature of delivery	No. (%)	Duration & Labour (hours)	Retention of urine	Complications cervical tear	Retained placenta
Spontaneous (F.T.)	21(52.5)	8-16	4 (In 1st tri.)	1	1
Spontaneous (preterm)	3(7.5)	8-12	—	—	—
Vacuum	2(5)	16-24	—	—	—
Forceps	7(17.5)	16-24	—	—	—
Caesarean (F.T.)	3(7.5)	20-24	—	—	—
Abortion	2(5.0)	—	—	—	—
2nd Tri. M.T.P.	2(5.0)	—	—	—	—

Except 21 cases of spontaneous labour at full term, 3 of spontaneous premature labour, 2 of spontaneous abortion and 2 of second trimester termination, rest 12 cases (33.33%) had prolonged labour. Twenty-four cases had come during second trimester of pregnancy and were treated by bed rest, reduction of prolapse by tampoon soaked with glycerine acriflavin for a variable period of time and ring pessary later on. Out of 8 cases who came during labour 3 required caesarean for cervical dystocia, premature rupture of membranes and prolonged second stage of labour respectively. Duhrssen's incisions were not employed on any occasion.

Foetal Outcome

Amongst 36 live births (excepting 2 spontaneous abortions and 2 M.T.P.s) 6 died, 3 due to prematurity, 2 due to septicaemia and 1 due to neonatal asphyxia. Two cases of neonatal septicaemia and 1 case of neonatal asphyxia were following forceps delivery. In both cases of septicaemia, there was history of prolonged labour and premature rupture of membranes in the mother.

Comments

Incidence of prolapse with pregnancy in India is more common than that in Western countries. Forty cases of uterine prolapse associated with pregnancy are presented. Complications such as spontaneous abortions, acute retention of urine, premature deliveries, sepsis, cervical tears and retained placenta are supposed to be commoner in such cases. Not a single case of gross intrauterine sepsis was noted. Venous obstruction, stasis, oedema and, resultant ulceration and sepsis favour abortion and preterm labour. An incidence of 5% and 7.5% respectively of abortion and preterm labour are concordant with that reported by Kunders (1967), Durandhar *et al* (1967), and Kawathekar and Lal (1973). There were 4 cases with acute retention of urine, all of them in the first trimester. Piver and Spezia (1968) also reported 10% incidence of acute urinary retention, while Durandhar *et al* (1967) did not have a single case of urinary retention.

As far as treatment is concerned, reduction of prolapse and to maintain reduction is of primary importance. The reduction may be achieved by complete bed rest with elevated foot end of the bed to reduce odema and to facilitate replacement. The reduction is maintained by ring pessary or tampoon. Moir's (1967) method of closure of the interoitus, although simple is not usually practised. The replacement of cervix is important from the point of view of complications such as cervical dystocia, premature rupture of membranes intrauterine infection and fetal, rarely maternal death. It should be noted that all the 3 cases requiring caesarean section for cervical dystocia, and prolonged labour were admitted during labour. Early detection and replacement of prolapse during antenatal period could have prevented the cervical dystocia. In case of prolonged labour either vacuum, forceps or timely caesarean section can prevent maternal and foetal morbidity and mortality. Duhressen's incisions although advocated, are infrequently used because of associated risks of haemorrhage and shock.

Prolapse associated with pregnancy undoubtedly exposes the woman to additional risks and should be prevented. Preventive measures include proper spacing, early anbulation during puerperium, perineal exercises, proper in-

tranatal care, and recognition and treatment of smaller degrees of prolapse before conception.

Acknowledgements

We are thankful to Dean, Dr. J. V. Bhatt, T.N. Medical College, Bombay for his permission to publish the hospital data.

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