Incarcerated Uterine Prolapse: A Result of Neglect

Adhikari A,[1] Poudel A,[1] Dangal G[2]

[1]Department of Obstetrics and Gynecology,
Paropakar Maternity and Women's Hospital,
National Academy of Medical Sciences (NAMS),
Kathmandu, Nepal.

[2]Department of Obstetrics and Gynecology,
Kathmandu Model Hospital,
National Academy of Medical Sciences (NAMS),
Kathmandu, Nepal.

Corresponding Author

Anjana Adhikari
Department of Obstetrics and Gynecology,
Paropakar Maternity and Women's Hospital,
National Academy of Medical Sciences (NAMS),
Kathmandu, Nepal.

E-mail: dr.anjana9@gmail.com

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ABSTRACT

An 80-year-old lady was brought with the three-month history of irreducible prolapse with infected ulcer at anterior vaginal wall. She initially attempted home remedies for infection with locally available materials. On examination she was ill looking, febrile with stage IV prolapse according to pelvic organ prolapse quantification classification. She was treated initially with antiseptic wash, followed by local estrogen therapy and glycerine. Prolapse was repositioned when edema decreased and held in place with silicon ring pessary with definitive management planned for later date.

KEY WORDS

Incarcerated prolapse, Irreducible prolapse, Ulcer

INTRODUCTION

Uterine prolapse is a common condition which affects 41-50% of women above 40 years.[1,2] Although not life threatening, prolapse has a significant impact on women's physical, psychological, and social well-being and quality of life. Prolonged duration and advanced stages of prolapse may lead to hydronephrosis and obstructive neuropathy, which may worsen progressively leading to kidney damage.[3] Incidence of incarceration of uterine prolapse is unknown because, it is rarely reported. Incarceration may be due to narrowed introitus, cul-de sac abscess, vesical calculi, carcinoma cervix, cervical fibroid, and pelvic mass.[4-8] In our case incarceration was due to neglect leading to edema, inflammation, and ulcer.

CASE REPORT

An 80-year-old lady, home maker, illiterate, living by herself, sexually not active, menopausal since 25 years, para 6 living 2, was brought to our hospital with something coming out of introitus and generalised ill health. The mass something coming out of the introitus from 56 years. She first noticed the mass when she was 21 years old, which was immediately after the delivery of her second child. The mass gradually increased in size, initially it was reducible spontaneously on lying down, gradually she must reduce it manually and in the last 15 years it was completely outside the introitus and irreducible. She had to reduce mass digitally to facilitate complete voiding. From 3 months, the mass has become heavy and hard, and stained her clothes with blood. She was brought to the hospital by her granddaughter in law who noticed mass hanging out of the introitus which was foul smelling and covered with multiple white worms. They removed the worms by pouring tobacco and camphor-soaked water in the prolapsed area. They repeated the procedure daily for three days and then they came to visit us. Because of the lack of toilet facilities

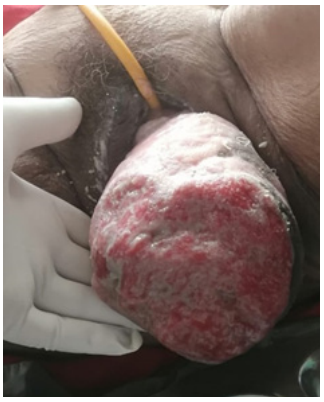

Figure 1. Prolapse with ulcer at Presentation

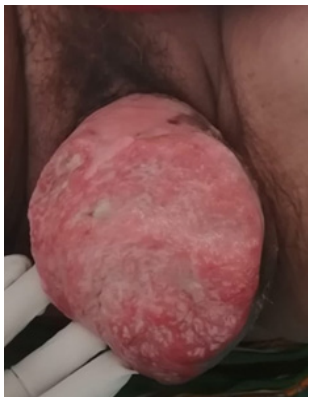

Figure 2. Prolapse after conservative treatment

at her place, lady must use an open field for defecation. During which mass touches on the field while defecating and sustained scratches and injuries. She limited her food and water intake so that she need not go for urination and defecation frequently.

She gives history of chronic constipation and passage of hard pellet like stool. She gives no history of any other chronic medical conditions, and she has visited hospital for the first time. She liked to remain at home because she had difficulty in walking with prolapse, she felt heavy and painful. Since she was living alone, she was performing her daily chores with difficulty. She was very sad and cursing herself and asking death wish to God. This indicates that the condition has greatly impacted her everyday life and overall quality of life. Until now she has not sought medical care because of shame, also she didn't want to bother others, and she cannot go by her own.

On general examination she was ill looking, febrile, Height 148 cm, weight 40 kg, Body mass index (BMI) 18.26 kg/m^2, Blood Pressure 130/90 mmHg, other systemic examination was normal. On pelvic organ prolapse, stage IV prolapse according to POP Q, hard, irreducible, edematous, with ill-defined ulcer on the anterior vaginal wall including cervix measuring 7 cm X 5 cm.

Her haemoglobin was 9 gm/dl, C-reactive protein was positive, renal function test was within normal limit, ultrasound abdomen and pelvis were normal. Her bladder was catheterized as she had difficulty in passing urine. She was admitted and treated with broad spectrum antibiotics, cleaning of the prolapsed part initial few days with betadine and later with normal saline, daily dressing and packing with local estrogen and glycerin. After 15 days of conservative management, the prolapse was reduced under anaesthesia and a silicon ring pessary of appropriate size was placed. Definitive surgical management planned for a later date after ulcer heals, but patient did not want any surgery.

DISCUSSION

The prevalence of Pelvic Organ Prolapse (POP) in Nepal varies in different studies ranging from 10% to 45%.[9] According to demographic health survey of Nepal 2006, around 600,000 women were suffering from uterine prolapse and one-third of them require immediate treatment. But there is delay in seeking care because of various reasons including shame and embarrassment, or misperceptions about the available treatment options.[10] This may lead women to perform attempts to solve problem at home which at times may be life threatening.[11] In our case also she did not seek medical care initially and attempted self-treatment at home with locally available materials.

Irreducible prolapse could be due to various factors and is susceptible to trauma and injury which may further lead to complications as in our case.[4-8] There are reports of mortality due to prolapse because of septicaemia, urinary complications, ischaemia of uterus and bowel strangulation, which is expected to be rare nowadays due to availability of treatment options and surgical facilities.[12] In our case the lady was ill looking, she was febrile, and had raised C-Reactive Protein; all were indicating towards septicaemia.

The initial management is to decrease edema and reduce prolapse typically by pessary or obstetric balloon in rare case. and plan surgical management at later date.[4] Surgical management is definitive management and it may be obliterative or restorative procedure, depending on various factors like age, general condition, medical comorbidities, associated conditions, and woman's preference.[9]

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