REVIEW OF FIVE HUNDRED CASES OF PROLAPSE

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SUMMARY

A retrospective review of 500 cases of genital prolapse is reported. Fothergill's repair was done in 209 cases and 180 cases were repaired by Mayo Ward operation.

Introduction

Genital prolapse is one of the common problems in gynaecology, 8-10% cases out of the total attendance in an out-patients department is likely to be of genital prolapse. In the present paper a review of 500 cases of genital prolapse is presented.

Material and Methods

Five hundred consecutive cases of prolapse, attending the gynaecological out-door of S.S. Hospital, B.H.U. were included in this study. Detailed history was taken, clinical examination was done and relavent investigations were done in each case. Patients were screened for the presence of aggravating factors e.g. smoking, heavy manual work, chronic cough and constipation etc. Type of treatment administered was studied. These patients were followed later in the post-treatment period.

Observations and Discussion

Prolapse was observed as early as at the age of 16 years. Maximum number of patients were between 21-30 years as against the Western literature where most of cases fall in peri-menopausal group. Most of the patients of younger age group were of the low socio-economic status. Prolapse was common in this class, probably because of mismanaged labour. Majority of the postmenopausal patients presenting with prolapse came after 3 or more years after attaining menopause.

Although genital prolapse is described and known to be a problem of parous women, it is not unknown in nulliparous patients. In nulliparous group it is either seen in younger patients or after menopause. The parity status in the present series is as shown in (Table I).

TABLE I
Parity Distribution

Parity	No. of patients	Percentage
Nulliparous	48	9.6
Primiparous	102	20.4
Multiparous	350	70.0
Total	500	100.0

The presenting symptoms in the series, as observed in the order of priority were

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—something coming out of of the vagina during straining or otherwise, dysuria,, frequency of micturition, backache, non-haemorrhagic and haemorrhagic vaginal discharge, infertility and stress incontinence. Urinary symptoms were not very common in this series. Incontinence of urine was present in 2.5% cases as against the 40% incidence of stress incontinence in Jeffcoate's series.

Two per cent cases had some respiratory disease like asthma or chronic cough and 2 patients were in congestive cardiac failure.

The different types of genital prolapse observed in the present series are shown in Table II. Commonest was Cystocele and rectocele with or without cervical discent.

TABLE II
Types of Prolapse

Types of prolapse	No. of cases	Percentage
Cystocele and rectocele	156	31.2
Cystocele, rectocele and utero-cervical descent	248	49.6
Utero-cervical descent only	93	18.6
Vault prolapse	3	00.6
Total	500	100.00

The treatment given in these patients varied from conservative to surgical therapy. Conservative treatment was given especially in those primiparas who became overconscious for the laxity of vaginal outlet after first confinement. They were counselled and perineal exercises were taught to them by which majority of the patients were benefited. A total of 30% (150) patients were put on conservative treatment, out of which 79 (15.3%) patients responded well with conservative treatment alone and surgery was not required in them. In remaining 71, surgery was required ultimately. Apart from the primiparas with minor laxity of vaginal outlet, patients of prolapse with pregnancy, with decubitus ulcer, old patients reluctant for surgery and cases of poor surgical risk were also put on conservative treatment. Patients with decubitus ulcer had the ulcer treated first operative treatment was done later. A total of 421 (84.7%) patients required surgical correction of the prolapse. Various types of operations done for the correction of prolapse are as shown in Table III. Decision about the type of operation was based on the age, parity and associated genital pathology. Several workers favour vaginal hysterectomy with pelvic floor repair instead of Fothergill's repair in major degree of uterocervical descent. This was not practiced at our Centre. Operation was deferred in 2 patients till ovarian cyst and massive ascites were treated in them.

TABLE III
Types of Operations in Cases of Prolapse

Types	No. of cases	Percentage
Fothergills repair	202	47.98
Vaginal hysterectomy	180	42.76
Abdominal sling operation	24	5.7
Anterior calporrhaphy and posterior calpo-perineorrhaphy	15	3.56
Total	421	100.00

Note:—Patients willing for sterilisation were sterilised by vaginal tubectomy.

Post-operative complications were uncommon due to proper pre-operative preparation and proper selection of the type of operation. Post-operative complica-

tions observed in this series are as shown in Table IV.

TABLE IV
Post Operative Complications

Complications	No. of cases	Percentage
Primary haemorrhage	30	7.1
Secondary haemorrhage	45	10.6
Pelvic abscess	3	0.7
Shock	9	2.9
Recurrence	9	2.9
Total	96	24.2

Pelvic abscess occurred in the patients who had big infected decubitus ulcer or chronic cervicitis with pelvic cellulitis, which could not be treated properly prior to surgery. Recurrence was more common in the patients who had improperly supervised child birth after the operation.

Pregnancy and Prolapse

Pregnancy with Prolapse

Forty-eight patients became pregnant after repair and attended for antenatal care. The cases seen were grouped as in Table V. Three patients at 32-36 weeks gestation with third degree prolapse presented with severe oedema of the cervix and difficulty in walking. After conservative management, 1 delivered vaginally and 2 had caesarean section. The patient who came in labour with third degree prolapse was helped during late first stage with Ventouse extraction of the foetus.

TABLE V
Pregnancy and Prolapse

Gestation period (in weeks)	Degree of Prolapse	
	Second No. of cases	Third No. of cases
12-16	11	—
32-36	—	3
In Labour	—	1
Total	11	4

Pregnancy after Prolapse Repapir

Forty-eight (9.6%) Patients came for antenatal care after repair. During labour routine episiotomy was done. Instrumental vaginal delivery or abdominal delivery were performed only when indicated but not due to prolapse repair. One had cervical dystocia and caesarean section had to be done. Three patients had sling operation prior to conception. Out of these 3, 2 had vaginal delivery with the help of Ventous in the second stage of labour and the third one had caesarean section for cephalo-pelvic disproportion.

Fertility did improve after the treatment of prolapse. Secondary infertility and imcompetent os were not seen after prolapse repair in this series.

Nine patients (2.1%) had recurrence of prolapse after repair as shown in Table VI.

TABLE VI
Recurrence of Prolapse After Repair

Type of recurrence	No. of patients	Percentage
Cystocele and rectocele	6	1.4
Cystocele, rectocele and uterine prolapse	2	0.48
Vault prolapse	1	0.24
Total	9	2.12