

## A Case Report On Procidentia

Dr.Neelima.K.Rajan<sup>1</sup>,Dr.ElizabethCivia Vincent<sup>2</sup>,Dr.LinsaLinet V<sup>3</sup>

<sup>1</sup>(Pharm.Dintern,St.Jameshospital,India)

<sup>2</sup>(Pharm.Dintern,St..Jameshospital,India)

<sup>3</sup>(Pharm.Dintern,St.Jameshospital,India)

**Abstract:**Procidentia refers to the complete prolapse beyond the level of hymen distally so the uterus is permanently protruding out of the vagina. There are different type of pelvic organ prolapse they are cystocele, urethrocele, uterine prolapse, vaginal vault prolapse, enterocele and rectocele. Here we are reporting a case of procidentia with chronic cervicitis with ulceration and squamous metaplasia. A 76 year old multiparous women presented to out patient department with mass protruding out and dribbling of urine for past 2 years with a history of DM, HTN and CAD. We had done hysterectomy and the pathology report shows squamous metaplasia. We also assure pre and post surgical prophylaxis with proper antibiotic coverage.

Date of Submission: 25-06-2020

Date of Acceptance: 15-07-2020

### I. Introduction

Pelvic organ prolapse is common among old multiparous women. Pelvic organs include bladder, uterus, cervix, vagina and rectum [1]. When the anterior vaginal compartment herniates through the vaginal introitus, this is a cystocele. When the posterior vaginal compartment is herniating through the vaginal introitus, this is a rectocele. When the apical vaginal compartment is herniating through the vaginal introitus, this area can include bowel or uterus, describing an enterocele or uterovaginal prolapse respectively [2]. The first recorded documentation of pelvic organ prolapse dates back to 1550BC in the Egyptian medical papyrus of herbal knowledge, Ebers Papyrus [2].

Historical management of prolapse varied, including acts of manual manipulating of the prolapsed organ, cleansing the prolapsed organ with oils and wines, and inhaling malodorous fumes.[2]

Hippocrates also described a process termed succession, which was a maneuver that placed women upside down on a ladder while the ladder frame moved up and down with the hopes that gravity would restore the pelvic organs to their anatomical position.[3][4][5]. [2]

Over the 19 and 20 century, improvements in surgical instrumentation, anaesthesia, and antibiotics decreased the morbidity rates of performing hysterectomies [2].

The precise prevalence of pelvic organ prolapse is not known because there are different classification systems and women do not initially seek medical attention for prolapse.[6] However, about 1 in 10 women will undergo surgical intervention for pelvic organ prolapse by the age of 80 years old.[7] The prevalence of pelvic organ prolapse surgery varied from 6 to 18%, based on symptomology ranged from 3 to 6%, and upwards to 50% based upon vaginal examination.[6]

Here we discuss case of procidentia in a 76 year old female patient.

#### 1.1 Case report

A 76 year old (P5L5) multiparous women presented to the OP department with complaints of mass protruding from vagina for 2 years and dribbling of urine. She had a past history of DM, HTN, CAD and was well controlled with medication including T. Dytol plus, T. Corbis, T. Telplus, T.Renerve D, T. Prazopress XL and T. Aztolet. Initially she was managed by inserting ring pessary under aseptic conditions.

She was re-admitted after 2 days with very uncomfortable mass in the vagina, vaginal itching and bleeding PV. Physical examination shows Procidentia with atropic uterus. Since we had failed to manage with ring pessary and considering above symptoms and age being sexually not active we planned for surgery.

Several surgical options were discussed with her and she was with vaginal hysterectomy with pelvic floor repair. Before surgery blood routine, sugar profile, renal function test and ECG were normal. Ultra sound of abdomen reveals no significant pathology. After obtaining the fitness from various department, surgery was planned for the very next day of admission.

Surgery was done under spinal anaesthesia and epidural. As planned earlier vaginal pack was inserted towards the end of the procedure and removed on 1<sup>st</sup> post-operative day. After surgery the specimen was send to

histopathology. It shows uterus measuring 6X3X2CM ,chronic cervicitis with ulceration and squamous metaplasia, flaps unremarkable.

The procedure was completed with minimum blood loss. Inj. TT was given prior to the surgery. On the day of surgery pain was controlled with Inj.Pethidine single dose and for further days it was replaced with Inj.Diclogesic RR. The pre and post surgical prophylaxis were done by Inj.Stelzone SB and Inj.Metrogyl. On the 3<sup>rd</sup> post-operative day she had antibiotic induced diarrhoea and managed with IV fluids and prebiotics .The antibiotic was changed to inj.Ciplox .On gastro consultation T.Rifaxigress was added. On the 4<sup>th</sup> post-operative day IV therapy is switched to oral therapy. On 5<sup>th</sup> post-operative day electrolytes were checked and potassium was found to be 3.1mmol/L. On the bases of lab report we started syp. Keylite. She got discharged on 8<sup>th</sup> post-operative day.

She got discharged without any complaints and was very satisfied with the treatment procedure. The discharge medication include T.Gemiking HD, T.Ascorbate, T.Rifaxigress, Syp.Keylite and Metrogyl P ointment for local applications. Review was advised in OP department after 1 month.

## **II. Discussion**

The well known risk factors of pelvic organ prolapse are aging, multi-parity, congenital weakness, traumatic or prolonged labour, multiple vaginal deliveries, genetic factors, myopathy and collagen abnormalities. The root cause of prolapsed uterus and vaginal vault is failure of cardinal ligaments that support the uterus [8].

Uterine prolapse can occur at any age in women but most commonly seen in post menopausal women with a history of multiple vaginal deliveries [9].Swift et al found that over 50% of asymptomatic women presenting for annual gynaecologic examination have atleast stage 2 prolapse on examination[10].

The conservative treatment option for uterine prolapse include, uterine sparing procedures such as special pelvic exercise called “Kegel exercise” which help to strengthen the pelvic floor muscle. This is only found to be effective in mild to moderate cases. A women with uterine abnormality and post menopausal bleeding are not good candidates for uterine sparing procedure [10].

The next treatment option for uterine prolapse is insertion of vaginal pessary. It is a device that fits around or under the cervix thus helps to support and hold the uterus in its place. For the effective treatment, the perineum must be capable to hold the pessary in place else the pessary will frequently fall out [10].

If the conservative therapy fails then move on to surgical management. Vaginal hysterectomy and abdominal hysterectomy are the common surgical measures. Those who have live pelvic inflammatory disease or any previous intra-abdominal operation for an inflammatory process , vaginal hysterectomy is not advisable instead an abdominal hysterectomy is preferred [10].

In this case initially we tried with the conservative treatment like pelvic muscle exercise and insertion of vaginal pessary. Since the patient is not capable for holding the pessary and by considering her age we planned for vaginal hysterectomy.

In surgical prophylaxis, the purpose of antibiotics is not to sterilize the tissues, but to reduce the colonization pressure of micro- organisms introduced at the time of operation to a level that the patient’s immune system is able to overcome. Before a drug can be considered, there must be evidence that it reduces post operative infections [11].

A hysterectomy is considered as ‘class II’ or clean contaminated wound. The method of hysterectomy can modify the inheritant risk of post operative infections. A Cochrane review suggested that vaginalhysterectomy results in fewer infections or febrile episode than abdominal hysterectomy [11]. A review by Duff and Park included 20 studies, the majority were post operativetrial (18/20) and many of which were double blinded (13/20). Without prophylaxis the incidence of febrile morbidity averaged 40 – 50% but reduced to 5 – 20% with prophylaxis antibiotics. The drug of choice for prophylactic therapy for vaginal hysterectomy is intravenous 1<sup>st</sup> or 2<sup>nd</sup>generation cephalosporins [11].

In our present case by considering her age and comorbidities we opted wide spectrum antibiotic, 3<sup>rd</sup> generation cephalosporins – ceftriaxone with sulbactam along with metronidazole which have a limited spectrum of activity, mainly anti-protozoal, anti-parasitic, and anti-bacterial (bacterial vaginosis). It is also effective against gram positive and gram negative anaerobes [12]

## **III. Conclusion**

This case report emphasize on the diagnostic and therapeutic methods of procidentia. From the above data we conclude that procidentia is not a rare case in the world. It is more common among postmenopausal women with multiple vaginal deliveries. The untreated condition can lead to various complications. And the surgical prophylaxis for a class II or clean contaminated wound include 2<sup>nd</sup> or 3<sup>rd</sup> generationcephalosporins.

### Reference

- [1]. Tomohiro Matsuo, Yasuyoshi Miyata, Kojiro Ohba, Yasushi Mochizuki & Hideki Sakai, Recovery from life-threatening pelvic organ prolapse in an 80-year-old Japanese woman: a case report, *Clinical Case Reports*, 2(4), 2014, 118-121.
- [2]. Josephine Doo, Jimmy Khandalavala, Procidentia, Treasure Island (FL): Statpearls Publishing; 2020 [Updated 2019 June 11]. Available From : <https://ncbi.nlm.nih.gov>
- [3]. Barbalat Y, Tunuguntla HS, Surgery for pelvic organ prolapsed: a historical perspective, *CurrUrol Rep*, 13(3), 2012, 256-61.
- [4]. Shah SM, Sultan AH, Thakar R, The history and evolution of pessaries for pelvic organ prolapse, *IntUrogynecol J Pelvic Floor Dysfunction*, 17(2), 2006, 170-175.
- [5]. Bash KL, Review of Vaginal Pessaries *ObstetGynecolSurv*, 55(7), 2000, 455-60.
- [6]. Barber MD, Maher C, Epidemiology and outcome assessment of pelvic organ prolapsed, *IntUrogynecol J*, 24(11), 2013, 1783-90.
- [7]. Olsen AL, Smith VJ, Bergstrom JO, Colling JC, Clark AL, Epidemiology of surgically managed pelvic organ prolapsed and urinary incontinence, *ObstetGynecol J*, 89(4), 1997, 501-6.
- [8]. Harun Toy, Hakan Camuzcuoglu, Halef Aydin, Utrine prolapse in a 19 year old pregnant woman: a case report, *J Turk GerGynecol Assoc.*, 10(3), 2009, 184-185.
- [9]. MD Barber, C Maher, Epidemiology and outcome assessment of pelvic organ prolapse *International urogynecology journal* 24 (11), 2013, 1783-1790.
- [10]. Medscape database.
- [11]. Nancy Van Eyk, MD, Halifax NS, Julie van Schalkwyk, MD, Vancouver BC, Antibiotic Prophylaxis in Gynaecologic Procedures, *J ObstetGynaecol Can*, 34(4), 2012, 382-391.
- [12]. Melissa Conrad Stöppler, MD, Bacterial Vaginosis, Symptoms, Causes, Remedies, Treatments, Cure, MedicineNet.

Neelima.K.Rajan, et. al. "A Case Report On Procidentia." *IOSR Journal of Research & Method in Education (IOSR-JRME)*, 10(4), (2020): pp. 45-47.