

Utero-vaginal prolapse in far western region of Nepal

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Background: Utero-vaginal prolapse (UVP) is very common among Nepalese women. There are about 600,000 patients suffering from this gynaecological condition, amongst which 200,000 require immediate correction.¹ UVP is multifactorial and results in weakening of pelvic support, connective tissue and muscles as well as nerve damage.²

Methods: Prospective, descriptive study, conducted in the Far-western region vaginal hysterectomy camp from 14th to 29th April 2009.

Result: Of 325 women with UVP, 45.54% were Biswakarmas, 38.08% Brahmin, 17.23% Chhetri, 5.23% Tharu and 0.925 from other communities. Early return to work (within 10 days of delivery) among Biswakarma and Brahmin was 95.27% and 91.09% respectively where as smoking and chronic cough in Biswakarma and Chhetri was 92.57%, 66.22% and 78.56%, 34.4% respectively.

Conclusion: Early return to work, smoking and chronic cough are major contributors of UVP in far western Nepal which is more prevalent in the Biswakarma community.

Key words: Utero-vaginal prolapse, UVP, contributing factors.

Introduction

Utero-vaginal prolapse (UVP) is the protrusion of pelvic organs or structures beyond its anatomical boundaries. The exact prevalence of prolapse is difficult to determine because often prolapse is not complained about.³ Nepal there are 600,000 diagnosed cases of symptomatic UVP, 200,000 requiring immediate surgery.¹ Stallworthy in 1971 noted that 20% of patients waiting for gynaecological surgery were for UVP.⁴ The incidence rises in elderly.⁵ It has been estimated that over the next 30 years, the demand for treatment of pelvic organ prolapse will increase by 45 percent which commensurates with an increase in the population of women older than 50 years of age.^{6,7} Factors which contribute to the development of this condition includes: congenital defect, child birth trauma, raised intra abdominal pressure, dietary deficiency, menopause and iatrogenic factors.³

Objective

To identify the common contributing factors of UVP in far western region of Nepal among different ethnic groups.

Study design

It is a prospective descriptive study done in Kailali from 20th to 29th April, 2009. After taking verbal consent, 325 women with second to fourth degree UVP screened for vaginal hysterectomy were included in the study. Women with congenital uterine prolapse and those who did not give consent were excluded from the study.

Methodology

All women with UVP screened for vaginal hysterectomy were examined after taking history in detail which included the nature of onset of prolapse, its relation with child birth, parity, birth spacing place of birth, duration of labor, mode of delivery, duration of labor, birth attendance, placental

separation, return to work after delivery, type of work, smoking and history of chronic cough.

Results

Most of the 325 patients were from deprived Biswakarma community (45.54%), followed by Brahmins (38.08), Chhetris (17.23%) and Tharu (5.23%). Other three patients were mainly beggars coming from India (Figure 1).

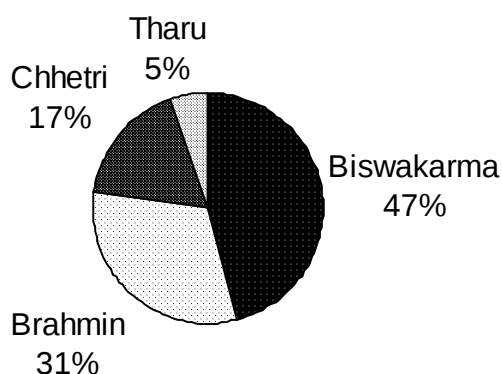


Fig. 1. Ethnic distribution among 325 women with Utero-vaginal prolapses in far-western region:

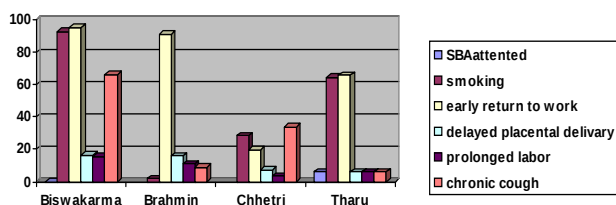


Fig. 2. Contributing risk factor of Utero-vaginal prolapse among different ethnic groups in far-western region of Nepal

Hospital delivery was found to be negligible; none in the Biswakarma community had had hospital delivery and even traditional birth attendant (TBA) assisted delivery was lacking. However, among Brahmin and Chhetri women, 14 and 11 deliveries were conducted by TBA respectively and in each community there were only three hospital deliveries. Prolonged labor was found in 15.54 % women in Biswakarma, 10.89 % in Brahmin, 3.57% in Chhetri and 5.88 % in Tharu community. Delay in the delivery of placenta was observed in 16.22% of Biswakarmas, 15.84 % Brahmins, 7.14 % Chhetris and 5.88% Tharus (Figure 2). Parity of the patients ranged from one to thirteen with average of 5.8 which was highest in Biswakarmas then in Brahmins. Birth spacing ranged from 11 to 48 months with average of 28 months and the shortest period was observed in

Biswakarmas.

Discussion

Though hysterectomies were done in Kailali and Kanchanpur which are Tharu populated districts; Tharu women were not in significant number. Most of the women were Biswakarmas. This can be interpreted in two ways; either awareness about the problem is more in this community or more women suffering from UVP in this. Among the woman of this group, 95 % return to heavy work within 10 days of delivery, more than 95% were smokers and most of the smokers were suffering from chronic cough. The parity was highest in Biswakarmas followed by Brahmins which favors the high incidence of UVP observed in women from this community. Birth spacing was least in Biswakarmas which again is the predisposing factor for UVP. Though they had history of prolonged labor and delayed placental delivery, the exact duration of true labor could not be determined solely on the basis of history and cause of delayed placental delivery; whether there was late separation or timely separation; was in vagina and late delivery etc could not be determined. It seems that incidence of UVP can be reduced by increasing awareness of about the benefit of adequate postpartum rest; hospital or skilled birth assistant assisted deliveries; hazards of smoking, early return to work and low birth spacing.

Conclusion

The common predisposing factor of UVP in far western region of Nepal are early return to work after child birth and chronic smoking, consequence of which is chronic cough, and other factor like unattended home deliveries with prolong labor and delayed placental delivery. All these factors in general population play vital role in the high prevalence of prolapse in this region.

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References

1. WHO, UNFPA and TU Teaching hospital study of Utero-vaginal prolapse 2006.

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2. Holly E Richter, R.Edward Varner. Pelvic Organ Prolapse; Berek and Novak;s Gynecology, Fourteenth Edition; 897-934.
3. S.L.Stanton. Vaginal Prolapse. Dewhurst's Textbook of Obstetrics and gynaecology for Postgraduates, Sixth Edition;462-473.
4. Stallworthy JA. Prolapse.Br Med.J. 1971;**1**, 499-500, 539-40.
5. Lewis AC (1968). Major Gynaecological surgery in the elderly. J Int Fed. Gynaecol.. Obstet.6, 244-58.
6. BoylesSH, Weber AM , Meyn L. Procedures for pelvic organ prolapse in the United States 1979-1997.Am J Obstet Gynecol 2003;**189**,70-75.
7. Luber KM, Boero S, Choe JY. The Demographics of Pelvic floor disorders: Current observation and future projections. Am J Obstet gynecol; 2001;**184**:1496-1501.