Case Report

Procidencia with rare complication -a case report

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Abstract:

Mrs. Lalbanu 65 years old lady presented to us with the complaints of something coming down per vagina for 10 years, foul smelling discharge for 2 months, fever & maggot formation for 5 days, she also gave history of applying some chemical substances on her prolapsed mass of genitalia, and she also complains of lower abdominal pain for last 5 days. On examination, prolapsed mass was distorted, edematous, infected, irreducible & there were maggots, her temperature was raised & having lower abdominal tenderness. She was treated at first conservatively & then surgically. Now she is well & with our follow up.

Introduction

Prolapse, procidentia or downward descent of the vagina & uterus is a common & disabling condition. Vaginal prolapse can occur without uterine prolapse but the uterus cannot descent without carrying the upper vagina with it. According to one scheme, three degrees of uterine descent are recognized, first degree - uterine descent but cervix remain within the introitus, second degree - uterine descent with the cervix projects through the vulva when the women is strain or standing. A third degree is complete procidentia or genital prolapse- the entire uterine prolapse outside the vulva[1].

Pelvic organ prolapse is one of the common clinical conditions met in day to day gynaecological practice. Up to half of the normal female population will develop uterovaginal prolapse during their life time, twenty percent of these women will be symptomatic & need treatment[2]. A North American actuarial analysis reveal that a woman up to the age 80 year has an 11% risk of needing surgery for pelvic floor weakness. Further more, if she has an operation, she has a 29% risk of requiring further surgery[3]. The striated muscle of the pelvic floor, in common with other striated muscle through out the body, undergoes a gradual degeneration with age[4]. The pelvic floor muscle denervation is increased by vaginal delivery, particularly in the active second stage of labour is prolonged[5]. So the genital

prolapse occurs due to weakness of the supporting structures of the organs in position. these factors may be anatomical or clinical-it may be predisposing factors like- trauma of vaginal delivery & aggravating factors like- postmenopausal atrophy,obesity, chronic cough & constipation etc.[6]

Case Report:

Mrs. Lalbanu 65 years old lady, came from Gopalpur, Enayetpur, Sirajgonj, got admitted in Gynae ward with the complaints of something coming down per vagina for 10 years, foul smelling P/V discharge for last 2 months, blood stained P/V discharge for 15 days, fever & maggots formation for 5 days. She was normotensive, nondiabetic. The prolapsed mass was initially small & gradually its size increased. She was a mother of 10 children & they were delivered per vaginally.

She was menopause for 15 years. She had occasional dry cough. When she felt watery & foul smelling p/v discharge, she went for a traditional treatment with kabiraj & took some chemical materials for applying on the prolapsed mass, then she developed a burn & damage on this prolapsed area with supper added infection, lastly maggot was formed with profuse foul smelling discharge. Then she admitted in Gynae ward of

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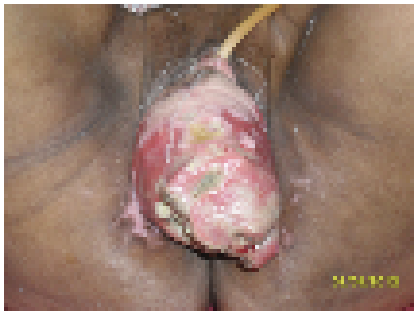
On examination:

She was ill looking, anxious & anaemic. Her prolapsed mass was partly distorted, oedematous, hard, & irreducible.

There was profuse foul smelling discharge & maggot was seen in situ about 20-24 in numbers.



(Damaged prolapsed mass with maggots)

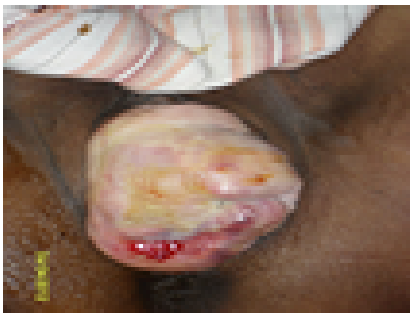
Other systematic examination revealed no abnormality.

Investigations:

CBC:

Hb%: 8.9 gm/dl.
Nutrophilic leucocytosis
ESR:-Raised
Serum creatinin: normal.
RBS: 6.0 mmole/L.
X-ray chest P/A view: Normal.
USG whole abdomen: Normal.
ECG: Normal.

She was given conservative treatment with daily dressing & ice pack to reduce the oedema for about 15 days & kept in complete bed rest with raised foot end & also given 3rd generation antibiotic & metronidazole. Then infection was subsided and oedema also subsided & prolapsed mass became soft & reducible. Again daily dressing & vaginal pack was given for further healing of ulceration.



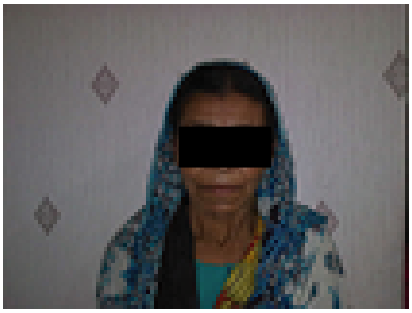
(Now oedema & infection-subsided & ulcer - healing on.)

Patient needed prolong stay in hospital for conservative treatment with daily dressing of prolapsed mass due to very poor general condition & finally it became healthy for surgical management.

(Now the prolapse mass is healthy for surgery)

The specific management was done surgically by vaginal hysterectomy with pelvic floor repair. There were no post operative complications & patient was discharged on 5th post operative day with advice.

Then she followed up after 6 months-having no complaints



Discussion:

Prolapse is the downward displacement of genital organ through the natural urogenital hiatus in the pelvic floor. It is infact a form of hernia. There are many complications may occur in prolapsed part, like keratinization of the vagina, decubital ulceration, hypertrophy of the cervix, congestion & oedema, Glandular hypertrophy, obstructive lesion of the urinary tract, infection of urinary tract & renal failure, incarceration of the prolapse, carcinoma of cervix & vagina (rarely).The common differential diagnosis include Gartner's cyst, chronic inversion of uterus, congenital elongation of cervix, fibroid polyp6. So detail clinical history & careful examination are needed for proper diagnosis & treatment. The following guidelines may be prescribed to prevent or minimize genital prolapse.

Adequate antenatal and intranatal care, adequate postnatal care, general measures- to avoid strenuous activities, chronic cough, constipation & weight lifting, to avoid future pregnancy too soon & too many by contraceptive practice.[6]

There are two treatment options for prolapse, conservative & surgical. Some women elect for non surgical treatment of their prolapse either because:

The prognosis offered for treatment is not sufficiently attractive. Unfit for surgery & wish to delay surgical treatment. Conservative treatment may involve-

- Life style advice, improvement of general health.
- Pelvic floor physiotherapy.
- Vaginal passary.
- Oestrogen replacement therapy in postmenopausal women.

Surgical management - Over the last 100 years, surgery has been considered to be the treatment of choice for the utero vaginal prolapse. In 1909, white[7] described the vaginal paravaginal repair to a cystocele. Four year later Kelly[8] described the anterior vaginal repair with a central plication of pubo cervical fascia. The classical posterior vaginal repair involves not only plication of the fascia underlying the vaginal skin but also a central plication of the fascia overlying the pubococcygeus muscle. Our patient receives at first conservative management due to complications of the prolapsed mass then surgical management-vaginal hysterectomy & pelvic floor repair.

Conclusion:

Genital prolapse due to pelvic floor muscle weakness causes mechanical & functional symptoms. Improving our understanding of the aetiology of prolapse should help to direct the treatment including non-surgical & surgical methods[9]. By making awareness about the aetiological factors for development of genital prolapse may helps the prevention of genital prolapse or procidentia. Also its early detection & treatment can prevent various types of serious complications & help to reduce both morbidities & mortalities.

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