When Prolapse Becomes a Surgical Emergency!

Lounas Benghanem
Professor Lounas Benghanem Gynecology and Obstetrics Department, Mustapha University Hospital Center Faculty of Medicine, University of Algiers I, Algeria

Lydia Faïd
Gynecology and Obstetrics Department, Mustapha University Hospital Center Faculty of Medicine, University of Algiers I, Algeria

Sabrina Benslimane
Gynecology and Obstetrics Department, Mustapha University Hospital Center Faculty of Medicine, University of Algiers I, Algeria

Kamel Hail
General surgery Departement, Mustapha University Hospital Center Faculty of Medicine, University of Algiers I, Algeria

Radia Benyahia
Radiology Department, Marie Curie Centre Faculty of Medicine, University of Algiers I, Algeria

Chahira Mazouzi
Abderrahmane-Mira University of Béjaïa, Algeria

Amine Habouchi
Radiology Department, Mohamed Lamine Debaghine, University Hospital Center Faculty of Medicine, University of Algiers I, Algeria

Abstract
It is accepted by all, patients and doctors alike, that prolapse is not an emergency and that it can wait. No one dies from prolapse, but what about the repercussions on the upper urinary tract and the risk of renal failure, which is moreover bilateral?
In this article, we report a clinical case of operated genital prolapse complicated by renal failure.

Introduction
Pelvic organ prolapse is one of the most frequent indications for surgery [1]. This functional surgery, known as comfort surgery, is only proposed when there is a repercussion on the quality of life. It is a programmed surgery which aims to relieve the symptoms related to this organ descent, these symptoms can be urinary, gynaecological or digestive.
We report the case of a 63-year-old patient with a prolapse complicated by renal insufficiency, which therefore became a surgical emergency.

Patient and Observation
Patient Information
The patient was a 69-year-old postmenopausal woman with multiple pregnancies and no notable pathological history. She presented with significant genital prolapse, pelvic pain, dysuria and constipation.
Clinical examination revealed a prolapse classified as C3H4R3 according to the POPQ classification, without stress urinary incontinence (Figure 1).
Biological examination revealed renal insufficiency with urea at 0.8 gr/l and creatinemia at 23 mg/l.
The uroscanner showed a significant increase in the volume of both kidneys, with the right measuring 132 mm and the left 160 mm (Figure 2).
Bilateral dilatation of the entire excretory tract
And a posterior uterine myoma FIGO 3 measuring 50 mm.
Therapeutic Intervention
The patient underwent vaginal surgery under locoregional anaesthesia. The operation was a triple perineal operation with hysterectomy, the uterus was not preserved as there was a uterine myoma, and Richter sacrospinofixation was performed (Figure 3) (Figure 4).

Follow-Up and Results
The patient was monitored regularly after the operation, with a spectacular improvement in renal function.

Discussion
Pelvic organ prolapse is the protrusion of the pelvic organs through the vulvogenital orifice. They include the bladder, rectum or uterus and often occur from the age of 55. It is important to look for them by questioning and examination, as they can cause urinary, digestive and sexual symptoms. The main risk factors are pregnancy, childbirth and age [2]. Physiopathologically VIRCHOW, in 1856, was the first to observe the impact of genital prolapse on the upper urinary tract. But when do we talk about the impact on the upper urinary tract: at the ultimate stage which is renal failure, or as soon as there is a dilatation of the
excretory tracts, the latter must be retained to avoid reaching renal failure.

There are several possible causes of dilatation of the excretory tract:
The first hypothesis is compression of the ureters by the medial border of the levator muscles [3].
The second hypothesis is compression by the uterine vessels [4].
The third hypothesis is that of GREGOIR [5], dilatation evolves in two stages: in the first stage, stretching of the ureter leads to progressive dilatation. In the second stage, the trigone tilts and its bladder side looks backwards; this change in orientation of the trigone results in the creation of a right angle on the ureter and therefore an overlying ureter.

Clinically, in the case of very large prolapses, upper tract involvement should always be sought by questioning, clinical examination looking for signs of arterial hypertension or renal insufficiency, and assisted by biology and radiology [6].

Therapeutically, the treatment of prolapse is essentially surgical, involving reconstruction and anatomical restoration, as well as functional and comfort surgery. Its indication must weigh up the expected gain in comfort against the surgical and anaesthetic risk. The pros and cons of this surgery must be weighed up. But sometimes, as in the case of our patient with renal failure, treatment of the prolapse can be a real life-threatening emergency [7].

Emergency surgery to reduce the prolapse is often sufficient if the operation is performed before the damage to the renal parenchyma becomes irreversible.

Conclusion
Genital prolapse is a pathology of the elderly woman, which can sometimes be neglected out of fear, modesty or even ignorance. But this pathology, which remains functional, can sometimes present a real and not negligible risk if the diagnosis and treatment are not made in time.

Conflicts of Interest
The authors declare no conflicts of interest.

Authors' Contributions
Lounas BENGHANEM: data collection, bibliographic research and writing of the article.
Lydia FAÏD: proofreading and supervision of the writing of the article.
Kamel HÂİL: proofreading and supervision of the writing of the article.
Radia BENYAHIA: proofreading and supervision of the writing of the article.
Chahira MAZOUZI: proofreading and supervision of the writing of the article.
Rachid NEMMMAR: proofreading and supervision of the writing of the article.
Mohamed Amine HABOUCHI: proofreading and supervision of the writing of the article.

References