



CASE REPORT

A 39-Year-Old Woman's Grade 3 Uterine Decent: Case Report

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Abstract

Introduction: The length of the uterine cervix is a characteristic that is frequently examined during obstetric exams. However, there is limited knowledge of the relationship between cervical length and gynecologic illnesses. This is particularly unexpected as cervical length measurements are a common tool used by obstetricians and gynecologists to make judgments.

Case Presentation and Intervention: A 39-year-old woman was admitted to the gynecology ward on JAN 11, 2024, complaining of pain in the pelvic area during sexual activity, something coming out of the vagina during urination, and white discharge from the vagina without a bad odor. The gynecological ward provides treatment that includes maintaining an aseptic approach to prevent infection and attaching IV fluids. Improvement of health condition, maintenance of body temperature, reduction of stomach discomfort, preservation of life, maintenance and preservation of the airway, and prevention or repair of problems are the goals during this period.

Conclusion: The patient saw considerable improvements in her health throughout the brief duration of therapy, including less vaginal white discharge, decreased stomach discomfort, and maintenance of a normal temperature. Make even greater progress toward her goal of going back home. Even though the patient responded well to the treatment, even better outcomes may be possible in the future with the application of additional therapies.

Keywords: Uterine Decent, Adolescence, Grade III.

Introduction:

This disorder is characterized by a woman's uterus (womb) slipping or sagging out of its natural place. A bulge or protrusion may form if the uterus slides far enough into the vagina (birth canal). The term "incomplete prolapse" describes this problem. When the uterus slips so much that tissue goes outside of the vagina, complete prolapse takes place. If left untreated, uterine prolapse can lead to issues with the bladder, intestine, and sexual function [1].

The uterus is one organ that is a component of your reproductive system. The pear-shaped organ located in the pelvic region is called the uterus, or womb. During pregnancy, the growing baby is kept inside the uterus [2]. In reality, it grows throughout pregnancy to provide room for the growing baby, and it decreases once the baby is born [3]. Use a grading system to indicate how much of the uterus has protruded into the vagina: In Stage 1, the uterus extends slightly into the vaginal canal. Stage 2 has the uterus protruding close to the vaginal entrance. In Stage 3, the uterus protrudes outside the vaginal canal [4].

Case Presentation:

The patient, a 39-year-old female, was admitted to the gynecology ward at Acharya Vinoba Bhave Rural Hospital on January 11, 2024, with complaints of pelvic discomfort, the sensation of something protruding from her vagina during urination, and white vaginal discharge without foul odor. She has no significant past medical history such as diabetes, hypertension, or asthma. Her obstetrical history indicates G3P3A0L3, with no history of pregnancy loss, menarche at the age of 13, and her last menstrual period dated January 3, 2024. On psychosocial evaluation, she was found to have good interaction with her family, neighbors, and relatives. Her environmental history revealed a comfortable living situation with proper garbage disposal and a closed drainage system. On physical

examination, her vital signs were stable with a temperature of 99.8 °F, pulse rate of 90 bpm, respiration rate of 28 breaths/min, and blood pressure of 120/80 mmHg. She measured 155 cm in height, weighed 46 kg, and had a BMI of 19.1. She was alert and oriented to time, place, and person. Breast examination revealed symmetrical breasts with mild discomfort but no augmentation. Abdominal examination showed no scars, presence of striae gravidarum, and absence of linea nigra. Her speech was coherent, and she was able to communicate effectively.

The patient was admitted to the hospital with complaints of pelvic pain, white vaginal discharge without foul odor, and a sensation of something protruding from the vagina while passing urine. At the hospital, she was given symptomatic treatment, and her condition was monitored for progress.

Clinical Findings and Diagnostic Assessment:

Blood investigation: The mean corpuscular hemoglobin concentration is 32.5 g, and the CBC hemoglobin level is 13.3 mg/dl (13–16 mg/dl). The mean corpuscular volume (MCV) is 83 fl (78–98 fl), the red blood cell distribution width (RDW) is 16.9 (11.6–14.8), the white blood cell count (WBC) is 7900 (4500–11,500 k/ul), the platelet count is 254,000/ml (150,000 to 450,000), and the Hematocrit (Hct) levels are 40.8 % (37 %–47 %), Monocytes are 2% (00–15%), Eosinophils are 1%, Lymphocytes are 29% (20–40%), and the Red cell distribution width Neutrophils make up 67% and Basophils, 0% (0–1%).

The KFT values for urea, Creatinine, Sodium, and Potassium are 29 (9.81 – 20.1 mg/dl), 0.6 mg/dl (0.7–1.4 mg/dl), 142 meq/l (135–145 meq/l), and 4.4 (3.5–5.5 meq/l), respectively.

Therapeutic intervention and outcome:

The medical management of the patient included the administration of antibiotics such as tablet doxycycline, injection Metrogl 100 ml, and injection Ceftriaxone 1 gm, along with antipyretics including injection Neomol, 10 cc of tramadol, and 40 mg of pantaprazole. The patient's breathing was closely monitored, and after positioning her in a semi-Fowler's posture, oxygen was administered as needed. Fluid replacement therapy was provided to maintain electrolyte balance, and baseline laboratory parameters such as hematocrit, blood glucose, urea, creatinine, and electrolytes were monitored. Kegel exercises were advised to strengthen the pelvic muscles and maintain weight, in addition to lifestyle modifications such as maintaining a healthy diet, engaging in regular exercise, preventing constipation, managing chronic cough, avoiding heavy lifting, and practicing proper body mechanics.

Nursing management focused on thorough assessment, which revealed discomfort in the lower abdomen, loss of appetite, generalized weakness, and difficulty walking as a result of third-degree uterine prolapse. Based on this, nursing diagnoses included lower abdominal pain due to pelvic organ displacement, weakness leading to fatigue, activity intolerance, anxiety, frequent micturition, risk of infection, compromised skin integrity, altered sexual activity, and imbalanced nutrition below body requirements. Nursing interventions involved the use of pessaries—vaginally inserted devices such as plastic rings or pulls to support pelvic organs—which required replacement every three to four months, provision of adequate comfort measures, guidance on pelvic floor muscle training, and instructions on hand hygiene before and after restroom use. Nutritional advice included a diet rich in iron and fiber, along with maintenance of good personal hygiene. The expected outcomes of these interventions were improved ability to perform daily activities, early reporting of new problems to the physician, and

improved nutritional status as reflected by a healthy body weight.

Discussion:

Uterine prolapse is a very uncommon pregnancy problem, however it frequently affects older women who are not pregnant. The outcomes of uterine prolapse surgery, both alone and in conjunction with vaginal prolapse repairs, are documented in the literature [5]. The variety of the individuals analyzed in many recent research has posed challenges, as a sizable portion of patients underwent concurrent suburethral tape treatments and continence surgery. A hysterectomy for uterine prolapse may be performed by the vaginal or abdominal route [6]. Pregnancy-related uterine prolapse is an uncommon condition that may develop throughout the pregnancy or may already be present. Urinary tract infections, mild cervical infections, spontaneous miscarriage, acute urine retention, and preterm labor are among the consequences of uterine prolapse in pregnancy, along with maternal and fetal mortality [7]. Moreover, women who are afflicted could be more likely to experience dystocia during childbirth, necessitating an emergency delivery [8].

According to the earliest medical literature, uterine prolapse is a condition that has most likely affected women throughout history. Looking at the turning points in the field's documented history can help us understand how urogynecology has developed and provide perspective on the challenges that modern female pelvic medicine and reconstructive surgeons confront in their attempts to treat uterine and vaginal vault prolapse [9].

Conclusion:

Uterine prolapse is the result of weakening pelvic muscles and tissue. This opens the vaginal canal to your uterus. Common symptoms include

constipation, lower back discomfort, vaginal swelling, pelvic fullness, and urine leakage. [10] Treatment options for uterine prolapse include pessaries, lifestyle modifications, and uterine excision surgery. Losing weight, eating a lot of fiber, giving up smoking, and doing Kegel exercises can all help you prevent this issue [8].

Throughout therapy, the patient's condition significantly improved, enabling him to get closer to his objective of going back home.

Informed Consent: Written informed consent was obtained from the patient family for the publication of this case report.

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