Infravaginal Cervical Elongation in Premenopausal 30 Years Old Women

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ABSTRACT

Congenital uterovaginal prolapse is a very rare condition especially if it was a missed diagnosis at birth or early childhood as in our case. The main cause of Congenital Uterovaginal prolapse is poor innervation and weakness of pelvic floor muscles and the ligaments that support it. Treatment methods which are used in the past with such cases are multiple and different. In our case report, we reported infravaginal elongation of the cervix in a young pregnant woman, when she presented in labor. She was taken for emergency lower segment cesarian section due to failure to cervical dilatation and breech presentation.

Keywords: Uterovaginal, Prolapse, Cervix, Infravaginal, Women

INTRODUCTION

Urogenital prolapse has a very bad impact on the quality of life of women generally and childbearing age especially. Pelvic organ prolapse includes the prolapse of the vaginal wall and/or the uterus.

In general, 40 % of women with prolapse of the pelvic floor have cervical elongation, the extent of cervical elongation is proportionate to the degree of uterine descent[1]. The normal length of the cervix is approximately 2.5 cm^2, and the vaginal and supravaginal parts are equal in length. There are two types of cervical elongation - either supravaginal or infra vaginal. Supravaginal elongation is usually associated with uterine prolapse and the vaginal parts of the cervix will be elongated with chronic infection, cervicitis which ends up in a picture of hypertrophy and bulky cervix. The main reason for the cervical elongation is the force that is imposed by pulling the cardinal ligaments by the uterus's weight.

While on the other hand infravaginal elongation or congenital elongation, the fornices are deep, fixed in their positions equal in length. In other words, infravaginal elongation will not be associated with rectocele or cystocele same as the supravaginal elongation of the cervix. The vaginal parts of the cervix will be elongated while the uterus size will always be within the normal size range. The length of the uterocervical canal will be increased in both presentations infravaginal or supravaginal cervical elongation.

CASE PRESENTATION

A 30 years old female, P1A3 came with complaints of something coming out of the vagina for 7 years and inability to have normal coitus. She did pelvic floor exercises for more than 3 months, with no complaints of urinary incontinence. Regular cycles last for 4-5 days, with normal flow and no dysmenorrhea.

Past obstetric history: - I-1st trimester miscarriage D & C done II- LSCS (Oct. 2015 because of congenital elongation of the cervix with the appearance of a prolapse. III- 1st-trimester spontaneous miscarriage. IV 1st trimester blighted ovum spontaneous miscarriage.

On examination, an elongated cervix was noticed protruding from the introits, 3rd degree prolapse, the fornices are in their normal position both equal in length no rectocele and no cystocele are noticed, the entire elongation in occupying the vaginal space, the patient was diagnosed with Intracervical elongation, which explains her secondary infertility. She was posted for Manchester Fothergill Procedure.

Intraoperatively: cervix elongation was measured as 10 cm long (Figure 1), Uterus sound was 8 cm. Under aseptic techniques the incision made cervicovaginomususa circumferentially, the transverse cervical ligament was clamped and cut bilaterally elongated cervix was removed (Figure 2), cervical stump closed with hemostasis (Figure 3). The postoperative stay was uneventful, she was discharged the following day advised her the following: no intercourse for at least 2 months, the patient can try to conceive after 4 months from the date of surgery and in case of pregnancy, she has to be on cervical cerclage at 13 weeks as a prophylactic measure.

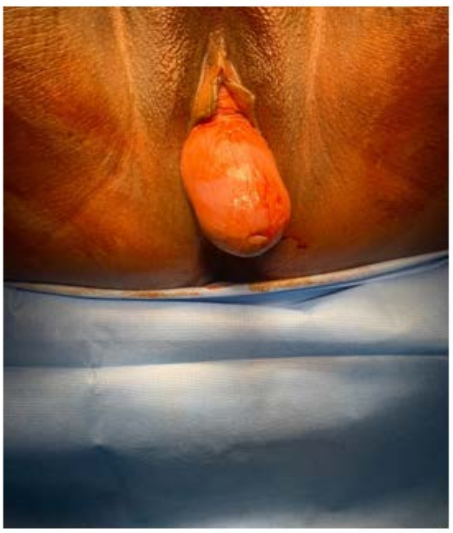

Figure 1: Preoperative

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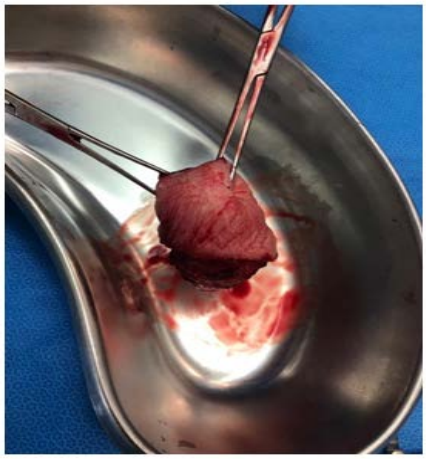

Figure 2: Amputated cervix

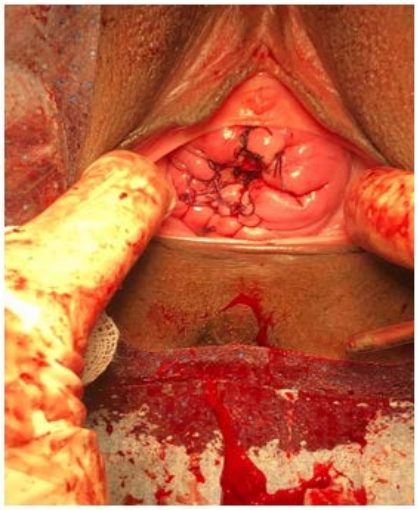

Figure 3: After Manchester-Fothergill procedure

DISCUSSION

Genital organ prolapse or Pelvic Organ Prolapse (POP) is a common clinical entity seen in gynecological practice, which includes the descent of the vaginal wall and/or the uterus[3]. Preoperative assessment of cervical elongation by measuring the uterocervical length with a uterine sound may help in planning the initial circumferential incision and may guide the surgeon in opening the anterior and posterior peritoneum[4].

However, cervical elongation is considered a relative contraindication for retaining the uterus and requires amputation of the cervix for better results[5]. Although, the cervix may elongate postoperatively after uterine preservation[6].

The Manchester-Fothergill procedure, which involves amputation of the cervix and shortening of suspensory ligaments, was first performed in 1888 by Donald in Manchester (United Kingdom) to treat cervical elongation; these were later modified[7], The Manchester -Forthergill procedure was performed in our case.

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Competing Interest: None

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REFERENCES

1. Berger. Is cervical elongation associated with pelvic organ prolapse? Int Urogynecol J 2012;23(8):1095-103.
2. Hiremath PB, Bansal N, Hiremath R. Extreme cervical elongation. Int J Reproduction, Contraception, Obstetrics, Gynecology 2014;777-9.
3. Dutta DC. Displacement of the uterus. In: D. C. Dutta, eds. D. C. Dutta's Textbook of Gynecology, 6th ed. New Delhi: Jaypee Brothers Medical Publishers 2013;198-226.
4. Falcone T, Walters MD. Vaginal hysterectomy. In: Karram MM, Baggish MS, eds. Atlas of Pelvic Anatomy and Gynecologic Surgery. 3rd ed. St. Louis, MO: Elsevier Saunders 2011;1303-6.
5. Walters MD. Uterovaginal prolapse in a woman desiring uterine preservation. Int Urogynecol J Pelvic Floor Dysfunct 2008;19(11):1465-70.
6. Rosen DM, Shukla A, Cario GM, et al. Is hysterectomy necessary for laparoscopic pelvic floor repair? A prospective study. J Minim Invasive Gynecol 2008;15(6):729-34.
7. Geoffrion R, Louie K, Hyakutake MT, et al. Study of Prolapse- Induced Cervical Elongation. J Obstet Gynaecol Can 2016;38(3):265-9.