

Unusual Perils of Pelvic Organ Prolapse

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Abstract

Background: Prolapse can be treated with expectant management, pessary, or surgery. Although we consider the first two options benign, rare but serious complications can arise.

Case 1: A 64-year-old presented with recurrent grade 4 prolapse. After 6 months of expectant management, she developed a fistula from an ulcerated area of the prolapse into the peritoneal cavity.

Case 2: An 81-year-old who diligently cared for her ring pessary for 18 years presented with a vesicovaginal fistula.

Case 3: An 80-year-old with a longstanding pessary who stopped using vaginal estrogen for 2 years before developing a vesicovaginal fistula.

Conclusion: Management of prolapse expectantly and with pessaries are effective treatments, especially to avoid surgery, but can present with their own unusual and infrequent complications, such as fistula formation.

Résumé

Contexte : Les prolapsus peuvent être traités de façon non interventionniste ou au moyen d'un pessaire ou d'une chirurgie. Bien qu'elles soient considérées comme bénignes, les deux premières options peuvent entraîner des complications rares, mais graves.

Cas 1 : Une femme de 64 ans présentait un prolapsus récidivé de stade 4. Après six mois de prise en charge non interventionniste, une fistule s'est développée d'une zone ulcérée du prolapsus jusque dans la cavité péritonéale.

Cas 2 : Une femme de 81 ans ayant bien pris soin de son pessaire en anneau pendant 18 ans a développé une fistule vésicovaginale.

Cas 3 : Une femme de 80 ans utilisant un pessaire depuis longtemps a cessé de prendre des œstrogènes par voie vaginale et a développé une fistule vésicovaginale deux ans plus tard.

Conclusion : Il est efficace d'aborder un prolapsus de façon non interventionniste ou de le traiter au moyen d'un pessaire, surtout pour éviter une chirurgie. Cependant, ces approches peuvent s'accompagner de complications rares et inhabituelles, comme la formation de fistules.

Key Words: Urogynaecology, fistula, pessary, prolapse, complication

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INTRODUCTION

Pelvic organ prolapse is commonly seen as a significant quality of life issue, and first line treatments consist of expectant management or pessary use. These treatment options are non-invasive alternatives to surgery, but they are not without their own complications. Common symptoms of untreated prolapse include bulge and pressure, as well as urinary, defecatory, and sexual dysfunction.¹ Pessaries are usually considered benign treatment options with relatively low-risk complications such as superficial vaginal erosions, irritation, urinary retention, and infection.^{2,3} More significant complications, such as vesicovaginal or rectovaginal fistulas, are usually confined to those with poor pessary care. We present three cases of unusual complications illustrating the potential risks of pelvic organ prolapse and pessary use. The first case is a patient with recurrent pelvic organ prolapse who spontaneously developed a fistula through a vault ulcer into the peritoneal cavity. The second case involves a patient who used vaginal estrogen and diligently cared for her ring pessary for 18 years before developing a vesicovaginal fistula. The third case is a patient who had a longstanding pessary for vault eversion, but stopped using vaginal estrogen and developed a vesicovaginal fistula 2 years later.

Case 1

A 64-year-old, gravida 2, para 2 with a history of a total abdominal hysterectomy 21 years ago and two subsequent prolapse repairs presented with recurrent pelvic organ prolapse. On physical exam, she was found to have grade 4 vault prolapse that was approximately 4 × 5 cm in size. A 2.5-cm ulceration was noted on the most dependent portion of the prolapse. She was treated expectantly at the time and booked for surgery.

Figure 1. A 2.5-cm ulcer with a 1-mm central opening (fistula) from the most dependent part of the vault prolapse to the peritoneal cavity.



Six months after her first consultation, she returned for a laparoscopic sacrocolpopexy. On the day of surgery, the patient reported new onset watery discharge from the vaginal ulcer. On examination, it was noted that the vaginal ulceration had a 1-mm perforation through to the abdominal cavity (Figure 1) with clear fluid leaking through. The ulcer was excised, and the defect was closed with a running locked 2-0 Polysorb suture. The laparoscopic sacrocolpopexy was performed with a Y-mesh of polypropylene on top of an interposing bovine collagen matrix biological mesh to decrease the risk of mesh complications. The final pathology of the excised ulcer was benign.

The patient did well postoperatively. At her 3-year follow-up, she had no recurrence of her prolapse or the perforated ulcer, nor had she developed any mesh complications, such as erosion.

Case 2

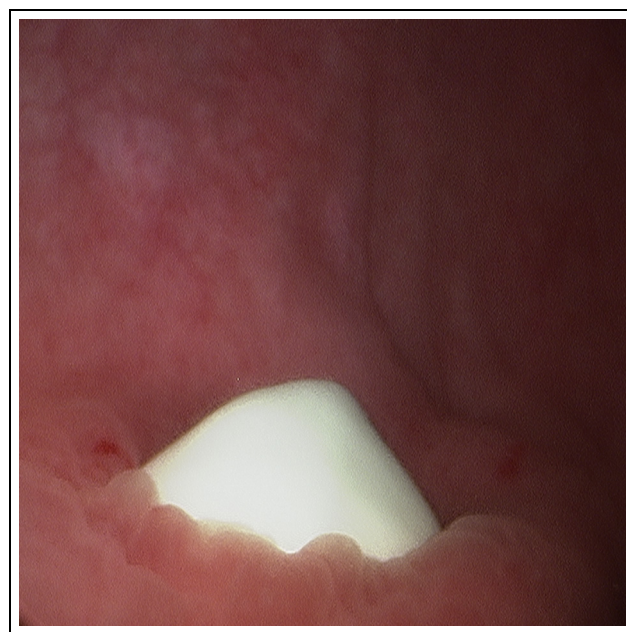
An 81-year-old, gravida 5, para 5 who had been wearing a ring pessary for 18 years presented with new onset urinary incontinence. Although some episodes were associated with urgency, others occurred without warning. For the 18 years in which she has been using the pessary, she performed self-maintenance (removal, cleaning, and replacement of the pessary) every 2–3 days and used local vaginal estrogen cream twice a week. She reported occasional small amounts of blood with removal of the pessary.

On examination, the patient had a grade 2 uterine prolapse, grade 4 cystocele, and grade 1 rectocele. On speculum exam, urine was seen draining from the vagina. Cystoscopy was performed, and a 1-cm vesicovaginal fistula was found in the posterior aspect of the bladder wall, in the midline, and away from the trigone. Bilateral ureteric jets were seen.

The patient was taken to the operating room for surgical correction of the fistula. Also, in order to provide a permanent solution for her pelvic organ prolapse, a vaginal hysterectomy and anterior and posterior repair were performed. Prior to performing the hysterectomy, the fistulous tract was identified and noted to be surrounded by ulcerated and granulation tissue vaginally. A 16 French silastic catheter was placed in the fistulous tract and the balloon was inflated for easy identification.

Once the hysterectomy had been completed, a 17 French cystoscope with a 70-degree lens was used to visualize the fistula from within the bladder (Figure 2). The fistula was again found to be far from the trigone, and ureteric jets were seen bilaterally. Vaginally, 3-0 Biosyn stay sutures were placed circumferentially around the fistula, and the edges of the tract were excised. Several interrupted sutures of 2-0 Polysorb were used to reapproximate the opening of the fistula. The stay sutures were then cross-tied to provide a second layer of closure. Methylene blue was instilled into the bladder with no evidence of leak from the fistula repair site. Cystoscopy was performed once again to visualize the

Figure 2. Fistula seen via cystoscopy with a gloved finger in vagina.



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