GENITAL PROLAPSE

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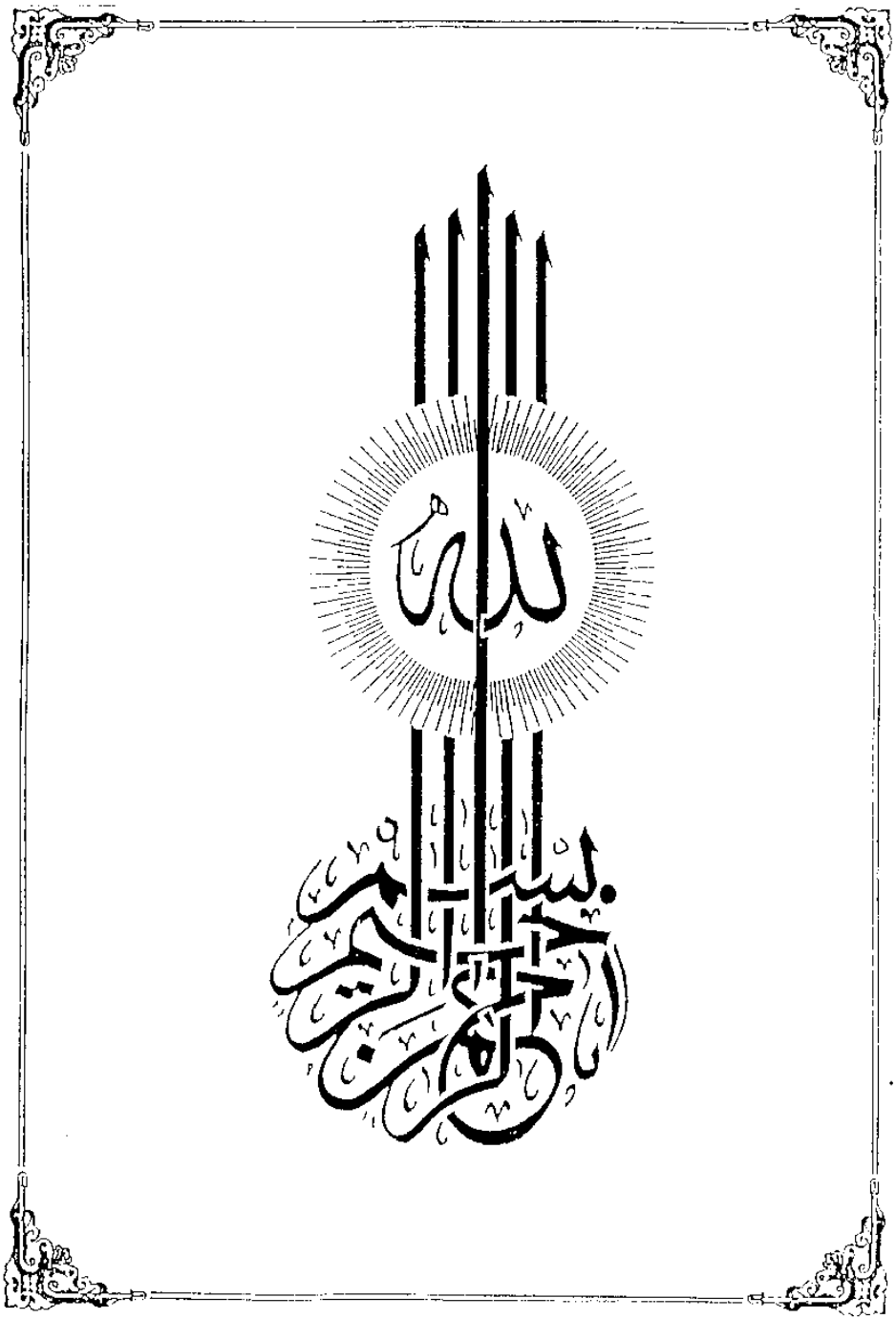

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GENERAL ASPECTS OF PROLAPSE

GENITAL PROLAPSE

INTRODUCTION:

Prolapse, Procidentia (from the Latin procidre, to fall) or downward descent of the vagina and uterus is a common and disabling condition; (**Jeffcoate, 1987**).

It appears that prolapse occurs rather frequently among the white races, the Egyptians, and the women of India. It occurs less frequently among Orientals and American Negroes and is particularly uncommon in the South African Bantu as well as in the Negro of West Africa (**Nichols, 1991**).

The most common single etiologic factor of genital prolapse is parturition and it may be related to increased intra-abdominal pressure and softening of the pelvic connective tissues and smooth muscles as a result of hormonal influences (**Nichols, 1991**).

Basically, genital prolapse falls into either of two large groups: Prolapse of the upper vagina or eversion of the lower vagina. These may occur separately or together, simultaneously or at different times, but they are produced by quite different etiologic factors, the significance of which was recognized by **Victor Bonney in (1914) (Bonney, 1914)**.

Jeffcoate, (1987); (mentioned classification of) uterine

prolapse into three degrees: first degree, second degree and third degree (Jeffcoate, 1987).

The amount of discomfort and inconvenience experienced by the patient is extremely variable. Some women suffer complete procidentia for many years without being seriously incommoded, and without having to restrict their activities. On the other hand, other women complain bitterly when they suffer only a moderate degree of uterine or vaginal descent; the difference may in part be explained on the basis of resistance offered by the supporting ligaments (Jeffcoate, 1987).

It is particularly important in the interests of preserving uterine supporting tissues and the integrity of vaginal support that the woman in labour be urged not to bear down and not to work with the pains, at least until the cervix is known to be fully dilated and, almost equally important, not until the presenting part has traversed the upper vagina, descent is evident, and the presenting part is beginning to distend the perineum (Nichols, 1991).

Different lines of treatment have been used to treat genital prolapse: including the medical treatment which includes the prophylactic treatment during labour and the puerpurium, physiotherapy when there is only a minor degree of prolapse and pessary treatment as a palliative treatment consisting of preventing the descent of the uterus and

vaginal wall by means of a supporting pessary but it does not cure prolapse.

Surgical treatment is nearly always the best treatment for established prolapse but it is only necessary if the condition is causing symptoms or interfering with the woman's normal activities (Jeffcoate, 1987).

AIM OF THE WORK:

The aim of the work is to review the problem of genital prolapse and its various aspects.

These aspects include:

1- Introduction; including the definition, incidence, and historical background. Comparative study to veterinary problems.

2- Anatomy of the female genital tract.

3- Aetiology of genital prolapse.

4- Types of genital prolapse.

5- Clinical assessment of genital prolapse.

6- Treatment of genital prolapse.

7- Recurrent prolapse.

8- Stress urinary incontinence.

9- Summary.

10- Protocol of treatment.

11- References.

12- Arabic summary.

HISTORICAL

The history of genital prolapse and proposals for its treatment can be traced past the days of Hippocratic medicine to a record in the Kahun papyrus of Egypt. **(Emge and Durfee, 1966).**

A. Benedetti (1947) was the first person to use the word "procidentis" in describing genital organ prolapse.

The first true vaginal hystrectomy was ddone by J. Berengarioda Capri in 1521 **(Emge and Durfree, 1966).**

In 1603, R. de Castro suggested a most unique method for treatment of uterine prolapse: "by attacking it with a piece of iron- red hot- as if to burn it, whereupon fright will force the prolapsed part to recede into the vagina" **(Emge and Durfee, 1966).**

Romain Geradin, (1821) suggested the cure of cystocele by anterior colporrhaphy. **Marshall Hall in (1831)** modified Geradin's procedure and seems to have been the first to suggest narrowing of the vagina. **In (1833) Frick of Hamburg** advised suturing of the labia majora (episiorrhaphy). **In (1837) Dienffenback** described his operation of combined episiorrhaphy and perineorrhaphy. **Phillips of London in (1839)** described this method and advised nitric acid for that purpose; Jobert de Lamelle at a later date recommended nitrate of silver.

In (1887) Le Fort, recommended suturing the anterior and posterior vaginal walls after removal of a central flap from each wall **(Mahfouz, 1949).**

"Marion Sims", in the (1886) edition of his celebrated book, stated that for the treatment of prolapsus uteri there are three surgical processes from which to choose:
(1) Amputation of the cervix, (2) Perineal operations or (3) Narrowing of the vagina by the trowel or triangular-shaped denudation of its anterior wall as performed by Emmet and himself. "No one seems to have combined these three operations until some members of the staff of the Woman's Hospital attached to the University of Berlin and Donald of Manchester independently began to do so in 1888".

A study of previous failures (from vaginal wall suturing-colporrhaphy) convinced Donald that success could only be attained when the narrowing of the vagina was obtained by suturing the deep structures as well as the superficial.

At a later period, Fothergill modified the operation by making the incision of the anterior colporrhaphy triangular in shape, with a wide base near the cervix, and by a circular incision around the cervix. He combined the amputation of this organ with the anterior colporrhaphy **(Crossen and Crossen 1938).**

In (1898) Thomas J. Watkins first performed the

interposition (Transposition) operation for cystocele and uterine prolapse and reported it the following year. Basically the operation consisted of amputating the elongated cervix and suturing the fundus of the uterus beneath the large cystocele. Improved techniques of Vaginal Hystrectomy and repair of the vagina gradually led to the abandonment of the Watkins operation (**Mattingly and Thompson 1985**).

Crossen & Crossen (1938) pointed out that repair of the relaxed pelvic floor is a part of practically every prolapse operation.

There may be individual and racial differences in connective tissue strengths noted by the relative infrequency with which black women sustain lacerations from spontaneous delivery and their relative immunity from uterine prolapse (**Nichols, 1991**).

The racial incidence of genital prolapse and its significance were reported by **F. G.Geldenhuys from (1945)** through (1949) was 6.5% (**Geldenhuys, 1950**).

During the same period, in Bantu gynecologic patients, it was 0.6% . In Switzerland, in Zurich, the incidence was 12% and in Geneva 5.7% . In Hamburg 5.4% and in Rome 6.4% .

Prolapse was common in India and in North America. Heyns also reported prolapse to be common in Brazil and in Egypt, but less common among Indonesians and Chinese.

It appears that prolapse occurs rather frequently among

the white races, the Egyptians and the women of India. It occurs less frequently among Orientals and American Negroes and is particularly uncommon in the South African Bantu as well as in the Negro of West Africa (Nichols, 1991).

COMPARATIVE STUDY TO VETERINARY PROBLEMS

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Prolapse Of The Vagina

Typically, prolapse of the vagina is a condition of ruminants in late gestation. Occasionally, it is seen after parturition and rarely it occurs unconnected with pregnancy or parturition.

Cattle of the beef breeds, particularly Herfords, are most commonly affected (**Woodward and Queensberry, 1956**) and it has been suggested that in them, the anatomical anchorage of the genital tract is less efficient than in other animals. An excessive deposition of fat in the perivaginal connective tissue and ligamentous relaxation, may increase the mobility of the vagina. Both these effects might be due to a state of endocrine imbalance, in which oestrogenic hormones predominate. **Bennetts, (1944)**, stated that where oestrogenic substances are present in the subterranean clover pastures of Western Australia or when they are purposedly fed for flattening purposes, vaginal prolapse may frequently occur.

It is postulated that the endocrine predisposition to vaginal prolapse is inherited. Mechanical factors such as the increasing intra-abdominal pressure of late pregnancy and gravity, acting through the medium of a sloping byre floor, are of probable aetiological significance (**McLean and Claxton, 1960**).

In both sheep and cattle, vaginal prolapse is commoner in pluripara than primipara.

Whatever the cause of prolapse of the vagina, parturition or abortion relieves the condition (Arthur, 1989).

Symptoms and course:

Initially the lesion involves a protrusion of the mucous membrane of that part of the vagina which lies just in front of the meatus urinarius. In severe cases, the whole of the anterior vagina and cervix may protrude.

In the mildest cases, the lesion appears only when the cow is recumbent; and in time, a larger bulk protrudes and does not disappear in the standing position. The dependent tissue, with its circulation impeded, is prone to injury and infection. The resultant irritation causes expulsive straining efforts. This increases the degree of prolapse and a vicious circle is established. Eventually the whole of the vagina, cervix and even the rectum may become everted. Thrombosis of the prolapsed organ, ulceration and necrosis accompanied by toxaemia and severe straining lead to anorexia, rapid deterioration in bodily condition and occasionally death (Arthur, 1989).

Treatment:

Replacement and retention of the prolapsed portion (Arthur, 1989).