From Midtrimester Procidentia to Delivery: Managing Complete Uterine Prolapse Throughout Pregnancy

A Case Report

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GENERAL OBSTETRICS

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ePoster Presentation

1 Background

- Pelvic organ prolapse (POP) in pregnancy is rare, occurring in an estimated 1 in 10,000–15,000 pregnancies.
- Complete uterine procidentia — descent of the uterus beyond the vaginal introitus — represents the most severe form of POP.
- Management is challenging: evidence is limited to case reports, anatomy changes across gestation, and both maternal and fetal complications are possible.
- Reported complications include cervical oedema, ulceration, urinary retention, infection, and preterm labour.

Keywords: uterine prolapse · procidentia · pregnancy · pelvic organ prolapse · caesarean section

2 Case Presentation

- 42-year-old, G2P1, conceived via IVF; prior POP after first vaginal birth, previously pessary-managed.
- ~21 weeks: presented with complete, irreducible procidentia and cervical oedema → operative reduction under anaesthesia with vaginal packing.
- Ring and Gellhorn (size 7, then 6) pessary trials failed due to urinary retention.
- ~30 weeks: recurrent descent without pessary support; patient declined admission for bed rest.
- Complicated by cholelithiasis (26 weeks) and intrahepatic cholestasis of pregnancy (late 3rd trimester).
- Multidisciplinary input: obstetrics, urogynaecology, obstetric medicine.
- Elective caesarean section at 37+4 weeks (spinal anaesthesia); EBL ~500 mL; healthy infant, uncomplicated recovery.
- 3 months postpartum: stage III cervical prolapse with elongation, managed with a size 4 cube pessary; definitive repair pending.

3 Clinical Findings

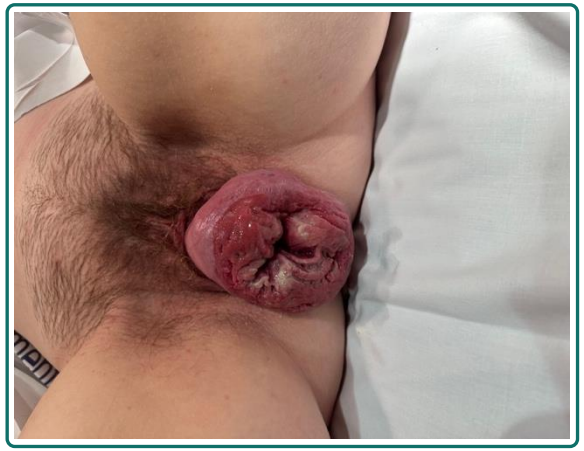

Figure 1. *Complete uterine procidentia at initial presentation (~20 weeks' gestation), showing the cervix and uterus prolapsed beyond the vaginal introitus with associated cervical oedema.*

4 Discussion

- Optimal mode of delivery in uterine prolapse complicating pregnancy remains controversial, with no clear consensus.
- Vaginal delivery may be feasible without mechanical obstruction; successful cases are described in the literature.
- Caesarean section is often favoured when prolapse persists, conservative management fails, or other obstetric indications coexist.
- In this case, caesarean section reflected persistent procidentia, failed pessary management, concurrent cholestasis, and informed patient preference.
- Procidentia does not resolve with delivery alone — ongoing urogynaecological follow-up is essential postpartum.

Why this case matters

- Documents operative reduction with vaginal packing as a viable escalation strategy, infrequently reported in modern practice.
- Illustrates the practical limits of pessary management when cervical elongation and oedema are present.
- Confirms good maternal and neonatal outcomes are achievable through sustained multidisciplinary care.

LEARNING POINTS

- **Complete procidentia is rare but may worsen with advancing gestation.**
- **Conservative management (reduction ± pessary) should be attempted first.**
- **Operative reduction may be needed when conservative measures fail.**
- **Multidisciplinary, individualised delivery planning optimises outcomes.**

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