

CLINICAL PROFILE AND MANAGEMENT OF UTEROVAGINAL PROLAPSE WITH LOWER URINARY TRACT SYMPTOM (LUTS)

*S BEGUM¹, S SHARMIN², P SULTANA³, AN CHOWDHURY⁴, P SULTANA⁵, S NABI⁶, MN UDDIN⁷, MM HASAN⁸

Abstract:

Genital prolapse affects the quality of life of many women during their pre-menopausal and post menopausal years. The aim of the study is to record the aetiological aspect, precipitating factors in the causation of genital prolapse. The objective is to evaluation of cases in terms of clinical profile, different modalities of treatment and the complication associated with prolapse. It is a prospective type of study was carried out in the Department of Obst. & Gynae in district hospital Comilla from January 2009 to December 2009. 72 cases of uterovaginal prolapse admitted in the study period were enrolled in this study. In this study most of the cases (36.11%) were in the age group between 51-60 yrs, having 5-9 children (54.16%) and early resumption of activity after delivery (52.77%), prolonged labour (22.22%) and chronic cough (27.77%) is the common cause. In this study maximum cases were poor (56.94%) and something coming down per-vagina (100%), urinary problem (72.22%) and backache (62.50%) is the main symptom. Most of the patient had 2^o uterovaginal prolapse and vaginal hysterectomy with ant colporrhaphy with or without posterior colpoperinorrhaphy is the main method of treatment.

Key words: Uterovaginal Prolapse, lower urinary tract symptom

Introduction:

Uterovaginal prolapse is a downward descent of uterus and or vaginal wall through the pelvic aperture of uterovaginal hiatus^{1,2}. It is a highly prevalent chronic or residual maternal morbidity in South East Asia, frequently among Bangladeshi women.

In Bangladesh uterine prolapse appear to be widespread, but little published evidence exist. The most commonly perceived causes of prolapse was reported by gynaecologist is lifting heavy weight, including the postpartum period. Most reports describe heavy household and physical working during pregnancy as well as pre and post delivery is the main causes and risk factors for this problem in Bangladesh. Similarly lack of access to skilled attendant during delivery,

frequent conceiving, giving birth too many children and lack of nutritious food are also responsible³.

There are various modalities of treatment among them hysterectomy, specially vaginal hysterectomy has the advantage that no abdominal incision is needed, thereby reducing operative pain and hospital stay. This can be combined with anterior colporrhaphy and posterior colpoperineorrhaphy. Open abdominal or laparoscopic sacrohysteropexy can be performed if the women wishes to retain her uterus. The uterus is attached to the longitudinal ligament over the sacrum, mesh is used to hold the uterus in placed⁴. Sacrospinous fixation is one of the treatment of prolapse uterus. Unilateral or bilateral fixation of uterus to the sacrospinous ligament, performed by via vaginal route. It has lower success rate than sacrohysteropexy. Risk of injury to the pudendal nerve and vessels and sciatic nerve. In this study most of the patient treated by vaginal hysterectomy with anterior colporrhaphy and post colpoperinorrhaphy was done when necessary. The objective of the study is to summarize the clinical profile and management of uterovaginal prolapse attending in Gynae & obst department in general hospital Comilla.

Materials and Method:

This was a prospective type of study, carried out in the department of Gynae & obst in general hospital Comilla, from January 2009 to December 2009. All the patient admitted with uterine prolapse taken as target population. Sampling was done perpusively. Total 72 patients of uterovaginal prolapse were included in this study.

Data sheet and questionnaire form was made for recording all relevant parameters. After admission a detail socio-demographic history was taken. A details history including menstrual, obstetric and family involvement history was taken. General, physical and pelvic examinations were done. Various investigation reports were noted and type of operation and complication also recorded. All the information were analysed result were presented in tables.

Results:

This study was carried out on 72 cases of genital prolapse in general hospital Comilla in 2009.

Table-I
Age distribution of patients (n=72)

Age group (yrs)	No. of patients	Percentage (%)
31-40	13	18.05
41-50	24	33.33
51-60	26	36.11
61-70	06	8.33
> 70	03	4.16

Table-I shows most of the cases were in the age group between 51-60 yrs (36.11%).

Table-II
Distribution of parity (n=72)

Parity	No. of patients	Percentage (%)
0	0	0
1-4	30	41.66
5-9	39	54.16
> 10	03	4.16

Table-II shows most of the women had 5-9 children (54.16%).

Table-III
Etiology of genital prolapse (n=72)

Etiology	No. of patients	Percentage (%)
H/O prolonged labour	16	22.22
Lifting heavy weight	18	25
Early resumption of activity	38	52.77
Application of forcep	00	00
Chronic cough	20	27.77
Chronic constipation	12	16.66

Table-III show early resumption of activity is the most common cause (52.77%).

Table-IV
Socioeconomic condition (n=72)

Socioeconomic condition	No. of patients	Percentage (%)
Poor	41	56.94
Middle class	25	34.72
Upper middle class	06	8.33

Table-IV shows maximum cases belongs to the poor socioeconomic condition (56.94%).

Table-V
Symptomatology of genital prolapse (n=72)

Presenting symptoms	No. of patients	Percentage (%)
Something coming down	72	100
Urinary incontinence (stress)	05	6.94
Discharge	30	41.66
Defaecation problem	16	22.22
Backache	45	62.5
Urinary problem	52	72.22

Table-V shows all cases had the common problems something coming down the per vagina (100%) about 72.22% cases suffered from LUTS.

Table-VI
Examination finding (n=72)

Findings	No. of patients	Percentage (%)
Uterine problem		
• 1 ⁰	08	11.11
• 2 ⁰	58	80.55
• 3 ⁰	06	8.3
Cystocoele	72	100
Hypertrophied cervix	10	13.88
Uterine atrophy	38	52.77
Rectocoele	54	75
Decubitous ulcer	15	20.83
Discharge	30	41.66

Table-VI shows most of the cases had 2⁰ uterine prolapse (80.55%) & all the patient had uterine problem with cystocoele (100%).

Table-VII
Types of operation done (n=72)

Name of operation	No. of patients	Percentage (%)
Vaginal hysterectomy with anterior colporrhaphy and post clopperineorrhaphy	57	79.16
Vaginal hysterectomy with anterior colporrhaphy	12	16.66
Fothergill,s operation	02	2.77
Vault repair	01	1.38

Table-VII shows all the patient are managed surgically. Most of the patient treated by vaginal hysterectomy with anterior colporrhaphy and post clopperineorrhaphy (79.16%).

Table-VIII
Morbidity during and after operation (n=72)

Complications	No. of patients	Percentage (%)
Bleeding		
• average	30	41.66
• more than average	08	11.11
• minimal	34	47.22
Temperature	16	22.22
UTI	15	20.83
Urinary retention	03	4.16
Blood stained discharge	23	31.94

Table-VIII shows most of the patient had minimal blood loss (47.22%) during operation & blood stained discharged is the common postoperative complication (31.94%).

Discussion:

This study was carried out with an aim to find out the clinical profile and management pattern of uterovaginal prolapse in Bangladesh. Total 72 patients were admitted in department of Obstetric & Gynaecology in general hospital Comilla with uterovaginal prolapse during the period of 1st January 2009 to 31st December 2009 were enrolled in the study.

In this study most of the patients (36.11%) were in age group between 51-60 years, followed by 33.33% within

41-50 years and 18.05% within 31-40 years. A total 479 woman were examined by swift the average age of their series was 44 years.⁵ In Sultans study (2008) Shows maximums patients (57.0%) were belonged to 51 years and above age group⁶. Out of all patients in this study 54.16% were multipara having number of children 5-9 and none of the patient were nullipara.

In Marahatta & Shah⁷ maximum numbers of women were having children eight and more (48.51%) only 1.9% of women with genital prolapse were nulliparous. In Sultans series 96% were multipara and 4% were nullipara⁶. In this study more than 52% patients gave history of early resumption of house hold activity during puerperium and 25% lifted heavy weight during their daily activities, 27.77% patients had history of chronic cough, 22.22% patients had H/O prolonged labour and 16.66% had chronic constipation. In Sultans study 36.0% patients had chronic cough, 35% had H/O lifting heave weight, 13.0% chronic constipation, 42% prolonged labour & 3% had forcep delivery⁶. The study conducted by Bodner Adler et al. showed most of affected women were smoker and most of them were post menopausal, 35% of affected patients had chronic COPD, nearly all patients reported that they were working heavily during pregnancy as well as in the postpartum period (87.%), extensive physical labour during pregnancy and immediately after delivery, low availability of skilled birth attendants, smoking and low maternal weight due to lack of nutritious food were mainly responsible for prolapse uterus, 12.5% patients had family history of uterovaginal prolapsed.⁸ Most of the patient did not known about their family history of prolapse in Khan K. series 23.47% had family history⁹.

About the socioeconomic study of the patients 56.94% patients were poor, 34.72% middle class and 8.33% belongs to upper middle class. In Sultans series 63.% were from lower class, 37.0% from middle class and 33.0% patients were come from urban, 67.0% from rural area.⁶ Which is more or less similar to this study. All the study population had something coming down P/V, (72.22%) had urinary problem, 62.5% cases had backache, 41.66% patients had vaginal discharge, 22.22% had defecation problem and 6.94% patient had urinary incontinence (stress). In Sultans study 2008 all cases had something coming down per vagina, 97.0% had backache, 97.0% and 82.0% had complications of frequency of micturation and sense of incomplete voiding respectively, 5% had complaints of retention of urine, 59% cases had complaints of difficulty in defecation and 41% had constipation⁶.

In Luka et al. series the prevalence of prolapse was 70%, stress incontinence 15.0% and overactive bladder was 13.0%¹⁰. In Khan K. (2005) series 100% cases had complaints of some thing coming out per vagina, then urinary problem (69.57%) including stress incontinence (14.78%). 39% cases had backache, excessive discharge with defecation problem in 26.09% cases. In this study 80.55% cases were second degree uterine prolapse, 11.11% had first degree prolapse and 8.3% had third degree prolapse, 100% patients had cystococle, 75% patients had rectococle, 52.77% patients had uterine atrophy, 41.66% had vaginal discharge, 20.38% had dicubitus ulcer and 13.88% patients had hypertrophied cervix. In Sultana's series maximum 66.0% patients had second degree uterine prolapse followed by 19.0% third degree, 15% had first degree prolapse. 13% patients had vault prolapse, 76% patient had moderate cystococle followed by 18.0% had large and 6.0% had mild cystococle, 64.0% patients had mild rectococle and 36.0% patients had moderate rectococle⁶. A study in Italy showed 65.3% had prolapse degree I and 34.7% degree II and III¹¹. This is not consistence with the present study but more or less similar to Sultana's study.

Out of all patients 79.16% had vaginal hysterectomy with anterior colporrhaphy and post colpopembeorrhaphy, 16.66% patient had only vaginal hysterectomy with ant colporrhaphy, 2.77% patients had fothergills operation and 1.38% had vault repair. In Sultana's series all patients had gone through vaginal hysterectomy with anterior colporrhaphy and 76.0% patients had done post colpoperineorrhaphy⁶. In Khan series 60.07% required vaginal hysterectomy with pelvic floor repair, followed by vaginal hysterectomy with anterior colporrhaphy in 20% cases, only 3.34% cases underwent Fother gill's operation and 0.87% i.e. one case underwent laparoscopic assisted vaginal hysterectomy⁹. In the present study 41.66% patients had average blood loss, 11.11% had more than average and 47.22% had minimal blood loss, 33.94% had secondary haemorrhage, 22.22% cases had fever in post operative period, 20.83% cases had urinary tract infection. In Chowdhury's study 14% had pyrexia, 10% urinary tact infection and 7% had haemorrhage¹².

In Khan series 17% had pyrexia, 17% had UTI, 2.6% had retention of urine, 64% had more than average and 35% had minimal blood loss, blood stained vaginal discharge was 56%. This study was more or less similar to present study. In Sen's study 25% had pyrexia, 20%

had UTI, 5% had retention of urine and 4% had excessive blood loss¹³.

Conclusion:

In conclusion this study may give some idea about lack of maternity care during their antenatal, intranatal and postnatal period, which should reach to every corner of our country. Genital prolapse cases come from remote villages. To reduce the genital prolapse we should take attempt to provide maternity benefit including extra nutritional supplement to the pregnant mothers like other develop countries, to update the training program for skilled birth attendants and to improve transport facilities. Education, awareness of health status of the people and acceptance of "Two child family norm" may improve the living standard to some extant and prevent the occurrence of genital prolapse also. Whatever may the cause genital prolapse with lower urinary tract symptom (LUTS) can be managed successful by surgical method.

References:

1. Bhatta. N. Jeffcoatee's Principles of Gynaecology, 6th ed. Arnold, London, 2001:263-81.
2. Cardozo L. prolapse. In Whitfield CR, ed. Dewhurst's Textbook of obstetrics and Gynaecology for postgraduates. Oxford: Blackwell Science, 1995:642-652.
3. Begum A, Khan HT. Obstetric related residual morbidities among the women in Bangladesh, J Prev Soc Med. 1999; 18(1): 22-29.
4. Alan H. DeCherney Lauren Nathan. Pelvic organ prolapse. Current obstetric & gynaecologic diagnosis and treatment, 10th edition McGraw-Hill, Medical Publishing Department New York. 2007:p. 720-735.
5. Swift SE. The distribution of pelvic organ support in a population of female subjects seen for routine gynaecological health care. Am J Obstet Gynaecol 2000;183(2): 277-285.
6. Sultana N. Clinical profile & management of 100 cases of uterovaginal prolapse in Holy Family Red Crescent Medical College Hospital, Dhaka (Dissertation) Bangladesh College of Physicians & Surgeons, 2008:64.
7. Marahatta RK, Shah A. Genital prolapse in women of Bhaktapur, Nepal. Nepal Med Coll J 2003;5(1): 31-33.
8. Bodner- Adler B, Shrivastava C, Bodner K. risk factor for uterine prolapse in Nepal. Int urological J (2007) 18: 1343-1346.

9. Khan K. Surgical management of genital prolapse and its immediate morbidity, (Dissertation) Dhaka: Bangladesh College of Physicians & Surgeons, 2005:54.
10. Lukacz ES, Lawrence JM, Contreras R, Nager CW, Luber KM, Parity, Mode of Delivery, and pelvic floor disorders. *Obstet Gynaecol* 2006;107:1253-1260.
11. Progetto Menopusa Italia Study Group. Risk factor for genital prolapse in non hysterectomized women around menopause. Results from a large cross sectional study in menopausal clinic in Italy. *Eur J. Obstet Repord Biol* 2009; 93(2): 135-140.
12. Chowdhury SK. Operative treatment of genital prolapse in young women. *J Indian MA.* 80:11-12.
13. Sen S. Mukherjee KK, Chakraborty BK. Genital prolapse J. *I Indian MA.* 1984; 82: 159-161.

Authors

1. Assistant Professor, Obs. & Gynae, Comilla Medical College.
2. Medical Officer, Obs. & Gynae. General Hospital, Tangail.
3. Medical Officer, Obs. & Gynae. General Hospital, Comilla.
4. Assistant Professor, Obs. & Gynae, Comilla Medical College.
5. Lecturer F Medicine, Enam Medical College, Savar, Dhaka.
6. Assistant Professor, Cardiology, NICVD.
7. Assistant Professor, Urology, Comilla Medical College.
8. Assistant Professor, Urology, Comilla Medical College.