A new look at the solution to the problems of female genital prolapse

Professor of science Navruzov S.N.
Sobirova M.R
Navruzova R.S.
Navruzova Sh.B.

Summary

The article provides an overview of the clinical case, grade IV genital prolapse, 64 year old woman, grade III obesity. A new technique for the operation of vaginal hysterectomy with suturing of the round uterine and sacro-uterine ligaments has been proposed.

Key words: genital prolapse, uterus.

Prolapse of the Female Sexual Organs: A Global Ongoing Issue

Prolapse of the female sexual organs remains a significant problem worldwide. The etiology and pathogenesis of the disease leave many unanswered questions. The condition causes discomfort and disrupts women's sexual and reproductive functions, ultimately lowering quality of life. The disease is particularly severe in older women [1, 3].

Chronic conditions such as obesity, diabetes, rheumatoid diseases, digestive system disorders, colon diseases, and others worsen the severity of the condition. Often, surgery is the only correct treatment for treating prolapse in older women. However, choosing the appropriate surgical method is difficult because it should not only eliminate the prolapse but also prevent long-term complications [2]. To achieve this, a strong ligament apparatus of the pelvic cavity must be formed. In modern gynecology, synthetic prostheses are often used [5].

Clinical Case:

A 64-year-old woman, S.I., from Tashkent city, was admitted to the surgical gynecology department of the 6th maternity hospital. She complained of discomfort and pain in the perineal area, a foreign body sensation in the genital area, and the inability to have sexual intercourse. These complaints had troubled her for several years, but she had not visited any doctors and had been managing the situation on her own.

Anamnesis:
The patient's medical history includes a satisfactory general condition. She had suffered from ARI (acute respiratory infections), chickenpox, and Hepatitis A in childhood. She has had hypertension for 8 years. No allergies or epidemiological concerns were reported.

Gynecological History:
Menarche occurred at 14 years of age, and she married at 20. She had 6 pregnancies, 4 births, and 2 abortions. The births were physiological, with soft tissue tears during childbirth, and two large babies were delivered (4600g and 4850g). For a long period, she used barrier contraception methods. She has been in menopause for 18 years. Gynecological issues included cervical erosion (treated in 1997), colpitis, and bacterial vaginosis.

Gynecological Examination:
External genitalia were well developed for her age. Examination revealed generalized prolapse of the sexual organs at stage IV (Figure 1). The vaginal cavity was capacious. The hernia sac descended from the genital cleft (complete uterine prolapse). Both the bladder (cystocele) and the rectal wall (rectocele) were bulging.

Figure 1: Pre-surgical condition



The uterus appeared normal in size, mobile, and painless upon palpation, located within the thickening of the vaginal wall. The cervical area was hypotrophic, with erosive patches. The vaginal vault was hanging. According to the patient, urination was not difficult or painful. The stool was irregular, with a tendency toward constipation.

Initial Investigations:
The following tests were performed: blood and urine general analysis; biochemistry; coagulogram; three-point swab test; ultrasound of the abdominal cavity and small pelvis; colposcopy; and ECG. All clinical and laboratory tests were normal.

The patient was examined by specialists: cardiologist and therapist. The diagnosis of generalized prolapse of the sexual organs was confirmed, with a complete uterine prolapse. Cystorectocele and obesity (III degree) were also noted.

A decision was made to proceed with surgical treatment, which included vaginal extirpation of the uterus with strengthening of the pelvic muscles using Prolene mesh.

Surgery:
Under spinal anesthesia, after sterilizing the external genitalia with an antiseptic solution, the vagina was opened with speculums, and the cervix was removed using a clamp. A radial incision was made in a “fish-mouth” shape. The walls of the bladder

were separated, and the anterior and posterior vaginal walls, cardinal, sacro-uterine ligaments, and vascular structures were sequentially ligated on both sides (Figure 2).

Figure 2: Sequential ligation of the ligament apparatus



The uterine cervix was cut from both angles, and tissue terminals were sutured. The posterior vault of the vagina was cut. Both appendages were not significant. The sacro-uterine ligaments were sutured with Prolene mesh, and the proximal canal of the mesh was fixed to the round uterine ligaments on both sides. A strong conglomerate was formed, stabilizing the pelvic cavity. Peritonization was performed using a continuous suture. The deep vault of the vagina was created, and a strong ligament apparatus was formed.

The risk of recurrence of prolapse was eliminated post-surgery. Subsequently, anterior-posterior colpoperineolevatoroplasty was performed using the classical method. Total blood loss was 180 ml, and the urine output via catheter was 200 ml of clear urine. The surgery lasted 75 minutes.

Figure 3: Post-surgical preparation



Figure 4: Post-surgical condition



Macroscopic Findings:

The uterus was of normal size, with an elliptical cervix. Upon cutting, the endometrium was pale pink without visible focal changes.

After a satisfactory post-surgical period, the patient was discharged on the 4th day. Forty days later, she reported feeling great, and her quality of life was restored.

Conclusion:

This surgical technique, involving the repair of the sacro-uterine ligaments and uterine round ligaments, allows for the formation of a strong pelvic floor, preventing the likelihood of recurrence. Further research is needed in this field of surgical gynecology.

References:

1. Bezhenar VF. Comparative assessment of quality of life after correction of genital prolapse using various synthetic implants: scientific publication / VF Bezhenar, ES Guseva, et al. // Obstetrics and Gynecology Journal. - St. Petersburg, 2013. - Vol. LXII, No. 5. - P. 15-28.

2. Buyanova S. N. Features of treating patients with severe and recurrent genital prolapse in old age and senility: scientific publication / S. N. Buyanova, M. V. Mgeliashvili, S. A. Petrakova, T. B. Marchenko // Russian Obstetric-Gynecological Bulletin. - Moscow, 2015. - Vol. 15, No. 4. - P. 81-84.

3. Qurbonov BB. Modern surgical tactics for treating genital prolapse and stress urinary incontinence // BC. Mother and Child. - 2018. - Vol. 1. - P. 1.

4. Lucot JP, Bot-Robin V, Giraudet G, Rubod C, Boulanger L, Dedet B, Vinatier D, Collinet P, Cosson M. [Vaginal mesh for pelvic organ prolapse repair]. Gynecol Obstet Fertil. 2011 Apr; 39(4):232-44.

5. Migliari R, De Angelis M, Madeddu G, Verdacchi T. Tension-free vaginal mesh repair for anterior vaginal wall prolapse. European Urology. 2000; 38(2):151-155.

6. Sobirova M.P. Differential peculiarities of uterine prolapse surgical treatment // RUzb. UYK-2021. No. 3, P. 175-177.