

Uterine Prolapse in Women of Different Age Groups: 4 Cases Report

Dr Ramya Bala Prabha.G¹, Rama Rao.T², Palle Sree Lakshmi³, Mohd Qhader Shareef³, Jeevana Kumari.C³, K. Sindhuja³, Syeda Juveriya Amreen³, Syeda Tazheen Fatima³

¹ Assistant Professor, CMR College of Pharmacy, Kandlakoya, Medchal, Telangana, India.

² Professor and Principal, CMR College of Pharmacy, Kandlakoya, Medchal, Telangana, India.

³ CMR College of Pharmacy, Kandlakoya, Medchal, Telangana, India.

*Corresponding author's E-mail: ramyapharmd66@gmail.com

ABSTRACT

Pelvic organ prolapse (POP) is a disorder that has a negative impact on women's quality of life. Uterine prolapse affects 35-50 percent of women, and the prevalence rises with age and parity. Approximately half of all women who give birth vaginally may experience genital prolapse. Age, hormones, oestrogen, collagen density, birth damage, obesity, chronic cough, and chronic constipation are all key risk factors for uterine prolapse. Ligaments, pelvic floor muscles, pelvic organs, and fascia are all affected by these factors. This was a retrospective assessment of medical case data from proven instances of uterine prolapse admitted to the Hospital in Hyderabad, Telangana, India. Following permission from the Institutional Ethics Committee, it was carried out in 2021 and 2022. During their pregnancies, none of the three women studied developed uterine prolapse. Women who have had two vaginal births are four times more likely than nulliparous women to experience prolapse, according to earlier research. The treatment of uterine prolapse in pregnancy should be tailored according on the degree of the prolapse, the patient's parity, the gestational age, and their preferences. This should be done while the patient is in labour.

Keywords: Uterine prolapse, adolescence, Purandare, collagen.

INTRODUCTION:

Pelvic organ prolapse (POP) is a disorder that has a negative impact on women's quality of life. Uterine prolapse affects 35-50 percent of women, and the prevalence rises with age and parity

[1]. Approximately half of all women who give birth vaginally may experience genital prolapse. Age, hormones, oestrogen, collagen density, birth damage, obesity, chronic cough, and chronic constipation are all key risk factors for uterine prolapse [2]. Ligaments, pelvic floor muscles, pelvic organs, and fascia are all affected by these factors [3].

Uterine prolapse is uncommon in young women of reproductive age, with about 2% of nulliparous women experiencing POP [4]. According to one study, individuals with uterine prolapse had lower collagen levels. Patients with immature collagen cross-links had a greater component than non-POP patients [5]. This newly generated collagen degrades more easily than older glycosylated material, resulting in reduced collagen matter and glycosylated collagen tissue diseases with diminished mechanical force [6]. Greater metalloproteinase activity indicated increased collagen breakdown in POP patients [7].

METHOD:

This was a retrospective assessment of medical case data from proven instances of uterine prolapse admitted to the Hospital in Hyderabad, Telangana, India. Following permission from the Institutional Ethics Committee, it was carried out in 2021 and 2022. A validated proforma was used to collect data, which included sociodemographic information, obstetric information, details of the presenting symptoms, degree of uterine prolapse, related pelvic structural prolapse, and treatment methods.

The socioeconomic status was evaluated. According to WHO categorization, body mass index was categorised as underweight, normal, or overweight.

PRESENTATION OF CASES:

Case 1:

A 30-year-old female patient with gravida 2, para 2, with previous history of normal vaginal delivery and not tubectomised, presented to the hospital with complaints of abdominal pain, cystocele and rectocele on 19th of February, 2022.

Previous pregnant record was as follows: healthy babies with normal vaginal delivery.

On examination: Patient was conscious, afebrile, PR (Pulse rate) – 88 bpm, CVS (Cardiovascular sounds)- S₁S₂(+), P/A (Per abdomen) – soft, SPO₂ (Oxygen saturation)- 98% with RA (Room air), GRBS (general random blood sugar)- 116 mg/dl.

Laboratory findings:

T₄- 7.6 µg/dl, TSH (Thyroid stimulating hormone) – 1.08 µ/u/ml.

Case 2:

A 43-year-old, adult female patient with gravida 5, para 3, with previous history of normal vaginal delivery and tubectomised 20 years back, presented to the hospital with complaints of bleeding since 2 months with cervical poly menopause on 16th of February, 2022. Patient had history of biomass exposure.

Previous pregnant record was as follows: death of 2 babies after normal vaginal birth.

On examination: Patient was conscious, afebrile, PR (Pulse rate) – 92 bpm, CVS (Cardiovascular sounds)- S₁S₂(+), P/A (Per abdomen) – soft.

Laboratory findings:

T₄- 8.8 µg/dl, TSH (Thyroid stimulating hormone) – 1.03 µ/u/ml.

Case 3:

A 65-year-old, elderly female patient with history of nulligravida, presented to the hospital with complaints of post menopausal bleeding with 3rd degree UV prolapse, and known case of hypertension.

Previous pregnant record was as follows: Nulliparous.

On examination: Patient was conscious, afebrile, PR (Pulse rate) – 72 bpm, CVS (Cardiovascular sounds)- S₁S₂(+), P/A (Per abdomen) – soft, Blood pressure (BP) – 110/70 mm of Hg.

Laboratory findings:

T₄- 7.1 µg/dl, TSH (Thyroid stimulating hormone) – 3.7 µ/u/ml.

Case 4:

A 28-year-old, adult female patient with gravida 3, para 3, with previous history of normal vaginal delivery and not tubectomised, presented to the hospital on 19th of February, 2022 with complaints of mass per vagina, burning micturition since 1 week and bleeding per vagina on & off since 5 months.

Previous pregnant record was as follows: patient reported history of 1 abortion at first trimester, 2 healthy babies with normal vaginal delivery.

On examination: Patient was conscious, afebrile, PR (Pulse rate) – 86 bpm, CVS (Cardiovascular sounds)- S₁S₂(+), P/A (Per abdomen) – soft.

THERAPEUTIC APPROACH:

- All the patients have been prescribed with Tablet. Cefixime and Ofloxacin of 200mg, twice daily, Tablet. Metronidazole of 400mg trice daily, as prophylaxis for infection.
- Tablet. Ranitidine 50mg, twice daily, before food, Multivitamin tablets once daily, to prevent heart burn.
- Tablet Tranexamic Acid and Ethamsylate, twice daily to control per vaginal bleeding.
- Syrup. disodium hydrogen phosphate, to prevent urinary tract infections (UTI).

DISCUSSION:

Uterine prolapse is frequent in elderly women who are not pregnant; however, uterine prolapse complicating pregnancy is an uncommon occurrence that either existing before to pregnancy or develops suddenly during pregnancy [8].

During pregnancy, the pathogenesis of uterine prolapse is likely complex. Parity, malnutrition, race, vaginal delivery, short intervals between consecutive pregnancies, increased strain on the support of the uterus, physiologic change of pregnancy causing cervical elongation, hypertrophy and relaxation of the support ligament, and a history of prolapse are among the most prevalent risk factors [9].

Pregnancy-induced polyps (POP) are rare, although they might reoccur after the birth of the baby.

In this case study, there were four women who were above the age of adolescence. Three of the women were multiparous, while the fourth was nulliparous. Pregnancy-related uterine prolapse is more common in women who have already given birth. During their pregnancies, none of the three women studied developed uterine prolapse. Women who have had two vaginal births are four times more likely than

nulliparous women to experience prolapse, according to earlier research. Women who have given birth to one child have a relative risk of developing uterine prolapse of 2.48 (95 percent confidence interval [CI], 0.69–9.38), whereas that risk rises to 4.58 (95 percent CI, 1.64–13.77), 8.4 (95 percent CI, 2.84–26.44), and 11.75 (95 percent CI, 3.84–38.48) in comparison to nulliparous women (those who have delivered 2, 3, or >3 children) [10].

CONCLUSION:

It is important for all engaged caregivers, including obstetricians, to be aware of this unusual phenomena, since early diagnosis is the key to ensuring a healthy pregnancy. When these patients are treated conservatively throughout their pregnancies, they have a better chance of having an uncomplicated, normal, and spontaneous birth. The treatment of uterine prolapse in pregnancy should be tailored according on the degree of the prolapse, the patient's parity, the gestational age, and their preferences. This should be done while the patient is in labour.

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