

A Case Report on Vaginal Vault Prolapse



Paramedical

KEYWORDS :

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INTRODUCTION.

Vaginal vault prolapse is a common complication following vaginal hysterectomy with negative impact on women's quality of life due to associated urinary, anorectal and sexual dysfunction. A clear understanding of the supporting mechanism for the uterus and vagina is important in making the right choice of corrective procedure. This condition is common after a hysterectomy; with upwards of 10% of women developing a vaginal vault prolapse after undergoing a hysterectomy. Ten to 20 % of these women are symptomatic.

A 53 years old female patient admitted to the hospital with complaints of mass in the vagina and heaviness, urinary frequency, burning micturation, bleeding per vagina. By physical examination and ultrasonogorphy she was diagnosed to have vaginal vault prolapse.

Past medical history: she has undergone hysterectomy 3 years back for unusual uterine bleeding and she was on HRT for 6months. She is nulliparous women

Investigation:

Hematology : Hb- 9.5g%, WBC-18,000/mm³, Netrophils-86%,esinophils-09%,

ESR -14mm/1ST hr, FBS- 108mg/dl.

Urine micro – RBCs- 12-13/ cells, epithelial cells4-6/LPF, cast &crystals –not seen ,

pus cells – Nemours

USG- vault prolapsed

Treatment given

Surgery- Laproscopic sacrospinous ligament fixation

Medication

Inj. Taxim 1gm 8th hourly x10days

Inj.Ciplox 500mg 12th hourly x10days

Inj Rantac 50mg 12th hourly x10days

Inj Buscopan 40mg SOS

DEFINITION

Vaginal vault prolapse has been defined by the International Continence Society as descent of the vaginal cuff below a point that is 2cm less than the total vaginal length above the plane of the hymen.

Risk factors

- Age over 40
- Childbirth (especially multiple births, long labors, and large babies)
- Chronic straining to empty the bowel or bladder
- Menopause (reduces levels of estrogen, which helps strengthen muscles and ligaments)
- Obesity
- Prior hysterectomy
- Prior pelvic surgery (weakens supportive structures within the pelvis)
- Strenuous activity (e.g., frequent heavy lifting)



CHARECTERISTICS

- Sensation that structures in the pelvis are out of place.
- Pressure in the vagina or pelvis (usually decreases when lying down),
- Painful intercourse (dyspareunia),
- Pexyppervt urinary tract infections .
- Vaginal bleeding
- Heaviness or pressure in the pelvis
- Recurrent bladder infections
- Urinary incontinence
- Urinary frequency or urgency
- Difficulty emptying the bladder
- Constipation
- Enlarged vaginal opening
- Abnormal or excessive discharge from the vagina
- Protrusion of tissue from the opening of the vagina

DIAGNOSIS

- Medical history and performing a physical examination.
- **Pelvic examination**
- **Bladder function tests** (urodynamic testing)
- Imaging tests, such **ultrasound** and magnetic resonance imaging

CONSERVATIVE MANAGEMENT AND PREVENTION OF VAGINAL PROLAPSE

Depends on the cause of the condition and the severity of the symptoms.

- **Activity modification** (e.g., avoiding heavy lifting),
- **Kegel exercises** can help to improve pelvic organ prolapse, depending on the severity, and may slow progression of the condition. Success of these exercises depends in part on proper execution. First, the patient must be able to locate the correct muscle group by stopping or slowing the flow of urine without tensing leg muscles, or the patient can visualize squeezing the rectal muscles as if to prevent a bowel movement.

There are two types of Kegel exercise:

- Quick contractions–rapidly tighten and relax the sphincter muscle

- Slow contractions—contract the sphincter muscle and hold to a count of 3, gradually increasing to a count of 10

Exercises should be performed 10 to 15 times per session, at least 3 times each day.

- **Biofeedback** may be used with Kegel exercises to reinforce proper technique. Patients visualize and identify the pelvic floor and abdominal muscles that are contracted during the exercises. Weak muscles can be activated on demand, tense muscles can be relaxed, and muscle activity can be coordinated using biofeedback.
- **Neuromuscular electrical stimulation (NMES)** may be used, in some cases, to retrain and strengthen weak pelvic floor muscles, which can improve bladder control. Electrical stimulation of nerves in the pelvic area (e.g., the pudendal nerve) causes pelvic floor and urethral and anal sphincter muscles to contract. A probe is inserted into the vagina and a current is passed through the probe at a level below the pain threshold, causing a contraction. The patient is instructed to squeeze the muscles when the current is on. After the contraction, the current is switched off for 5 to 10 seconds. Treatment sessions last approximately 20 to 30 minutes.
- **Vaginal pessaries** are silicone or latex devices inserted into the vagina to compress the urethra, support the bladder neck.

SURGICAL MANAGEMENT

• **SACROSPINOUS LIGAMENT FIXATION**

A sacrospinous fixation is an operation designed to restore support to the uterus or vaginal vault. Through a cut in the vagina, stitches are placed into a strong ligament in the pelvis and then to the cervix or vaginal vault. The stitches can be either permanent or slowly absorbed over time, eventually they are replaced by scar tissue that then supports the vagina or uterus.

• **UTERO SACRAL LIGAMENT SUSPENSION**

A uterosacral ligament suspension is an operation designed to restore support to the uterus or vaginal vault. The uterosacral ligaments are strong supportive structures that attach the cervix to the sacrum. Weakness and stretching of these ligaments can contribute to pelvic organ prolapse. A uterosacral ligament suspension involves stitching the uterosacral ligaments to the apex or top of the vagina, thereby restoring normal support to the top of the vagina. This operation can be done vaginally, abdominally or laparoscopically.

• **ILIOCOCCYGEUS SUSPENSION**

In iliococcygeus fixation, the vaginal apex is fixed bilaterally to the iliococcygeus fascia. The incision and dissection are carried out posteriorly on both sides.

• **ABDOMINAL SACRAL COLPOPEXY**

The abdominal approach is indicated after failed vaginal repair, when concomitant abdominal surgery is required or when the surgeon is unfamiliar with the vaginal approach. The procedure involves attaching the vaginal vault to the sacrum using autologous, allograft or synthetic material to bridge the gap. The suspension mesh is attached to the upper sacrum and promontory at the S1-S2 level, where blood vessels are more visualized and avoided.

• **Vaginal wall repair with mesh**

An incision is made in the vaginal skin and supporting tissue (fascia), they are then separated from the underlying organ (bladder or bowel, depending on the site prolapse). The mesh implant is placed underneath the vaginal skin and fascia.

o **PROGNOSIS**

Vaginal vault prolapse is rarely a life-threatening condition. Some cases that are mild can be treated without surgery, and most severe cases of vaginal vault prolapse can be completely corrected with surgery. Vaginal vault prolapse surgery results are usually good, with a low recurrence rate.

CONCLUSION

Vaginal vault prolapse repair remains a real challenge for urogynecologists. There is no consensus on the mechanism and management of vault prolapse, but what is accepted by all is the need to properly assess these patients, involve them in the management and to agree on the type of surgery that will be suitable for their own peculiar circumstance.

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