ORIGINAL ARTICLE

CERVICAL PROLAPSE DURING THIRD TRIMESTER: A RARE ENTITY

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ABSTRACT: Uterine prolapse is a common gynaecologic condition but is extremely rare during pregnancy. We present a 26-year old woman with g2p1l1, who came with pelvic organ prolapse for the first time during the third trimester, followed by uneventful labour and vaginal delivery at home. As early diagnosis is very important for an uneventful gestation, obstetricians should be aware of this rare condition.

KEYWORDS: Cervical prolapse, third trimester, pregnancy.

INTRODUCTION: Cervical prolapse is a common condition seen in gynaecological practice but its occurrence during pregnancy is uncommon. The estimated incidence rate is about 1 per 10,000-15,000 deliveries worldwide. Fewer than 300 cases have been reported in the literature with less than 10 cases reported during the last decade.[1] Incidence of uterine prolapse in India is much more common, estimated to be as high as 1 in 547 deliveries.[2] Genital prolapse may develop initially during pregnancy. However, in the majority of cases, pregnancy is superimposed on a pre-existing prolapse. The concomitant phenomenon of a third trimester pregnancy with a significant degree of pelvic organ prolapse is extremely rare.[3] We report a rare occurrence of pelvic organ prolapse for the first time during the third trimester followed by uneventful labour and vaginal delivery at home.

CASE REPORT: A 26-year-old woman with gravida 2, para 1, living 1 presented at 34 weeks of gestation with complaints of low backache, abdominal pain and mass per vagina since 1 day. The present pregnancy was uneventful during the first and second trimesters. She noticed a mass per vagina one day back which occurred suddenly. She had no history of straining, cough or systemic complaints. There was no past or family history of prolapse. Her first pregnancy four years back was uneventful. There was no history of pelvic trauma, prolapse or stress incontinence during or after the previous pregnancy. Her general physical examination was unremarkable. On local examination uterus was relaxed and prolapse of uterine cervix was seen. The cervix was oedematous and protruding beyond the introitus, but easily reducible. The internal os was closed. Other systems were normal.

Her routine haematological, urine, liver function tests, blood urea and serum creatinine levels were normal. Ultrasound showed normal cervical length. She was admitted and prolapse was reduced manually. She was given antibiotics, intramuscular betamethasone (12mg, two doses), prophylactic tocolytic, isoxuprine 10 mg orally three times daily and was advised bed rest. She was discharged on request after three days and was lost for follow up.

After three weeks she had an uncomplicated vaginal delivery at home and the prolapse reduced on its own. She came to us on the 20th post natal day with recurrent mass per vagina since one day. On examination the cervix was outside the introitus and uterus was of normal size.

There were no signs of puerperal sepsis. Patient was given a course of antibiotic, iron and calcium and counseled for sling surgery and permanent sterilization after puerperium.

DISCUSSION: Cervical prolapse is rare in pregnancy despite being commoner in non-pregnant older women. It may develop initially during pregnancy but in majority of cases, pregnancy is superimposed on a pre-existing prolapse. When some degree of prolapse is present before pregnancy, it usually persists until the pregnancy progresses to a stage where spontaneous correction occurs. This spontaneous correction is due to the uterus becoming an abdominal organ in the second trimester, thereby pulling the cervix up into the vagina. In such cases symptomatic prolapse recurs in third trimester. If it occurs for the first time during pregnancy it usually occurs in the third trimester and disappears after labour and delivery.

Various predisposing factors for this morbid condition are congenital or developmental weakness of supporting structures, injury sustained during child birth and menopause. A single pregnancy and vaginal delivery can weaken the area enough to cause prolapse eventually, especially if the birth was traumatic, in the form of a prolonged intense pushing stage and not allowing tissues to stretch gradually. The uterine descensus condition, however, also may be aggravated by pregnancy as a result of physiological increases in cortisol and progesterone, which lead to a concomitant softening and stretching of the pelvic tissues. In our case the first delivery occurred at home and there was no history suggestive of predisposing factors for occurrence of prolapse.

Complications of pregnancy with prolapse are abortion, retention of urine, premature rupture of membranes, chorioamnionitis, early rupture of membranes, cervical dystocia, prolonged labour, obstructed labour operative interference, sub involution and uterine sepsis.[4] Spontaneous abortion may occur as a result of trauma and vascular congestion that accompany the prolapsed cervix. An impairment of blood flow and cervical edema and subsequent anoxia also may contribute to a higher incidence of abortion and preterm labour with prolapse. Severe cervical dystocia may occur during labour due to non-retractable oedematous cervix.

The management strategies are conservative like bed rest and use of vaginal pessary, laparoscopic uterine suspension and concomitant caesarean hysterectomy with abdominal sacrocolpopexy. Pessary support however maybe more beneficial in a woman with pre-existing prolapse rather than in those in whom the condition presents during mid to late pregnancy. In these cases pessaries will not remain in place or prevent preterm labour.[2]

Majority of women with prolapse are delivered by normal vaginal delivery. However, when considering the mode of delivery obstetrician should look out for cervical inflammation and edema which may complicate an otherwise normal vaginal delivery especially if there is inadequate time for sufficient ante partum treatment.[5] If the cervix is oedematous and elongated elective caesarean section near term is to be considered to avoid further pelvic floor damage.[6]If there are no such complications the decision ultimately lies with the patient.[7]

In our case the patient presented with the prolapse for the first time in the third trimester without any previous history or predisposing factors for prolapse and delivered at home without any complications. After delivery the prolapse reduced on its own only, to recur during early puerperium. Ambulation after delivery may have caused recurrent prolapse in our case. Although

a rare occurrence there is a need for obstetricians to be aware of the management of uterine prolapse for uneventful labour and delivery.

Fig. 1: Cervical prolapse in third trimester

Fig. 2: Cervical prolapse after delivery

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