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## UTERINE PROLAPSE DURING 3<sup>RD</sup> STAGE OF LABOUR-CASE REPORT

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### ABSTRACT

Intrapartum uterine prolapse is an uncommon but life threatening obstetric emergency. The reported incidence varies considerably, with reports ranging from 1 in 10,000-15,000. It is due to difficulty in delivering the placenta associated with weakness of supporting ligaments. It can lead to various complications like irreversible shock and can even cause maternal death. It is imperative that the condition is recognised quickly and managed promptly in order to minimise the maternal morbidity and mortality. Here we are presenting a case of uterine prolapse during 3<sup>rd</sup> stage of labour managed successfully.

**Keywords:** 3<sup>rd</sup> stage of labour, Uterine prolapse, Retained placenta.

### INTRODUCTION

Uterine prolapse during third stage of labour is an uncommon but life threatening obstetric emergency. Reported Incidence: 1 in 10,000 - 15,000 deliveries<sup>1</sup>. It is hypothesized that the descent of the uterus is initially associated with prolongation of the cervix followed by descent of the body of uterus<sup>2</sup>. No clear guidelines are given on management of this condition. It is thought to be due to difficulty in delivering the placenta or use of fundal pressure to supplement expulsive efforts in 2<sup>nd</sup> stage of labour. It can lead to various complications like Postpartum haemorrhage, irreversible shock and even maternal death. Here, we present a case of a lady who developed uterine prolapse during third stage of labour and managed successfully.

### CASE REPORT

A 25 year old Para4Living4Abortion1, was referred to BLDEA's Shri B.M. Patil Medical College as retained placenta with mass descending per vaginum while attempting to

deliver the placenta. She reported to us 4 hours following delivery having been delivered by a trained dai at home. On General physical examination she was severely pale, conscious, oriented and her Pulse rate was 140 bpm, Blood Pressure was 100/60 mm Hg. Per abdominal examination revealed well contracted and retracted uterus. On Local examination there was third degree uterine prolapse with oedematous cervix with placenta in situ (Fig-1). Supportive treatment with I.V. fluids and simultaneous removal of the placenta and later manual reduction of prolapse was done (Fig-2).

### DISCUSSION

The case presented pinpoints the problems faced by women in the process of delivering their babies in the developing countries. The fact that trained dais trying to deliver retained placentae with such complications, shows their lack of knowledge to deliver placentae. Our literature review showed few reported cases of prolapsed uterus during pregnancy and

labour. Complications reported range from patient discomfort, cervical desiccation and ulceration, urinary tract infection, acute urinary retention and even maternal death<sup>5</sup>. Predisposing factors reported are: Multiparity, absence of active management of third stage of labour, placenta accreta, increta, application of fundal pressure in second stage of labour, excessive cord traction in third stage labour, short umbilical cord, relaxed uterus/ congenital weakening of ligament and precipitate labour<sup>3</sup>. The Condition needs to be differentiated from uterine inversion. In case of uterine inversion, absence of uterine fundus on abdominal examination and palpation of the inverted fundus in the lower uterine segment, cervix, vagina and perineum depends on the stage.

Shock is out of proportion to blood loss in 40% of cases as in uterine inversion<sup>4</sup>. The prolapsed uterus is usually managed by reducing the prolapsed organ and bed rest in a slight trendelenberg position during the antenatal period<sup>6</sup>. It is essential for the obstetrician to look for the presence of cervical inflammation or oedema which may complicate a vaginal delivery. Daskalakis *et al* suggested elective caesarean section near term to avoid further pelvic damage<sup>5</sup>. Management of postpartum uterine prolapse includes treatment of hypovolaemic shock and manual replacement of prolapsed uterus with use of gellhorn pessary. Our patient had postpartum hemorrhage and was transfused with 2 units of blood. Postpartum Haemorrhage and blood transfusion complicate about 65% and 47.5% of patients with such conditions<sup>3</sup>. Our patient was placed on broad spectrum antibiotics due to risk of superimposed infection resulting from delayed replacement of the prolapsed uterus. Surgical intervention is rarely needed.

## CONCLUSION

Uterine prolapse in pregnancy and labour is a rare occurrence and best managed

conservatively. Training and retraining of health workers in rural areas will help them to improve in the maternal health services and referral will go a long way in decreasing morbidity and mortality associated with severe conditions such as uterine prolapsed and uterine inversion.

## CONFLICT OF INTEREST

Nil

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**Figure-1-3<sup>rd</sup> degree Prolapse Uterus with oedematous cervix lying outside the intoitus with placenta in situ**



**Figure-2 Repositioned prolapsed uterus**

