Medical and Research Publications
International Open Access

Case Report **Journal of MAR Gynecology (Volume 4 Issue 5)**

A Rare Case of Pregnancy with Stage II Uterine Prolapse

Dr. Saima Najam *

Corresponding Author: Dr. Saima Najam, FCPS, PG Certification IN Medical Education (DUNDEE), Head of the Obgyn Department, Dr. Sulaiman Al Habib hospital, Sweidi, Riyadh, Saudi Arabia.

Received Date: February 13, 2023

Published Date: March 01, 2023

Abstract

The uterine descent is a common gynaecological finding but it is very rarely seen in pregnant patients. Once there is a prolapse it does not only lead to increase chances of vaginal infection, cervical ulceration and preterm delivery but can also increases the risk of cessarian section due to cervical dystocia and failed progress.

We are reporting a case of 31 years old para 4 who was diagnosed of having second degree prolapse at 13 weeks and was managed conservatively with the ring pessary. She reached term and had spontaneous labor. She came at 37 weeks and 3 days with irregular contractions, so after evaluation the pessary was removed, as she was in early latent phase of labour so she was sent back home. She came with regular contractions after a day and was admitted monitoring the progress of labour. Her labour progressed smoothly with significant reduction in the duration of the active phase of the first stage. She delivered a 2.8 kg baby girl with good Apgar score. Her post-natal recovery was uneventful, and she was discharged in stable condition. She was evaluated after puerperium for the prolapse and the prolapse was found to be first degree only. She was offered pelvic floor rehabilitation therapy.

Key words *Uterovaginal prolapse, pregnancy, vaginal pessary.*

Introduction

The uterine prolapse is the prolapse of the uterus beyond its normal confines. Pelvic organ prolapse (POP) can pre exist or may become evident for the first time in pregnancy. **[**1**]** The prolapse that exists before the pregnancy frequently resolves as the pregnancy advances to the end of the second trimester.**[**2**]**

POP is a common gynaecological finding but is very rarely seen in pregnant patients. Once there is a prolapse it does not only lead to increase chances of vaginal infection, miscarriage, cervical infection/ ulceration, preterm delivery , urinary tract infection (UTI) urinary retention **[**3**]** but can also increase the risk of cessarian section due to cervical dystocia and failed progress.**[**2**]** It is also reported to cause fetal demise, maternal sepsis and death. **[**4**]**

The incidence of the uterine prolapse in pregnancy is 1 in 10,000-15,000 deliveries worldwide. [5] POP before the pregnancy is seen less frequently and usually resolves during pregnancy. Acute onset of the uterine prolapse in pregnancy is a typical finding. [6] There are multiple factors which lead to the POP in pregnancy, i.e, age, malnutrition, race, vaginal deliveries, short inter delivery interval, physiological changes during pregnancy, previous history of prolapse and multi parity. [6,7] In developed world as the parity is decreasing the incidence of the POP is decreasing as well. [8]

Majority of the cases reported in the literature are managed conservatively with rest in the Trendelenburg position and pessary. [9] I report a case of second degree uterine prolapse which presented for the first time at 13 weeks, and was managed conservatively with rest in Trendelenburg position and the ring pessary.

A Case Report

31 years old Middle eastern, housewife, who was married for 17 years and was a known case of hypothyroid for 15 years for which she was taking thyroxine 100mcg once daily, was G5P4L4A1 with one set of twins and with the history of all previous spontaneous vertex deliveries at term presented at 13 weeks with the complaint of something coming out of vagina from last 2 weeks. There was no history of chronic cough or constipation. No significant medical or surgical history was found except for nasal adenoidectomy 6 months ago. Detailed evaluation of the patient was done, the baby was doing well. The only positive finding on examination was the second degree uterine descent with mild cystocoele and rectocoele. The examination was done in both left lateral and supine position. After detailed counseling the patient agreed for the ring pessary and the ring pessary of size 85 mm was placed in the vagina under aseptic conditions. The pessary is shown in figure 1.

She had regular antenatal visits and her antenatal course was uneventful. At 26 weeks the ring pessary was removed, disinfected and placed again as the patient still felt the prolapsed uterus. At 36 weeks the patient was reassessed after removal of the pessary, the prolapse still bothered her so new pessary was placed inside.

Figure1: Ring pessary

At 37 +3 weeks she came with off and on contractions and was found to be in latent phase of labour, so the pessary was removed and the patient was sent home to be back with regular contractions.

She came back after a day with regular contractions and was admitted for further monitoring as she was 3.0cm dilated with good bishop score. Her labour progressed smoothly she entered in active phase of labour after 10 hours she then progressed quickly the duration of the active phase was 36 minutes only (from 5.0 cm till fully dilated). Her second and third stage of labour was uneventful and she delivered a 2.8 kg female baby with Apgar score 9/10/ and 10/10 after one and five minutes respectively with intact perineum. Placenta and membranes were delivered completely. Her post-natal recovery was uneventful, and she was discharged in stable condition.

She was evaluated after puerperium for the prolapse and the prolapse was found to be first degree only.

She was offered pelvic floor rehabilitation therapy.

Discussion

This case report is about the rare event of the stage II uteroveginal prolapse which was first reported during pregnancy treated with rest and the pessary and then resolves after delivery. There are multiple ways of classifying POP. For the purpose of this case report we have used POP quantification system as shown in table 1.

Stage 0	No prolapse (apex can descend with in 2.0cm of the hymen)
Stage I	Leading edge descends to 1.0cm above the hymen
Stage II	Leading edge descends to within 1.0 cm of the hymen
Stage III	Leading edge extends 1.0cm > beyond hymen but 2.0 cm <of total vaginal length
Stage IV	Complete eversion, leading edge 2.0> of the total vaginal length

Table 1: Pelvic organ prolapse quantification (POPQ) staging system

Acute onset of the POP with pregnancy is a more frequent occurrence than the pregnancy with preexisting POP, this might be due to the effect of pregnancy hormones on the pelvic tissues and the apical, cardinal and the uterosacral ligaments, supporting the uterus.**[**13,14**]** The patient under discussion has presented at 13 weeks of gestation with the uterine prolapse for the first time in pregnancy. Similar case is reported by the DeVita D and Giordano S whose patient presented at 10 weeks with uterine prolapse and the pessary was used to keep the uterus supported and was removed at 24th week. The prolapse did not reoccur and the patient was delivered by elective lower segment cessarean section (LSCS). **[**10**]** Zang and colleagues also describe a case of POP at 13 weeks which was treated with pessary and then the pessary was removed at 30th week of gestation.this patient delivered at 39 weeks as spontaneous vertex delivery (SVD) and was discharged with complete resolution of the prolapse.**[**6**]**

Zang reported another case with the prolapse at 8 weeks of gestation and for that patient. For whom only bed rest was used probably because she refused pessary, at 39 weeks she presented with pre labor rupture of membranes and was delivered by em LSCS due to failure to progress. **[**6**]**

Agarwal and colleagues and Abdalla found the uterine prolapse in third trimester in contrary to our patient who presented in the first trimester **[**11,12**]**

Agarwal reported two cases one presented at 29 weeks and despite of tocolysis delivered a preterm baby, similarly the second patient reported had prolapse at 24 weeks managed with pessary, presented at 34 weeks in labour. She was delivered by LSCS due to cervical dystocia and failure to progress.**[**11**]**

Abdallah reported a patient at 36 weeks with prolapse who was managed with bed rest and delivered at home at 40 weeks, however she presented at 25th day with prolapse again and was advised sling operation after puerperium.**[**12**]**

The literature review revealed the importance and success of the conservative management of the prolapse in pregnancy. Most of the cases in the literature were treated with rest in the Trendelenburg position and the pessary. In the case under discussion the pessary was placed and cleaned at regular intervals and was kept till the patient started having contractions as per the recommendations found in literature. **[**2,7,8**]** the second reason for continuing the pessary till labour was that every time it was removed, the prolapse reoccurred after removal. Similar was the experience of Agarwal and colleagues who removed the pessary at 28 weeks as the patient had abdominal pain, the prolapse reoccurred for her but the patient opted for continuing the pregnancy without pessary.**[**11**]**

This is in contrary to the findings of DeVita D and Giordano S who removed the pessary at 24 weeks and the symptoms of the patient did not reoccur. **[**10**]**

It is very important to monitor the progress of labour closely in these patients as the risk of dystocia is higher which can lead to failed progress and can increase the risk of LSCS. In addition obstructed labour, cervical trauma and the uterine rupture are also reported.**[**14**]**

Conclusion

Though the uterine prolapse in pregnancy is a rare event, all the obstetricians should be aware of different treatment options as it can lead to antenatal and intra partum complications. After 6 weeks of the delivery reassessment of the patient for the prolapse is essential to decide the future treatment for the prolapse.

All patients even those in which the uterus has returned to its normal position should be advised pelvic rehabilitation services to improve the existing pelvic dysfunction.

Reference

1. Atilgan AE, Altuntas SL. Pregnancy with pre existing total uterine prolapse. Clin Med Rev Case Rep.2020;7:315-18.

2. Tsikouras P, Dafopoulos A, vrachnis N, lliodromiti Z, Bouchlariotou S,Pinidis P, et al.Uterine prolapse in pregnancy: risk factors, complications and management. J Matern Fetal Neonatal Med.2014;27(3):297-302.

3. Partsinevelos GA, Mesogitis S, Papantoniou N, Antsaklis A. Uterine prolapse in pregnancy: a rare condition an obstetrician should be familiar with. Fetal Dagn Ther,2008;24(3):296-8.

4. Kim JO, Jang SA, Lee JY, Yyun NR, Lee SH, Hwang SO. Uterine prolapse in a primigravid women. Obstet Gynecol Sci,2016;59(3):241

5. Latika,Nanda S, Chauhan M, MalhotraV. Pregnancy with third egree uterine prolapse: a rare case report.Int J Reprod Contracep Obstet Gynecol. 2016;5(2):579-81.

6. Zeng C, Yang F, Wu C, Zhu J, Guan X, Liu J. Uterine prolapse in pregnancy : two cases report and literature review. Case Rep Obstet Gynecol.2018;2018:01-05.

7. Yousaf S, Haq B,Rana T.Extensive uteronaginal prolapse during labor. J Obstet Gyecol Res.2011;37(3):264-6.

8. Rusavy Z, Bombieri L, Freeman RM. Procidentia in pregnancy: A systematic review and recommendations for practice. Int Urogynecol J.2015;26:1103-9.

9. Dabi BK, Sori DA, Disasa FA. Uterovaginal prolapse in a primigravida presenting in active first stage of labor: a case report. J Med Case Rep.2022;16,141.

10. De vita D, Giordano S. Two successful natural pregnancies in a ptient with severe uterine prolapse: A case report. J Med Case Rep.2011;5:459.

11. Agarwal H, Acharya N, Shrivastava D, Mohammad S. Pregnancy with uterine prolapse- rare cases with distinct labour outcomes. J Evolution Med Det Sci.2021;10(05):329-32.

12. Abdalla A. Genital prolapse at the end term of pregnancy: A case report.Gynecol Obstet Case Rep.2017;3(2):54-6.

13. Skurupii DA, Sonnyk EG, Sizonenko VM. Multiorgan failure syndrome in newborns. Role of social and anatomical co-functional features.(Literature review). Wiad Lek. 2018;71:777-80.

14. Mohamed SuphanN, Ng RK.Uterine prolapse complicating pregnancy and labor: a case report and literature review. Int Urogynecol J.20122;23(5):647-50.

15. Hill PS. Uterine prolapse omplicating pregnancy. A case report.J Reprod Med.1984;29(8):631-3.