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CASE REPORT

Persistent Uterine Prolapse During Pregnancy and Labour

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Introduction

Prolapse of uterus is a commonly encountered clinical condition seen in Indian settings, where delivery by untrained personnel is still quite common in the society. The incidence of uterine prolapse in India is much more common, estimated to be as high as 1 in 547 deliveries [1]. Certain myths related to labour, premature bearing down, maternal malnutrition, etc. are different etiological factors that underlie this condition. However, conception with uterine prolapse makes a lady to stand in the high-risk category due to the pertaining risk factors of abortion, preterm labour, etc.

Case History

A twenty-four years old, G2P1L1A1, presented in our clinic as a case of second degree uterine prolapse with secondary infertility.

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Her previous issue was a 39 weeks gestation, 1.6 kg, precipitate delivery at a local hospital, where she had observed labour pains for only 2–3 h, 4 years prior to current pregnancy. She started noticing the lump coming out through her vagina about three years post-delivery.

As an initial workup, her basic nutritional status was corrected, pelvic infection treated and she conceived by ovulation induction (letrozole 2.5 mg daily day 2–6) and timed intercourse.

The first trimester was uneventful. High protein diet, and folic acid supplementation was given. Kegel's perineal exercise, a preferably prone position at rest, avoidance of extreme degrees of physical activity was advised in the view to encourage the taking up of the cervix with the increasing gestation.

However, the descent persisted to about 2 inches outside the introitus in sitting and standing postures. This prolapse however reduced spontaneously and at times manually in supine position. On examination, Cystocele ++ and Rectocele + were also present.

The symptomatology included a dragging kind of sensation and pain in the perineum. Cervical oedema and minor ulceration developed on the post lip of the cervix for which acriflavin–glycerine tampons were inserted in vagina twice daily, leading to significant clinical improvement and symptomatic relief to the woman.

At 30 weeks gestational age, the foetus started developing intra-uterine growth retardation with a disparity of two weeks. Conservative treatment in the form of bed rest, progestogens, low dose aspirin, lycopenes, aminoacid and

multivitamin supplementation were advised in addition to Iron and calcium.

Investigations

Ultrasonological examination revealed the following cervical lengths—36 mm at 7 weeks gestation and 30 mm at 31 weeks gestational age.

She spontaneously went into labour at 39 weeks. Augmentation of labour was done by oxytocin infusion. Though the cervix was prolapsed outside the introitus at the time of admission, it was kept reduced inside vagina during labour.

In the second stage of labour, though the fetal head had descended down to the introitus, the external os did not fully dilate and continued to form a ring around the head, due the fibrotic changes that it had undergone in the concomitant period.

Cervical incision was given at 2 o'clock and 10 o'clock position following which the delivery was conducted smoothly. It was repaired subsequently.

The post-partum period was uneventful. At subsequent follow-up at 3 weeks, there was a cervical descent till the introitus. Patient was advised to continue perineal exercises, high protein diet, iron, multivitamin and calcium supplementation and avoid strenuous activities that lead to a state of high intra-abdominal pressure.

Discussion

Uterine cervical prolapse concurrent with pregnancy is rare. Although cervical prolapse is rarely encountered in pregnancy, the threat to preterm labour and delivery warrants close observation [2, 3]. Early recognition and close follow-up during pregnancy is essential. Successful pregnancy outcome requires individualised treatment but bed rest should always be considered [3].

Prolapse that existed before onset of pregnancy usually resolves spontaneously by the end of second trimester, without further complications [3].

Prolapse that develops during pregnancy is usually first noted in the third trimester, and management consists of bed rest in a slight Trendelenburg position. In these cases pessaries will not remain in place or prevent preterm labour [2, 3]. Considering the extent of protrusion of the cervix beyond the introitus, pessary was not advised in our case, however an acriflavine glycerine tampon, though it was repeatedly expelled on straining and in supine position, was effective in decreasing the cervical edema.

Patient's discomfort, urinary tract infection, acute urinary retention, premature labour and prenatal losses are still major complication. Prolapsed cervix usually persists or relapses after labour [4]. Treatment depends on the severity of the condition and the patient's preference.

Prolapse with cervical elongation is a rare complication of pregnancy [3]. In our study case, the cervical length was in normal range, both on clinical as well as ultrasonological examination.

In another case report [5], a case of uterine prolapse developing during pregnancy, the cervix reached the introitus at 10 weeks gestation and protruded progressively, as the gestation advanced. In the fourth month on postpartum follow-up, there was no evidence of uterine prolapse.

Cervical incisions, during vaginal deliveries, are a good option in such kind of fibrosed cervix, as prolonged compression of the cervix between fetal head and maternal pubic bone may lead to cervical tears and ischaemic necrosis of bladder (if not kept evacuated) and cervical tissues intervening.

Elective caesarean section is only partially effective in preventing pelvic organ prolapse, caesarean delivery during active labour and vaginal delivery had similar effect on pelvic organ support. This indicates that prolapse developed during the first and not the second stage of labour. Black women are as susceptible to developing pelvic organ prolapse during child birth as their white counterparts [6].

Caesarean hysterectomy followed by vaginal cuff suspension to the periosteum overlying the sacral promontory was a suggested therapeutic option in women who have completed their families and are suffering from pelvic organ prolapse complicating the third trimester of pregnancy, particularly in developing countries where access to health care is limited [7].

Incarceration of a retroflexed gravid uterus should be considered in the differential diagnosis in any women who presents with voiding difficulty in late first or second trimester. Uterine prolapse is a risk factor for incarceration of a retroflexed uterus [8].

In active labour, a prolapsed cervix that is enlarged and oedematous can be managed with a topical concentrated magnesium solution to prevent cervical dystocia and laceration [9].

The management of pregnancy associated with uterine prolapse is highly individualized and varies according to the symptomatology, clinical findings, age and reproductive status.

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