CASE REPORT

MANAGEMENT OF SECOND DEGREE UTEROVAGINAL PROLAPSE

Iqbal Begum and Naila Jadoon

Uterovaginal prolapse, though not a life threatening disease, can greatly affect the quality of majority of women especially during their menopausal period. Hysterectomy, vaginal or abdominal is usually the treatment of choice. Lefort's operation is sometimes advocated for severe prolapse in elderly women and for vaginal inversion after hysterectomy.[1] It can also be performed under local anaesthesia if needed.

Key Words: *Second degree uterovaginal prolapse, Lefort's operation.*

INTRODUCTION

Prolapse or procedentia means the descent of vagina or uterus. Vaginal prolapse can occur alone but the uterus cannot descend without vaginal descent. Lefort's colpocliesis, although rarely performed now a day in elderly frail ladies, is virtually free of complications and may be performed if needed under local anaesthesia.[2]

CASE REPORT

A sixty-year-old postmenopausal lady presented with pressure perineum and something coming out of vagina. She gave no history of any previous hospitalization or any major or minor surgery. She was married for the last forty years and had borne four children. Two were alive. The last birth was thirty years back.

Her general physical examination was normal except for restricted chest movements during respiration. On pelvic examination she had a second degree uterovaginal prolapse, cervix was hypertrophied, and uterus atrophic. She was provisionally posted for a vaginal hysterectomy. Her X-ray chest showed bilateral milliary shadows she was declared unfit for general anaesthesia both by the physician and anesthetist. It was then decided to perform a Lefort's operation under local anaesthesia.

Her preoperative and postoperative stay was uneventful, and she was discharged home on her sixth postoperative day. During her six months postoperative follow up she was healthy and free of symptoms.

DISCUSSION

Prolapse is a common gynecological problem though not life threatening can severely affect the quality of life of many women majority of whom are parous and menopausal.

From Ayub Medical College, Abbottabad, Pakistan.
IQBAL BEGUM, Assist. Professor Obst/Gynae.
NAILA JADOON, TMO Deptt. of Obst/Gynae.

Uterovaginal prolapse is described as first degree when the cervix descends into the vagina but does not reach the introitus, second degree when the cervix comes out of the vagina on straining and third degree or complete procedentia when the whole of the uterus is outside the body and vagina is completely inverted. Majority of women who have borne children would have some degree of laxity of the pelvic floor but most of them could be asymptomatic. About 10 to 20% of women will be symptomatic. About 2% of symptomatic women are nulliparous. The pelvic floor consists of layers of muscle and fascia. The levator-ani muscles act as a support for pelvic organs.

The pelvic floor may be weakened by childbirth or may be congenitally weak. This leads to a funneling in the levator plate, which can cause the uterus, rectum and vagina to herniate through it. Women with a prolapse will almost always complain of something coming down which is worse towards the end of the day. Other symptoms depend upon the organ, which has prolapsed into the vagina.

In case of a cystocele urinary symptoms like stress incontinence may occur. A rectocele may be asymptomatic even if it is quite large, however the patient may present with difficulty in defecation. The definitive treatment for prolapse is surgery. The choice of treatment lies between either a hysterectomy or a Manchester repair. A vaginal hysterectomy[3] is now a days considered as the treatment of choice as there are no absolute contraindications for this procedure. The relative contraindications being uterus larger than 12 weeks' gestation size, endometriosis, pelvic inflammatory disease and suspected malignancy.[4]

Lefort's operation was originally used for treatment of complete procedentia,[5] and consisted of denuding a long narrow triangle on the anterior and posterior wall of vagina with the base towards the cervix. Vaginal closure was brought about by approximating these areas. Nowadays rectangular strips of mucosa are excised from the upper portion of anterior and posterior vaginal walls. The uterus is pushed back into its normal position and raw surfaces of vagina are sutured together to produce a partial closure of vagina

with only narrow lateral channels left on each side for drainage and secretions. It is necessary that the cervix and endometrial cavity are properly assessed by a cytologic smear and by a dilatation and curettage to make certain that there is no evidence of occult uterine malignancy before the vagina is closed. Lefort's colpocliesis is an effective, quick and relatively simple method of vaginal obliteration but has a few disadvantages. It retains the uterus that may bleed in future and determination of cause is difficult because access to uterine cavity is hindered by partial vaginal closure. A cystocele may be effectively corrected but it may not correct the associated stress incontinence. In fact, traction produced by obliterating scar tissue under bladder neck may actually cause or aggravate stress incontinence.

REFERENCES

1. Jeffcoate N. Genital prolapse. In: Jeffcoate principles of gynecology. Revised by Tindall VR London. Butterworth, 1987; pp.272.
2. Linda Cardazo. Prolapse. In: Dewhurst textbook of obstetrics and gynaecology for postgraduates. Blackwell Science Ltd, 1995; pp.642-51.
3. Dicher RC, Scally MJ, Green spar JR et al. Hysterectomy among women of reproductive age-trends in USA. 1970- 1978, JALA-1982, 248; 323-27.
4. Nichlos DH. Update on surgery Contemp. J. Obstet Gynaecol 1987,29; 92-109.
5. Thompson JD. Surgical techniques for pelvic organ prolapse. Tilendes operative gynaecology. Lippincott-Raven Publishers. 1997, pp.975-1013.
6. Dorr CH. Relaxation of pelvic supports. Current Obstetrics and Gynecological diagnosis and treatment. Appleton and Lange, 1987; pp.811.