

CERVICAL PROLAPSE IN PREGNANCY: RARE CASE

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Received : October 2016

Accepted : November 2016

ABSTRACT

-Uterine cervical prolapse with pregnancy is rare, the threat to preterm labour and close observation needed. Here we present a case of gravid 2 para 0 abortion 1 and live 0 with 38 weeks of pregnancy with third degree cervical descent with labour pains. Pt on her previous visit was kept ring pessary and advice for follow up. Patient underwent emergency lower segment caesarean section on 21/9/2016 with copper-T insertion after observation. She delivered female baby of weight 2.8 kg and apgar score 8 & 9. The patient cervix remain prolapsed in early postpartum period. The patient was discharged and scheduled for further follow up in gynaecology clinic. Genital prolapse may develop before or during the pregnancy. Prolapse occurs due to tearing down of support structure of uterus. Pre- existing prolapse has been associated with infertility and spontaneous abortion. Women during late pregnancy encountered the complication of cervical dystocia due to non-retractable oedematous cervix. Management depends on the degree of prolapse and gestational age. Conservative management with bed rest, vaginal pessary, tocolysis to prevent pre-term labour and to achieve near term gestation, with few delivery complication and at last caesarean section.

Key words: Cervical Prolapse, Pregnancy, Preterm Labour, Caesarean section

INTRODUCTION

Uterine prolapse is a rarity in pregnancy. The estimated incidence been 1 in 10,000-15000 deliveries worldwide, although a decline has been noted due to gradual decrease in parity. Prolapse existing before onset of pregnancy usually resolves spontaneously by the end of second trimester whereas prolapse developing during pregnancy is usually first noted in the third trimester. Complications in this condition varies from minor cervical infection, spontaneous abortion, preterm labor and fetal death.

Case report

A 30 years old woman Gravida 2 Parity 0 Live 0 Abortion 1 presented in Eras Lucknow Medical College And Hospital, at 29 weeks of gestation with third degree uterine prolapse. She complained of something coming out of vagina since 1 month associated with dragging sensation in perineum, unassociated with discharge or increased frequency of micturition. She had undergone a previous spontaneous abortion 1 year back at 10 weeks of gestation for which she had undergone suction and evacuation. Her medical and obstetric history was unremarkable regarding pelvic trauma, prolapse or stress incontinence of urine nor did she had surgical history or family history of connective tissue disease.

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On obstetrical examination On per abdomen – fundal height 28 weeks. On inspection- third degree cervical descent (pelvic organ prolapse quantification stage 3)

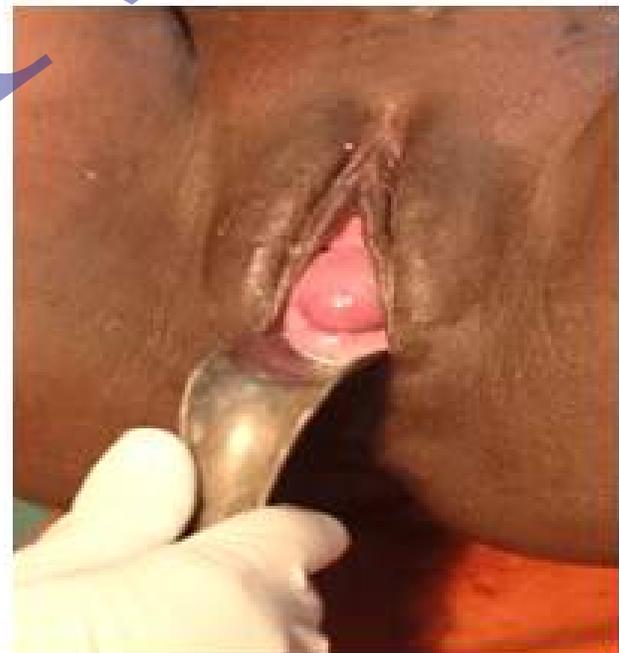


Figure 1-showing third degree cervical descent

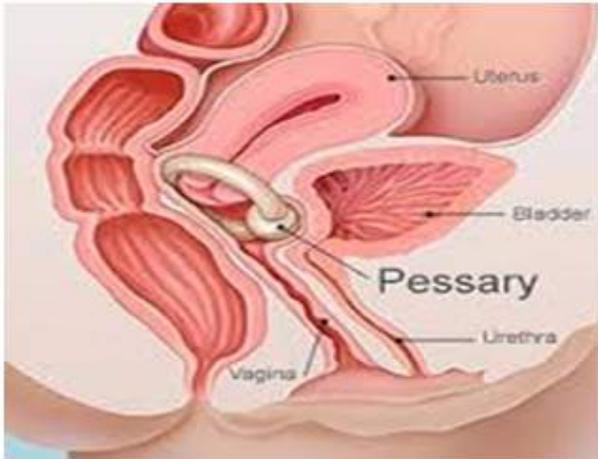


Figure 2- showing pessary kept after prolapsed reposition.



Figure 3- shows different size of vaginal pessary

USG examination- revealed gestational age of 29 weeks 5 days , estimated fetal weight 1.452kg, adequate liquor, and grade 1 upper uterine segment placenta. The ring vaginal pessary applied to keep uterus inside pelvis after manual reposition and patient was discharged after advising Kegel's perineal exercise and avoidance of heavy physical activity or weight bearing. The patient missed her next scheduled antenatal visit and was lost to follow up.

Two months later, she attended the emergency ward at 38 weeks of gestation in early labour. On abdominal examination, the uterus appear term size with moderate intermittent contraction (2-3 in number lasting for 15 seconds every 10 minutes

On inspection-external genitalia healthy, cervix lay outside the vagina, cervix large and oedematous. On per vaginal examination-internal os was approx. 2 cm

dilated and membrane present and station at -3. She recalled that the pessary had expelled about a day ago.

MANAGEMENT

The cervix was repositioned and patient was taken up for emergency caesarean section.

A live female baby 2.8 kg with apgar score 9/10 was delivered by emergency caesarean section for cervical dystocia .Intracesarean Cu-T was inserted.

The postpartum period was uneventful but cervical descent persisted outside the intoitus .Reposition was done with T-bandage. On discharge it was reduced upto introitus. The patient was called for Fothergill repair's but the patient did not turn up for visit.

DISCUSSION

Loss of vaginal support during pregnancy among nulliparous woman leads to uterine prolapse which progress during pregnancy and is irreversible in the postpartum period. This is due to softening and stretching of the pelvic tissue and physiologic changes of pregnancy in terms of cervical elongation and hypertrophy in presence of increased levels of progesterone and cortisol. [1]

Multiparity, vaginal delivery , and age are more common risk factors for prolapse. Each vaginal delivery increases the risk of prolapse by 1:2 fold. Vaginal delivery with emergency caesarean have been associated with denervation injuries of the pubococcygeus- puborectalis muscle complex with incidence of 42-80% whereas the same risk has not been noted in elective caesarean.

No statistically significant difference were found with regards to risk of subsequent prolapse delivery in women with undergoing elective caesarean compared to nulliparous.

Pathological collagen metabolism increased type 3 collagen synthesis and deposition as well as genetically determined collagenosis (Ehlers Danlos, Marfan syndrome) increases the risk of preterm labour and subsequent genital prolapsed. [2,3]

Spontaneous vaginal delivery in these women increase risk of uterine rupture during labour, instrumental vaginal delivery and increased peri- operative blood loss during caesarean section.

In this case , uterine prolapse ocured in second trimester and was unassociated with any history of trauma or obstetrical complication. So this could have been due to physiological changes of pregnancy. The

major antepartum complications remains preterm labour, abortion, cervical ulceration and infection, vaginal discharge along with urinary tract infection, even maternal death have been reported. [4]

The key to management with prolapse is individualisation of plan. Bed rest in moderate Trendelenberg position should be advised with maintenance of good genital hygiene. Continuous use of pessary recommended which should not be removed till onset of labour.[5,6]

In intrapartum period, the edematous cervix resist dilatation leading to high incidence of cervical dystocia as seen in our case.[7]

Labour induction with misoprostol or oxytocin should be avoided and most authors recommend conservative management followed by elective caesarean.[8]

In postpartum period, avoidance of lifting high objects and use of pessary is advised.

CONCLUSION

Uterine prolapse in pregnancy is a rare occurrence and best managed conservatively. This is usually attained with bed rest and placement of an appropriate pessary. When considering the mode of delivery, obstetricians should look out for cervical inflammation and oedema which may complicate an otherwise normal vaginal delivery.

REFERENCE

1. Sawyer d, Frey K. Cervical prolapse during pregnancy. 1999, 13 (3); 216-8
2. Brown HL Cervical prolapse complicating pregnancy. J Natl Med 1997; (89);346-8
3. Dietz HP, Simpson JM Does delayed child-bearing increase the risk of levator injury in labour. Aust NZ J Obstetrics 2007; (47);491-5
4. Luckacz ES, Lawrence JM, parity, mode of delivery, and pelvic floor disorders. 2006;(107);1253-60
5. O Boyle AL, Ricks RE, et al. The natural history of pelvic organ support in pregnancy. 2003;(14);46-9.
6. Buyukbayrak EE, Yilmazer G. Successful management of uterine prolapse during pregnancy with vaginal pessary. Case report. Gynecol 2010;(11);105-6
7. Gupta R. Uterine prolapsed during pregnancy and labour. Obstet and Gynecol 2012;(1);568-570.
8. Partsinevelos GA. Uterine prolapsed in pregnancy. 2008;(24); 296-8.

