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Enormous Uterine Prolapse: A Case Report

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Abstract : *Female genital prolapse can be defined as a hernia in the vaginal cavity (colpocele) in which one or more elements of the pelvic contents become involved. Organs from all three pelvic compartments may be involved: - In front, anterior colpocele (known as cystocele because it contains the bladder). - Middle or apical compartment: the uterus (hysteroptosis) or the vaginal fundus (prolapse of the vaginal fundus) if the patient has had her uterus removed. - Posteriorly, posterior colpocele which may contain the rectum (rectocele) or the peritoneal cul-de-sac (elytrocele) with abdominal contents (intestine, omentum). The most specific symptom and the one best correlated with the existence of a prolapse is the vaginal ball perceived or felt by the patient. Pelvic heaviness and urinary symptoms are frequently associated with genital prolapse. The most frequently reported urinary symptoms are overactive bladder syndrome, dysuria and stress urinary incontinence (SUI), although these are not specific to prolapse and a high stage prolapse may mask SUI. Our patient presented with pelvic heaviness associated with stress urinary incontinence. Conservative treatments may provide significant improvement without the need for surgery, or may be offered in combination with, in addition to, or pending surgical management. Surgery may be performed vaginally or via an upper approach using a synthetic plate, either by open surgery or laparoscopy. Our patient had undergone open promontofixation with the insertion of a synthetic polypropylene plate. Postoperative recovery was straightforward.*

Keywords : Genital prolapse, pelvic heaviness, urinary incontinence.

INTRODUCTION

Female genital prolapse is common and can occur at any age. It is a hernia of the pelvic floor which manifests itself as a descent of organs. It often feels like a "ball" or foreign body in the vagina. Other clinical manifestations may be associated, such as stress urinary incontinence or urgency.
A number of factors may be involved, in particular a history of prolapse during or outside pregnancy, a long labour delivery, multiple pregnancies, chronic coughing or constipation, repeated or heavy physical effort and congenital damage to the supporting aponeurotic tissues [1].
The management of this condition remains controversial in the literature, although most authors recommend conservative treatment with pessary insertion. [2]

OBSERVATION

A 41 year old patient, 2 vaginal deliveries, who consulted for a sensation of pelvic heaviness with associated stress urinary incontinence. On clinical examination, the patient presented with a de novo stage IV uterine prolapse with an associated stage II cystocele (according to the BADEN WALKER classification) without an associated rectocele (Figure 1,2). There was no evidence of prolapse during the previous pregnancy or of pelvic trauma. The cervico-uterine smear was normal. The patient was very uncomfortable and underwent promontofixation by median laparotomy under the umbilicus with insertion of a synthetic polypropylene plate. Post-operative recovery was straightforward. The intravaginal mesh and bladder catheter were removed and the patient discharged the following day.
On examination on the 10th postoperative day, the patient was very satisfied and there was no pevic heaviness or urinary incontinence.

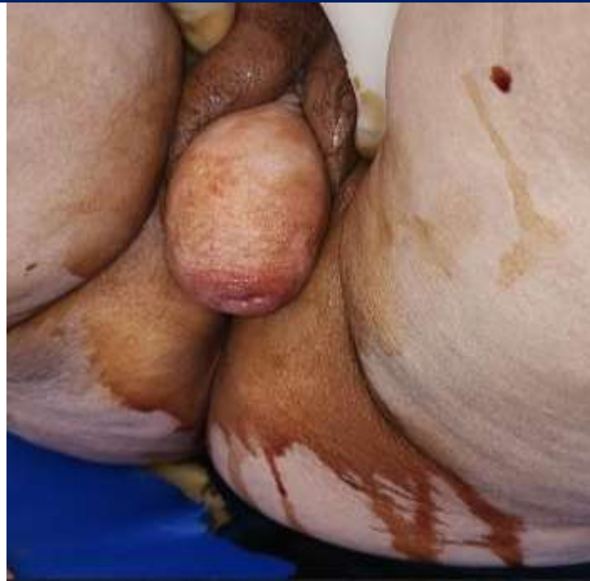

Figure1 : Spontaneously exteriorized hysterocele (Grade IV)

Figure 2 : Under-Valve examination showing associated cystocel

DISCUSSION

Female genital prolapse can be defined as a hernia in the vaginal cavity (colpocele) in which one or more elements of the pelvic contents are involved. Organs from all three pelvic compartments may be involved. [3]

The most specific symptom and the one best correlated with the existence of a prolapse is the vaginal ball perceived or felt by the patient. Pelvic heaviness and urinary symptoms are frequently associated with genital prolapse. The most frequently reported urinary symptoms are overactive bladder syndrome, dysuria and stress urinary incontinence (SUI), although these are not specific to prolapse and a high-stage prolapse may mask SUI. Anorectal problems may also be associated, such as terminal constipation (dyschesia) sometimes accompanied by digital exoneration manoeuvres or anal incontinence. Symptoms associated with genital prolapse can affect physical activity and sexual function. It can also result in symptoms of depression, anxiety and mood disorders. Symptoms or the impact on quality of life can be assessed using self-questionnaires.

During the clinical examination, it is advisable to examine the patient in the supine or gynaecological position, then standing if the genital prolapse is not visible in the supine or gynaecological position. During the clinical examination, it is advisable to ask the

patient to push and cough to assess the extent of the prolapse. In order to characterise the different compartments of the prolapse, the clinical examination with effort can be carried out with the help of valves (or hemispeculum).
Rehabilitation (for stage < 3 prolapses) and the use of a pessary are the two non-surgical conservative treatments recommended as first-line treatment. Hygienic and dietetic measures may be necessary, such as weight loss combined with a healthy diet, management of chronic constipation and advice on limiting sedentary lifestyles and encouraging physical activity. Pessaries are effective treatments for the symptoms associated with genital prolapse and improve quality of life. Their effectiveness on symptoms is immediate and appears to be equivalent to that of surgical treatment.
Re-education is one of the conservative, non-surgical treatments recommended as first-line treatment for moderate genital prolapse. Surgery still has a place in the treatment of prolapse, and there are several techniques such as vaginal approach and promontofixation by high approach with synthetic prosthesis, as well as vaginal closure in women who no longer wish to have sexual intercourse. [4]

CONCLUSION
Uterine prolapse is common. Several risk factors may be responsible. Management of this condition remains controversial and must be individualised according to the severity of the prolapse.

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