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A rare case of cystocele in pregnancy: Case report from a tertiary care hospital in Northern India

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Abstract

Background: Pelvic organ prolapse complicating pregnancy is an extremely rare entity. Obstetricians must be familiar with this condition as early recognition and follow up can help to avoid possible fetomaternal risks. Isolated cystocele in pregnancy has not been reported in literature till now. Case reports available mention concomitant uterovaginal prolapse along with cystocele.

Case Report: We present a patient with isolated cystocele during pregnancy. She presented to us at 28 weeks gestation with cystocele protruding out of the introitus with complaints of preterm labour pains. She was managed conservatively, but had preterm vaginal delivery at 30 weeks gestation. Both mother and baby are healthy following delivery.

Keywords: Cystocele, pregnancy, case report

Introduction

Pelvic organ prolapse is a bulge or protrusion of pelvic organs and their vaginal segments into or through the vagina. A cystocele is the herniation of urinary bladder through the anterior vaginal wall. In developing countries such as India, the incidence of prolapse in pregnancy can be as high as 1 in 547 deliveries^[1]. Data for incidence of isolated cystocele in pregnancy is scarce because the condition is extremely rare. It can lead to complications in the antepartum, intrapartum and postpartum period. Urinary retention, recurrent urinary tract infections and foetal loss remain serious complications which cannot be overlooked^[2].

Case Report

A 24 year old Indian female presented at 28 weeks period of gestation with complaints of preterm labour pains. This was her second pregnancy with previous one vaginal delivery. Her pregnancy was unsupervised until this time. When she presented at hospital she gave history of mass protruding out through vagina for the past 4 months. She had poor nutritional status and was pale on examination. Vital signs were stable. Pelvic examination revealed a third degree cystocele with no utero-vaginal prolapse. The prolapsed part measured 4 x 4 cm outside the introitus with cystocele as the leading part. Manual reduction of the mass was possible. Patient was admitted in view of preterm labour pains. In index pregnancy, she started noticing a mass protruding out of her vagina for the last 4 months. No prolapse was present prior to conception. The mass gradually increased in size over the past few months and was associated with increased frequency of micturition and feeling of incomplete emptying of bladder.

Her antenatal period until now had been uneventful. Antenatal investigations revealed moderate anaemia with haemoglobin of 8.2 g/dl. She had hypoproteinaemia and her serum albumin was 2.57 mg/dl. Her previous pregnancy record was significant as she gave history of precipitous labour, where she had experienced labour pains for 2-3 hours prior to delivery. It was conducted at a local hospital and she gave birth to a baby girl weighing 1.5 kg with good Apgar's. Inter-pregnancy interval was 3 years.

Preterm labour pains subsided after admission. She received steroid cover over the next 2 days and was conservatively managed. Routine obstetric examination revealed polyhydramnios which was confirmed by ultrasound. It also revealed a short cervical length of 1.3cm. Blood sugar profiles were normal. Gross foetal malformations were ruled out on ultrasound. Patient was discharged and advised bed rest.

She came back in active labour after 10 days and had a preterm vaginal delivery. She gave birth to a baby girl weighing 1.56 kg with good Apgar's. Cystocele had to be manually reduced during second stage of labour to allow for easy descent of the foetal head. Baby was shifted to the Neonatal ICU because of respiratory distress arising out of prematurity. Pelvic examination on third day of postpartum showed a significant reduction in size of the prolapse. Urinary complaints subsided and she was discharged on fourth day of postpartum along with her baby after counselling about Kiegel's exercises and a high protein diet.

She will follow up in postpartum clinic at 6 weeks when we shall look for regression of cystocele or associated uterovaginal prolapse.

Discussion

Pelvic organ prolapse in pregnancy is a rare entity, and even lesser data is available for cystocele in pregnancy. There are multiple reasons which can predispose to cystocele in pregnancy, such as short duration between pregnancies, physiological changes in pregnancy which cause ligaments to relax and previous history of precipitous labour^[3]. Trauma during childbirth is the most common cause of prolapse in pregnancy in developing nations^[4]. Older maternal age and multiparity can add to weakness of pelvic floor and predispose to prolapse^[4]. It is more common in women with poor nutritional built. Pelvic organ prolapse usually presents in the third trimester of pregnancy, and usually disappear post delivery^[3]. It is noted that, if pelvic organ prolapse exists prior to onset of pregnancy, it spontaneously resolves by the end of second trimester and causes no further complications^[5].

This case report will hold unique importance in literature as there are few or almost no mentions about isolated cystocele in pregnancy. Cystocele is the bulging of the urinary bladder outside the vagina. During the intrapartum period, the cystocele may act as an obstruction to the outflow tract for the foetal presenting part, if it shows signs of irreducibility. Due to lack of relevant data, we are not able to comment on the need for a caesarean delivery in such a scenario.

In a case report on persistent uterine prolapse during pregnancy^[6], though there is mention of cystocele in physical examination of the patient, the management only talks about effects of utero-cervical prolapse on antenatal, intra partum and post-partum period. Whereas preterm labour and perinatal loss is a threat in uterovaginal prolapse^[6], such literature is lacking for cystocele in pregnancy. Vaginal pessaries with bed rest in trendelenberg position may reduce complications in pregnancy with uterovaginal prolapse^[2, 7], but no such data could be gathered with respect to cystocele in pregnancy. Our patient had other risk factors for premature labour such as polyhydramnios and short cervical length and hence it is not possible to make an association between the presence of cystocele and preterm labour in her.

Only one case report with severely oedematous, ulcerated and irreducible cervix^[8], mentions concomitant caesarean hysterectomy in management of pelvic organ prolapse in pregnancy because the entire lower segment was prolapsed. Pelvic floor muscles require rehabilitation after delivery if we want to prevent prolapse in subsequent pregnancies. Urodynamic studies, endoanal ultrasounds and neurophysiological studies for the pelvic floor muscles is recommended in most patients to understand the pathology and provide targeted therapy^[6]. The use of pessaries in cystocele is not useful and hence bed rest, building up of nutritional status

along with symptomatic management of any infection were included in the management of our patient^[9].

All said and done, there is a need for more comprehensive literature on managing pelvic organ prolapse in pregnancy. Each case is different and demands a patient centric approach.

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