

# Clinical and Therapeutic Aspects of Genital Prolapse at Hôpital du Mali about 100 Cases

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## Abstract

To study the epidemio-clinical aspects, and the therapeutic attitudes of genital prolapse (GP) in the gynecology department of Hôpital du Mali (HDM). This is a descriptive retro-prospective study over five (5) years from January 2015 to December 2019, conducted in the gynecology department of HDM. We had collected 100 cases of GP out of 989 surgeries, with a frequency of 9.89%. The age group of 60 years and over accounted for 33% of our patients, with a mean age of 50 years. Multiparous were the most affected (89%). The notion of obstructed labor was observed in 52% of patients. The most found reason for consultation was the feeling of lump in a vagina, with 65%. Grade III according to BADEN-WALKER classification system (BWCS) concerned 72% of our patients. Triple perineal surgery and hysterectomy involved 56% of our patients. Spinal anesthesia was performed in 96% of cases. Per and postoperative complications were dominated by urinary retention in 4% and by infection of the surgical site in 2%. The average hospital stay was 3.2 days. We recorded 88% of satisfied patients after the intervention. No deaths were recorded during the study. The management of genital prolapse remains essentially surgical; it requires a semiological analysis and a mastery of the surgical technique.

## Keywords

Genital Prolapse, Therapeutic Attitudes, Hôpital du Mali

## 1. Introduction

Genital organ prolapse or pelvi-genital prolapse is an anatomico-clinical entity corresponding to the failure of the support and suspension systems of the female pelvic organs, which protrude through the vulvovaginal orifice [1]. Typically, the following entities are described [1]:

- Cystocele or bladder prolapse: represents 4 out of 5 cases (or 80% of cases).
- Hysterocele or prolapse of the uterus.
- The rectocele or prolapse of the rectum.

All the intermediaries are observed between the minor anatomical anomaly (non-invalidating or associated with functional signs unrelated to the prolapse) and the total prolapse exteriorized in its historical and typical form [2].

Externalization of the pelvic organs can be associated with functional urinary disorders, such as urinary incontinence which is sometimes the main or only reason for consultation, or functional anorectal disorders (anal constipation or incontinence) [3].

The diagnosis is clinical and easy, but the essentially surgical treatment poses a problem given the various surgical techniques ranging from restorative surgery to the fitting of prostheses [2].

Several risk factors are described: multiple and obstructed deliveries, macrosomia, menopause, chronic constipation and any other cause of pelvic hyper-pressure [4].

The prevalence of prolapse varies from 3% to 31.8% in France, according to a 2019 report from the National College of French Gynecologists and Obstetricians [5].

In Africa, mainly in Mali, this frequency is underestimated because of the lack of consultation on socio-cultural grounds [6]. We report this first study which aimed to study the epidemio-clinical aspects, and the therapeutic attitudes of GP at Hôpital du Mali.

## 2. Patients and Method

Our study was retrospective and prospective descriptive over five (5) years from January 1, 2015 to December 31, 2019. It was carried out in the gynecology department of Hôpital du Mali.

Our study included any patient seen in an outpatient clinic with a clinically diagnosed uterine prolapse. It was associated or not with a urinary leakage.

Patients who had already undergone surgery, or who had postoperative complications in another department were not included.

The clinically diagnosed lesions were classified according to BADEN and WALKER, in order to define the therapeutic modalities. After the consultation, a detailed report was made to the patient, explaining to her: the surgical procedure, the status of the genital organs and the post-surgery sexual experience. The parameters studied were: age, profession, level of study, parity, type of prolapse, complications observed. The media used were medical records, operating report

registers, anesthesia records.

We had performed the Bonney maneuver which consisted of placing two fingers, or open-long forceps on either side of the bladder neck (3 cm from the urethral meatus) by pushing the vaginal wall towards the pubic symphysis, without compressing the urethra. This maneuver was performed after the voluntary cough test; it is said to be positive when it stopped the leak of urine.

The Bethoux maneuver also practiced consisted of applying pressure towards the promontory using forceps carrying a compress introduced into the lateral fornices of the vagina. This test was said to be positive if the leakage of urine on exertion is eliminated.

Compared to the classification of prolapse, there is that of BWCS and that of the International Continence Society (ICS) (pelvic organ prolapse questionnaire [POP-Q]).

We had used that of BWCS which was recommended in current practice. The concept of grade or degree of prolapse remains essential for good follow-up of the patient, and also for the evaluation and publication of the results of a therapy.

The classification concerned the four pelvic floors:

Cystocele, hysteroptosis (or prolapse of the vaginal vault after hysterectomy), elythrocele and rectocele:

- Grade 0: normal position of the stage studied;
- Grade 1: descent of the stage halfway between its normal position and the hymen;
- Grade 2: descent from the floor to the level of the hymen;
- Grade 3: externalization of the level beyond the hymen;
- Grade 4: maximal exteriorization or eversion [7].

Our patients underwent a pre-operative check-up (biological examinations) and medical imaging (ultrasound and hysterosalpingography) and a pre-anaesthetic consultation. A fasting period of at least six (6) hours was advised according to the protocol of the hospital's anesthesia department. It was associated with an evacuating enema the day before surgery. We performed an anterior colporrhaphy for grades 1 and 2. A triple perineal operation is for grades 3 and 4. For the rectocele, a section and approximation of the levator ani was performed.

All patients had undergone vaginal surgery. The ablation of the intravaginal wick was made after 24 hours of the intervention, and that of the bladder probe 24 to 48 hours postoperatively. It was recommended to get up early 24 hours after the intervention. Antibiotic prophylaxis was systematic for all our patients, as well as anticoagulant treatment at a preventive dose postoperatively. The resumption of sexual activity was recommended three (3) months after the intervention. All our patients were followed for a year after surgery. Patient satisfaction criteria were assessed on the basis of: absence of lump in the vagina, urinary continence and comfort in sexual intercourse.

Our data was collected on a survey sheet. The analysis and data entry were carried out by software: Word 2013 and epi info version 7.2.

### 3. Results

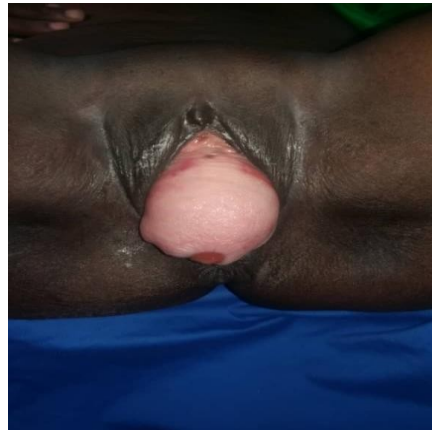
Over five (5) years, 100 cases of GP were collected out of 989 surgeries, with a frequency of 9.89%. The age group of 60 years and over represented 33% of our patients with a mean age of 50 years and extremes ranging from 22 to 86 years. Housewives accounted for 87%. Multiparas were the majority (89%), and an average parity was 6.2. The notion of obstructed labor was found in 52% of patients and the history of home birth concerned 29% of cases (Table 1). The main reasons for consultation were vaginal lump (65%), urinary incontinence (20%) and vaginal swelling (15%) (Table 2). Grade III according to BWCS was found in 72% of cases (Figure 1). Our patients aged 60 and over who had grade III accounted for 24% (Table 3). The triple perineal operation associated with hysterectomy was performed in 56% of cases (Figure 2). This type of operation concerned 24% of our patients aged 60 and over. The cystocele cure was performed in 29% of cases, and concerned 15% of our patients aged 40 to 49 years. The cure for uterine prolapse was performed in 7% of patients, among them, the age group 30 - 39 years represented (4%) (Table 4). Spinal anesthesia was performed in 96% of cases. Per and postoperative complications were dominated by urine retention (4%) and surgical site infection (2%) (Table 5). The average length of hospital stay was 3.2 days. Postoperative satisfaction was affirmed by 88% of patients. We did not record any deaths during our study.

**Table 1.** Sociodemographic and clinical characteristics.

Characteristics	Number (n = 100)	Percentage
Age	(60 years and more) n = 33 Mean age 50 years	33
Profession	(Housewives) n = 87 Shopkeeper n = 10	87 10
Gesture		
Parity	(multiparous) n = 87	87
Surgical history	(Cure of prolapse) n = 8	8
History of home birth	n = 29	29
Obstructed childbirth concept	n = 52	52
Spinal anesthesia	96	96
Postoperative satisfaction	(Satisfactory) 88	88

**Table 2.** Distribution of patients according to reason for consultation.

Reason forconsultation	Number	Percentage %
Vaginal lumpsensation	65	65
Incontinence ofurine	20	20
Genital swelling	15	15
Total	100	100



**Figure 1.** Grade III uterine prolapse image.



**Figure 2.** image of triple perineal intervention.

**Table 3.** Distribution of patients according to grade and age group.

Age	Grade I	Grade II	Grade III
20 - 29	-	3	5
30 - 39	-	4	11
40 - 49	1	2	22
50 - 59	-	3	10
60+	-	1	24
TOTAL	1	13	72

**Table 4.** Distribution of patients according to surgical technique and age group.

Age	Cure of cystocele	Cure of prolapse	Cure of rectocele	TOP	Cure of tracheocele	Total
20 - 29	1	2	0	0	0	3
30 - 39	13	4	0	4	2	23
40 - 49	15	1	3	16	1	36
50 - 59	0	0	1	16	1	18
60+	0	0	0	20	0	20
Total	29	7	4	56	4	100

**Table 5.** Distribution according to the types of complication.

Postoperative complications	Effectif	Pourcentage
Urine retention	4	4
Bladder fistula	1	1
Recidivism	2	2
Featureless	93	93
Total	100	100

#### 4. Discussion

We had conducted a study on the clinical and therapeutic aspects of genital prolapse in the gynecology department at Hôpital du Mali (HDM) over a period of 5 years. HDM is a 3<sup>rd</sup> reference health structure in Bamako.

During the study period, 100 cases of genital prolapse were collected out of 989 gynecological surgeries, or a hospital frequency of 9.89%. It was higher than that of Coulibaly B *et al.* [8] in Mopti in central Mali, reported 0.4%. This difference can be explained by the fact that Coulibaly B *et al.* [8] had taken into account all the gynecological and obstetrics interventions. However, it was lower than (11.4%) that reported by Sliker *et al.* [9].

The average age of our patients was 50 years old with extremes of 22 and 86 years old. This age was different from those of other authors: Salaheddine A [10] (60 years with extremes of 38 to 88 years); Coulibaly B [8] (58 years old with extremes of 32 to 80 years old) and Bendimrad H [11] (61.69 years old with extremes of 30 to 82 years old).

Age is a risk factor for GP, due to the physiological aging of different tissues.

Housewives accounted for 87%. This rate was lower than those of Coulibaly B [8], and Lukmany [12] in Ethiopia who obtained 98.41% and 92.2% respectively. But it is higher than that of Salaheddine A [10] which was 80%.

Multiparity concerned 89% of our patients. This corroborates with the literature that the risk of GP increases with the number of parity [13]. This rate was slightly different from those of: Salaheddine A [10], Chennoufi-MB [14], and Bendimrad H [11] who pointed 88%, 82.5% and 83.56% respectively. But Coulibaly B [8] reported a lower rate of 63.50% of multiparous.

The average parity in our series was 6.22. This was comparable to that of Bendimrad H (6) [11]; but slightly lower than the 5.24 of Salaheddine A [10].

The feeling of vaginal lump constituted 65% of the reasons for consultations. This rate was lower than those of: Salaheddine A [10] and Bendimrad H [11] who figured out 88.8% and 78.75%. It was higher than that of Coulibaly B [8] who reported 49.20%.

Urinary incontinence associated with prolapse concerned 20% of our patients. These data were different from the 18.75% of Bendimrad H [11] and 26.3% of Costantini E [15]. They were clearly higher than the 10% of Diabaté L [16] in Dakar and the 11.10% of Coulibaly B [8] in Mopti. This difference between the

authors can be explained by the diagnostic approach. We had performed the physical examination on a full bladder, in order to assess vaginal trophicity, urethral mobility, the existence of leaks through the urethra during repeated coughing and abdominal thrusting efforts. Some authors had made the diagnosis by questioning the patient.

According to BWCS, grade III was found out in 72% of cases. These data were superimposed on those of Salaheddine A [10] and Bendimrad H [11] who reported 73% and 74% for the same grade. Regarding the correlation of prolapse grade with age; patients over 60 years old accounted for 24% for grade III. This rate is significantly lower than that of Salaheddine A [10] who reported 74% of patients aged 60 and over for the same grade.

History of obstructed labor accounted for 52%. Bendimrad H [11], Rebecca G [3] reported 12.2% and 13.41% of obstructed labor in their series. In our context this difference could have a multifactorial etiology among others; the level of education of the patients and the accessibility to obstetric care.

The rate of home birth history was reported by 29% of our patients. It was similar to that of Rebecca G [3] (30%). However, it was significantly lower than those of Salaheddine A [10] (85%) and Bendimrad H [11] (83.5%).

The management of GP imposes a reflection on the surgical option which remains fundamental. It is an anatomical but also functional restoration surgery. On the other hand, the question remains as to the surgical strategy to adopt, depending on the disorders present and the patient. In our series, all cases of prolapse had undergone surgery with a vaginal approach.

The vaginal route is the surgery of choice for GP, as it allows the treatment of the three usual components of prolapse. The triple perineal operation associated with hysterectomy was performed in 56% of cases. This rate was close to those of Bendimrad H [11], and Diabaté L [16] who reported 60% and 61.16% of cases. This type of surgery was performed in 24% of patients aged 60 and over. Our data were lower than those of Bendimrad H [11] (42%) and Diabaté L [16] (45%). However, they were higher than those of Salaheddine A [8] (11%) and Rebecca G [3] (38.10%). In their studies, the young age of the patients and the desire for children were obstacles to this type of surgery.

The cure of cystocele had been practiced in 29% of our patients ( $n = 29$ ). This rate was comparable to that of Salaheddine A [10] who reported 28% of cases. However, Sokol *et al.* [17] pointed out a higher rate (69%). Among the patients who had benefited from a cure for cystocele, the age group of 40 to 49 years, represented 51.72%. Our results were comparable to those of Salaheddine A and al [10] (48.5%) and Sokol [17] (50.6%).

The simple cure for uterine prolapse involved 7% of our patients ( $n = 7$ ). Among the patients who had benefited from a simple cure for prolapse, the age group of 30 to 39 years, represented 57.14%. This rate was close to that of Salaheddine A [10] who reported 9% of simple cure for uterine prolapse, among them 55.5% for the same age group.

There are several surgical approaches for GP surgery. In our study, all our interventions were performed vaginally. Aitsakel A *et al.* [18] had performed the tranobturator approach, while Bendimrad H [11] had performed promontofixation by laparotomy in 29.49% of cases. Salaheddine A [10] (10%) and Rebecca G [3] (4.1%) opted for prosthetic surgery. Prosthetic surgery depends on the availability of the material, and above all on the experience of the surgeon.

The type of anesthesia depends on the surgical technique. We performed spinal anesthesia in 96% of cases, as reported by the other authors [10] [11].

Per and postoperative complications were dominated by urine retention in (4%) and by surgical site infection in (2%). Salaheddine A [10] and Bendimrad H [11] had each reported 2.5% bladder complications.

We did not record any deaths, unlike Salaheddine A [10] who noted 2% of mortality.

Our patients were satisfied with the result after surgery in 88% of cases. The same observation had been reported by other authors [3]. We had recorded 2% recurrence of postoperative prolapse in six months. Salaheddine A [10] reported 6.6% recurrence.

The average length of hospitalization was 3.2 days; same observation was made by others [3] [10] [11].

#### **Limitations of the study**

- Absence of prosthesis placement.
- Loss of sight of some patients after surgery.
- Lack of identification of risk factors in some patients.

## **5. Conclusion**

Genital prolapse (GP) was a frequent reason for gynecological consultation. Age, multiparity, obstructed deliveries are predisposing factors in its occurrence. Management is exclusively surgical, based on semiological analysis and mastery of the operating technique.

## **Author Contributions**

All authors contributed to the conduct of this work. They approve the final version of the manuscript.

## **Conflicts of Interest**

The authors declare no conflicts of interest regarding the publication of this paper.

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## Appendices

SURVEY FORM N° 1

1) PATIENT IDENTIFICATION

{Q1} Name =

{Q2} First name =

{Q3} Age =

{Q4} Profession 1 = Housewife 2 = Shopkeeper 3 = Civil servant 4 = Other

{Q5} Marital status 1 = Single 2 = Married 3 = 4 Widow

{Q6} Residence = 1 = BAMAKO 2 = OUTSIDE BAMAKO

{Q7} Ethnicity = 1 = Bambara 2 = Peuhl 3 = Bozo 4 = Songhai 5 = Dogon 6 = Tamashek 7 = Bêlas 8 = Other

2) FUNCTIONAL SIGNS

{Q8} Reason for consultation

1 = Vulvar swelling 2 = Pelvic heaviness 3 = Stress urinary incontinence 4 = Other 5 = (1 + 2) 6 = (1 + 3) 7 = (2 + 3) 3

3) BACKGROUND

{Q9} Obstetrical history 1 Gestité = 2 Parity = 3 = Abortion

{Q10} Dystocic delivery history = 1 = Instrumental delivery 2 = Delivery with abdominal expression 3 = Large fetus history 4 = Perineal tear history 5 = Home delivery history

{Q11} Surgical history = 1 = yes = no if yes, please specify

{Q12} Medical history = 1 = yes = no if yes to be specified

4) PHYSICAL EXAMINATION {Q13} URINARY SIGNS

1 = stress urinary incontinence 2 = pollakiuria 3 = dysuria

{Q14} CLASSIFICATION

1 = grade 1 - 2 = grade 2 - 3 = grade 3 - 4 = grade 4

{Q15} ASSOCIATED CONDITIONS

1 = Yes 2 = No If yes, please specify

{Q16} ADDITIONAL EXAMINATIONS

1 = Yes 2 = No If yes, please specify

5) TREATMENTS

1 = Placement of pessary 2 = Hormone therapy 3 = None 4 = Others If other, please specify SURGICAL TREATMENT

{Q17} ROUTE OF SURGERY

1 = High 2 = Low

{Q18} TYPE OF SURGERY

1 = Conservative 2 = Non conservative

{Q19} COMPLICATIONS

1 = Urinary lesions 2 = Rectal lesions 3 = Hemorrhage 4 = Infection 5 = None 6 = Other If other to be specified

6) HOSPITALIZATION

Length of stay = 2 Duration of urinary catheter =

{Q20} SHORT TERM EVOLUTION

1 = Exeat 2 = Transfer 3 = Death 4 = Escaped Q21} EVOLUTION AT THREE MONTHS

1 = Simple follow-up 2 = Recurrence Q22} EVOLUTION AT TWO YEARS

1 = Simple follow-up 2 = Recurrence Q22} follow-up and sexual experience

1 = Not satisfactory 2 = Satisfactory 3 = Very satisfactory