OBSTETRIC OUTCOME OF PREGNANCIES COMPLICATED BY GENTIAL PROLAPSE

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SUMMARY

One of the important causes of genital prolapse in developing countries is inadequate obstetric management. When uterovaginal prolapse complicates pregnancy, there is an increased risk both to the mother and the foetus. Ninety eight pregnant women with genital prolapse were studied over a period of 10 years. The major symptomatology of prolapse complicating pregnancy, their obstetric outcome, complications and the perinatal outcome were analysed. Twenty two pregnant women (28.9%) had lower segment caesarean section and 54 (71%) had vaginal delivery. Twenty two out of the 98 pregnant women did not turn up for follow up. Prematurity and septicemia were the main causes of neonatal mortality and morbidity in the present study.

INTRODUCTION

Genital prolapse during pregnancy is encountered in India far more often than in Western countries. This may be because of the prevalence in our vast countryside of the traditional methods of conducting delivery by untrained birth attendants, and unrestricted parity, lack of antenatal and postnatal care being the additional contributory factors. Presence of this preventable and easily treatable condition during pregnancy is associated with increased maternal and fetal morbidity. The objective of the present study was to analyse the obstetric outcome of pregnancies complicated by genital prolapse.

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METHODS

The present study was carried out in the department of Obstetrics and Gynaecology of JIPMER, Pondicherry. All case records with the diagnosis of genital prolapse

complicating pregnancy were studied for 10 years from August 1984 to July 1994. The data was entered in a predesigned proforma and results analysed.

RESULTS

During the study period, a total of 98 cases of genital prolapse with pregnancy were recorded. Total number of deliveries during this period in this Institute was 35,569 giving the incidence of 1 in 373 deliveries.

Seventy six (77.5%) patients were in the age group of 21-30 years, 16 (16.3%) were in the age group of 31-40 years and 6 (6.1%) were less than 20 years of age.

Thirty five (35.7%) patients were of parity 3 or more, 32 (32.6%) had 2 children, 23 (23.5%) were primipara and 8 (8.16%) were nulliparous.

In 39 (40%) cases duration of prolapse was less than one year, in 30 (30.6%) it was 1-3 years and in 29 (29.5%) it was more than 3 years.

All patients had 3rd degree of prolapse. 90 (91.8%) patients had associated cystocele, rectocele and enterocele where as 8 (8.2%) patients had an elongation of the cervix alone.

Table No.I shows the symptomatology of the patients. Out of 34 patients with urinary symptoms, only 3 had bacteriologically proved UTI.

All these patients were treated by conservative methods like rest, foot end elevation and glycerine dressings. Retention of urine was treated by catheterisation and suitable antibiotic course.

Table No.II shows details of obstetric outcome of these patients. Out of 98, 22 patients did not come back for follow up. Out of the 76 patients who could be followed up 6 (7.8%) had spontaneous abortion, 36 (47.2%) delivered normally 22 (28.9%) had Caesarean section, 3.9% (n-3) delivered after Duhrssen's incision of the cervix and 1 after vacuum extraction.

Table No.3 shows indications for LSCS. 7 (9.2%) patients had premature labour and 7 (9.2%) had PROM and one patient had inco-ordinate uterine action. One patient

Table I
Symptoms of genital prolapse with pregnancy (n - 98)

Symptoms	Number	%
* Mass descending PV	98	100
* Urinary symptoms	34	34.6
a) burning	6	6.1
b) frequency	3	3.0
c) retention of urine	25	25.5
* discharge PV	10	10.2
a) blood stained	3	3.0
b) excessive white discharge PV	7	7.1

Table II
Obstetric outcome (n-76)

Outcome	No.	%
* Abortion	14	18.4
a) Sponteneous	6	7.8
b) Induced	8	10.5
* Preterm Labour	7	9.2
a) S V D	5	6.5
b) L S C S	2	2.6
* Term delivery	55	72.3
a) S V D	31	40.7
b) Duhersen's incision	3	3.9
c) Instrumental	1	1.3
d) LSCS	20	26.3
Lost to follow up	22	

Table III
Indications for LSCS (n-22)

Indication	Number	% (out of 76)
Cervical dystocia	7	9.2
PROM with chorioamnionitis (2 preterm)	5	6.5
Foetal distress	3	3.9
Transverse lie	3	3.9
CPD	2	2.6
Previous sling operation for prolapse	1	1.3
In co-ordinate uterine action	1	1.3

had cervical tear and 6 (6.1%) had intrauterine sepsis. No PPH was observed in this study. No prolapse was irreducible.

Out of 98 pregnancies complicated by prolapse, 22 were lost to follow up. Out of 76, 14 had abortions and 62 delivered in our hospital, one of which was fresh SB due to prematurity and chorioamni-

onitics (wt. 1 kg). Among the 61 live births 8 were LBW (7 preterm and 1/UGR). One neonate was lost 2 days after birth due to extreme prematurity.

DISCUSSION

Co-existence of genital prolapse with pregnancy is not an uncommon entity in developing countries. Incidence of 1 in 373 deliveries in our study is similar to those quoted by various Indian sutides like Ambiye and Alwani (1983) (1 in 565 deliveries), Kawathekar and Lal (1973) (1 in 102 deliveries). Mitra (1975) (1 in 183 deliveries) but much more as compared to various western studies like Keetle (1941) (1 in 13,000 deliveries). Higher incidence in our country can be because of large rural population where doctor or midwife is not available and deliveries are conducted by untrained dais. Bearing down before full dilatation of cervix, unscientific method of ironing out vagina, prolonged labour, no episiotomy, not repairing tears, early resumption of household and manual work predispose to uterovaginal prolapse after delivery. However the use of prophylactic forceps, timely episiotomies, avoiding difficult and traumatic vaginal deliveries by early resort to caesarean section and postnatal exercises have reduced the incidence of prolapse following delivery.

Most of the cases of genital prolapse with pregnancy were parous (90/98), prolapse occuring after previous delivery. In the study by Mitra (1975) also similar finding was observed (29 out of 30). Prolapse in primigravida may be existing before pregnancy and may be due to congenital elongation of cervix.

Retention of urine is the commonest urinary complication seen in genital prolapse with pregnancy. Presence of cystocele alongwith enlargement of retroverted gravid uterus favours retention of ruine which can be easily corrected by catheterisation. Incidence of retention of urine was much higher in our study(25%) than quoted by Mitra (1975) (6.66%) and Piver and Sepziè (1968) (9%). No such complication is reported in the study by Dhurandhar et al (1967) or by Kawathekar and Lal (1973). Incomplete emptying of the bladder due to associated cystocoele favours UTI. In our study 3 patients had bacteriologically proved UTI.

Abortion and premature labour are the obstetric complications seen in prolapse complicating pregnancy. Venous obstruction and stasis leads to edema of the protruding cervix. The mechanical trauma to the edematous cervix causes ulceration and infection. These two factors are said to favour abortion, PROM and premature labour. In our study 7.8% patients had spontaneous abortion. Abortion rate quoted by Kawathekar and Lal (1973) was 7.6%, Mitra (1975) was 6.6%, Ambiye and Alwani (1983) was 5%. Incidence of premature labour in our study is 9.2% similar as given by Kawathekar and Lal (1973) (23%), Mitra (1975) (3.3%), Ambiye and Alwani (1983) (7.5%) and Dhurandhar et al (1967) (10%).

Caesarean section rate in our study was 28.9% of which 9.2% were for cystocia, 6.5% for PROM. Kawathekar and Lal (1973) have reported 7.6% caesarean section rate for cervical dystocia. In the series by Mitra (1975) (13.3%) had Caesarean section for cervical dystocia. Mitra (1975)

reported 6.6% Caesarean section rate for obstructed labour as compared to 7.6% by Kawathekar and Lal (1973). In the present series there was no case of obstructed labour.

In our study 3.9% patients delivered after Duhrssen's incision as compared 30.7% in Kawathekar's (1973) study.

Incidence of intrauterine sepsis is high in patients of genital prolapse with pregnancy. In our study 7.8% patients developed intrauterine sepsis compared to 13.3% reported by Mitra (1975) 23.0% by Kawathekar and Lal (1973) and 3% by Piver and Sepzle (1968). Cervical tear occurred in only 1 patient (1.0%). Piver and Sepzle (1968) have reported cervical tear in 21.2%. In the study by Kawathekar and Lal (1973) there was no cervical tear.

Prematurity and intrauterine sepsis are the main causes of fetal mortality in these patients. In our study 2 (2.0%) babies were lost; one due to extreme prematurity and other due to prematurity with septicemia. In the study by Mitra (1975) there were 3% still births and 3% neonatal deaths. Dhurandhar et al (1967) reported neonatal deaths in 30 cases, Kawathekar and Lal (1973) reported 2 still births and one neonatal death in 13 cases.

CONCLUSION

Genital prolapse complicating pregnancy undoubetedly exposes the women and the fetus to additional risk and hence the association should be prevented. Multiparity is the most contributory factor which can be reduced by suitable family planning methods. Proper antenatal, intrapartum and postnatal care and treatment of smaller degree of prolapse would go a long way in preventing the association.

Conservative management during pregnancy with rest and other conservative methods to keep prolapse reduced will help in reducing the intranatal complications.

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