))Genital Prolapse((

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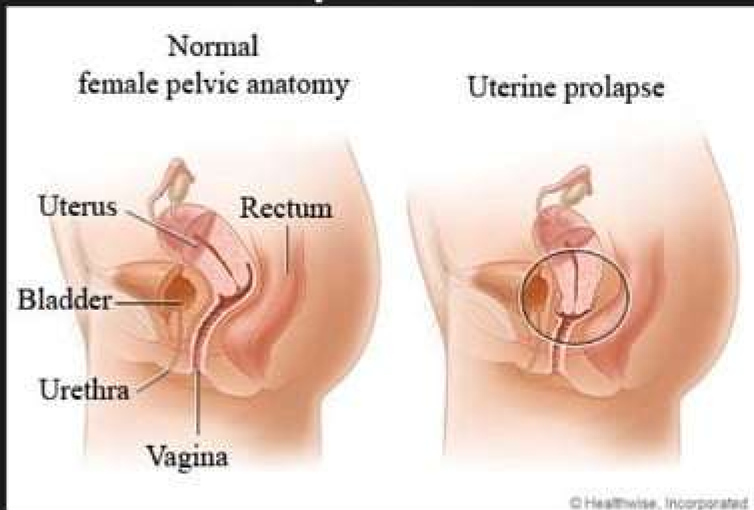
Structures that help keep the uterus in place



- Levator ani muscles
- the uterosacral, cardinal and round ligaments being examples.

Genital prolapse is the descent of one or more of the genital organ (urethra, bladder, uterus, rectum or Douglas pouch or rectouterine pouch") through the fasciomuscular pelvic floor below their normal level.

:Varieties of prolapse

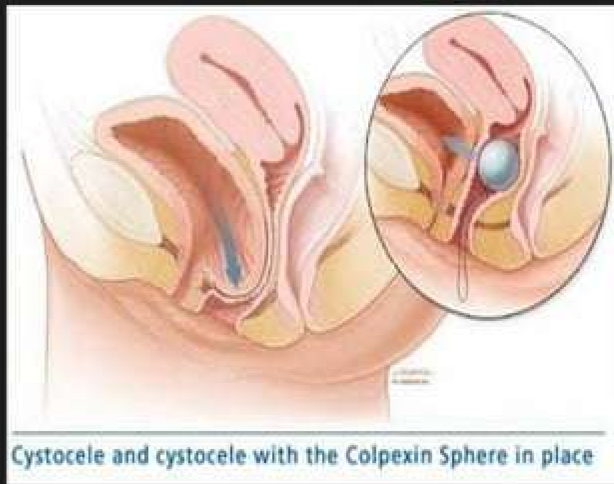
Vaginal Prolapse:

1) Anterior vaginal wall prolapse:

a. Prolapse of the upper part of the anterior vaginal wall with the base of the bladder is called **cystocele**

b. Prolapse of the lower part of the anterior vaginal wall with the urethra is called **urethrocele.**

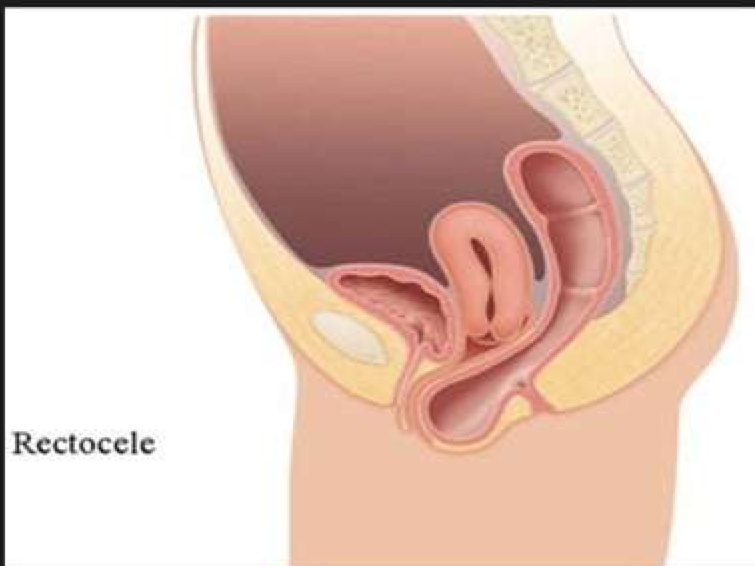
c) Complete anterior vaginal wall prolapse is called **cysto-urethrocele.**


Cystocele and cystocele with the Colpexin Sphere in place

2) Posterior vaginal wall prolapse

a) It is called **rectocele** if the anterior wall of the rectum is also prolapsed with the middle third of the posterior vaginal wall.

b) It is called **entrocele** (hernia of the pouch of Douglas) if the upper third of the posterior vaginal wall descends lined by the peritoneum of the Douglas pouch and containing loops of the intestine


Rectocele

3) Vault prolapse:

(descent of the vaginal vault, where the top of the vagina descends)or inversion of the vagina) after hysterectomy.

* Vault prolapse is more likely to occur after subtotal than after total hysterectomy.

Female pelvic anatomy
(post-hysterectomy)
Uterus
(removed)
Rectum
Bladder
Urethra
Vagina

Vaginal vault prolapse
Sagging
uterovaginal canal

II) Uterine prolapse:

1)**Utero-vaginal** (the uterus descends first followed by the vagina): This usually occurs in cases of virginal and nulliparous prolapse due to congenital weakness of the cervical ligaments.

2) **Vagino-uterine** (the vagina descends first followed by the uterus):This usually occurs in cases of prolapse resulting from obstetric trauma.

Degrees of uterine prolapse

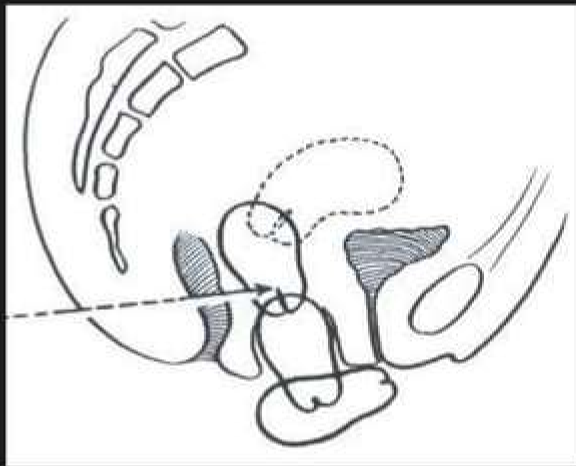
1st degree:
The cervix desent below its normal level on straining but does not protrude from the vulva.

2nd degree:
The cervix protrudes from the vulva on straining

3rd degree: (**Complete procidentia**) the whole uterus is completely prolapsed outside the vulva and the vaginal wall becomes most completely inverted over it.
Enterocele is usually present.

Degrees of uterine prolapse

- 1st degree-2nd degree-3rd degree



factors have a significant influence on pelvic floor support:

- 1.CONGENITAL.
- 2.AGE
- 3.CHILDBIRTH INJURY.
- 4.ENDOCRINE.

CONGENITAL.1:

Congenital differences in collagen behaviour are clinically evident in women who have increased joint elasticity.

Women with hyperextensible joints will develope uterovaginal prolapse at an earlier age. Such women often excel at sports requiring increased joint elasticity (such as gymnastics) and they develop fewer striae gravidarum during pregnancy because of increased skin elasticity.

AGE.2:

The fascia of the pelvic floor will provide weaker support with advancing years.

- Gynaecologists repairing the pelvic floor often recognize that the tissues used for building a repair are **of poor quality and are poorly vascularized.**
- The repair after surgery will heal with less strength and more slowly. The recurrence of prolapse seen after surgery in **one out of three** cases must in some part be due to a deterioration of fascial strength with age.

CHILDBIRTH INJURY.3:

- Most women recognize that their pelvic floor is different after vaginal delivery.
- regaining the tone and shape of their anterior abdominal wall is also often a difficult challenge.

- **These changes are due to a combination of muscle and fascial changes. whether pelvic floor fascia stretches or tears during pregnancy and childbirth.**

ENDOCRINE.4:

- Women often declare that prolapsed symptoms are worse around the time of menstruation.
- This is thought to be **secondary to higher progesterone levels increasing fascial elasticity**.

:Symptoms of prolapse

1. Before actual prolapse. the patient feels a sensation of weakness in the perineum. particularly towards the end of the day.
2. Later the patient notices a mass which appears on straining.

3. Urinary symptoms are common and trouble some even with slight prolapse:

a) Urgency and frequency by day.

b) Stress incontinence.

c) Inability to micturate unless the anterior vaginal wall is pushed upwards by the patient's fingers.

d) Frequency and scalding day and night when cystitis develops

4. Rectal symptoms.

5. Backache

6. Leucorrhoea

:-Examination

Examination is best carried out with the patient in*
the left lateral position or sims position using sims
. speculum

The presence , type & extent of prolapse &*
presence of stress incontinence if any can usually
be determined by asking the patient to bear down
.or to cough during examination

If there is doubt the patient should be asked to*
.stand or walk for some time before examination

Treatment of *Prolapse*

:A) Prophylactic treatment for Obstetric prolapse

1. **Proper ante-natal care (before delivery):** The pelvic floor should be both strong and elastic.
2. **Proper intra-natal care (during delivery):** Avoid aetiological factors as straining during the first stage(before full cervical dilatation); avoid the application of forceps before full cervical dilatation; episiotomy should be done when indicated to avoid hidden perineal lacerations; and avoid fundal pressure to deliver the placenta.
3. **Proper post-natal care (after delivery):**

   Accurate repair of perineal tears or episiotomies, encourage pelvic floor exercises, prevent puerperal constipation in order to avoid strong bearing down efforts while the supporting ligaments of the uterus are slack

:-B-conservative treatment Pessary treatment

Ring pessaries are made of inert plastic , are- of different size , can be left in place for up to .one year

Shelf pessaries are helpful in severe- .utrovaginal prolapse

The two main complication of pessaries are- vaginal ulceration & incarceration leading to .discharge & bleeding

:-Indication of pessaries treatment are-

- During & after pregnancy awaiting involution of tissues .
- As a therapeutic test to confirm that surgery might help .
- When the patient is medically unfit or refuses surgery .
- for relief of symptom while the patient is awaiting surgery.

C-Surgical Treatment:-

prolapse is not life threating condition but surgery has its mortality & morbidity .

a) Anterior repair (anterior colporrhaphy):-

- Correct cystocele or cystourethrocele .
- The vaginal skin is divided in the midline , the bladder is reflected upwards & the pubocervical fascia on either side inforced with interrupted stutures , redundant vaginal skin is excised & vaginal skin is closed .
- Postoperative urinary retention is common .

)b) Posterior repair(colpo-perineorrhaphy

- Correct rectocele
- A vertical posterior vaginal wall incision is used to descet the posterior vaginal wall from the rectum , the edges of the levator ani muscles are sutured together in the midline & the posterior vaginal skin is closed .

:-c) Vaginal hysterectomy with repair

- It is now the standard operation for utro-vaginal prolapse .
- It is also the operation of choice when an enterocele present .
- Best well when there is procidentia .

d) Manchester (fothergill) repair :-

- Appropriate for the small number of women with severe utro-vaginal prolapse who wish to have further children .

- It combines shortening of the transverse cervical ligament with amputation of the cervix & anterior colporraphy .

-full amputation of the cervix may not be necessary in less severe cases .

e) Leefort operation

f) Hysterosacropexy

))References((

- Gynecology By Ten Teachers 19th edition
- Dr. Rozhans lecture
- www.slideshare.com

Thank you for your attention

Any Qs???