PROLAPSED UTERUS- A CASE STUDY

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ABSTRACT

Uterine prolapse is a condition in which a woman's uterus (womb) sags or slips out of its normal position. It is a common general problem in which 50% of parous women have some degree of prolapse and 10-20% of these cause symptoms. Pelvic organ prolapse is very frequent; one out of nine women will need a surgery to repair her uterine prolapse. Existing facts on uterine prolapse do not show exactly how many women are affected. However, various studies indicate that it is a common condition and that women face an increased risk as they age. Uterine prolapse can happen to women of any age, but it often affects postmenopausal women who've had one or more vaginal deliveries. Weakening of the pelvic muscles that leads to uterine prolapse can be caused by: Damage to supportive tissues during pregnancy and childbirth, Effects of gravity, Loss of estrogen, Repeated straining over the years. If you have mild uterine prolapse, treatment usually isn't needed. But if uterine prolapse makes you uncomfortable or disrupts your normal life, you might benefit from treatment.

KEYWORDS: Uterus Prolapse, Prevalence, Associated Factors, Treatment

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INTRODUCTION

The uterus (womb) is usually held in place by muscles, tissue and ligaments\(^1\). Prolapse happens when the tissues that support the uterus become so weak that the uterus cannot stay in place and it slips down from its normal position. Also, as a woman ages and with a natural loss of the hormone estrogens, her uterus can drop into the vaginal canal, causing the condition known as a prolapsed uterus\(^3\). Weakening of pelvic muscles and supportive tissues contribute to uterine prolapse. This may happen as a result of Pregnancy, Trauma during childbirth, Delivery of a large baby, Difficult labor and delivery, Loss of muscle tone, Less circulating estrogen after menopause. The Women's Health Initiative in the U.S. showed some degree of prolapse in 44 percent of women, 14 percent of those women had uterine prolapse, A follow-up of the WHI study showed uterine prolapse regressed in almost 48 percent of women. Another study in the U.S. found women have an 11 percent lifetime risk for the condition, A U.K. study reported that surgery was required in 16 of 10,000 cases, Women with a body mass index (BMI) greater than 35 are at higher risk, 95 percent of hysterectomies in a U.K. study were for uterine prolapsed.

CASE STUDY OF MRS. B

Mrs. B, aged 70 years, came with the complaints of mass descending per vagina since 3 years, complaints of pre-menstrual spotting episodes 3 months back, complaints of cough and cold for 10 days, burning micturation for 2 months on and off. She also has complaints of itching over the external genitalia; there is no significant family history and past medical history. She attained menarche at the age of 12 years, her menstrual cycle is regular. She got married at the age of 15 years. She maintains normal sexual relationship with her husband, no history of using contraceptives. She has attained her menopause.

DEFINITION

Prolapse of the uterus refers to a collapse, descend or change in the position of the uterus in relation to surrounding structure in the pelvis\(^2\)

ALTERNATIVE NAMES

Pelvic relaxation - uterine prolapse; pelvic floor hernia; Prolapsed uterus

CAUSES

There are several factors that may contribute to the weakening of the pelvic muscles, which includes

- AGEING AND MENOPAUSE:
  the aging process weakness the pelvic muscles and also the natural reduction of the hormone oestrogen at menopause also causes the muscles to become less elastic and weak\(^1\)

- PREGNANCY AND CHILD BIRTH:
  Normal vaginal delivery is also one of the reasons to cause pelvic organ prolapse. Because of the long, difficult and multiple child birth process causing the muscles and ligaments to become stretch, slack and less elastic.\(^3\)

OTHER RISK FACTORS INCLUDE:
- Conditions that put pressure on the pelvic muscles, such as chronic cough and obesity
- Pelvic tumour (rare)\(^4\)
- Repeated straining to have a bowel movement due to long-term constipation can make the problem worse.
- Previous pelvic surgery
- Large fibroids and tumours
- Spinal cord injury
- Genetic conditions
- Symptoms may be worse when you stand or sit for a long time. Exercise or lifting may also make symptoms worse.

My patient is 70 years old and she has attained her menopause.

She has delivered five babies by full term normal vaginal delivery. Her obstetrical score is P7L5D2.

- presence of chronic cough
- constipation
- heavy weight lifting
**SHAW’S CLASSIFICATION OF UTERINE PROLAPSE**

Muscle weakness or relaxation may allow your uterus to sag or come completely out of your body in various stages:

- **First degree:** The cervix drops into the vagina.
- **Second degree:** The cervix drops to the level just inside the opening of the vagina.
- **Third degree:** The cervix is outside the vagina.
- **Procidentia:** The entire uterus is outside the vagina. This condition is also called procidentia. This is caused by weakness in all of the supporting muscles.

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**Figure 2: Degrees of Uterine Prolapse**

Mrs. B is having 3rd Degree uterine prolapse with Cystocele and Rectocele. Erosion positive around the cervix

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**SYMPTOMS**

<table>
<thead>
<tr>
<th>BOOK PICTURE</th>
<th>PATIENT PICTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure or heaviness in the pelvis or vagina</td>
<td>Present</td>
</tr>
<tr>
<td>Problems with sexual intercourse</td>
<td>Present</td>
</tr>
<tr>
<td>Leaking urine or sudden urge to empty the bladder</td>
<td>Present</td>
</tr>
<tr>
<td>Low backache</td>
<td>Present</td>
</tr>
<tr>
<td>Uterus and cervix that bulge into the vaginal opening</td>
<td>Present</td>
</tr>
<tr>
<td>Repeated bladder infections</td>
<td>Present</td>
</tr>
<tr>
<td>Vaginal bleeding and discharge</td>
<td>Present</td>
</tr>
<tr>
<td>Increased vaginal discharge</td>
<td>Present</td>
</tr>
<tr>
<td>Lower abdominal pain</td>
<td>Present</td>
</tr>
<tr>
<td>Frequency of micturition</td>
<td>Present</td>
</tr>
<tr>
<td>Difficulty in emptying bowel</td>
<td>Present</td>
</tr>
</tbody>
</table>

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**SIGNS**

<table>
<thead>
<tr>
<th>BOOK PICTURE</th>
<th>PATIENT PICTURE</th>
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</thead>
<tbody>
<tr>
<td>Bimanual Examination - reveals the cervix is directed upwards and forwards, the body of the uterus is felt through the fornix</td>
<td>Present</td>
</tr>
<tr>
<td>Speculum Examination - the cervix comes in view much easily and external os points forward</td>
<td>Present</td>
</tr>
<tr>
<td>Rectal Examination - helps to confirm the diagnosis</td>
<td>Present</td>
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**DIAGNOSTIC EVALUATION**

<table>
<thead>
<tr>
<th>BOOK PICTURE</th>
<th>PATIENT PICTURE</th>
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</thead>
<tbody>
<tr>
<td>History collection</td>
<td>History collection has taken</td>
</tr>
<tr>
<td>A complete physical examination</td>
<td>Physical examination is done</td>
</tr>
<tr>
<td>A pelvic examination: ask the woman to bear down will show how far the uterus comes down</td>
<td>Mass descending per vagina</td>
</tr>
<tr>
<td>Laboratory studies: complete blood count (CBC), basic metabolic panel,</td>
<td>Total WBC count-10370 cells/cumm, neutrophils-58.3%, lymphocytes-34.9%, eosinophils-3.4%, basophils-0.4%, haemoglobin-10.8gm/dl, ESR(1hr)-64mm, haematocrit(PCV)-35.2%, platelets count-3.28 lakhs/cumm</td>
</tr>
<tr>
<td>Blood biochemistry</td>
<td>Urea-27mg/dl, Creatinine-1.1mg/dl, Glycosylated Haemoglobin (HBA1C)-6.32%</td>
</tr>
<tr>
<td>Urinalysis: Urine culture and Sensitivity</td>
<td>Thyroid Function test: Free T3-2.65pg/ml, Free T4-1.18ng/dl, Thyroid Stimulating Hormone (TSH)-5.74IU/ml</td>
</tr>
<tr>
<td>Ultrasound Imaging</td>
<td>Gram Stain: Gram negative bacilli seen, few pus cells seen,</td>
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<tr>
<td></td>
<td>colony count-10^5 cfu/ml</td>
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<tr>
<td></td>
<td>ESCHERICHIA COLI grown in culture</td>
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<td></td>
<td>IMPRESSION:</td>
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<tr>
<td></td>
<td>Bilateral hydroureronephrosis</td>
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<td></td>
<td>Prolapsed uterus</td>
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<td></td>
<td>Thickened endometrium</td>
</tr>
<tr>
<td></td>
<td>Bilateral hydrosalpinx</td>
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MANAGEMENT OF UTERINE PROLAPSE

PREVENTIVE:
1. Adequate antenatal and intranatal care: to avoid injury to the supporting structures.
2. Adequate postnatal care: to encourage early ambulation and pelvic floor exercises (Kegel exercises).
3. Limiting and spacing pregnancies helps to avoid pelvic relaxation.
4. General measures: to avoid strenuous activities, chronic cough, constipation, and heavy weight lifting.

CONSERVATIVE:
1. Estrogen Replacement therapy: may improve minor degree prolapse in postmenopausal woman.
2. Obese patient may be instructed to reduce weight in order to reduce pressure on pelvic organs.

NON-SURGICAL MANAGEMENT:
A Pessary is placed inside the vagina to support the pelvic organs for patients who do not desire surgery, waiting for surgery or unfit for surgery.

SURGICAL MANAGEMENT:
Options in the surgical treatment of uterine prolapse encompass the open, laparoscopic, or vaginal approaches.

NURSING MANAGEMENT:
Monitor vital signs, start IV fluids, collect all the investigation reports, administer pre-medication, consent form should be/get signed, explain the client about her condition and treatment measures, check for anaesthetist opinion, give psychological support.

Mrs. B is planned for vaginal hysterectomy

Nursing care was given to Mrs. B like monitoring vitals, maintained IV fluids, getting consent, due drugs given, got anaesthetist opinion, pre-medication given, explained all the procedure and adequate psychological support was also given.

Complication following surgery may include haemorrhage within 24hrs (primary) or between 5th and 10th day (secondary). Retention of urine, infection, wound sepsis and vault cellulites. The remote complication may include dyspareunia, recurrence of prolapse, vesicovaginal fistula following bladder injury, infertility and cervical incompetence. Conservative management with close follow-up and bed rest can alleviate clinical symptoms and reduce potential complications correlated with this condition.

CONCLUSION

Prolonged labour and vaginal delivery involving sphincter and vaginal tear are the main determinants of uterovaginal prolapse. Pelvic exercises (Kegel exercises) and pessaries are the current mainstays of nonsurgical management of patients with uterine prolapse. The presence of many modifiable risk factors warrants health programs to strongly consider these issues and to develop interventions targeting the prevention of uterovaginal prolapse.

CONFLICT OF INTEREST

Conflict of interest declared none.

REFERENCES
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