Case Report

Uterine Prolapse during Pregnancy: a Case Report

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Abstract

Background: Pelvic organ prolapse is a common gynecologic condition in women that rarely occur in pregnancy and can complicate the pregnancy. A woman with prolapsed uterus in second trimester of pregnancy and her follow up are presented here.

Case Report: A 35-years old G2P1 woman with history of last normal pregnancy and successful vaginal delivery attended to emergency ward of hospital. She was in 14th week of pregnancy and had complain of acute urinary retention and vaginal bulge. She successfully is managed by application of pessary till an uneventful normal vaginal delivery.

Conclusion: Management of pelvic organ prolapse during pregnancy is based on patient symptoms. Application of pessary is treatment of choice in such patients. They need to regular follow up during pregnancy in order to control pessary and monitor the pregnancy complications.

Keywords: POP, uterine prolapse, vaginal pessary

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Introduction

Pelvic organ prolapsed (POP) or herniation of the pelvic organs to or beyond the vaginal walls is a common condition. Anatomic support of the pelvic organs in women is provided by interaction between muscular structure of the pelvic floor and attachment of connective tissue to bony pelvis. The most important risk factor that prone women to POP are included, parity, vaginal delivery, advancing age, race obesity, chronic constipation and some connective tissue disorders such as Ehlers-Danlos syndrome and positive family history[1-4].

In the other hand, uterine prolapse during pregnancy is a rare condition with incidence of one in 10000-15000 pregnancy and this may be a high-risk pregnancy[5].

We presented a woman with uterine prolapse in second trimester of pregnancy and its management till successful vaginal delivery.

Case Presentation

A 35-year old woman G_2P_1 attended to emergency department with complain of acute urinary retention and sensation of a vaginal bulge, from one week ago. Her gestational age was 14 wK+5 day and her previous pregnancy was an uneventful normal pregnancy 9 years ago with normal vaginal delivery at term and a healthy 2700 gr boy. She had the surgical history of cystocele and rectocele repair 5 years ago and didn't have any complain of pelvic organ prolapse prior to current pregnancy. In pelvic examination, the cervix had normal shape and closed and prolapsed approximately 2 cm outside the interoitus. Ultrasound revealed a singleton 15 weeK normal fetus and 32 mm cervical length.

After manual reduction of prolapsed uterus, bladder

catheterization was down and a silicon shaped middle–size vaginal pessary was placed in the vagina. After that, she could void without any problem and cervix remained intra-vaginal.

She was discharged from hospital with recommendation to regular follow up. In her follow up, she didn't have any complain except gestational diabetes mellitus that was controlled perfectly with diet.

At 37 week, she was admitted and pessary was removed. The patient gave birth a healthy 4100 gr boy with apgar score of 9 -10 by spontaneous vaginal delivery. There was not any problem or cervical prolapses during the second or third stage of labour.

Discussion

Pelvic organ prolapse (POP) is a common condition but its occurrence in pregnancy is rare and may be present with urinary incontinence. There is little case with uterine prolapse in pregnancy that reported in articles[5-8]. Pelvic floor disorders (PFD) is included pelvic organ prolapse, urinary incontinence and fecal incontinence.

There are several risk factors for POP include, parity, advancing age, smoking obesity hysterectomy, race and ethnicity, some connective tissue disorders, congenital abnormalities, positive family history of POP and any chronic conditions that accompanied with repetitive increase in intra-abdominal pressure such as chronic constipation. Parity contained several component (Pregnancy, Labor, Delivery) that each of them may contribute to pelvic relaxation. There is controversy about the effect of labor, without vaginal delivery; most of studies suggest that it has a negligible effect on the POP but some data have yielded opposite results[9].

Vaginal delivery especially operative vaginal delivery with forceps is an important risk factor for development of POP[10].

Because of lack of evidence, elective cesarean delivery in order to prevention of POP is not recommended (11).

Pelvic pressure or vaginal bleeding and urinary symptoms are the most common complaint of patients with POP in pregnancy (such as our case). Chronic protrusion of cervix and vagina may be resulted in chronic discharge or ulceration.

Management of such condition is conservative and symptom base. If there is voiding problem, the urinary catheterization is recommended. Manual reposition of the cervix and application of the vaginal pessary or pelvic floor exercises are conservative treatments that are recommended. In our case and also Martines-Vera and Buyukbayrak application of pessary was effective. In one case that reported by Gupta, manual reduction and conservative management was helpful[6-8]. Despite risk of preterm labor in POP in this and another case reports all the patients had term pregnancy.

The patients must be taught about how to remove and clean pessary and the time of second visit and follow up[8].

Conclusion

We have to consider that although some risk factors of POP such as race and age or connective tissue disorder are not modifiable but other risk factors such as obesity, smoking or chronic constipation are modifiable and women's health care providers should focus on them.

Conflict of Interest

The authors have no financial interest in the products discussed in this article.

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