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Pelvic Organ Prolapse in Women in a Tertiary Hospital: Evaluation and Management.

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Abstract

Background: Pelvic organ prolapse is the common clinical problem met in day to day gynaecological practice specially amongst the parous women both in developed and developing countries. It affects the quality of life of many women during their pre-menopausal and post- menopausal life. **Objective:** This study was under taken to evaluate the incidence of pelvic organ prolapse in women of Thangamara, Bogra. **Methodology:** This prospective study was carried out in the Department of Obstetrics and Gynaecology of TMSS Medical college & Rafatullah Community Hospital, Thangamara, Bogra from January to December 2013. A composite discriminative gynaecologic examinations, intravenous pyelography and different laboratory investigations were done to arrive at a correct diagnosis. **Results:** 200 patients of pelvic organ prolapse admitted in the hospital were enrolled in the discussion. In this study the age group was between 25 to 60 years. A total of 178 patients had 2? degree uterine prolapse (89%), Decubitus ulcer in 40 cases (20%). Vaginal hystrectomy with anterior colporrhaphy with or without posterior coloperineorrhaphy was the main method of surgical treatment. **Conclusion:** This study suggests that the pelvic organ prolapse is the sequelae of obstetrical trauma due to repeated child birth and can be reduced by taking proper antenatal, intranatal and post natal cares.

Key words: Prolapse, Evaluation, Management.

Introduction

Prolapse, procidentia from the latin word procidere, to fall or down ward descent of the vagina and uterus. Vaginal prolapse can occur without uterine prolapse but the uterus cannot descent without carrying the upper vagina with it[1]. Clinically pelvic organ prolapse broadly grouped into two- (I) Vaginal prolapse (II) Uterine prolapse (uterovaginal prolapse).[2] But to address the problems, the International Continence Society has approved a new system, The Pelvic Organ Prolapse Quantification Staging System (POP-Q) that Standardizes terminology of female Pelvic organ prolapse.[3]

In Bangladesh, pelvic organ prolapse appears to be wide spread, but a little published evidence exist. The most commonly perceived causes of prolapse reported were heavy household and physical works during pregnancy and soon after delivery and lifting heavy weight. Lack of skill birth attendant during delivery, frequent conceiving, giving birth too many children, inadequate antenatal and postnatal cares with lack of nutritious food were also responsible. In this study, it was seen that most of the patients complained feeling of something coming down per vagina while she was moving about, excessive whitish or sometimes blood stained discharge per vagina. There are various modalities of treatment of pelvic organ prolapse such as preventive, conservative and surgery[3,4]. Preventive and conservative managements were not indicated for these patients and surgery was the treatment of symptomatic prolapse.

Materials and Methods

This prospective study was carried out in the Department of Obstetrics & Gynaecology of TMSS Medical college & Rafatullah Community Hospital, Thangamara, Bogra and 200 patients

admitted with pelvic organ prolapse were enrolled in this study. Data sheet and questionsnaire forms were made for recording all relevant parameters. After admission a detailed socio- economic background including menstrual, obstetric and family involvement history was taken. General, physical and pelvic examinations were done. Various investigation reports were noted and type of operations were also recorded.

Results

The study was carried out on 200 patients and Various informations with results are shown in the tables

Table-I Age distribution of patients (N =200)

Age group in years	Number of patients	Percentage (%)
25- 30	20	10
31- 40	30	15
41- 50	40	20
51- 60	100	50
61 and above	10	5

Table-I shows that 20 patients were in the age group of 25 to 30 years (10%), 30 patients between 31 to 40 years (15%), 40 patients between 41 to 50 years (20%), 100 patients between 51 to 60 years (50%) and 10 patients between 61 and above (5%). Most of the cases were between 51 to 60 years of age.

Table-II Distribution of parity (N =200)

Number of Children	Number of patients	Percentage (%)
1-2	30	15
3-4	70	35
5-7	100	50

Table-II shows that 30 patients had 1- 2 children (15%), 70 had 3- 4 children (35%) and 100 had 5- 7 children (50%)

Table-III Aetiological aspects of prolapse (N =200)

Aetiology	Number of patients	Percentage (%)
Home delivery by Daies (untrained birth attendants)	60	30
Heavy house hold and physical works during pregnancy and soon after delivery	100	50
Lifting heavy weight	20	10
Lack of antenatal, intranatal and post natal cares	20	10

Table-III shows that Home delivery by Daies (untrained birth attendants) (30%), Heavy house hold and physical works during pregnancy and soon after delivery (50%), lifting heavy weight (10%) and lack of antenatal, intranatal and post natal cares (10%) were the aetiological aspects of prolapse.

Table-IV Per vaginal examination (N =200)

Findings	Number of patients	Percentage (%)
1° uterine prolapse	14	7
2° uterine prolapse	178	89
3° uterine prolapse	16	8
Vault prolapse	1	0.5
Elongated cervix	1	0.5
Cystocele	200	100
Rectocele	110	55
Decubitus ulcer	40	20
Hypertrophied cervix	20	10
Discharge	100	50
Ovarian cyst	4	2

Table-IV shows that 178 patients had 2° uterine prolapse (89%), 200 patients had Cystocele (100%), 110 patients had Rectocele (55%).

Table V: Clinical conditions and types of surgical management (N= 200).

Clinical conditions	Types of operation	Number of patients	Percentage (%)
1° degree uterine prolapse with cystocele and ovarian cyst	Total abdominal hystrectomy with PFR and ovarian cystectomy	4	2
2° degree uterine prolapse with cystocele and rectocele	Vaginal hystrectomy with anterior colporrhaphy and posterior colpoperineorrhaphy	134	67
2° degree uterine prolapse with cystocele and decubitus ulcer	vaginal hystrectomy with anterior colporrhaphy	40	20
2° degree uterine prolapse with cystocele. (Family incomplete)	Fothergill's operation	4	2
2° degree uterine prolapse with cystocele. (Family incomplete)	Fothergill's operation	4	2
3° degree uterine prolapse with cystocele, enterocele and rectocele	vaginal hystrectomy with pelvic floor repair (PFR)	16	8
vault prolapse	Sacral colpopexy with culdoplasty and anterior colporrhaphy with posterior colpoperineorrhaphy	1	0.5
Elongated cervix	Amputation of cervix	1	0.5

Table- V shows the clinical conditions and types of operation. vaginal hystrectomy with anterior colporrhaphy and posterior colpoperineorrhaphy was done in 134 cases (67%), vaginal hystrectomy with anterior colporrhaphy in 40 cases (20%), vaginal hystrectomy with PFR in 16 cases (8%).

Among 200 women of reproductive age group 100 cases were between 51 to 60 years of age with 5 to 7 children (50%), history of home delivery by daies in 60 cases (30%), heavy house hold and physical works during pregnancy and soon after delivery in 100 cases (50%), lifting heavy weight in 20 cases (10%) and lack of antenatal, instranatal and post natal cares in 20 cases (10%). Depending on age, reproductive, sexual function, types and degree of prolapse of individual woman, different types of surgical procedures such as Total abdominal hystrectomy with PFR and ovarian cystectomy in 4 cases (2%),Vaginal hystrectomy with anteror colporrhaphy and posterior colpoperineorrhaphy in 134 cases (67%), vaginal hystrectomy with anterior colporrhaphy in 40 cases (20%), for preservation of reproductive function Fothergill's operation in 4 cases (2%), vaginal hystrectomy with pelvic floor repair (PFR) in 16 cases (8%), Sacral colpopexy with culdoplasty and anteror colporrhaphy with posterior colpoperineorrhaphy in 1 case (0.5), Amputation of cervix in 1 case (0.5%) were adopted. Before surgery, the patients had undergone intensive resuscitative measures by blood transfusion and proper antibiotics.

Discussion

Pelvic organ prolapse constitutes to be one of the major gynaecological problem throughout the world. It is as high as about 20 percent of all gynaecological admission in Indian hospitals[4]. In our study 200 patients had pelvic organ prolapse and the incidence was 20%. Schaaf et al reported that in west Nepal, 25% had third degree uterine prolapse and procidentia[5]. In the women's Health Initiative study, investigators found 41.1 percent prevalance of pelvic organ prolapse in post menopausal women older than 60 years who had not had a hystrectomy[6]. In this study 100 patients were in age group between 51-60 years with 5- 7 children (50%), In Gambia the patients were between 35- 54 years age with 4- 7 children.[7] Sultana. N's study shows maximum patients (57%) were belonged to 51 years and above age group with 5-7 children[8]. In marahatta & shah, maximum numbers of women having genital prolapse with 8 or more children (48.51%).[9] In the post operative period, none of the patients had urinary complication but some patients complained vaginal dischrage and vaginal bleeding which were managed by conservative measures. Dyspareunia was reported by some patients when they came for checkup. A high rate of dyspareunia was reported after prolapse surgery[10]. Vaginal intercourse are avoided by some women out of concern or embarrassment after prolapse surgery. Other women experiences urinary and fecal incontinence that interferes with sexual activity[11].

Conclusion

To reduce the pelvic organ prolapse in rural women, take attempt to provide proper antenatal, intranatal and postnatal cares to all pregnant women including extra nutritional supplement to them like other developed countries. To update the training program for skilled birth attendants, education, awareness of health status of couple and acceptance of "Two child family norm" may improve the living standard to some extent and will prevent the occurrence of pelvic organ prolapse.

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