

Case Report

Conservative management of pelvic organ prolapse during pregnancy: Report of two patients

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Abstract

Uterine prolapse is a rare complication in pregnancy and its frequency decreases as the parity declines in the last decade. In this report, we have aimed to present two patients who were admitted to our center with the complaint of uterine prolapse that first occurred during pregnancy and the conservative management of this rare condition was reported. In spite of performing elective cesarean section in cases of uterine prolapse complicating pregnancy, normal spontaneous vaginal delivery can be preferred in appropriate cases.

Key words:

Uterine prolapse, conservative treatment

Introduction

Pelvic organ prolapse during pregnancy is a very rare condition [1]. In this report, we have aimed to present two unusual cases who were admitted to our center with the complaint of uterine prolapse that first occurred during pregnancy. The conservative treatment strategy was presented in detail also.

Case presentation

Case 1: A 38-year-old woman, gravida 4, parity 3 was admitted to our hospital for routine examination for the first time at sixteenth week of gestation. There was no remarkable condition in her past medical history. The patient had deliv-

ered three babies whose birth weights were 3100, 3400 and 3600 grams respectively. There was no abnormality found on routine psychical examination and obstetric ultrasonography at 16th and 24th weeks. Patient's first complaint was at 30th week and she was admitted to our hospital with uterine prolapse. Pelvic examination revealed a stage 3 pelvic organ prolapse and cervical erosion (Figure 1a). Rifampicin and dexpanthenol cream dressing were prescribed to the patient. The patient had also used estriol cream proposed by another medical center, but she had not benefited from this treatment. Ring pessary was applied to the patient and she was hospitalized for 10 days. The patient did not get benefit from pessary treatment also. The patient's next examination was performed at 35th week. There was no change in clinical findings and fetal biometry was compatible for the gestational week. At the 38th week of gestation, the patient was admitted for rupture of the fetal membranes at full-term pregnancy time. The effacement of the cervix had begun and 2 cm dilation of the cervix was found during vaginal examination (Figure 1b). Cervical edema become obvious and topical magnesium sulfate treatment was applied during the active labor period. Spontaneous

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vaginal delivery was performed without any complications. Case 2: A 35-year-old woman, gravida 2, parity 1 was admitted to the hospital for routine examination for the first time at 27th week of pregnancy. Her past medical history revealed that small bowel resection caused by obstructive ileus 20 years ago and lumbar disc herniation surgery 5 years ago. Previous pregnancy birth weight was 3840 grams via vaginal delivery. Fetal biometry was consistent with gestational age. Pelvic examination revealed a stage 3c pelvic organ prolapse (Figure 2). Rifampicin dressing was suggested to the patient. It was hard to apply Pessary to the patient and called two weeks later. By the patient's examination at 35th week, cervical edema had become significant and topical magnesium sulfate treatment was begun. The patient was admitted at full-term pregnancy time (39 weeks and 4 days). The effacement of the cervix had begun and 4 cm dilation of the cervix was found during vaginal examination (picture could not be taken because of the lack of the patient consent). Spontaneous vaginal delivery was performed without any complication.

Figure 1.



The image of the pelvic organ prolapse of the case 1 before (A) and after (B) treatment

Discussion

The parity is believed to be an important risk factor in the development of pelvic organ prolapse [2-4]. Uterine prolapse is a rare complication in pregnancy and its frequency decreases as the parity declines in the last decade. The estimated incidence of this rare condition is 1 case per 10 000–15 000 deliveries and the complications of this condition include patient discomfort, urinary tract infection, acute urinary retention, abortion, preterm labor, and maternal

death [5]. Standard management of prolapse in pregnancy is still being debated. In the literature there are a few reports regarding the treatment options for this rare condition [6]. Gravida and parity were 4 and 3, respectively in one patient and 2 and 1, respectively in the other one, in our cases. Patients were treated conservatively until delivery.

Figure 2.



The image of the pelvic organ prolapse of the case 2 before treatment

With the active labor, cervix was ripened and spontaneous vaginal delivery took place. These cases have shown that, close follow-up of uterine prolapse during pregnancy, bed rest should be recommended to the extent possible with slight Trendelenburg position [7]. Topical therapy with magnesium sulfate is considered to facilitate reduction of the cervix without increasing the risk of maternal and fetal outcomes [8]. Conservative methods and topical magnesium sulfate therapy make the opportunity for vaginal delivery without any complication. In appropriate cases of uterine prolapse complicat-

ing pregnancy, normal spontaneous vaginal delivery can be preferred to elective cesarean section.

Declaration of Interest statement

There is no conflict of interest

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