Original Research Article

A study of management of uterine prolapse at tertiary health care center

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Abstract

Background: uterine prolapse is descent of the pelvic organs into the vagina, often accompanied by urinary, bowel, sexual, or local pelvic symptoms. Uterine prolapse is commonly encountered in gynaecology OPD. Uterine prolapsed is associated with deranged physical health and it affects quality of life of woman so this study was conducted to see the management of uterine prolapsed at a tertiary health care center. **Aim and objective:** To study the management of uterine prolapse at tertiary health care center. **Methodology:** Total 100 patients diagnosed as uterine prolapse were studied. Data was collected with pretested questionnaire regarding sociodemographic data, detailed history, clinical symptoms. Patients undergone preoperative assessment and surgery was done according to type of prolapse. Data analysed with appropriate statistical tests. **Results and discussion:** Mean age of the patient was 49.23± 2.1 years. Most of the patients were with parity 3-4 (73%). Out of 100 patients 71 were menopausal and 29 were premenopausal. Most common complaint of the patient was something coming out per vaginum (98%) Majority of the patients were with IInd degree prolapse (71%). Cystocele was most commonly associated with prolapse. Vaginal hysterectomy with AP repair (anterior colporrhaphy and posterior colpoperineorrhaphy) was done in 72 patients. No major complication was observed in the cases during follow up.
Key Word: uterine prolapse.

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INTRODUCTION

Prolapse is often asymptomatic and an incidental finding, and clinical examination may not necessarily correlate with symptoms.[1] Uterine prolapse occurs when pelvic floor muscles and ligaments stretch and weaken so pelvic floor cannot support uterus and it protrudes out of vagina.[2] Uterine Prolapses can occur in the anterior, middle, or posterior compartment of the pelvis. In the Anterior compartment prolapse into the vagina of the urethra (urethrocele) or bladder (cystocele) or both (cystourethrocele) occur. In the Middle compartment uterine or vault descent and enterocele (herniation of the pouch of Douglas) is seen. in the Posterior compartment prolapse of the rectum into the vagina (rectocele) is observed. Cystourethrocele is the most common type of prolapse, followed by uterine descent and then rectocele. Uterine prolapsed is classified according to descent of uterus. 1st degree (within the vagina), 2nd degree (descent to the introitus), or 3rd degree (descent outside the introitus). Symptoms are often related to the site and type of prolapse. Most commonly observed symptoms are something coming out of vagina, difficulty in micturation, difficulty in defeacation, bleeding etc. prolapsed uterus sometimes had decubitus ulcers, bleed. Precipitating factors for prolapse are chronic cough, constipation and heavy weight lifting which leads to increases intra abdominal pressure[3] Uterine prolapse is mainly treated by surgical procedures. Ring pessary can be used in medical unfit patients. Depending upon restoration of uterus, restoration of sexual function, fitness of patient and

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symptoms of patient surgery is done. Widely used surgical procedures for uterine prolapse are vaginal hysterectomy, anterior colporrhapy, posterior colpoperineorrhapy, leefort's procedure.

METHODOLOGY

This is a prospective study carried out in a tertiary care center. Total 100 patients diagnosed as uterine prolapse were included in the study.

Inclusion criteria

- Patients presenting with uterine prolapse

Exclusion criteria

- Prolapsed and pregnancy
- patients not willing for surgery
- Patients who have not given consent for study.

This study was approved by ethical committee of the hospital. A valid written consent was taken from patients after explaining about the study and operative procedure. After enrollement of the patients data was collected with pretested questionnaire. Data regarding age, parity and detailed history was collected. Local, clinical and bimanual pelvic examination were carried out. The patients were investigated for preoperative assessment for routine investigations like CBC, HB%, RBS and urine analysis and pelvic USG. Patient were treated according to type of prolapse. Depending upon type of prolapse, associated defect, fitness of patient and sexual life of patient surgery was done. Patients with uterine prolapse with cystocele were operated with hysterectomy and cystocele repair. Vault prolapse was operated by vaginal hysterectomy and prolapse with rectocele were operated for vaginal hysterectomy with repair of rectocele If patient had only cystocele it was treated with colposuspension and if only rectocele is present it was operated with mesh suspension with sacrocolopexy. Follow up of the patients was done after 15 days of discharge. Data regarding complications like hemorrhage, hematoma, suture gaping and other was collected. Data was analysed with appropriate statistical tests.

RESULTS

Total 100 patients were included in the study. Mean age of the patient was 49.23± 2.1 years. Table 1 shows distribution of patients according to sociodemographic variables. Majority of the patients were in the age group of 41-50 years (36%) followed by 51-60 years (19%). As parity increases incidence of prolapse increases. Most of the patients were with parity 3-4 (73%). Out of 100 patients 71 were menopausal and 29 were premenopausal. Most common complaint of the patient was something coming out per vaginum (98%) followed by backache (90%). 85 women complained of frequent micturation. 78 women complained of difficulty in defeacation. 42 women complained of difficulty in walking. Table 2 shows distribution of patients according to degree of prolapse. Majority of the patients were with IInd degree prolapse (71%) followed by IIIrd degree prolapse (18%). Total prolapse (procidentia) was seen in 9 patients. Table 3 shows distribution of patients according to associated pathology with prolapsed. Cystocele was associated with prolapse in 91% patients. Rectocele was seen in 78% patients. Urethrocele was seen in 24% patients. Enterocele was not seen in any patients. Table 4 shows different surgeries done in all patients. Vaginal hysterectomy with AP repair (anterior colporrhaphy and posterior colpoperineorrhaphy) was done in 72 patients. Vaginal hysterectomy with posterior repair was done in 15 patients. Total abdominal hysterectomy with bilateral salpingoopherectomy was done in 2 patients due to pathology in surrounding structures of uterus (tuboovarian mass) Leefort's operation was done in 5 patients as they didn't have sexual life. Ring pessary was advised in 5 patients to conserve the uterus as they are medically not fit for surgery. All patients were followed upto 6 months. Immediate symptom relief was obtained in the patients. No major complication was observed in the cases. Complaints of abdominal pain and bleeding was seen in 10 patients. patients were investigated and treated accordingly.

Table 1: Distribution of patients according to sociodemographic variables

Sr no	Variables	No of patients	Percentage
1	Age group (years)		
2	31-40	16	16%
3	41-50	36	36%
4	51-60	19	19%
5	>60	29	29%
6	Parity		
7	0	00	0%
8	1-2	04	4%
9	3-4	73	73%
10	≥5	23	23%
11	Menopausal status		
12	Premenopausal	29	29%
13	Menopausal	71	71%

Table 2: Distribution of patients according to degree of prolapse

Sr. no	Degree of prolapse	No of patients	Percentage
1	Ist degree	02	2%
2	IInd degree	71	71%
3	IIIrd degree	18	18%
4	Procidentia	09	9%

Table 3: Distribution of patients according to associated pathology with prolapse

Sr no	Associated pathology	No of patients	Percentage
1	Cystocele	91	91%
2	Rectocele	78	78%
3	Urethrocele	24	24%
4	Enterocele	00	0%

Table 4: Distribution of patients according to type of surgery

Sr no	Surgery	No of patients	Percentage
1	Vaginal hysterectomy with AP repair	72	72%
2	Vaginal hysterectomy with P repair	15	15%
3	Total abdominal hysterectomy	02	2%
4	Leefort's operation	06	6%
5	Ring Pessary	05	5%
	Total	**100**	**100%**

DISCUSSION

Total 100 patients were included in the study. Mean age of the patient was 49.23± 2.1 years. Similar results were seen in previous studies like Burrows *et al* [4] where they found the average age of patient was 58.8 years. Another study by Swift SE *et al* [5] observed mean age of 44 years. As parity increases incidence of prolapse increases. Most of the patients were with parity 3-4 (73%). Vaginal birth is the most common risk factor for uterine prolapse. Due to repeated pregnancies pelvic floor becomes weak by trauma. The risk of Pelvic Organ Prolapse is increased 1.2 times with each vaginal delivery [2] Median parity in our study was 4. similar to our finding Burrows *et al* [4] found parity of 3. Out of 100 patients 71 were menopausal and 29 were premenopausal. Similar findings were seen in a study by Burrows *et al* [4] where they found 75% were postmenopausal, and 25% were premenopausal. Most common complaint of the patient was something coming out per vaginum (98%) followed by backache (90%). In a study by Christopher *et al* [6] the commonest symptom experienced by women with prolapse is the sensation or feeling, or seeing, a vaginal bulge Difficulty in micturation was seen in 85 patients. similar findings were seen in previous studies[7-9] Majority of the patients were with IInd degree prolapse (71%). Cystocele was associated with prolapse in 91% patients. Rectocele was seen in 78% patients. Brubaker *et al* [10] confirmed that surgery should be planned according to patient's risk for surgery, risk of recurrence, previous treatments, and surgical goals. In our study Vaginal hysterectomy with AP repair (anterior colporrhaphy and posterior colpoperineorrhaphy) was done in 72 patients. Vaginal hysterectomy with posterior repair was done in 15 patients. Total abdominal hysterectomy with bilateral salpingoopherectomy was done in 2 patients due to pathology in surrounding structures of uterus (tuboovarian mass) Leefort's operation was done in 5 patients as they didn't have sexual life. In our study ring pessary was advised in 5 patients to conserve the uterus as they are medically not fit for surgery. In a prospective study of 100 consecutive women with symptomatic pelvic organ prolapse fitted with a pessary, 73 women retained the pessary two weeks later. After two months, 92% of these women were satisfied with the pessary; virtually all symptoms of prolapse and 50% of urinary symptoms had resolved, although occult stress incontinence was unmasked in 21% of the women [11].In our study No major complication was observed in the cases.

CONCLUSION

Uterine prolapse is associated with increased age, menopause, increased parity. Cystocele is most commonly observed defects in prolapse. Surgical treatment of uterine prolapse includes hysterectomy with conservative procedures.

REFERENCES

1. Samuelsson EC, Arne V, Tibblin G, Svardsudd KF. Signs of genital prolapse in a Swedish population of women 20 to 59 years of age and possible related factors. *Am J Obstet Gynecol* 1999; 180: 299-305.
2. Schorge JO, Schaffer JI, Halvorson LM, Hoffman BL, Bradshaw KD, Cunningham FG, Pelvic Organ Prolapse Williams Gynecology 2008:532-533

3. Kumar P., Malhotra N.: Pelvic Organ Prolapse. Jeffcoate's Principles of Gynaecology, 7th international edition 2008; 283.
4. Burrows, Lara J., Meyn, Leslie A.*et al* : Pelvic Symptoms in Women With Pelvic Organ Prolapse Obstetrics *and* Gynecology 2004;104(5):982-988
5. Swift SE, Tate SB, Nicholas J. Correlation of symptoms with degree of pelvic organ support in a general population of women: what is pelvic organ prolapse? Am J Obstet Gynecol 2003; 189:372-7.
6. Christopher Maher, Benjamin Feiner, *et al*, Surgical management of pelvic organ prolapse in women reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in The Cochrane Library 2013, Issue 4
7. Ellerkmann RM, Cundiff GW, Melick CF *et al*: Correlation of symptoms with location and severity of pelvic organ prolapse. Am J Obstet Gynecol 185, 2001: 1332, discussion 1337
8. Jelovsek JE, Barber MD, Paraiso MFR, *et al*: Functional bowel and anorectal disorders in patients with pelvic organ prolapse and incontinence. Am J Obstet Gynecol 193, 2005:2105
9. Weber AM, Walters MD, Ballord LA, *et al*: Posterior vaginal wall prolapse and bowel function. Am J Obstet Gynecol 176, 1998:1446\
10. Brubaker, Linda, Maher, Chris, Jacquetin, Bernard, Rajamaheswari, Natarajan, von Theobald, Peter, Norton, Peggy Surgery for Pelvic Organ Prolapse Female Pelvic Medicine *and* Reconstructive Surgery 2010;16(1):9-19
11. Clemons JL, Aguilar VC, Tillinghast TA, Jackson ND, Myers DL. Patient satisfaction and changes in prolapse and urinary symptoms in women who were fitted successfully with a pessary for pelvic organ prolapse. Am J Obstet Gynecol 2004; 190:1025-9.

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