Practical Highlights of Genital Prolapse

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What is Genital prolapse ?

This is the herniation of the pelvic organs through the vagina below their normal anatomic position.

What are Clinical types encountered in practice ?

A. Vaginal Prolapse (a) Cystocele - descent of urinary bladder with anterior vaginal wall below cervix (b) urethrocele - descent of the urethra (c). Rectocele - descent of rectal wall with middle part of posterior vaginal wall (d) Enterocele - descent of Pouch of Douglas with upper third of posterior vaginal wall (e) Vault prolapse - descent of vaginal vault following hysterectomy.

B. Acquired uterine prolapse. (i) First degree - descent of uterus within vagina (ii) Second degree - cervix descends at and outside vaginal introitus on straining (iii) Third dgree (Procidentia) - permanent descent of whole uterus below vaginal-introitus. Uterine prolapse can be (a) Vagino-uterine prolapse. Primary vaginal introitus. (b) Uterine prolapse without vaginal prolapse. (c) Congenital uterine prolapse in nulliparous young girl forms about 1% of genital prolapse. All types are encountered in practice.

When Genital Prolapse Developes ?

It increases with age and is associated with vaginal childbirth and menopause. There is genetic element in it.

Precipitating Factors are : Chronic cough, constipation, prolonged lactation, water lifting from well and tubewell, heavy domestic work without rest following childbirth, ill health, chronic dysentery, anaemia and worms.

What is the incidence of Genital Prolapse ?

In teaching hospitals in India, genital prolapse surgery forms around one quarter of gynaecological surgery, herein even young girl in 20s coming from rural home can have procidentia following a childbrith. A multiparous woman in reproductive period comes with all clinical types of genital prolapse. In hospital and private practice, postmenopausal women come with uterine and vaginal prolapse. Procidentia comes with decubitus ulcer.

Is incidence of Genital Prolapse Falling ?

In urban private sector, women who had obstetric care, its incidence has certainly fallen while in district hospital its incidence has not shown appreciable fall because of poor obstetric care still prevalent in rural areas.

Diagnosis

"Something coming down per vagina" is the classic symptom of genital prolapse. Symptoms of bladder and bowel function have to be carefully identified. While doing pelvic examination asking the woman to strain on coughing reveals visible descent of vagina and cervix at vaginal introitus in second degree prolapse. Gripping the base of protruded lump at introitus (Grip test) by thumb and fingers identifies second or third degree uterine prolapse. Visible stress incontinence is identified on coughing.

Treatment Prevention. In urban sector fall of incidence of genital prolapse is due to routine antenatal care (Ideally by Dawn Rule of Ten)., better Hb% and better nutrition during pregnancy, labour care by trained personnel, avoidance of prolonged second stage labour by episiotomy, low forceps/Vacuum extraction, abandoning difficult forceps delivery, 1-2 child family, postchildbirth afternoon 2 hour rest, avoidance of heavy domestic work and physiotherapy.

Unless all above preventive measures are available incidence of genital prolapse in rural area can not fall. In the west it is claimed prolonged Hormone Replacement Therapy (HRT) can reduce the incidence. However HRT can not be run in India amongst urban lower middle class and rural women.

Pessary

Ring pessary has now limited use in (a) uterine prolapse in early pregnancy and puerperium for a few weeks (b) as palliative measure for a few months when patient is made fit for surgery.

Surgery

Repair surgery is curative for genital prolapse. Surgery is done when patient is inconvenienced for something coming down. Repair surgery is basic gynecological residency training programme. Throughout his/her professional career a gynaecologist becomes gradually expert on this repair surgery. General Surgeon in many places in India does abdominal hysterectomy but dares not to do repair surgery for genital prolapse. Thus profession should take pride in doing repair surgery for genital prolapse. Currently almost all cases of genital prolapse can have repair surgery because of improved and safe anesthesia.

When to do Repair Operation ?

This is cold surgery. Practitioner must not hurry for surgery. Health is properly checked for fitness. Her hemoglobin must be built to 11gm% by oral iron and adequate food and rest. Urine must show puscells below 5 HPF and urine culture no growth. Under no circumstance repair operation can be performed in cystitis with infected urine. Postprandial blood glucose must be normal. Any systemic disease is well controlled.

Where not to do Surgery ?

Elderly woman with first degree cystocele having acute cystitis, At times anal fissure is combined. She needs cure of cystitis on identification of urinary bacteria by culture and multiple prolonged courses of antimicrobial therapy sensitive to bacteria. Blood glucose has to be tested.

Repair Operation for Vaginal Prolapse.

This is indicated where cystocele is second degree causing dysuria without evidence of UTI.

Similarly second degree rectocele causing incomple defecation needs repair.

Repair for uterine prolapse.

Vaginal hysterectomy with pelvic floor repair operation (WardMayo's operation) is the surgery of choice for uterine prolapse of any degree unless otherwise rarely indicated for Manchester operation. For secure repair of genital prolapse the operation is superior to Manchester operation sice vault prolapse following Wardmayo's operation in skilled hand seldom occurs. On the other hand, recurrence of uterine prolapse following Manchester Operation does happen. The operation has to be done by a skilled gynaecologist in classical steps. A few important practical points are focussed.

1. Building preoperative good health and Hb, fitness of patient for major surgery, cure of chronic cough, routine chest x-ray and skilled anaesthetic service ensure safety.
2. For decubitus ulcer, scrape cytology from the ulcer margin is done.
3. Two units of blood for transfusion is arranged if the prolapse is massive/needs more than 1½ hour surgery even on 11 gm% blood hemoglobin.
4. Enterocele repair is routinely done. Douglas pouch is supported by stitching uterosacral and Mackenrodt ligament in the Midline. As a routine Mackenrodt stump is fixed to the posterior vaginal vault by a separate vicryl 0 suture in Wardmayo's Operation.
5. Bladder fascia in case of huge cystocele needs midline apposition by interrupted Vicryl 0 suture.
6. Vaginal repair is done skillfully avoiding too narrowing of vagina but at the same time posterior

colpoperineorrhaply is done to build up pelvic floor.

7. Self retaining Foley's catheter is kept for 48 hours in case of huge cystocele repair. Thereafter she is taken to toilet to pass urine. Routine postoperative catheter is no more used.
8. Peroperative antibiotic ciprofloxacin 500 mg i.v. infusion is given in drip during operation and eight hourly for another 2 doses in Mayoward's operation. In all other repair operation single dose is given during operation. When catheter is kept Inj. Genticyn 60-80 mg. i.m. is given thrice daily for 5 days especially during days of catheter keeping.
9. Bowel is moved by milk of magnesia or cremaffin (pink) 4 teaspoon full at bed time on 2nd postoperative day. Enema is avoided.
10. All above steps, anatomical suturing of tissue, perfect haemostasis by using diathermy coagulation of bleeding points, strict aseptic environment on O.T. prevent secondary vaginal haemorrhage.

Manchester Operation

In teaching hospital this operation is currently done for uterine prolapse only in 5% while Mayowards operation in 80%, other repair operations 15%. This is because of chance of recurrence of uterine prolapse following Manchester operation, When Wardmayo's Operation is needed. Main indication is uterine prolapse in 20s where woman desires to have a child. In operative steps cervix is amputated keeping cervical length 1", fixing Mackenrodt ligaments to front of cervix by vicryl 0 suture, suturing of uterosacral below Douglas Pouch and proper vaginal repair.

Because of space limits other types of prolapse can not be discussed.

Conclusion

Repair surgery of genital prolapse is gynaecologist's monopoly. This operation gives lot of relief to the woman when it is done skillfully and properly. When fitness of patient is ensured for surgery and skilled anaesthetist is available, mortality from repair operations is practically nil. Postoperative morbidity of UTI and secondary haemorrhage can be minimised by all the steps mentioned above.

Women must be counselled properly to have intercourse after 3 months when wound properly heals. She is afraid to have sex following operation. Dyparunia occurs only in improper repair of vagina.