

Extreme cervical elongation

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ABSTRACT

Uterine prolapse is a condition which has commonly affected women of all times. The problem of genital prolapse and its remedies is described in the oldest medical literature, the Egyptian Papyri. The normal length of the cervix is about 2.5 cm. The vaginal and supravaginal parts are of equal length. The elongation may affect either part of the cervix. The length of the uterocervical canal is measured by introduction of the uterine sound. Cervical elongation plays an important role in deciding the surgical treatment. We had a case of extreme cervical elongation and we faced difficulties during the surgery.

Keywords: Cervix, Uterovaginal prolapse, Hysterectomy, Cervical elongation, Supravaginal, Infravaginal

INTRODUCTION

The normal length of the cervix is about 2.5 cm. The vaginal and supravaginal parts are of equal length. The elongation may affect either part of the cervix. Elongation of the supravaginal part is commonly associated with uterine prolapse. The vaginal part of the cervix is always elongated congenitally and associated with chronic cervicitis which may produce some hypertrophy and make the cervix bulky.

The supravaginal part becomes elongated due to the strain imposed by the pull of the cardinal ligaments to keep the cervix in position, whereas the weight of the uterus makes it to fall through the vaginal axis. Chronic interference of the venous and the lymphatic drainage favours the elongation.¹

In the vaginal part of the cervix, there is chronic congestion which may lead to hyperplasia and hypertrophy of the fibro musculo glandular components. These lead to the vaginal part becoming bulky and congested and further elongation.¹

Clinically, in supravaginal elongation, vaginal fornices are shallow, vaginal part of the cervix remains normal in length and size of the uterus remains normal. In infravaginal or congenital elongation, fornices are deep, vaginal part of the cervix is elongated and uterine size is normal. The length of the uterocervical canal is increased in both the cases, as evidenced by introduction of the uterine sound.

CASE REPORT

Thirty nine years old female, P2L2, both FTND, LCB-12 years, sterilized, came to Sri Venkateshwaraa medical college hospital, Pondicherry, with the complaints of noticing a mass descending per vaginum for the past ten years. Patient also complained of chronic low back ache and excessive white discharge per vaginum, not associated with itching, not foul smelling. No history of menstrual complaints or any urinary or bowel disturbances.

On Examination, third degree uterovaginal prolapse with markedly elongated and hypertrophied cervix with small endocervical polyp with minimal cystocele and rectocele. Size of the uterus was found normal. No evidence of

stress urinary incontinence or decubitus ulcer. Her pre-operative work up was normal and patient was posted for vaginal hysterectomy with anterior colporrhaphy with posterior colpoperineorrhaphy.

Intra operative findings (Figure 1 & 2) were same as above and Utero-Cervical Length (UCL) was 17 cm. We faced difficulty in opening the peritoneal folds anteriorly and posteriorly due to extreme infravaginal cervical elongation with no evidence of uterine descent. We proceeded by pushing the bladder and clamping, cutting and ligating bilateral mackenrodt and uterosacral ligaments. Inspite of releasing the above ligaments and constant downward traction on the uterus, it was difficult to locate the uterovesical fold (UV fold) and the Pouch Of Douglas (POD). However we proceeded with releasing bilateral uterine arteries by keeping the bladder away under the Sim's speculum. Further, fold of peritoneum anteriorly and posteriorly were identified by digital palpation, held by artery and then opened. We had difficulty in releasing and securing the upper pedicles, as there was no uterine descent. However, both ovaries were visualized as normal and preserved. Subsequently, anterior and posterior repair was done. Bladder catheterized and vagina was packed.

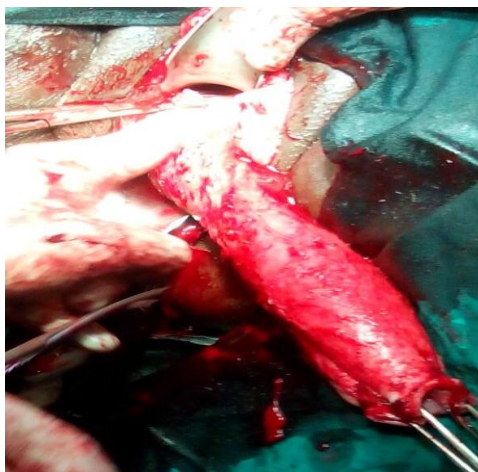


Figure 1: Intraoperative findings.



Figure 2: Gross specimen.

Post operatively the patient received one unit of blood transfusion. Continuous bladder drainage was done for one week and patient recovered well in the post-operative period. She was discharged on 7th post-operative day.

DISCUSSION

Genital organ prolapse or Pelvic Organ Prolapse (POP) is a common clinical entity seen in gynaecological practice, which includes downward descent of the vaginal wall and/or the uterus.¹ In general, 40 % of women with POP have cervical elongation. The extent of cervical elongation is proportionate with the degree of uterine descent.² Cervix may elongate either in the supravaginal or infravaginal part. Supravaginal elongation is commonly associated with uterine prolapse, whereas infravaginal elongation is congenital. It is not uncommon for the cervix to elongate as much as 10 cm in length. The cervix may be hypertrophied and congested.³

Cervical elongation plays an important role in the decision between hysterectomy and uterine preservation during genital prolapse surgeries. In recent years, uterine sparing procedures are becoming more common, though hysterectomy has classically played a role in pelvic floor reconstructive surgeries.^{4,5} However, cervical elongation is considered as a relative contraindication for retaining the uterus and requires amputation of the cervix for better results⁴. However, cervix may elongate postoperatively after uterine preservation.⁶

As in our case, elongation of the cervix may affect one's decision about sites of peritoneal entry in vaginal hysterectomy. Preoperative assessment of cervical elongation by measuring the uterocervical length with a uterine sound, may help in planning the initial circumferential incision and may guide the surgeon in opening the anterior and posterior peritoneum.⁷

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