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FETOMATERNAL OUTCOME IN PATIENTS OF UTERINE PROLAPSE DURING PREGNANCY MANAGED WITH VAGINAL RING PESSARY.

Gynaecology

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ABSTRACT

The management of uterine prolapse in mid trimester is quite challenging to treating gynaecologist. Laxity of pelvic ligament and fascia aggravated in pregnancy due to further softening leads to prolapse in pregnancy. Third degree prolapse have many complications to mother and baby. Treatment of uterine prolapse in pregnancy with vaginal pessary may be helpful to avoid complications of this condition and should be considered during patient counseling.

KEYWORDS

Uterine prolapse, pregnancy, vaginal pessary POP pelvic organ prolapse

Introduction

Preexisting prolapse along with pregnancy is commonly described than uterine prolapse that occurs during pregnancy which is a rare condition(1). Previous estimates have put incidence of prolapse in pregnancy 1 in 10,000 to 15,000 deliveries worldwide(2).POP with pregnancy was quiet common in past ,with around 250 cases reported mostly before 1990(3). However in recent times cases of "POP associated with pregnancy" are actually cases of "POP during pregnancy" and this number is unlikely to fall in near future, as pointed out by Miyano N et al.(4). Exact cause of POP only during pregnancy is not known. Of all factors multiparity(4) is a predominant risk factor predisposing for the same. Other factors are prolonged labour ,difficult delivery(5). Cervical elongation and hypertrophy, due to hormonal changes in pregnancy i e increased level of cortisol, progesterone and relaxin could contribute to same(6). Some other factors like BMI, age, congenital weakness of pelvic floor muscles, increased intraabdominal pressure,pelvic tumours and pelvic trauma. association was studied but not proved (3,5,6) Pelvic organ prolapse is common in Indian women at younger age due to malnutrition, minimal birth spacing, early age of marriage, home deliveries conducted by dais and poor postnatal rehabilitation. Most common symptoms feeling of heaviness in perineum or something coming out of introitus if neglected hav bad effects on mother and the foetus. Irreducible, extensive prolapse leads to cervical laceration, sepsis, premature rupture of membranes, preterm labour and ruptured uterus leading to maternal death. Management is usually conservative with emphasis on keeping the cervix reduced throughout pregnancy. The options include bed rest in tredlenberg position, use of pessary and packing with glycerine, acroflavine or megsulf(7).Treatment with pessaries most of the time is successful but it is found to fail at the onset of third trimester (8). Here we have studied 10 cases of pregnancy with prolapse in which ring pessaries are inserted, and all lead to successful outcome.

Methodology

Almost all patients are presented in mid trimester pregnancy. One with acute urinary retention. Anomaly scan done. After excluding local infection and urinary tract infection, ring pessary size is selected after assessing vaginal wall laxity. Ring rubber pessary is kept in betadine solution after washing with soup water,antiseptic solution in sterile container with lid for 24 hours (Fig.1). With aseptic precautions, prolapse is reduced gently after cleaning with normal saline. Labia is separated with left index finger and thumb. Pessary is folded and inserted vaginally. Proximal part is directed towards posterior fornix.It is unfolded and distal end is kept beneath the pubic symphysis. It is checked that cervix ring is encircled by inner part of ring pessary. Patient then advised to stand up and walk a few steps after insertion and enquired about sensation of inserted pessary. It is reconfirmed by doing per vaginal examination that complete cervix is protruding through the proximal inner ring. No speculum is done. Patient is kept admitted for 24 hours to see bowel /bladder complaints. Any difficulty in micturition or defaecation is ruled out. Patient is advised abstinence throughout preganancy then after. Patient is discharged and advised regular antenatal follow up. Asked them to report if any complaint such as per vaginal white discharge, pain , leaking or fever. Pessary is removed at the onset of true labour.

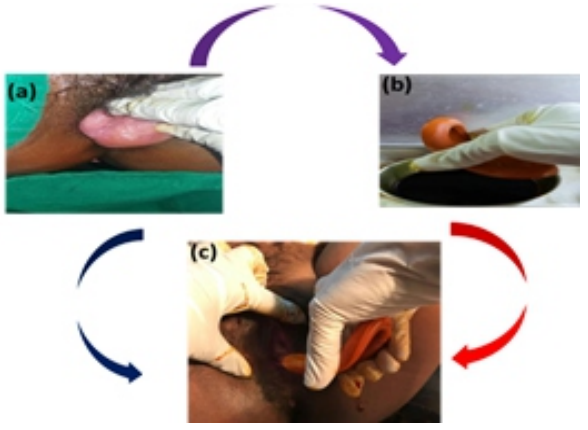


Fig.1. the methodology of the procedure a) The prolapse was reduced under aseptic condition b) Appropriate size of pessary was selected and kept in betadine solution under aseptic condition for 24 h. c) Pessary folded and inserted

Observation table

Table 1

Mode of delivery in current pregnancy	Numbers
Full term normal deliveries	2
Preterm delivery (36 wks)	1
abnormal presentation (breech vaginal delivery)	1
Full term caesarean sections	1
Early term 37 weeks vaginal deliveries	5

- Out of 10 patients 4were full term pregnancies. Of them 2 were full term normal deliveries,1 LSCS,and 1 breech delivery
- 1 was 36 wks preterm delivery. 5 were early term (37 wks) deliveries
- None of them had neonatal morbidity or mortality

Table 2

Size of pessary	Numbers
Medium (3 inches)	**8**
Large (3and ¼ inches)	**2**

- Pessaries are categorized as small (2 and ½ inches) ,medium(3 inches) ,large(3 and ¼ inches)and extra large(3 and ½ inches)
- Most of them needed medium size pessary

Table 3

Previous obstetrics history	
LSCS	**0**
Preterm labours	**2**
1 FTND	**3**
2 FTND	**3**

nulliparas	**2**
Home deliveries	**6**
Hospital	**4**

- 60% were home deliveries.
- 20% patients had preterm deliveries.

Table 4

parity	Number of patients
Primigravida	**2**
multigravida	**8**

2out of 10 were primigravida and 8 were multigravidas.

Discussions

There are two types of pop in pregnancy. One is acute onset of prolapse started in pregnancy itself and second is pre-existing prolapse complicated by pregnancy. 9 out of 10 our patients had acute onset of prolapse around 12 to 20weeks 8 of them them were multigravidas. In these patients excessive laxity and pelvic floor weakness due to prior birth events which increases in advancing pregnancy might be responsible for prolapse.

In our series only one patient had history of prolapse prior pregnancy for which she had undergone purandare's cervicopexy prolapse recurred after conception.

One patient out of 2 primigravida had history of primary infertility. Patients presented with complaints of prolapse only. Onlyone patient had acute urinary retention. All patients are treated with pessary. patients were sent home and were advised for bed rest which they might not followed correctly.

All patients had routine antenatal care. No interference is needed as no any obstetrics high risk factor.All of them spontaneously went into labour prior 40 weeks. It may be because of pelvic congestion and early release of prostaglandins. All other have smooth progress of labour. All patients except one delivered vaginally. No induction is done in any patients. Induction of labour in these patients is controversial(4).

Due to extreme rarity of occurrence no literature is available on induction of labour in these women(1).However it is said that it should be avoided as long as possible due to theoretical risks increased expulsive efforts worsening the condition and predisposing to uterine rupture(3)...Most authors have advised elective caesarean section (6,10). Incidence of cervical dystocia during active labour has been quoted as high as 9.1 -39.4% (7,10). However our observations have shown that spontaneous labor under watchful expectancy is an excellent option, with cesarean reserved for prolonged labour or cervical dystocia. In our study only one patient of Purandare's cervicopexy who has prolapse antecedating pregnancy had cervical dystocia and needed LSCS. Some authors says preterm labour is actual problem in this condition(3,4). We agree with them.

Pessary was inserted from 12-22 weeks in all patients. Previous studies showed that treatment with pessary may be successful in initial gestation but usually fails by the end of 3 rd trimester (8). Different types and shapes of pessaries used for management turned to be unsuccessful as it falls within few days. But in our patients we got excellent results and did not notice any fall. Only in one patient inspite of pessary prolapse continued in which we changed pessary size. In 2 patients, large pessary was needed as tissue oedema and large cystocoele was present. Vaginal discharge, odour, mucosal erosion, abrasions of vagina and urinary retention are the complications of vaginal pessaries (9). In our patients no one of had such complaints. Proper size selection of pessary may matter as oversize pessary may cause abrasions and urinary complaints. We did not notice any early preterm labour or fetomaternal complications. There are three case reports about successful use of pessaries(11). We found successful results in all our patients. In Turkiesh German association case report, patient is taught to take pessary out, clean and again reinsert of her own(13). In our study 4 patients were from remote places, uneducated. Self-removal of pessary was not feasible for them. Not only that they were scared to get it removed by any other doctor. We communicated with local doctor assured safe and easy removal by them. But they followed with us only and delivered .None of them had any complaint. So pessary once inserted removed at the onset of labour only. We used rubber ring pessary but there is a case report saying successful use of gelhorn pessary in which ring pessary failed(12). 9 out of 10 babies had wt less than 2.5 kgs below average wt may be related to maternal malnutrition. Only 1 had baby wt 3 kgs who delivered by breech vaginally. She reported late in labour.As soon as we remove her pessary, she progressed so fast that by the time we arrange every thing for caesarean,she delivered breech in operation theatre.

Conclusion

Insertion of ring pessry for management of prolapse presenting in mid-trimester is found to be good option with minimal economic burden to the patients. It is non-invasive OPD basis treatment but needed some technical expertise. Selection of proper size might have impact over success of the treatment. Average gestational age was around 37 weeks. That is 2 to 3 weeks prior term probably due to pelvic congestion. Though it is so, fetal maturity was good and none of them required neonatal intensive care admission. Possible advantages of cervical pessary include easy one off application, good patient tolerance, and low cost treatment. Abstinence is found to have played a role for non-occurrence of infection and slippage of pessary and fall of pessary. Further clinical trials are needed to establish clearly role of pessaries for treatment strategy worldwide.

Consent

Written informed consent was obtained from patient for publication of this article.

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