Report on:

RESEARCH
UTERO-VAGINAL PROLAPSE:
RISK FACTORS AND ASSOCIATED PROBLEMS IN WOMEN'S HEALTH
MATERNITY HOSPITAL, THAPATHALI

Submitted By:
Principal Investigator (PI): Dr. Indira Satyal
Co. P.I. Dr. N. L. Shrestha, Dr. N. Ojha
Members: Dr. Meena Jha, Dr. Chammaya Pun, Dr. Binita Shrestha

Submitted To:
Research Committee Maternity Hospital, Thapathali, Kathmandu
Baisakh 2060 B.S. (April 2003 A.D.)

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Table of Content

Utero- Vaginal Prolapse:

Risk Factors and Associated Problems in Women's Health.

Background

Uterovaginal prolapse (U.V.P) is a very common morbid condition in women during reproductive life and after menopause. This condition is more prevalent in rural and very rural regions as compared to plain areas of Terai and Urban. This condition is directly related with increased intra-abdominal pressure in conditions like chronic cough, chronic smokers (bidi, hukka, and cigarette...), and persons with chronic diarrhoea and constipation. Overwork during puerperal period and unattained labour including precipitated labour is other contributory factor.

A study in Nuwakot in 1993 (SCF/ US) 35 % of gynaecological cases were found to be genital prolapse. Similar studies in Achham and Doti by GTZ, UNFPA and HMG 2002 showed 1 in 4 women reported with pelvic organ prolapse (POP).

Gynaecology and Sexually Transmitted Infection (STI) camp in Siraha District 1996 showed 16.5 % patients suffering with UVP.

Maternity Hospital, Kathmandu, is a centrally located tertiary level referral centre. It has a turnover of one hundred eleven thousand one hundred sixty five (111,165) out patients in one year, utero-vaginal prolapse being 7% of total gynaecological admissions. Hospital data also shows utero-vaginal prolapse contributes 29% of total major gynaecological operations (Statistical Dept. Maternity Hospital, 2057 B.S.) Among the gynae admissions utero-vaginal prolapse is the third most-common diagnosis after abortion and menstrual disorder cases.

Introduction

UVP is the downward displacement of the uterus, bladder and bowel into the vagina due to weakening of the uterine support with or without symptoms.

The term urethrocoele is applied when part of the urethra descends down, Cystocoele when the urinary bladder descends down forming the bulge in anterior vaginal wall.

Similarly the uterus may descent down to the extent when the cervix remains within the vagina, which is 1st degree UVP, when it reaches upto introitus 2nd degree, and when whole uterus descends down outside the vagina it is 3rd degree also called Procedentia.

When there is descent of bowel in upper part posteriorly, it is called Enterocoele and a bulge in lower part of vagina, when there is descent of rectum it is called Rectocoele.

Women with genital prolapse may have associated problems like urinary incontinence or incomplete evacuation, pelvic fullness, dull dragging pain, discomfort, lower backache or in gross degree of UVP the woman even has to push the prolapsed uterus upwards in order to urinate or defecate.

Lower part of the uterus and cervix sometimes becomes swollen and congested and with continuous irritation can cause an ulcer (Decubitus Ulcer) which gets infected giving offensive discharge.

A huge Cystocoele causes obstructive uropathy, which leads to hypertrophy of urinary bladder wall and trabeculae, kinking of the distal ureters causing hydroureter, hydronephrosis and urinary tract infections (UTI).

Objective of the Study

General - To determine the risk factor associated with UVP.

Specific-

- To identify the problem associated with UVP.
- To find out the incidence of these problems
- To know the effect of UVP in women's health.

Need for study about UVP cases

Majorities of our women reside in rural and remote places, most of them poor with hard daily life to earn for livelihood. 90% of women have home-deliveries, either alone or attended by unquaified persons who can not manage complications of delivery, inadequate rest, overwork during puerperium, chronic malnutrition, superadded by infection due to poor hygiene at the time of delivery and their smoking habits leads to prolapse and its associated problems. Genital prolapse being such a morbid condition which hamper their daily life in earning and they are so much in mental stress from husband and in laws, the women has to face in her life. This condition needs to be prevented because this is a preventable condition. Furthermore this can be corrected in time if found during early condition of cystocoele or 1st degree UVP.

This study is being done only in small population coming to OPD, which is just a jest of real associated problem in women's health related to UVP. Larger studies need to be done at the rural and very rural community, which would definitely help our women in preventing this condition.

Significance of the Study

Datas taken from various studies shows rural and very rural women are the most sufferers from this disease. Hospital data for Maternity Hospital (1st Baisakh, 2058 to 30th Chaitra, 2058 / May-April 2001-2002) showing out of total 20454 gynaecological patients attending to OPD, 1248 patient of UVP were seen thus making a bulk of 7.11%. Observation showed 3-4 cases of UVP are seen per day in maternity hospital. Prolapse ranked the 3rd on the list of total major operations performed. Out of the 635 major operations in 1 year from 1st Baisakh, 2058 to 30th Chaitra, 2058- 212 operations were performed for prolapse making the incidence of 33%.

Similarly UVP formed 3rd major bulk of 6% gynaecological admission in Maternity Hospital, 45% for abortion and its complications, 10% menstrual disorder of various types.

Methodology

Study Design:
This is a hospital-based (Maternity Hospital) prospective, descriptive, cross-sectional study.

Target Population:
Women above 20 years of age attending the gynae outpatient department with utero-vaginal prolapse

Sample size and Sampling procedure:
180 cases with U-V prolapse will be taken
Convenient sampling procedure – after history taking and physical examination

Time Period:
Bhadra 15th to Magh 15th (5 months)

Inclusion criteria:
Women of all types of U-V prolapse above 20 years of age
Prolapse associated with pregnancy, previously repaired cases, congenital prolapse all are included in the study

Exclusion criteria:
Those patients who do not want to participate, deaf and dumb women and mentally handicapped

Ethical Consideration:
Informed consent taken in all patients by keeping one witness.

Data Processing and Analysis:

It was done manually and also with the help of computer. Discussions on the findings were done.

Literature Review

The supportive function of the pelvic floor muscle and ligament are necessary to keep the female genital organ in position. Genital prolapse results from failure of one or more of supports to pelvic organs. Developmental or inherent weakness of the fibro-muscular tissue, injury sustained during child-birth and atrophy of the supporting tissue at climacteric due to cessation of the ovarian function are the main predisposing factors (Ref: Tindall VR 1998)

Increased intra-abdominal pressure as in cough and constipation may precipitate the changes of developing U-V prolapse. (Ref: Padubiri 1994)

In India, 1.2-2% of nulliparous women had UVP (Banu 1997). Often nulliparous prolapse was associated with lifestyle of heavy physical labour producing increased intra-abdominal pressure. Congenital weakness of perenial structures is responsible for nulliparous women and prolapse following easy vaginal delivery (Dutta, 1994).

Situation in Nepal:

According to the study by Family Health Division (FHD) of Nepal 1998, 92% of all women deliver at home. Less than 10% of these births attended by health practitioner (Ranabhat 1997) in study investigating U-V prolapse cases attending Gynae OPD at Maternity Hospital reported that place of delivery of first child was at home in 92.6%, with labour lasting for more than 18 hours in first child in 31%. One interesting fact was that 80% had developed U-V prolapse before menopause.

In a study on menopausal women in Nepal by Prof. K. Giri 2001, more than half of women with U-V prolapse had more than six children and one-forth of women had four children. In the same study, during delivery, birth attendant at home suggested women to push hard for timely delivery; and in two-third of post natal cases, early load carrying practices was noted. Also during postnatal period, nutritious food like – fish, eggs, vegetables and fruits were prohibited suggesting them to be harmful for the mother and the baby.

UVP is a common complaint in Gynaecological patients, mostly in the postmenopausal and multiparous women. Nulliparous prolapse is rare and is seen in only 2% of cases and vault prolapse in seen in 0.5 % cases following hysterectomy.

The common aetiological factor in prolapse is atonicity and asthenia that follows menopause when pelvic floor muscle and ligaments become lax and atonic due to estrogen deficiency. (Shaw's textbook of Gynaecology 12th Ed. Cha. 20 pg. 257-264).

Genital prolapse can involve any of the main pelvic organs including the bladder, uterus, cervix and the bowel. Women suffering from cervical prolapse have associated urinary and bowel problems like incontinence and incomplete evacuation. This usually includes feeling of

pelvic fullness, discomfort, low backache, appearance of bulge in or out of vagina. In prolapse there is always retroversion of uterus; descend of vaginal wall and uterus. It is a form of hernia of uterus (D.C.DUTTA, text book of Gynaecology 1994 pg. 188).

Chronic premenstrual pelvic pain is due to varicosities in broad ligament produced by kinks. The manifestations are those of pelvic congestion syndrome. Low backache is due to same cause.

Dyspareunia - Deep Dyspareunia is due to direct thrust by penis against the retroflexed urteus or prolapsed ovaries lying in the pouch of Douglas.

Infertility - in III^{o} retroversion of cervix is away from seminal pool at the posterior fornix.

Prolapse is caused by injury to the supportive structures eg.

- Overstretching of Mackenrodt's ligaments and utero-sacral ligaments
- Premature bearing efforts prior to full dilatation of cervix
- Application of forceps or ventouse and traction proir to full dilatation of cervix
- Downward pressure on uterine fundus in attempt to deliver the placenta
- Precipitate labour
- Overstretching of the endo pelvic facial sheath of vagina
- Overstretching of the perineum due to prolongeded station of head on the perineum avoidance
- or delay in episiotomy or imperfect repair of the perineal injuries
- Sub-involution of the supporting structures
- In ill-nourished asthenic women early resumption of activities with greatly increased intra
- abdominal pressure before tissue regains their tone
- Repeated child births at frequent intervals
- Persistent over filling of the bladder in puerperium leading to stretching of pubo-cervical fascia
- Inadequate involution

Aggravating factors are:

- Post menopausal atrophy
- Increased intra abdominal pressure as in cough and in constipation
- Increased weight of the uterus as in fibroid and in myo hyperplasia
- Traction by anterior vaginal wall or cervical polyp

A large cystocele, perhaps in association with uterine prolapse, may lead to acute urinary retention. Recurrent UTI may occur in-patients in whom bladder emptying is incomplete. Leukorrhoea, abnormal uterine bleeding may result for infection or for disordered uterine and ovarian circulation, in prolapse.

Chronic decubitus ulcer may develop in procidentia, but whether or not the ulcer predispose to cancer is uncertain

UTI is common with prolapse because of cystocele and partial ureteral obstruction with hydronephrosis, may occur in procidentia.

Haemorrhoids result from stretching to overcome constipation

Small bowel obstruction may occur within a deep enterocele

All recent work points to the conclusion that parturition has the capacity to cause partial denervation of the pelvic floor and that this is a substantial fact in the etiology of prolapse.

(Ref: Prolapse and Urinary incontinence Pg. 683 Chapter 45 Dewhurst's Textbook of OB & GYNAE for PostGraduates.)

Social and Psychological Problem:

- UV Prolapse is a major morbid condition seen in women of our country predominently in very rural areas.
- Women are neglected by their husbands, in laws and relatives, they become isolated form the family.
- The husband not being satisfied with the wife marries again thus depriving her hormoneal sexual life.
- Difficult painful sexual relationship may lead to unsafe & insecure relationship with the husband leading to disharmony in the conjugal life.
- Difficulty walking, standing and carrying heavy loads may hamper the day to day work in a women's life having this problem.
- She may feel humiliated withdraw herself from the social events.
- She may be neglected by her family members.
- Potential emotional consequences of genital prolapse may be isolation, social degradation, lack of self esteem, emotional outbursts which can lead to psychosomatic problems in women's life.

The effects of U-V Prolapse

- Lower backache.
- Pelvic fullness.
- Dull dragging pain.
- Discomfort.
- Discharge- could be foul smelling due to infection.
- Urinary incontinence.
- Urinary retention.

- Incomplete evacuation.
- Inability to pass stool sometimes.

Dysparenuria- deep dysparenia may be due to direct thrust by penis against the retroflexed uterus or prolapsed ovaries lying in pouch of Douglas.

Infertility in 3rd degree retroversion- cervix is away from the seminal pool at the posterior fornix.

A larger Cystocoele perhaps is associated with uterine prolapse may lead to acute urinary retention. Recurrent UTI may occur in patients in whom bladder emptying is incomplete. Leucorrhoea, abnormal uterine bleeding and abortion may result from infection or from disordered uterine and ovarian circulation in prolapse.

Chronic decubitus ulcer may develop in procedentia but whether or not the ulcer predisposes to cancer is uncertain. UTI is common with prolapse because of cystocoele, partial ureteric obstruction with hydronephrosis may occur in procedentia. Small bowel obstruction may occur within deep enterocoele (current obs/ gynae diagnosis and treatment 1996 ch 11 pg 219-226).

All recent work points to the conclusion that parturition has the capacity to cause partial denervation of the pelvic floor and that this is a substantial fact in the etiology of prolapse. (Prolapse and urinary incontinence, Dewhursts textbook of obs/gynae for post graduates ch. 45 pg. 683)

UV Prolapse Results

Table 1: Age Wise

Less than 30 yrs	12	6.6%
30-35 yrs	16	
36-40 yrs	21	
41-45 yrs	25	
46-50 yrs	45	24.86%
51-55 yrs	42	
56-60 yrs	13	
61-70 yrs	6	3.31%
At 73 yrs of age	1	0.5%

This table shows that the lowest age of prolapse was 24 yrs and only 6.6 % of the patients were suffering from UVP in the early age group i.e below 30 yrs. Another point to be noted is that maximum numberof prolapse cases were in perimenopausal period 45 (24.86%). In the study the advanced age of having prolapse found was 73.

Table 2: Based on the areas

Urban	42	23.33%
Semi-Urban	53	29.44%
Rural	62	33.44%
Very Rural	23	12.77%

This table shows that most of the prolapse cases have been coming from suburban like Kavre, Dolkha, etc 53.33 %. 23.33 % from places like Dolpa, Sindhupalchowk, Kalikot, Rukum and Lamidada. These were referred cases.

Table 3: Based on occupation

Occupation	Husband	Wife
Service	22	-
Business Small & medium scale	46	3
Agriculture	87 (48.33%)	13 (7.22%)
Daily Wages	12	9
Unexplained	13	-
Housewives	-	155 (86.11%)

This table explains that the main occupation of both husband & wife is Agriculture 86.11%. Only small percentage of 6% was service holders. Housewives mostly are involved in agriculture.

Table 4: Based on education

Education	Husband	Wife
Illiterate	32 (17.77%)	10 (56.11%)
Prim/Sec	54	72 (43.88%
High school	79	7
upto Graduate	15 (8.33%)	-

Education wise female literacy is very less, 56%. Most of them do not know even alphabet, for males it is 18%. However 43.88 % of females had joined classes from 2-5. Graduated males were only 8%. No females were found to be graduated and only 7% of them had education upto SLC.

Table 5: Based on the type of Family

Single	84	46.66%
Joint	96	53.36%

Most of the cases belonged to joint families where they had burden of whole house and also the field.

Table 6: Based on the marriage

< 19 yrs	120	66.66%
20 & more	60	33.33%

In Nepal, majority of women are married at an early age i.e. during adolescence 66.66% and the earliest age of marriage was ...

Table 7: Based on parity

<2	**8**	**4.44%**
2-4	58	32.33%
5-7	103	57.22%
8 & more	11	6.11%

This shows the corelation between parity & prolapse.

Table 8: Based on birth spacing

<2 yrs	55	30.55%
>2 yrs	125	69.44%

Table 9: Based on rest during puerperium

None	40	22.22%
Few days (upto 10 days)	87	48.33%
More than 1 month	58	32.22%

This shows that more than 52% of women are at work after few days of rest. 22% of women go for household & outside a field after rest of only 2-3 days. About only 1/3rd of women get rest for about 1 month during puerperium.

Table 10: Based on smoking habits & use of alcohol in women

	SMOKING	ALCOHOL
YES	31(17.22%)	42(23.36%)
NO	149 (82.77%)	138(76.66%)

This table shows that small percentage of our women is indulged with smoking and drinking habits. In the very rural areas I have noted that the *tamang* community men and woman are very much indulged with alcohol taking and also cigarette or *bidi* smoking.

Table 11: Based on family planning awareness

YES	56	(31.11%)
NO	124	(68.88%)

Only few people knew about family planning & its methods.

Table 12: Based on family planning methods

YES	39	(21.7%)
NO	141	(78.33%)

Only small percentage of women used family planning methods.

Table 13: Based on choice of family planning methods

Injectables	14
Pills	10
IUD	5
Permanent sterilization	4
Condom	3
Norplant	3

Most popularly method used was Injectables.

Table 14: Based on family history of UVP

YES	24	(13.33%)
NO	156	(86.66%)

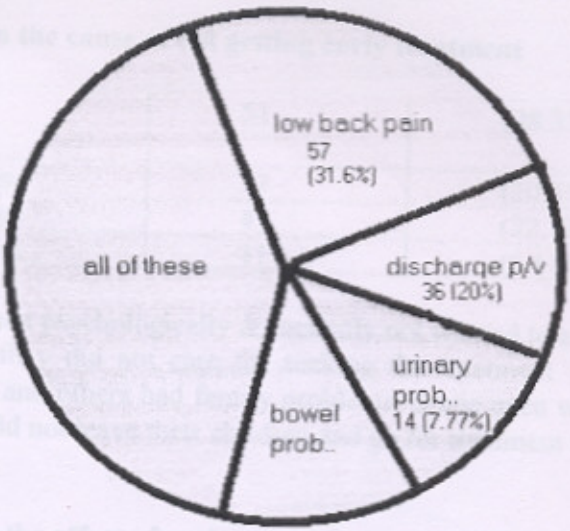
About 13% of women had family history of UVP in their near relatives of mother, sisters elder or younger.

Table 15: Prolapse associated with medical problems

Chronic cough	10
Asthma	10
H/o hypertension	8
H/odia betes mellitus	4

These were few associated medical problems.

Table 16: Based on main complaint of the patient.



Lowback pain	57	31.66%
Discha rgeper vaginum	36	20%
Urinary problem	14	7.77%
Bowel problem	14	7.77%
All of these	59	32.77%

Women with huge Cystocoele complained that they have to push the Cystocoele or the prolapsed uterus within the vagina then only they were able to pass urine. Similarly some of them said that before passing the stool they have to push the prolapse.

Table 17: Based on traditional treatment used

YES	58	(32%)
NO	12	(67%)

These women have gone to Dhami, Jhakri & where not. Some of them seeked primary health care centre or the health post and got themselves ring pessary. These women used heat therapy, pelvic exercises, and some herbal medicines during post natal period.

Table 18: Based on the cause of not getting early treatment

Shyness	51	(28.33%)
Monetary problems	37	(20.55%)
Unawareness	41	(22.77%)
Household problems	11	(6.11%)

Most of these women psychologically & mentally not wanted to expose their problem so due to shyness they did not care for seeking the treatment. Some of them had monetary problems and others had family problems. Some even went to the extent of telling that they could not leave their children and go for treatment so far off.

Table 19: Based on the effect of prolapse on their ability of women activity

Sexual life (Unsatisfactory)	66	(36.66%)
Physical work (Hindrance)	78	(43.3%)
Psychological (UnhappyFamily life)	24	(13%)
Social problems(II marriage, multiple part., threaten to wife, physical assault)	12	(6.66%)

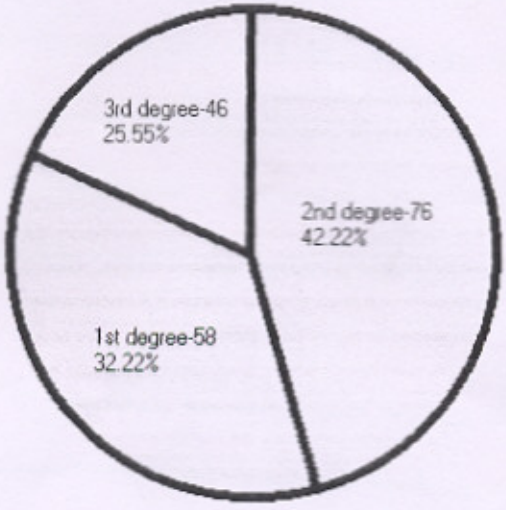
36.66% of women were actually suffering mentally from their husband's activity such as not satisfied wives were beaten up by them this actually created other problems like remarriage by husband 2 or more wives. Psychologically women feel neglected, lonely, feeling of insecurity and then depressed. 24 of them i.e. (13%) felt depressed. One woman (30 yr. old) with c/o husband was humiliating her by having sex with another woman who was her own cousin sister, in front of her.

43% of women c/o difficulty in doing daily routine work like bringing grasses from the field, bringing wood from forest and also bring water on their back 10-20 litres 2-3 times a day for a distance 1/2 - 1 hour. Some of them felt neglected by their friends, neighbours, mother in-laws and some from their steps.

Table 20: Based on type of UVP

1st degree (32.22%)	(w Cystocele ++ & Rectocele +)	58
2nd degree (42.22%)	(w Cystocele +++ & Rectocele ++)	76
Procedentia (25.55%)		46

Table 21: Based on the type of delivery



Normal	96 (53.33%)	
Abnormal	84 (46.66%)	
	LSCS	7
	Breech	34
	Vacuum	3
	Prematurity	36
	Twins delivery	4

Table 22: Based on the place of delivery

Home	107 (59.44%)
Hospital	62
Health post	6
On the way	5

Table 23: Based on the type of labour

...

Limitations of the Study

- Due to limitation of time, large sample could not be taken
- No research in UVP was found in Nepal except a few and literature was not enough
- Most of the cases delivered at home couldn't express the duration of labour pain
- In this study, there were many multiparous women who had one or two delivery at home and others in the hospital or health care centers.

Conclusion

Since majority of women reside in remote and far remote areas, who are poor, mostly engage themselves with agricultural work the whole day, illiterate, over-worked, they have no rest during the puerperal period.

Most of the prolapse cases attend to hospital at a older age seeking treatment. Higher incidence of prolapse was found in the patients who had home deliveries, attended by untrained personnel.

Another risk factor in this study was found that, women with chronically ill health, superimposed with chronic cough, dysentery and diarrhoea were at a high risk for this problem. Primi gravida, multi and grand multipara were having this trouble. It was also observed that in precipate labour cases, most of them were suffering from UVP during postnatal period while carrying heavy weight or working in the field.

The author experiences two cases of procedentia in camp in Nuakot. A 28-year-old woman with three children was suffering from III^0 where whole uterus was outside.Another case was 32-year-old woman in Sindhuli camp having similar problem. In both of these cases, uterus had to be removed.

Recommendation

Preventive measures, which can be advocated in the community level, are:

- Planned family – only 2 children and no more should be advised and use of different family planning methods
- Birth spacing – at least a gap of 2-3 years minimum should be advised
- Proper antenatal checkup should be promoted
- Proper preparation for labour and delivery
- Encourage hospital deliveries
- Trained birth-attendants should be available for home deliveries
- Proper puerperal rest at least for 6 weeks should be mandatory
- Proper nutrition and correction of anaemia for each pregnant and parturient cases by creating awareness in the family and community about nutritious food for girls, today's adolescent future mothers
- Pereneal exercises during puerperium
- Encourage to take nutritious food and keep physically healthy
- Prevention of prolonged labour by conducting deliveries by skilled manpower
- Avoidance of heavy loads and strenuous work during post natal period
- Proper lifting of heavy weight in proper position (male partner has to help her)
- Avoid tight abdominal binders (*patuka*) just after delivery
- Pelvic floor exercises during puerperium
- Discourage cigarette smoking and avoid constipation by changing food habits
- Early treatment of chronic dysentery and diarrhoea
- Local application of estrogen cream after menopause
- Rubber ring pessary may be the treatment for conservative management which can be instituted by grass root health workers
- Referral of the patient for surgery when there is symptom of prolapse which is hampering her in her routine work

ANNEXURE

Acknowledgment

First of all, I am thankful to Dr. Bimala Lakhey Director of Maternity hospital for her encouragement in doing this research.

I would like to thank the Research Committee for providing me grant in doing this research.

I would like to thank all research team for their endeavor for making this study success.

Finally – I extend my thank to Mrs. Jaya Poudyal & Ms. Gyanu Rana for kind help and for computer work.

Abbreviations

PI	–	Principal Investigator
Co-PI	–	Co - Principal Investigator
ANC	–	Antenatal Clinic
OPD	–	Out Patient Department
GOPD	–	Gynae Out Patient Department
IEC	–	Information, Education & Communication
UVP	–	Utero Vaginal Prolapse
POP	–	Pelvic Organ Prolapse
STI	–	Sexually Transmitted Infections
FGD	–	Focal Group Discussions
UTI	–	Urinary Tract Infection
WHO	–	World Health Organization
SCF	–	Save the Children Fund
HMG	–	His Majesty's Government
FHD	–	Family Health Division
LCB	–	Last Child Birth
TBA	–	Trained Birth Attendant (Sudeni in Nepal)
G...P	–	Gravida ,Para
MOH	–	Ministry of Health
GTZ	–	German Technical Assistance
UNFPA	–	United Nations Family Planning Association
US	–	United States

Operational Definitions

Paramedics	-	Medical person who is involved in medical care .
LCB	-	Youngest born child .
TBA	-	The woman who is trained for delivery
Wk Of Gestation	-	Pregnancy counted in weeks
Gravida	-	How many times the woman was pregnant
Para	-	How many times the women had delivered a child
Rubber Ring Pessary	-	A round ring which is kept inside vagina in order to keep the prolapsed organ in place

Ethical Consideration

Consent Form

I ..... am ready to participate in the above mentioned study. I am providing correct information to my knowledge. I have been explained about the study and understand it fully. I am providing this consent voluntarily.

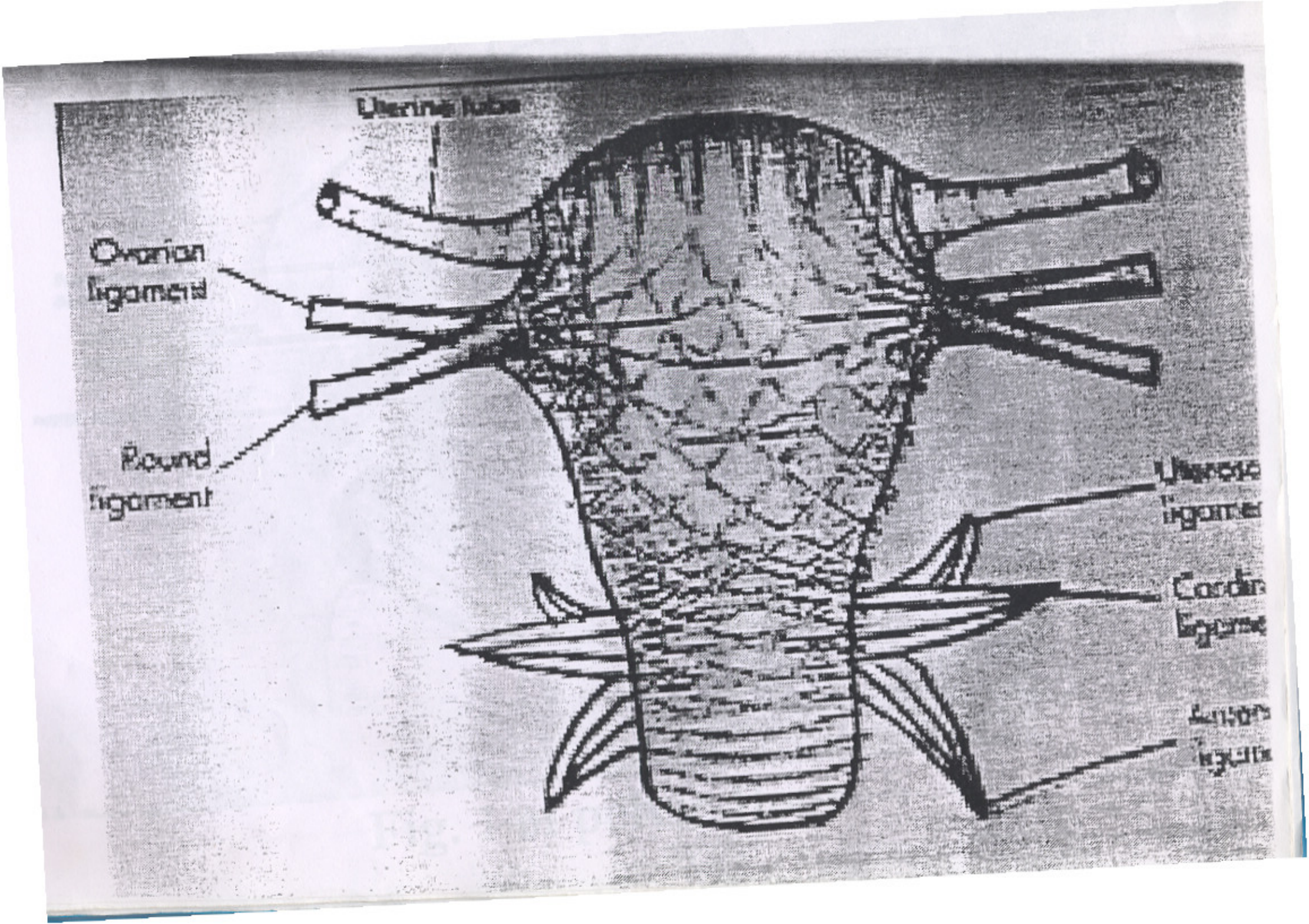
Signature

Thumbprint

Name

Address

Date


Uterine tube
Ovarian ligament
Round ligament

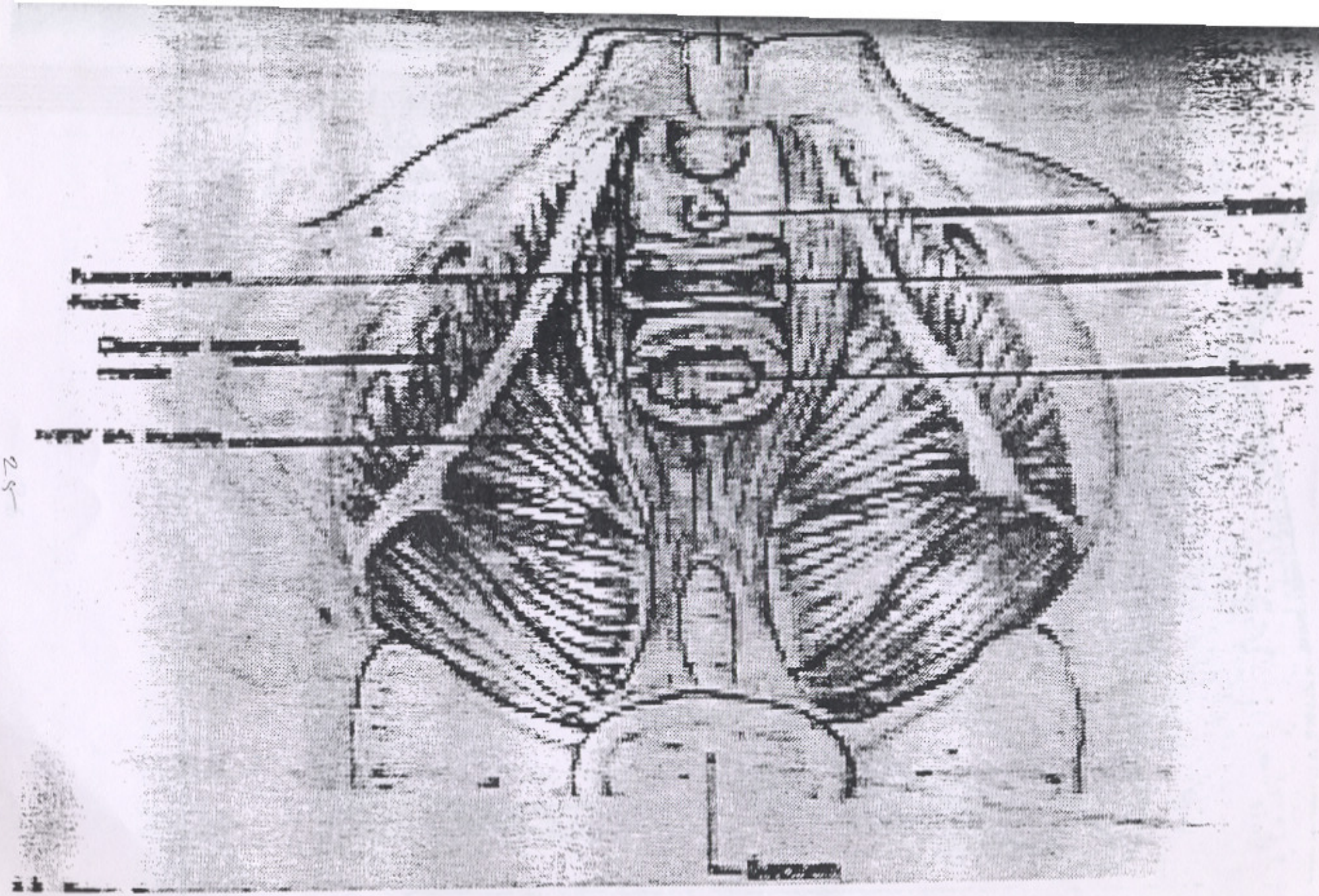


Fig. 1 of pelvic floor

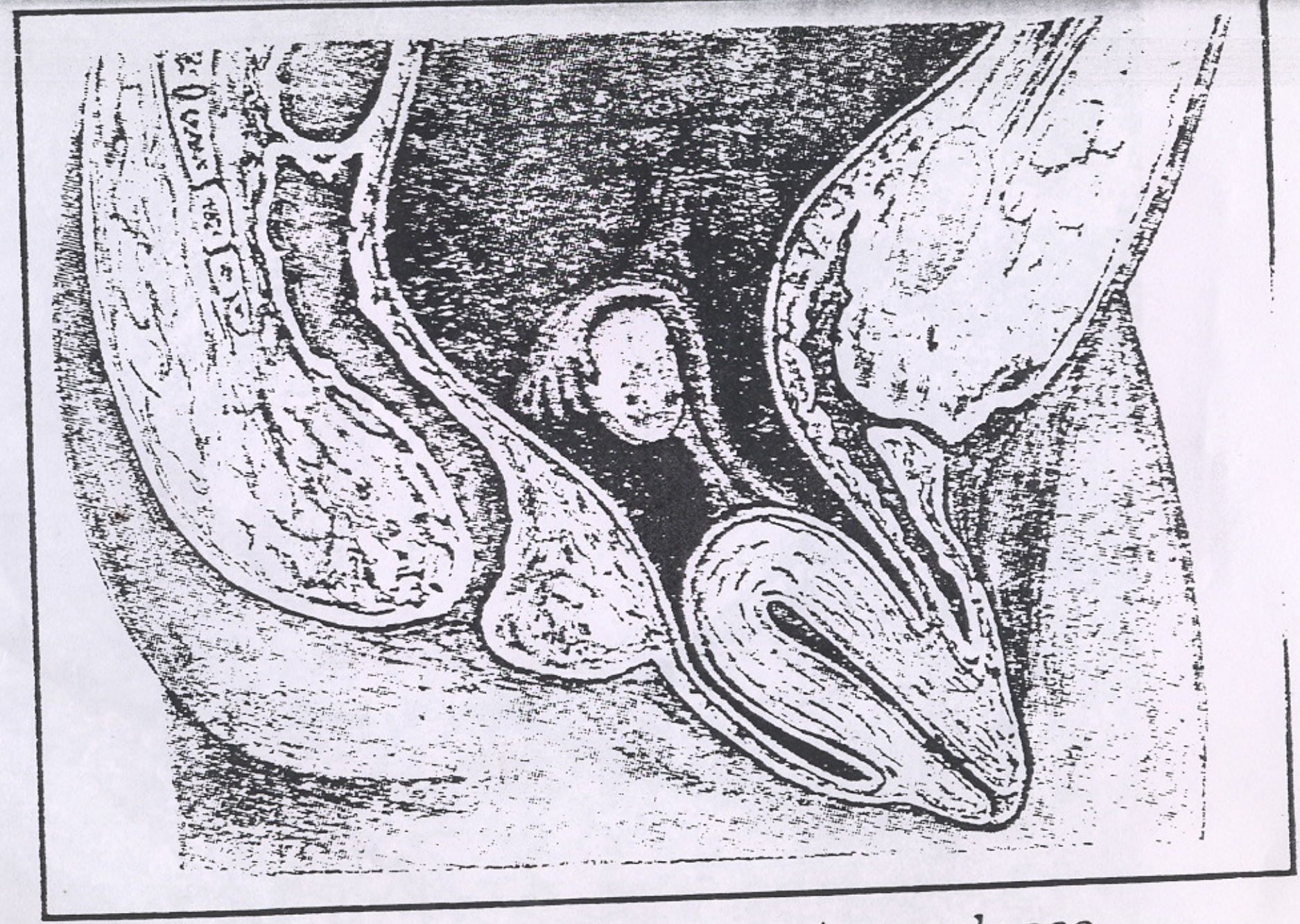


Fig.14.8. Third degree uterine prolapse

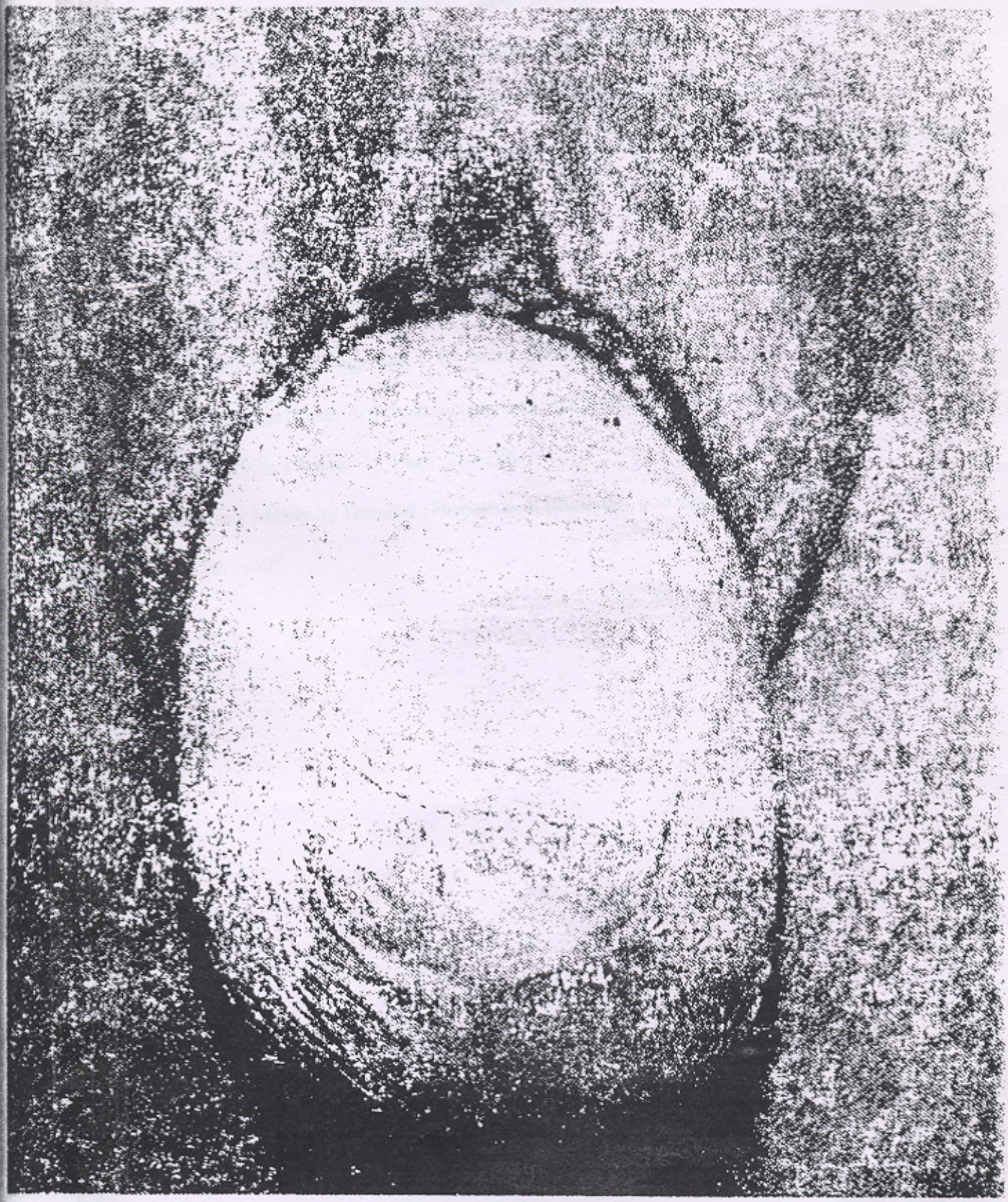


Fig.14.7. Second degree uterine prolapse. Cervix hypertrophied and there is decubitus ulcer.

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Interview Questions

Name
Age
Address
Education Husband
Wife

Height
Weight

Occupation Husband
wife

Age at marriage
Parity
Birth spacing
Duration of prolapse
Type of family
Last childbirth
Age at which prolapse noticed

Labour normal
abnormal-specify

Place of delivery home
Hospital

Type of delivery normal
abnormal- specify

Who attended the delivery none
Untrained person
Trained person

Puerperium

Rest how long
- none
- Few days
- puerperium

Prolapse
- how long after childbirth
- After how many childbirth

Associated medical problems

Chronic cough
Asthma
Hypertension
Diabetes
Tuberculosis
Others

Smoking yes, if yes –how long
How many per day
No

Alcohol yes, if yes daily /occasionally
No

Family planning yes if yes, type
No

Family planning awareness yes
No

Family h/o prolapse

yes
No

Any complains

-low back pain
-Something coming out PV
-Discharge PV
-Bleeding PV
-Urinary problems
-Bowel problem
-Others

Effects

-sexual life
-Physical work
-Psychological effects
-Social problems
-Others

Why not early treatment

-shyness
-Money problems
-Unawareness about treatment
-Familial problems
- Unavailability of the services Yes
No
-Others

Reasons for coming now

-increased severity
-Referred
-Self

Any treatment before

-traditional healer
-Ring pesky
-Medication
-Pelvic exercise
-Earlier operation

Examination & Dx

- I°
-II°
- III°
-procedentia

-cystocele	+	++	+++		
-Rectocele			+	++	+++
-enterocele	+	++	+++		
-Urethrocele	+	++	+++		

-Others

Final Dx -