ORIGINAL RESEARCH PAPER
Volume - 14 | Issue - 07 | July - 2025 | PRINT ISSN No. 2277 - 8179 | DOI : 10.36106/ijsr
INTERNATIONAL JOURNAL OF SCIENTIFIC RESEARCH

UTERINE PROLAPSE IN PREGNANCY: A RARE CLINICAL PRESENTATION WITH INSIGHTS INTO MANAGEMENT STRATEGIES

Obstetrics & Gynaecology

Dr. Pallavi Yadav Junior Resident, Department of Obstetrics and Gynecology, Santosh Medical College and Hospital, Santosh Deemed to be University, Ghaziabad.

Dr. Manisha Gupta* Professor and HOD, Department of Obstetrics and Gynecology, Santosh Medical College and Hospital, Ghaziabad. *Corresponding Author

Dr. Alpana Agrawal Professor, Department of Obstetrics and Gynecology, Santosh Medical College and Hospital, Ghaziabad

ABSTRACT

Uterine prolapse during pregnancy is an uncommon condition, occurring in approximately 1 in 10,000 to 15,000 pregnancies, and is associated with significant maternal and fetal risks. We report the case of a 26-year-old gravida 2 para 1 woman at 37 weeks of gestation who presented with uterine prolapse and premature rupture of membranes. Although labor commenced spontaneously, there was inadequate cervical dilatation, necessitating a cesarean section. A healthy male infant weighing 3000 grams was delivered. Postpartum management of the prolapse was conservative. This case highlights the need for prompt identification and multidisciplinary management of uterine prolapse in pregnancy. Cesarean delivery can be a safe and effective approach when vaginal delivery is not feasible. Long-term treatment options should be tailored postpartum based on the patient's symptoms and future reproductive goals.

KEYWORDS

Uterine prolapse, pregnancy, cesarean section, pelvic organ prolapse, conservative management

INTRODUCTION

Pelvic organ prolapse (POP) during pregnancy is a rare but potentially serious complication,with an estimated incidence of 1 in 10,000 to 15,000 pregnancies. It is typically encountered in the postpartum or menopausal period but can occasionally present during gestation due to hormonal changes, increased intra-abdominal pressure, and weakened pelvic floor support. Antepartum complications include urinary tract infections, abortion, and preterm labor. Intrapartum complications may involve obstructed labor and cervical lacerations, while the postpartum period carries risks of infection and hemorrhage. The rarity of this condition and limited literature make its diagnosis and management a clinical challenge. This report describes a unique presentation of uterine prolapse in late pregnancy and its successful management.

CASE REPORT

A 26-year-old woman, G2P1, presented to the emergency department at 37+1 weeks of gestation with complaints of clear vaginal fluid discharge for four hours. She was unable to recall her last menstrual period, but early ultrasonography confirmed her gestational age to be around 37weeks.

She reported a vaginal bulge progressively worsening since her previous vaginal delivery five years earlier. Her antenatal care included three routine visits at a peripheral health center.

Clinical Examination

Vitals: Within normal range

Abdominal Examination: Fundal height 32 cm, fetus in cephalic presentation, fetal heart rate 150 bpm, soft uterus with contractions

Speculum Examination: Entire cervix and anterior vaginal wall prolapsed and visible at vulva, external os closed, minimal clear liquor present

Vaginal Examination: Cervix 2 cm dilated, 40% effaced, membranes absent, fetal head well applied

Labor was allowed to progress for 8 hours; however, no further cervical dilation occurred. A decision was made to proceed with cesarean section.

Intraoperative Findings

- Bilateral tubes and ovaries were healthy
- A healthy male infant (3000 g) delivered in cephalic presentation
- Apgar score normal, cried immediately after birth
- Hemostasis achieved, blood loss within normal limits
- No surgical correction for prolapse was performed during cesarean

Postpartum Management

- Acriflavine-glycerine vaginal packing
- Pelvic floor strengthening exercises advised during puerperium
- Vaginal ring pessary prescribed on follow-up
- Planned surgical correction deferred, with Forthergill's procedure discussed as an option if needed

Surgical Management

- Forthergill'oprations
- preliminary D&C
- amputation of cervix
- plication of mackenrodts ligament in front of cervix anterior colporrhaphy
- colpoperineorrhaphy

DISCUSSION

Pelvic organ prolapse during pregnancy is uncommon and usually results from compromised pelvic support structures. Contributing factors may include multiparity, short interpregnancy intervals, and preexisting prolapse.Uterine prolapse is often observed to regress during the second trimester as the enlarging gravid uterus ascends into the abdominal cavity. However in this case the prolapse progressively worsened with advancing gestation which is an uncommon clinical course and contributes to the uniqueness of this presentation.

Complications can occur across all stages of pregnancy:

- Antepartum: Abortion, urinary retention, UTI, preterm labor
- Intrapartum: Obstructed labor, cervical laceration, failure to dilate
- Postpartum: Hemorrhage, infection, persistence of prolapse

Fetal complications include dystocia-related injuries, preterm birth, and sepsis due to PPROM.

Management is primarily conservative during pregnancy—pessary use, bed rest in Trendelenburg position, and avoiding unnecessary manipulation. Cesarean section is indicated when vaginal delivery is not feasible, especially in cases of non-reducible prolapse or failed labor progression.

Postpartum, the prolapse may regress, but definitive surgical treatment should be offered once the patient completes her family or if symptoms persist.

CONCLUSION

Uterine prolapse in pregnancy, though rare, requires careful obstetric management. In the presented case, cesarean section ensured

favorable maternal and neonatal outcomes. Conservative postpartum care can stabilize the condition, and surgical correction can be considered based on clinical need and patient preference.

REFERENCES

1. De Vita D, Giordano S. Two successful natural pregnancies in a patient with severe uterine prolapse: A case report. J Med Case Rep. 2011;5:459.
2. Tarnay CM, Dorr CH. In: DeCherney AH, Nathan L, editors. Current Obstetric and Gynecology Diagnosis and Treatment. New York: McGraw-Hill; 2003.
3. Obed SA. Pelvic Relaxation. In: Kwawukume EY, Emuveyan EE, editors. Comprehensive Gynaecology in the Tropics. Accra: Science & Education; 2005. p. 138–146.