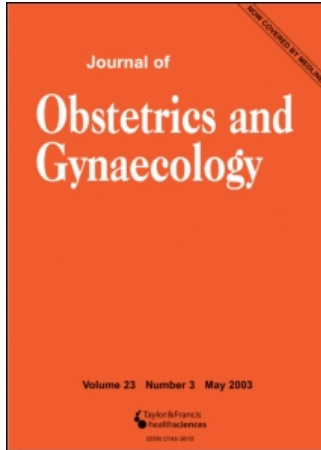


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Successful medical treatment of advanced urethral prolapse

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woman, we had thought that the ideal management was to have undertaken open laparoscopy to examine tissue viability after digital reduction of the prolapse but our options were limited by her general condition. There were no clinical signs of gut strangulation and so we advised her to have simple prolapse reduction and close clinical observation. She made an excellent recovery, avoiding abdominal surgery, which appears to have vindicated our conservative approach.

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Successful medical treatment of advanced urethral prolapse

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Case report

A 71-year-old woman presented with a short history of postmenopausal bleeding. Two years previously, she had been extensively investigated for frank haematuria, but no cause had been found. At the time of presentation, she had no other symptoms and there was no history of trauma. Urgent pelvic ultrasound showed normal endometrial thickness, normal adnexae and a small ill-defined echogenic area at the uterine fundus. Hysteroscopy was normal, but at the time of surgery, clinical examination revealed a vivid purple coloured doughnut shaped swelling at the site of the urethra (Figure 1). Urgent cystoscopy excluded a prolapsed urethrocoele. A diagnosis of urethral prolapse was made, and the patient was started on oral antibiotics, topical oestrogen cream and anti-inflammatory medications in combination with sitz baths. At a 6-month follow-up, there was no evidence of recurrence of her urethral prolapse recurrence.



Figure 1. Advanced urethral prolapse.

Discussion

Urethral prolapse is a rare condition, and as a result, the rate of misdiagnosis is high, leading to increased patient anxiety and inappropriate management. Increased physician awareness and early recognition of this condition leads to a successful clinical outcome. Some 80% of cases of urethral prolapse occur in premenarchal children, of whom more than 90% are of African origin. The incidence of urethral prolapse in young girls has been reported to be 1:3,000 (Rudin et al. 1997). Of the remaining cases, the majority have been in postmenopausal white women, similar to the present case.

The cause of urethral prolapse is unknown, but may include oestrogen deficiency (Richardson et al. 1982; Harris et al. 1998), leading to weak pelvic structures with poor attachment that cannot withstand increases in intraabdominal pressure (Valerie et al. 1999), perineal trauma, such as childbirth (Harris et al. 1998) and neuromuscular abnormalities (Rudin et al. 1997).

Patients with prepubertal urethral prolapse are predominantly asymptomatic. In contrast, patients with postmenopausal urethral prolapse are usually symptomatic. Vaginal bleeding is the most common presenting symptom, although affected women may also report dysuria, haematuria, urinary frequency or urgency, and nocturia. On physical examination, the urethral prolapse classically appears as a doughnut-shaped mass protruding from the anterior vaginal wall, and it may be painful to touch. The mucosa is ulcerated in most cases and usually bleeds upon contact. If the prolapsed urethra is large, the mucosal mass may become strangulated, which results in venous obstruction, thrombosis, and necrosis of the prolapsed tissue. The differential diagnosis should include trauma, urethral or vaginal malignancy, urethral caruncle, prolapsing urethrocoele, condyloma and rhabdomyosarcoma (Rudin et al. 1997; Valerie et al. 1999).

Due to its rarity, the optimal management of urethral prolapse remains controversial. Conservative or medical therapies aim to eradicate infection in the exposed denuded mucosa, which helps decrease oedema and thus allows the prolapse to resolve. The ideal regimen is a combination of oestrogen cream, topical antibiotics, and anti-inflammatory preparations, such as sitz baths and herbs (Trotman and Brewster 1993; Anveden-Hertzberg et al. 1995).

However, even though non-surgical treatment may reduce the severity of urethral mucosa prolapse, the recurrence rate may be as high as 67% (Jerkins et al. 1984). Failure of medical therapy or the presence of strangulated urethral prolapse indicates surgical excision, and many different surgical procedures, ranging from simple manual reduction to complete surgical excision, have been described. Although there are case reports of innovative techniques such as using manual reduction performed with the patient under local anaesthesia with a hyaluronidase injection (Ho et al. 2003). Surgical excision is still the most definitive therapy. Simple excision and repair provides prompt relief of symptoms, the highest cure rate few recurrences and minimal complications. Older techniques such as cautery, cryotherapy and ligation of the prolapsed urethra over a Foley catheter are no longer routinely practiced as they are associated with urethral stricture, meatal stenosis and postoperative urinary retention (Kleinjan and Vos 1996). In addition, recent evidence suggests that grey-scale ultrasound and colour Doppler sonography may be useful in detecting the presence of feeding arteries and draining veins in the prolapsed urethral mucosa to exclude the presence of necrosis and gangrene, thus allowing medical treatment to be tried first (Yang and Huang 2004).

Educational message

A rational treatment approach for urethral prolapse is as follows. Medical treatment, and close clinical follow-up, should be offered for children, adults with minimal symptoms and those patients not fit for anaesthesia. For those undergoing surgery, complete surgical excision with over sewing of the mucosa appears to be

gold standard, as well as being associated with the lowest recurrence rate.

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Massive vesico-vaginal fistula caused by a shelf pessary

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Case report

An 85-year-old woman attended the gynaecological outpatient clinic for a routine 4-monthly follow-up for her vaginal pessary. She had been using a ring pessary for many years but this was changed to a shelf-pessary (size 18) 1 year ago when the ring pessary was no longer controlling her symptoms, in spite of trying various sizes. During consultation, she complained that she had been experiencing pain in her vagina for the last few weeks and she seemed to have lost control over her bladder. She felt as if her shelf pessary had slipped down and was not effective anymore. She requested to have surgical treatment now, even though she had declined it in the past because of her history of myocardial infarction. On examination, the shelf pessary appeared to be in the correct place but it was very painful for the patient when its removal was attempted. She was therefore booked for pessary removal and vaginal hysterectomy and repair under anaesthesia.

The pessary was easily removed in theatre. However, on closer examination, she was found to have a horizontal, 4 cm long,

vesico-vaginal fistula in the upper one-third of the vagina 2 cm away from the cervico-vaginal junction. This was the area where the upper edge of the shelf pessary had been pressing. Vaginal hysterectomy was carried out in a standard fashion and a urologist was requested to repair the fistula. The vaginal wall was mobilised away from the bladder and the bladder was repaired horizontally using a 5-0 Monocryl suture. The vagina was stitched over it vertically, using 2-0 Vicryl suture in a continuous fashion. An indwelling urinary catheter was left for 14 days. A cystogram was performed before the catheter was removed and this showed no leakage. The patient had no urinary complaints subsequently and she was well at follow-up after 3 months.

Discussion

Although corrective surgery is the definitive treatment for utero-vaginal prolapse, vaginal pessaries are used as a non-invasive alternative in the elderly, in women who are at high risk for medical complications with surgery and in women who wish to avoid