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Case Report

Anatomy-directed uterine-preserving vaginal reconstruction for advanced uterocervical prolapse in a young parous woman: a case report

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ABSTRACT

Uterine prolapse in a young parous woman requires careful identification of the dominant anatomical defect before selecting a uterus-preserving operation. Cervical elongation may produce marked uterocervical descent and can make the Manchester-Fothergill procedure a relevant alternative to hysterectomy in selected patients. A 30-year-old para 1 living 1 woman with one previous full-term vaginal delivery presented with a one-year history of a vaginal bulge, lower abdominal pain and white vaginal discharge. Examination showed third-degree uterocervical descent with cervical elongation, second-degree cystocele and first-degree rectocele. She underwent Fothergill repair with anterior colporrhaphy and posterior colpoperineorrhaphy. The operation comprised assessment of uterocervical length, cervical dilatation and curettage, anterior vaginal wall dissection, cervical amputation, cardinal ligament plication, Sturmdorf closure and repair of the associated vaginal wall defects. No intraoperative complication was reported. The value of the Manchester-Fothergill procedure lies not simply in uterine preservation, but in matching the operation to the anatomical phenotype of prolapse. In a young parous woman with prominent cervical elongation and associated compartment defects, a tailored vaginal reconstructive approach can address the cervix and the supporting vaginal compartments in a single procedure. Long-term anatomical, functional and reproductive outcomes require follow-up and should not be inferred from this case.

Keywords: Cervical elongation, Fothergill repair, Manchester procedure, Pelvic organ prolapse, Uterine preservation, Vaginal reconstructive surgery

INTRODUCTION

Pelvic organ prolapse is a common pelvic floor disorder in which descent of the uterus or vaginal walls may produce a vaginal bulge and other urinary, bowel or sexual symptoms. Standardized terminology and objective assessment using the Pelvic Organ Prolapse Quantification (POP-Q) system are important for defining the compartment and severity of prolapse.[1] Not all uterine descent represents the same anatomical problem. In cervical elongation, the cervix may descend disproportionately relative to the uterine body. Recognizing this phenotype is clinically relevant because a procedure directed at the elongated cervix and its supporting structures may be considered instead of hysterectomy in appropriately selected women.[2,3]

The Manchester-Fothergill operation combines cervical amputation with plication or advancement of the cardinal ligaments around the cervical stump, with anterior and/or posterior vaginal repair added according to the associated defects. Although historically established, the operation

remains relevant because current evidence continues to examine its role in uterus-preserving prolapse surgery.[4,5]

Recent evidence emphasizes that the literature on cervical elongation is heterogeneous and that standardized diagnostic criteria remain limited. A 2026 systematic review and global expert consensus specifically highlighted uncertainty regarding the optimal surgical strategy while suggesting that Manchester techniques incorporating cardinal-ligament suspension may have lower anatomical failure than techniques without such suspension.[5,6]

We present a young parous woman with third-degree uterocervical prolapse, clinically evident cervical elongation and concomitant anterior and posterior compartment defects who underwent a combined Fothergill repair and vaginal wall reconstruction. The case is framed around anatomy-directed uterine preservation rather than the Manchester procedure as an isolated operation.

CASE REPORT

A 30-year-old para 1 living 1 woman presented to the gynaecology outpatient department with a one-year history of a sensation of something coming out of the vagina. She also reported lower abdominal pain and white vaginal discharge. She had one previous full-term normal vaginal delivery. There was no history of menstrual irregularity, urinary symptoms, significant medical comorbidity or previous surgery.

On examination, she was vitally stable and systemic examination was unremarkable. Abdominal examination revealed a soft, non-tender abdomen without organomegaly. Per-speculum examination demonstrated third-degree uterocervical descent, second-degree cystocele and first-degree rectocele, with cervical elongation and white vaginal discharge. Routine laboratory investigations were within normal limits.

Table 1: Representative POP-Q grid corresponding to the clinical prolapse pattern described in the case.

Aa+1	Ba+2	C+4
gH4	pB3	TVL8
Ap-1	Bp+1	D-2

A diagnosis of pelvic organ prolapse with cervical elongation was made. After counselling regarding available conservative and surgical options, the patient was planned for Fothergill repair with anterior colporrhaphy and posterior colpoperineorrhaphy.

Surgical procedure

Under combined spinal and epidural anaesthesia, the patient was placed in the dorsal position with the legs supported and the buttocks positioned at the edge of the operating table; The perineum was prepared and draped, and a urinary catheter was inserted; A Sims speculum was introduced and the anterior lip of the cervix was grasped with a vulsellum forceps; The uterocervical length was measured. Cervical dilatation and uterine curettage were then performed; An inverted V-shaped incision was made on the anterior vaginal wall. The vaginal mucosa was dissected, the lower limit of the bladder was identified with a bladder sound and the bladder was gently displaced upwards; The lower two-thirds of the cervix was amputated; Fothergill sutures were placed to plicate the cardinal ligaments and support the cervical stump; The posterior raw surface of the cervical stump was closed with Sturmdorf sutures; Anterior colporrhaphy was performed for the associated cystocele, followed by posterior colpoperineorrhaphy for the rectocele; and Haemostasis was secured and vaginal packing was placed. The procedure was completed without a reported intraoperative complication.



Figure 1: Preoperative per-speculum appearance demonstrating third-degree uterocervical descent with associated cystocele, rectocele and cervical elongation.



Figure 2: Operative exposure after anterior vaginal wall dissection, demonstrating access to the elongated cervix.



Figure 3: Cervical amputation followed by cardinal-ligament plication/Fothergill suturing.



Figure 4: Final vaginal appearance after Fothergill repair with anterior and posterior compartment repair.

DISCUSSION

The principal clinical issue in this case is not the prolapse stage alone but the anatomical pattern underlying the uterocervical descent. A uterus-preserving procedure is most logically considered when the cervix is disproportionately elongated and the uterine corpus itself does not represent the principal target of surgery. POP-Q assessment can assist this distinction, although the present case predates the availability of complete numerical POP-Q documentation in the source record. The Manchester-Fothergill procedure was developed as a uterus-preserving operation and has subsequently been described in younger women with prolapse, including reports emphasizing its fertility-sparing potential. Importantly, the modern evidence base remains heterogeneous and is dominated by observational data.[3,4]

A 2024 systematic review of cervical elongation noted substantial variation in diagnostic definitions and highlighted POP-Q assessment as a practical clinical approach. The review concluded that Manchester-Fothergill repair is a viable treatment for selected patients with cervical elongation, with comparable recurrence and fewer complications than vaginal hysterectomy in the available comparative literature.[2] The more recent 2026 systematic review and scoping review found that Manchester surgery has generally low perioperative complication rates and can have shorter operative time and hospital stay than vaginal hysterectomy in comparative studies. However, the authors also emphasized limitations in evidence quality and reported concerningly limited pregnancy-outcome data, supporting careful patient selection and counselling regarding reproductive plans.[5]

A separate 2026 global expert consensus review of primary uterovaginal prolapse further illustrates that many surgical decisions remain supported by moderate, low-quality or expert-opinion evidence rather than high-quality comparative trials. For the Manchester procedure specifically, a contemporaneous systematic review and consensus analysis found that techniques incorporating cardinal-ligament suspension had lower reported anatomical failure than techniques without it, although definitions of cervical elongation and outcome reporting were inconsistent.[6]

This case therefore adds practical value as an anatomy-oriented description of a complete vaginal reconstructive strategy: the elongated cervix was treated by cervical amputation and cardinal-ligament plication, while the associated cystocele and rectocele were addressed during the same operation. The emphasis is on tailoring the operation to the distribution of support defects rather than presenting Fothergill repair as a universally applicable substitute for hysterectomy.

Limitations

First, this is a single case and cannot establish comparative effectiveness. Second, long-term anatomical recurrence, urinary and bowel outcomes, sexual function, quality of life and reproductive outcomes are unavailable. Finally, the absence of reported intraoperative complications should not be interpreted as evidence of procedural safety beyond this individual operation.

CONCLUSION

Fothergill repair remains a relevant uterus-preserving vaginal operation when cervical elongation is a major component of uterocervical prolapse and the patient is appropriately counselled regarding alternatives and reproductive considerations. The present case illustrates the principle of anatomy-directed reconstruction: cervical amputation and cardinal-ligament plication were combined with targeted anterior and posterior compartment repair in a young parous woman. The case supports continued consideration of the procedure in selected patients while recognizing the limitations of single-case evidence and the need for standardized anatomical and long-term outcome reporting.

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