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CLINICAL VIGNETTE

Extreme pelvic organ prolapses complicated with massive urolithiasis — multiple steps repair

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INTRODUCTION

Pelvic organ prolapse (POP) is the disorder of the pelvic muscle floor and pelvic connective tissue, resulting in abnormal anatomy of pelvic organ organs and usually its function [1].

The symptoms may differ, depending on the POP advance, and usually appears in stage II/III in POP-Q scale [2]. The “bulging” — described as sensation of the feeling of fullness in the vagina is the main characteristic symptom of the POP and in the most advanced stages may occur as a visible vaginal bulge [3].

CASE REPORT

A 68-year-old patient was referred to a Operative Gynaecology and Oncologic Gynaecology Clinic due to a total pelvic organ prolapse. In the clinical examination the patient presented

massive POP with extensive vaginal wall ulceration (Fig. 1A). Due to hernia's oedema and pain during examination, the patient was qualified to the prolapse restoration under general anaesthesia.

During the surgery the prolapse was pushed back. To treat the vaginal ulceration, the dressing with anti-decubitus agent was inserted into vagina and absorbable stitches were applied on the vaginal introitus to prevent the dislocation of the prolapse (Fig. 1B).

The Foley catheter was also inserted to the urinary bladder. A few hours after the prolapse restoration the blood appeared in the urine. With no improvement after the antihemorrhagic pharmacological treatment, the cystoscopy was performed and it revealed massive urolithiasis.

The vaginal rinsing with antiseptics and change of the dressings was repeated every 2–3 days, initially in general anaesthesia.

A week after the first procedure, the patient was scheduled to the next step of prolapse repair with simultaneous treatment of the cystolithiasis.

During the laparotomy the cystotomy was performed with the bladder stones removal (Fig. 1C). The bladder wall was sutured with 2 layers of sutures and the catheterisation was scheduled for 14 days.

Due to the numerous fibroids the supracervical hysterectomy with bilateral salpingo-oophorectomy was performed. As the next step of POP repair, the cervix was fixated to the adnexal stumps and round ligaments and the McCall sutures were placed into the uterosacral ligaments.

In the early postoperative period patient presented the wound infection with need of broad-spectrum antibiotic therapy. The regular vaginal dressing was also performed. What was surprising, in the histopathological results, apart from fibroids, the patient was diagnosed with serous tubal intraepithelial carcinoma (STIC).

Four weeks after the laparotomy, when the vaginal wall ulceration was cured the patient was scheduled for the next step of the POP repair.

The kolpoperineoplasty was performed with iliococcygeus muscle fixation of the vaginal tissues. The abdominal wound inspection was also performed.

On the 15th day after the last surgery, when the temporary urinary retention was subsided, and the abdominal wound was healed properly the Patient was discharged.

The Patient had regular check-ups in the outpatient clinic with no complaints. Fourteen weeks after the final POP repair Patient didn't report any subjective complaints for the prolapse, the POP-Q scale was assessed as POP-Q IIaIIp (Fig. 1D).

CONCLUSION

Every case of total pelvic organ prolapse needs individual approach and sometimes multiple surgical steps should be performed to access functional and anatomical success. In long-term history of total POP, the massive urolithiasis can be considered as one of possible complications. It can cause problems with both relocation of the prolapse to the anatomical position and ureteral obstruction [4].

Article information and declarations

Ethics statement

Written consent was obtained from the patient.

Author contributions

The authors confirm contribution to the paper as follows: study conception and design: Kolodynska A., Rechberger T.; data collection: Struzyk A., Rechberger-Krolikowska E.; draft manuscript preparation: Kolodynska A., Struzyk A., Rechberger-Krolikowska E. All authors reviewed the results and approved the final version of the manuscript.

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None.

Conflict of interest

The authors declare no conflict of interest.

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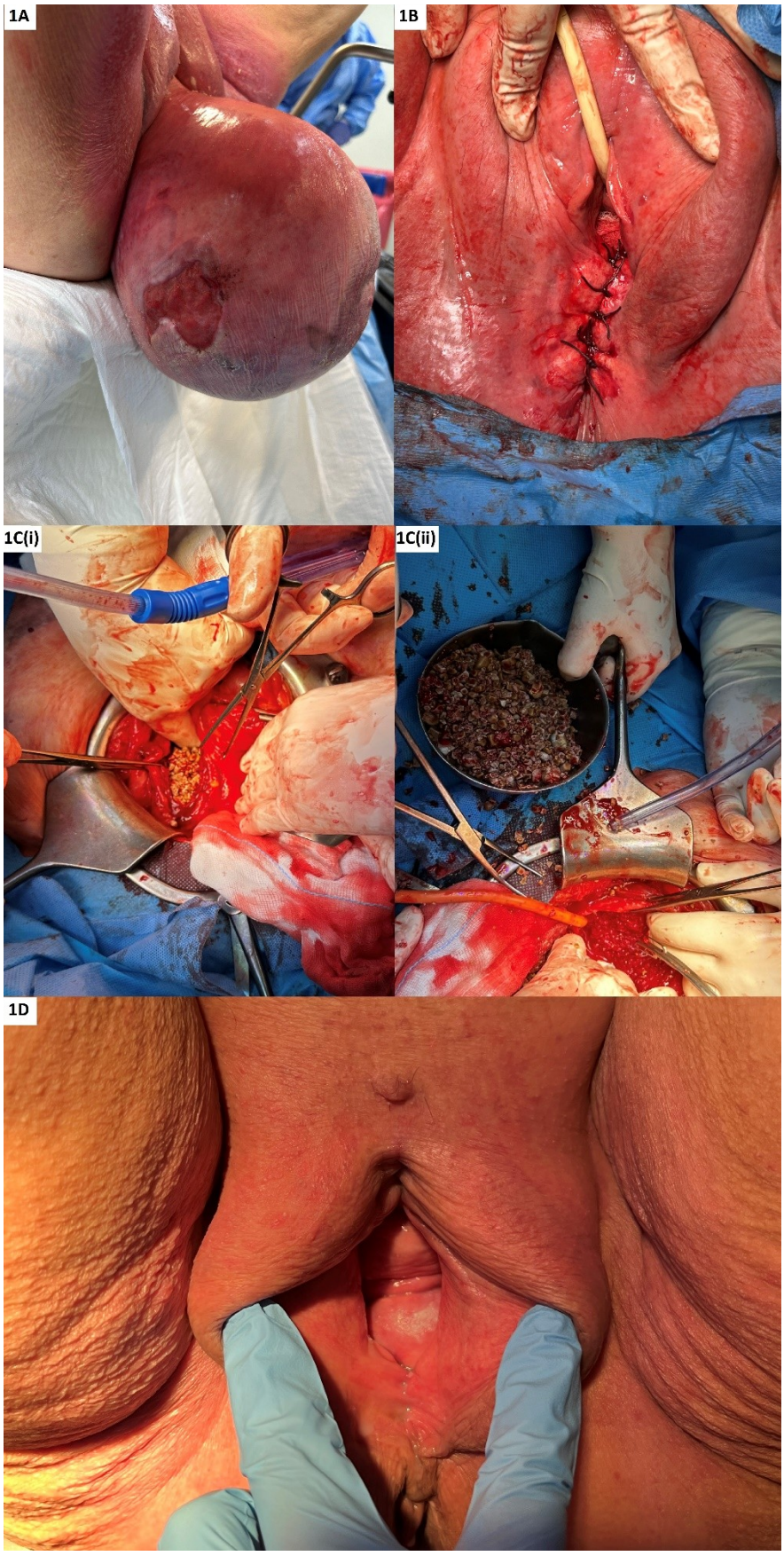

Figure 1. A. Total pelvic organ prolapse with massive vaginal wall ulceration; **B**. Absorbable stitches on the vaginal introlitus preventing the prolapse dislocation; **C.** Cystotomy; **C1** and removal of the bladder stones **C2**; **D.** The clinical appearance 14 weeks after the repair