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Uterine Prolapse during Pregnancy

Gebelik ve Uterine Prolapse

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Özet

Prolapse uteri, uterus ve serviksin vajen giriminden dışarı çıkması olarak tanımlanır. Gebelikte oldukça nadir izlenir; insidansı 10.000-15.000 doğumda 1'dir. Biz bu olgu sunumu ile 30 yaşında gebelik sayısı 5 doğum sayısı 3 olan ve gebelikte prolapse uteri tanısı ile takip edilen, ancak gebelik takipleri düzensiz, gebelik boyunca herhangi ciddi bir problem yaşamayan ve 38. gebelik haftasında elektif sezaryen ile doğum yaptırdığımız olguyu sunacağız. Hastanın sezaryen ile doğum sonrasında uterus prolapse hali devam etti. Sonuç olarak prolapse uteri gebelikte nadir görülen ve ciddi bir komplikasyona yol açmayabilen bir durumdur.

Anahtar Kelimeler: Gebelik, uterin prolapse, doğum

Abstract

Uterine prolapse is defined as descent of the uterus and cervix into or beyond the vagina. It is often caused by a weakness in the pelvic diaphragm and it is rarely diagnosed during pregnancy with the estimated incidence of 1 per 10,000 – 15,000 deliveries. We report the case of a 30-year-old pregnant woman, gravida 5 para 3, who was presented with a total uterine prolapse who did not have regular antenatal follow-up. An elective caesarean section was performed at 38 weeks gestation and the prolapse persisted after delivery. In conclusion, uterine prolapse during pregnancy is a rare condition and may not complicate pregnancy.

Keywords: Labour, pregnancy, uterine prolapse

INTRODUCTION

Uterine prolapse is defined as descent of the uterus and cervix into the vaginal canal or beyond the introitus [1]. It is a common gynecologic condition but it's extremely rare in pregnancy with the incidence of 1 per 10,000 – 15,000 deliveries [1]. Uterine prolapse may lead to the potential complications during pregnancy and conservative management is the preferred management [1; 2]. The optimal mode of delivery is controversial, although caesarean delivery should be recommended to avoid obstructed labour and the related uterine rupture [3]. Here we present the case of a 30-year-old pregnant female with total uterine prolapse who did not experience any serious complications at pregnancy related to the prolapse.

CASE REPORT

A 30-year-old multiparous female (gravida 5, para 3) at 37 weeks gestation with a bulge protruding from the vagina was admitted to our clinic. She had a past history of one vaginal delivery 9 years prior to an infant weighting 4100 g and two caesarean sections. Uterine prolapse occurred soon after the vaginal delivery and persisted during the subsequent pregnancies. She had a non-regular fallow up after deliveries so we did not have any idea about the degree of uterine prolapse among pregnancies. She did not experience any symptoms associated with the prolapse during current pregnancy and therefore did not need to receive any routine antenatal care. Upon examination, it was noted that she had a uterine prolapse with cervical elongation that protruded 12 cm beyond the introitus. The cervix was edematous and enlarged (Figure 1). The patient was offered a variety of treatment options including sacro-cervicopexy at the time of the caesarean section, but she refused any operative procedure for the prolapse. She underwent an elective caesarean section at 38 weeks gestation with delivery of a healthy male newborn weighing 2750 g with an Apgar score of 8/10. The post-partum period was uneventful, although the prolapse persisted after delivery.

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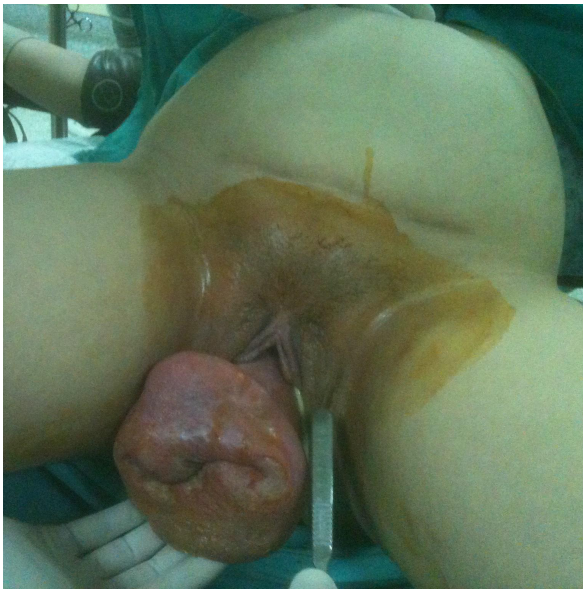

Figure 1 Uterine prolapse with edematous and enlarged cervix (This photo was taken before cesarean at 38th weeks of gestational age).

DISCUSSION

While uterine prolapse is a common gynaecologic condition, it is rare during pregnancy with an estimated incidence of 1 per 10,000–15,000 deliveries (1, 2). Having more than one vaginal birth and the use of forceps or vacuum during prolonged labour are the important risk factors for prolapse. Other predisposing factors include obesity, connective tissue disease, chronic coughing, ethnic origin and family history (3, 4). In our case, the prolapse occurred soon after delivery of her first baby and persisted during the subsequent pregnancies. She did not have any risk factors.

Uterine prolapse during pregnancy may lead to antepartum, intrapartum, and puerperal complications (4). Cervical ulceration, urinary tract infection, and acute urinary retention are common antepartum conditions that can complicate pregnancy (5). Uterine prolapse during pregnancy may also lead to abortion, preterm labour, and preterm birth. Additionally, obstructed labour and uterine rupture due to prolonged labour related to the prolapse remain serious and life-threatening intrapartum complications (6, 7). Although the mode of delivery is controversial in cases of uterine prolapse, caesarean section is recommended as the safest option to prevent potentially dangerous intrapartum complications, such as obstructed labour and uterine rupture (3, 8-10]. Management of a uterine prolapse concurrent with pregnancy consists of bed rest in a slight Trendelenburg position and the usage of pessary. Postpartum treatment depends on the severity, associated complications, and the patient's preferences. In women wishing to preserve fertility, sacrospinous fixation and sacro-cervicopexy seem to be effective and appropriate choices (10). Table 1 shows the management of the prolapse during pregnancy and postpartum period in different studies in literature (Table 1).

In our case report, the only complaint was the sensation of bulging in the vagina. No maternal and/or foetal complications occurred during pregnancy or delivery and the prolapse persisted after delivery. In conclusion, uterine prolapse can occur after the first delivery, even when there are no risk factors, and it may not complicate pregnancy. Nevertheless, a pregnant patient with uterine prolapse should be under careful surveillance for preterm labour and chorio-amnionitis.

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DECLARATION OF INTERESTS

The authors reported no conflict of interest.

Table 1: Previously Reported Cases of Uterine prolapse in Pregnancy from 2006 to 2014

Author, year	Age	Parity	Time of Onset (Week)	Prolapse Degree	Complication	Mode of Delivery	Management of Prolapsed After Birth
Cingillioglu et al. 2010	29	2	Two months before birth	Stage I (POP-Q)	None	C/S	None
G.A. Partsinevelos et al. 2008	37	0	31th	Stage IV (POP-Q)	Preterm birth	C/S	None
Gupta Rakhi et al. 2012	24	1	1th trimester	2nd degree	None	VD	Conservative
Davide De Vita et al. 2011	36	2	10th	Stage IV (POP-Q)	None	C/S	Refused surgery
Karataylı et al. 2013*	33	2	-	Stage IV (POPQ)	Preterm birth	C/S	Abdominal hysteropexy during C/S
Ishida et al. 2014	31	0	38th	Stage III (POP-Q)	None	C/S	None
Meydanli et al. 2006	30	5	Not reported	Stage III (POP-Q)	Preterm birth	C/S	C/S hysterectomy and abdominal sacrocolpopexy
Mohamed-Suphan et al. 2012	26	2	12th	Grade III	None	C/S	Refused surgery

*Twin pregnancy

Abbrevitions: C/S, caesarean section; VD, vaginal delivery; POP-Q, Pelvic Organ Prolapse Quantification System

REFERENCES

1. Cingillioglu B, Kulhan M, Yildirim Y. 2010. Extensive uterine prolapse during active labor: a case report. International Urogynecology Journal; 21(11):1433-4.
2. Mohamed- Suphan N, Ng RK. 2012. Uterine prolapse complicating pregnancy and labor: a case report and literature review. International Urogynecology Journal; 23(5):647-50.
3. De Vita D, Giordano S. 2011. Two successful natural pregnancies in a patient with severe uterine prolapse: A case report. Journal of Medical Case Reports; 14; 5: 459.
4. Tsikouras P, Dafopoulos A, Vrachnis N et al. 2014. Uterine prolapse in pregnancy: risk factors, complications and management. Journal of Maternal Fetal and Neonatal Medicine; 27(3):297-302.
5. Brown HL.1997. Cervical prolapse complicating pregnancy. Journal of National Medical Association; 89(5):346-8.
6. Hill PS.1984. Uterine prolapse complicating pregnancy; a case report. Journal of Reproductive Medicine;29(8):631-3
7. Sze EH, Sherard GB, Dolezal JM. 2002. Pregnancy, labor, delivery, and pelvic organ prolapse. Obstetrics and Gynecology; 100(5 Pt 1): 981-6.
8. Meydanli MM, Ustün Y, Yalcin OT. 2006. Pelvic organ prolapse complicating third trimester pregnancy: A case report. Gynecologic and Obstetric Investigation; 61(3):133-4.
9. Daskalakis G, Lymberopoulos E, Anastasakis, et al. 2007. Uterine prolapse complicating pregnancy. Archives of Gynecology and Obstetrics; 276(4):391-2.
10. Partsinevelos GA, Mesogitis S, Papantoniou N. et al. 2008. Uterine prolapse in pregnancy: a rare condition an obstetrician should be familiar with. Fetal Diagnosis and Therapy;24(3):296-8.