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Pregnancy and Delivery on Uterine Prolapse: A Case Report from the Sourô Sanou University Hospital Center

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Abstract

Background: Genital prolapse is a frequent pathology, but its occurrence during pregnancy is exceptional. Very few cases have been described in the literature. **Objective:** To describe and review the literature on uterine prolapse in pregnancy. **Presentation:** We report a case of uterine prolapse in a pregnancy of 35 weeks' amenorrhea in a 32-year-old tachy-multiparous woman living in a rural area who was admitted urgently to the maternity ward of the Sourô Sanou University Hospital Center of Bobo-Dioulasso (CHUSS). **Conclusion:** Improving patients' socio-economic conditions and access to quality antenatal care could considerably improve women's health, especially those living in rural areas.

Keywords

Uterine Prolapse, Pregnancy, Delivery, Burkina Faso

1. Introduction

Genital prolapse is a frequent pathology. However, its occurrence during pregnancy is exceptional. Uterine prolapse may initially develop during pregnancy, or pregnancy may occur over a pre-existing prolapse. Its occurrence during pregnancy is also rare. In the USA, the incidence is 1 case/10,000-15,000 deliveries [1]-[4]. In the Ivory Coast, according to Koffi, uterine prolapse complicating pregnancy is exceptional. Management requires the use of a pessary, and bed rest is

recommended during pregnancy. In the absence of any associated pathology, vaginal delivery is recommended [1]. It differs from pre-existing uterine prolapse, which generally disappears spontaneously at the end of the second trimester without complication [2]. This so-called gravidic or gestational prolapse is thought to be due to physiological changes in the maternal body during pregnancy in a woman with other predisposing risk factors. The prolapse of the gravid uterus makes pregnancy a high-risk pregnancy. Numerous maternal and perinatal complications have been described [2] [5].

We report a case of genital prolapse during pregnancy received at the maternity ward of the Sourô Sanou University Hospital in Bobo-Dioulasso, Burkina Faso.

2. Observation

2.1. Case History

Madame T.B., 32 years old, married, housewife, living in a rural area, eighth gesture fifth pare (G8 P5); five (5) living children, two (2) abortions. Resident of Sidi, referred from the Orodara Medical Center with Surgical Branch (CMA) for third-degree genital prolapse in a 35-week pregnancy (**Figure 1**). She was admitted to the emergency department of the CHUSS maternity hospital in Bobo-Dioulasso, where she was diagnosed with a third-degree hysterocele in an evolving 35-week pregnancy (**Figure 2**) with an edematous cervix. No emergency treatment was proposed. However, a manual reduction had been performed, and the patient had been advised to stop physical activity.

On questioning, the patient stated that the prolapse had occurred during the second trimester of pregnancy and that she used traditional techniques for self-reduction of the prolapse: "She used an upturned metal pot (as a pessary?)" as a stool whenever she had to sit down, which helped to reduce the prolapse (**Figure 3**). This could explain the local edema of the cervix, with a probable risk of cervical infection.

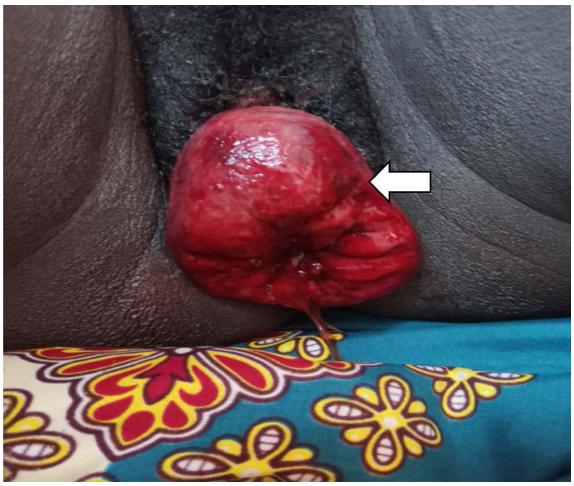

Figure 1. 3rd-degree uterine prolapse.

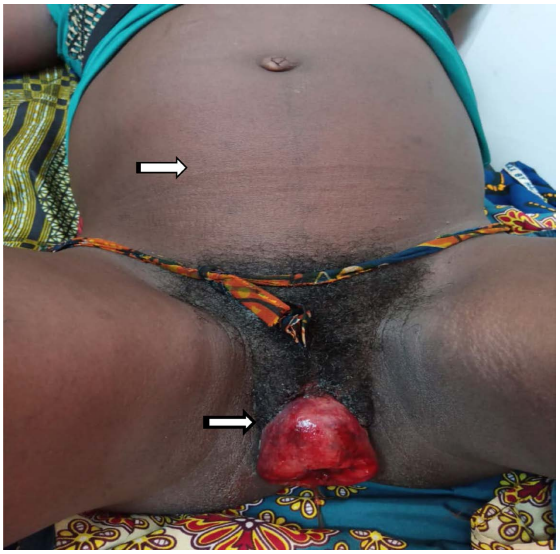

Figure 2. 3rd-degree uterine prolapse in an evolving pregnancy of 35 SA.

Figure 3. An illustrative example of the cooking pot used by the patient.

She would have undergone two prenatal consultations (CPN) during pregnancy, a two-dose anti-tetanus sero-vaccination (VAT 2), during which (CPN 1), her weight was 54 kg, brachial perimeter 28 cm, blood pressure 100/60 mmHg, pulse 99 bat/mn, no edema of the lower limbs, uterine height (HU) measured 21 cm, active fetal movements (AFM) and fetal heart sounds (FHB) present. On vaginal touch, the cervix was short, centered, and closed. However, the diagnosis of prolapse had not been made that day.

2.2. Exam

On entry, examination of the vulva noted the vulva showed POP-Q (pelvic organ prolapse) stage III uterine prolapse with cervical edema. On vaginal touch combined with abdominal palpation, the cervix was open to 3 cm, a cephalic position of the fetus. There was no associated cystocele or urinary incontinence.

Obstetrical ultrasound showed a progressive pregnancy at 35 SA with no fetal or adnexal anomalies. Biological tests were normal. The diagnosis of a 3rd degree hysterocele in a 35-week progressive pregnancy was made (**Figure 2**).

2.3. Treatment

No emergency treatment was proposed. However, careful manual reduction was performed after cervical asepsis, and the patient was advised to stop physical activity and follow up every week until delivery.

Following the spontaneous onset of abdominopelvic pain in an evolving pregnancy of 37 weeks' amenorrhea plus two days, she consulted the local health facility (CMA Orodara). On admission, she was clearly conscious, with a Glasgow score of 15/15, normal-colored conjunctiva, blood pressure of 110/70 mmHg, temperature of 37, uterine height of 34 cm, and membranes intact. Mobile cephalic presentation. The diagnosis of labor was made. She delivered a live male infant vaginally, APGAR score of 8-9-10, birth weight of 2800 g, head circumference (CP) of 32 cm, thoracic circumference (TP) of 32 cm, and height of 49 cm. Active Management of the Third Stage of Labor (AMTSL) was performed; the placenta was completed and delivered according to the Baudelocque method, weighing 600 g.

2.4. Postapartum Suite

Postpartum follow-up was straightforward for both mother and newborn.

Prolapse management had been proposed in the postpartum period, and she opted for promonto-fixation.

For the long-term management of her prolapse, the patient had posed a financial problem and had stopped keeping her follow-up appointments.

3. Discussion

Genital prolapse is a frequent pathology; however, the occurrence of prolapse in a pregnant woman is an exceptional situation. In multiparous and/or post-menopausal women, the weakness of the organs of support, suspension, and orientation, as well as the drop in estrogen impregnation, is another associated factor [1].

Numerous independent risk factors have been identified for the occurrence of this pathology [5]: a history of prolapse during or outside pregnancy, prolonged childbirth, multiple pregnancies, chronic coughing or constipation, repeated or severe physical exertion, and congenital damage to the supporting aponeurotic tissues [6] [7].

According to Boufettal [8], a hormone called relaxin, secreted during pregnancy, is involved in the development of connective tissue anomalies leading to ligament hyperlaxity. Thus, even minor obstetrical trauma is likely to aggravate the static anomaly, which could explain the occurrence of genital prolapse in young women.

In our case, in addition to hormonal factors related to pregnancy, the risk factors identified were essentially tachy-multiparity (eighth gesture fifth pare at 32

years of age) and the physical activities undertaken by the patient: living in a rural environment, she is subjected to rural work, carrying heavy loads, etc.

The presence of a prolapse during pregnancy can lead to complications such as childbirth and premature rupture of the membranes. During labour, mechanical obstruction caused by the prolapse can result in cervical oedema, leading to a number of complications, notably mechanical and dynamic dystocia. Cervical lesions and uterine rupture have also been described [9] [10]. In our case, the cervix was inflamed, and there were no other complications.

Our patient was admitted to the CHUSS maternity hospital as an emergency patient, and no emergency treatment was offered. A cautious manual reduction was performed, and advice was given on rest, hygiene, and the reduction of activities. However, the patient had taken up traditional management, using a pot as a "pessary" to reduce the prolapse, and had not considered it necessary to seek medical advice for this condition, which had arisen during the second trimester of her pregnancy.

Generally speaking, the prolapse persisted in the immediate and early postpartum period, with regression of the cervical edema, allowing reintegration of the uterus and use of the pessary [11]. Surgical repair of the prolapse may be proposed at a distance from delivery in patients planning to have children, giving preference to minimally invasive techniques with uterine conservation and without the use of prosthetic reinforcement. In the absence of a desire to become pregnant, conventional non-conservative suspension techniques can be used [5].

Definitive treatment of the prolapse had been proposed to the patient in the postpartum period, but she was unable to afford it. Counseling for long-term contraception was provided.

4. Conclusion

Uterine prolapse complicating pregnancy is exceptional. Improving patients' socio-economic conditions and access to quality antenatal care could considerably improve maternal health, especially for those living in rural areas.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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