Indira Gandhi
National Open University
School of Health Sciences

MME-102
Reproductive Health

Block

5
GYNAECOLOGICAL DISORDERS

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BLOCK INTRODUCTION

In the Indian society, a woman has to play multiple roles. Starting from mothering the children, sharing the economic responsibility to taking care of all family members is a routine activity for her. Thus her presence is indispensable for day to day running of the family. In such a situation of bearing the brunt of whole social burden, she tends to neglect her health and become vulnerable for morbidities and mortality.

In such a situation, you as a doctor in the society have a unique role to come to her rescue. Not only can she get advice during her maternity, she can hope to get gynaecological care at her doorstop. In the previous blocks, you have already learnt about the care of women during pregnancy and childbirth. This block deals with the common gynaecological issues.

There are five units in this block. Unit 19 deals with the gynaecological problems that are frequently encountered with. The adolescent gynaecological problems have been dealt in Unit 20. Infertility and RTI are dealt in Unit 21 and 22 respectively. The menopausal problems are dealt separately in Unit 23.

After going through this block, you should be in a position to manage most of the common gynaecological problems in a community set up. This will not only make the gynaecological care accessible at doorstep, but also the women may find it as affordable as they would be able to take care of their family members while being treated for their morbidity.

UNIT 19 COMMON GYNAECOLOGICAL PROBLEMS

Structure

19.0 OBJECTIVES

After completing this unit, you will be able to:

- describe the various problems which the women have in the reproductive life;
- diagnose the exact cause leading to any of the above specific problem;
- discuss the predisposing factors for each condition;
- change your own practice and prevent these problems to a certain extent;
- promote preventive measures.by giving correct counselling to women and their family and also imparting this information to the other medical and paramedical staff working with you; and
- identify women needing specialized treatment and refer them to appropriate centres.

19.1 INTRODUCTION

To have a healthy mother and subsequently a healthy child, it is of paramount importance that all problems in women during their reproductive life which cause morbidity are taken

care of. In this unit you will learn about gynaecological problems commonly seen by you in your day-to-day practice.

The commonest problem is vaginal discharge following by menstrual irregularities. Other common problems are dysmenorrhoea, backache and prolapse of uterus. All these cause general ill health of mother and disable her from looking after her family and also affect the future child bearing in her.

There are multiple diverse causes leading to these problems and most of these are pregnancy related. If you identify the correct reason as to how the problem has occurred and take appropriate precautions during pregnancy, during and after child birth or abortion you can prevent these problems. Correct diagnosis and appropriate management is, therefore, very important to improve the general health of the women and also to prevent complications due to these conditions during further child bearing.

19.2 VAGINAL DISCHARGE

This is the commonest symptom with which the women in reproductive age group come for consultation. The term used by them is “leucorrhoea” which actually means excess white discharge, but when they come complaining of leucorrhoea, the discharge may not always be white. It may be frothy, curdy white, blood stained, mucopurulent or purulent. The discharge which is abnormal, causes symptoms like itching and irritation of vulva, irritation and burning of vagina and dyspareunia. It also stains undergarments. You should always investigate abnormal discharge and find out the cause, then only you can give the right treatment.

You must remember that normally excess discharge does occur during midcycle and before periods, it causes no symptoms, and is normal in character and needs no treatment. You only need to reassure the woman that there is nothing wrong with her. You will observe that sometimes the women come complaining of excess vaginal discharge, but there is nothing abnormal detected. In these women you should take a detailed history, may be they suffer from infertility, dyspareunia or some sexual problems which they hesitate to tell unless specifically asked for, and they find the complaint of leucorrhoea a pretext to come for medical advice.

Please refer to Unit 22 for more about discharge.

19.2.1 Causes

a) **Infections of vagina and cervix:** In majority of women the abnormal vaginal discharge is due to infection of vagina and cervix. The commonest being bacterial vaginosis followed by infection due to Trichomonas vaginalis and Candida albicantis. Mixed bacterial infection is due to Gardnerella, Haemophilus influenzae, Gonococci and other gram positive and negative organisms. Infection of cervix following child birth and abortion may result in vaginal discharge which is very common.

   The infections like Gonococcal, Chlamydia or Trichomonal may be transmitted sexually. Bacterial infections may occur after delivery or abortion, if adequate aseptic precautions are not taken specially if the delivery is instrumental or aided by manipulations or if the person conducting the delivery harbours any infection. Infection also occur due to poor genital hygiene particularly during menstruation. Candida infection is predisposed during pregnancy and also if the patient is diabetic or has been on antibiotics or contieosteroids for prolonged period.

   Other specific infections of cervix like tuberculosis or amoebiasis are rare but may be seen in our country.

b) **Cervical erosion, cervical polyp or carcinoma cervix** may be responsible for abnormal discharge. In that case it may be blood stained or mucopurulent.

c) **Pelvic inflammatory disease, fibromyoma uterus, endometriosis, other pelvic tumours, a prolapse uterus, excessive sexual activity and sedentary habits** may cause pelvic congestion and thus cause excess secretion from the cervical and endometrial glands. Excess discharge in fibromyoma and adenomyosis of uterus is also due to increased endometrial surface.

General condition like debility, anaemia, anxiety state or emotional or psychological upset and oral hormonal contraceptive pills may cause excess discharge.

d) **After cryotherapy of cervix,** there may be a heavy vaginal discharge for 4-5 weeks.

e) **Chronic constipation which also causes pelvic congestion may be associated with excessive vaginal discharge.**

f) IUCD thread may cause infection of the cervix and uterus and may be responsible for vaginal discharge.

19.2.2 Management

Inspection of the discharge and speculum and pelvic examination will give you a fair idea of the probable cause of abnormal discharge.

Purulent discharge indicates acute bacterial infection including gonococcal infection. This purulent discharge may be seen at the urethral meatus and the cervical os. Vagina and cervix will appear angry red. Microscopic examination of pus smear after Gram staining will give an idea of the causative organism. Gonococci are seen as intracellular cocci. Vaginal epithelial cells heavily coated with bacilli "Clue" cells are seen in bacterial vaginosis and the discharge has fishy odour. The pus discharge can be sent for culture if facilities exist, for typing the organism and finding out the sensitivity to the different antibiotics. If this facility is not available you should treat these women with systemic antibiotics effective against both gram negative and positive organisms.

A combination of Norfloxacin 400 mg twice daily, Doxycycline 100 mg twice daily metronidazode 400 thrice daily for 1 week will take care of all organisms including trichomonas vaginalis and anaerobic bacteria.

Mucopurulent discharge is usually seen in chronic cervicitis, including that due to Chlamydia Trachomatis, infected erosion, and cervical polyp. It is difficult to isolate chlamydia. Special tests for antigen and antibody are required for the diagnosis. Chronic cervicitis and infected erosion are managed by local antiseptic or antibiotic pessaries. Long acting Tetracycline (Doxycycline 100 mg twice daily) for 3 weeks is the antibiotic of choice for treating chlamydia infection. If cervicitis and cervical erosion persist you should either do cryosurgery or cauterization and if the facility is not available you should refer the patient to the hospital with this facility. Cryosurgery has better results than electro cauterization.

Thin frothy or greenish or blood stained discharge is seen in Trichomonas Vaginalis infection. Cervix and vagina show patchy congestion (Strawberry cervix and vagina). Scratch marks may be seen in colour due to severe pruritus. Wet smear examination is described in the practical module. The wet smear (a drop of discharge mixed with a drop of saline) covered with a cover slip and examined under microscope will show Trichomonas Vaginalis, characterized by its shape and movements of flagella. 50-60% of cases can be diagnosed by this simple test. The standard treatment is Metronidazole 400 mg three times a day for 7 days. Lately Tinidazole 2 gm single dose or Secnidazole 2 gm single dose at bed time have been used with better tolerance and almost same results. Metronidazole is better avoided during first 20 weeks of pregnancy. Tinidazole vaginal pessary can be used instead. You must treat both partners at the same time otherwise recurrence will take place.

Thick curdy white discharge is almost diagnostic of Candida infection. It is usually stuck to the vaginal rugae and cervical mucosa and when removed leaves a red raw area. Wet smear with a drop of 10% KoH solution will show Candida hyphae or buds. Local Miconazole or Clotrimazole are more effective than Nystatin. These are used as pessaries for 6 nights. The creams are also available and can be used for vulval application and also

by male partners. For persistant or recurrent cases oral Ketoconazole 200-400 mg daily is given for 5 days. It is not used in pregnancy. Lately, Fluconazole 150 mg single dose has been given and is found effective with lesser side effects. The old standard method of treatment with application of 1% Gention Violet is messy as it stains clothes and occasionally causes local oedema. But it is very cheap. You can use it in resistant cases.

Blood stained discharge is almost always due to some pathological condition like carcinoma cervix, cervical or endometrial polyp, big cervical erosion or cervical ulceration. Some times it may occur in trichomanal vaginitis or after vaginal or perineal trauma. Speculum examination will be very helpful. It will show you if there is any cervical erosion, carcinoma, polyp or fibromyoma, or any vaginal lesion. These lesions require specific treatment. You can twist off small polyps with a sponge holding forceps. You must take a smear from cervix if it is abnormal and send it for cytology examination (Pap test).

Excessive discharge with normal characteristics is most often associated with conditions causing increased pelvic congestion or increased endometrial surface. You will be able to make out uterine enlargement due to fibromyoma or adenomyosis or any ovarian tumour on bimanual examination. Tender uterus or adnexa or palpation of adnexal mass or restriction of mobility of either pelvic organs will be indicative of pelvic inflammatory disease or endometriosis. In the absence of any pelvic pathology you must look for general disorders mentioned under causes, treat them and reassure the patient.

It is very important that in all cases of genital infections you must treat both husband and wife for lasting cure unless the infection is post abortal or peurperal.

19.2.3 When and Where to Refer

You should refer the patient to specialists if they have

a) uterine or ovarian tumours,

b) adnexal masses,

c) recurrent episodes of abnormal vaginal discharge inspite of treatment of both partners,

d) bleeding cervix inspite of treatment with local pessaries,

e) large cervical polyps which you cannot remove, and

f) cancer cervix.

All women suspected to have cancer cervix or ovarian malignancy should be referred to cancer centres where all facilities to treat cancer patients are available. The remaining should be referred to a district level hospital with facility to do investigations like special cultures, cytology, histopathology and major gynaecological surgery.

Check Your Progress 1

1) Fill in the blanks:

   a) Women with ..... need only assurance.

   b) Strawberry cervix is seen in .....

   c) Wet smear is useful for the diagnosis of .....

   d) The first line treatment for Chlamydia infection is .....

   e) Pap smear is a must in .....

2) Write short notes on:

   a) Clue cells

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b) Causes of excessive vaginal discharge

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c) Role of speculum examination in women with abnormal vaginal discharge

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19.3 MENSTRUAL IRREGULARITIES

Menstrual irregularities vary from complete absence of periods ***(amenorrhoea) to menometrorrhagia*** (heavy with inter-menstrual bleeding). Other irregularities are ***oligomenorrhoea*** (menstrual cycle of 45 days or more), ***hypomenorrhoea*** (less blood loss during menstruation), ***polymenorrhoea*** (menstrual cycle of less than 21 days), ***menorrhagia*** (excess blood loss during periods, either the bleeding continues for a long time and the flow is normal or the duration of bleeding is normal but the flow is excessive with passage of clots) and, ***metrorrhagia*** (intermenstrual bleeding). It is vital that you remember that the irregularity is only a symptom and not a disease. The underlying cause may be different in different women for the same type of irregularity. Hence the need for the diagnosis of underlying disease, so that you can successfully treat the symptoms. Before going into further details, it is better that you revise the mechanism and control of normal menstrual cycle. Disturbance in the normal ovulatory cycle may lead to menstrual disturbance and also may result in infertility and abortion. Besides hormonal disturbance menstrual irregularity may also result from pathological conditions like fibromyoma uterus, adenomyosis and cervical lesions which will be described below. Early treatment of these lesions causing heavy blood loss will be helpful in prevention of anaemia and maintenance of good health. The commonest type of menstrual irregularity is menorrhagia which will be discussed first.

19.3.1 Menorrhagia

It is a disturbance which is subjective hence it is important to assess the actual blood loss. Best way to assess is to ask her the total number of pads she used before and the number of pads she is using now and whether she is passing big clots. The degree of anaemia will also indicate whether she is having excessive blood loss. Most common cause of menorrhagia is:

Dysfunctional uterine bleeping which is due to disturbance in the hypothalamo-pituitary-ovarian axis. On examination no pelvic pathology is detected. There is imbalance of the ovarian hormones. Either there is no ovulation or if ovulation occurs there is inadequate corpus luteum function or persistance of corpus luteum. Thus there is either unopposed oestrogenic activity or there is imbalance between oestrogen and progesterone levels. Endometrial bleeding is controlled by prostaglandins which in turn are influenced by ovarian hormones. Relative decrease of PGF_2 alpha and increase in PGE_2 and PGI will cause increase in the endometrial bleeding. In anovulatory cycles, the bleeding is usually excessive and prolonged whereas in corpus luteum dysfunction (inadequate or persistant function), the bleeding is usually prolonged, most often in the form of premenstrual spotting or continuation of slight bleeding every day after a normal period.

Metropathia haemorrhagica or cystic glandular hyperplasia is an anovulatory type of dysfunctional bleeding. There is a period of 6-8 weeks amenorrhoea followed by prolonged bleeding. The endometrium continues to grow under the influence of oestrogen, a time comes when the circulating level of oestrogen is not adequate to maintain further growth of the endometrium which starts shedding and the bleeding starts. It is heavy and continues for prolonged period. Sometimes it stops only after the hormonal or surgical treatment. The patient becomes anaemic, pelvic examination shows a bulky uterus which may be of 6-8 weeks size pregnant uterus. This condition can be mistaken for abortion unless careful history is taken. History of symptoms of early

pregnancy and associated pain are suggestive of abortion. Endometrium resembles “Swiss Cheese” appearance and has characteristic histopathology showing cystic dilation of glands, hence the name cystic glandular hyperplasia. Whenever this condition is suspected dilatation and curettage is done and the tissue is sent for histopathological examination. Besides being diagnostic, curattage may be curative and the bleeding may stop. A positive pregnancy test will be diagnostic of threatened abortion. An ultrasound examination if possible can easily distinguish metropathia haemorrhagica from incomplete abortion.

Management of dysfunctional uterine bleeding is mainly hormonal, but in women in late thirties or early forties a premenstrual endometrial curettage or aspiration must be done. Histopathology may be proliferative, cystic glandular hyperplasia; adenomatous hyperplasia with or without atypia, secretory and irregular or mixed type of endometrium. Women with proliferative endometrium or mixed endometrium are treated with progestogens like any nortestosterone derivative e.g. Prorimolut N, Regesterone or Orgametril given orally from day 16th to 25th of each cycle for 3 cycles and if there is response, the treatment is done continued to another 3 months.

In women with endometrial hyperplasia of any type you give Medroxyprogesterone 10-20 mg daily from 16th to 25th day for 3-6 months. They need a review and a repeat endometrial study. You must follow these women specially with adenomatous hyperplasia with atypia even after successful treatment is done.

Women with secretory endometrium respond better to combination pills from 5th to 25th day of cycle for 3-6 months. You must always supplement the hormonal treatment with iron therapy to improve her anaemia. Haemostatic drugs may also be helpful.

Besides hormonal therapy you can try antiprostaglandin drug mefenamic acid (Meftal) which is effective in some cases. If there is no response at all you can consider Danazole (antiestrogenic and antigonadotrophic) or GnRH therapy or you can refer her for hysterectormy or hysteroscopic evaluation and specialized treatment like transcervical resection of endometrium.

If patient has menorrhagia following delivery or abortion or expulsion of vesicular mole you must investigate her to exclude choriocarcinoma which is rare but a fatal disease if not treated in time.

Other causes of menorrhagia include:

a) genital lesions like fibromyoma, adenomyosis, endometriosis and endometrial carcinoma

b) pelvic inflammatory disease

c) intra-uterine device in situ

d) injudicious use of hormones

e) psychological disturbance

f) general diseases like thyroid dysfunction and anaemia

g) rarely blood diseases like leukaemia, thrombocytopenic purpura and hereditary capillary fragility.

All these cases will require specific treatment which either you treat or refer these women to the specialists.

19.3.2 Polymenorrhoea

It can occur at any age. It may occur in isolation or in association with menorrhagia. It is due to ovarian function disturbance and mostly occur after abortion and child birth. It may also occur due 10 pelvic inflammatory disease in which case it improves after

antibiotic treatment. If there is associated infertility problem then you treat her with drugs for induction of ovulation. If polymenorrhoea occurs in isolation and there is no fertility problem no treatment is required unless the patient is mentally disturbed or inconvenienced. You give combined hormonal pills from 5th to 25th day of cycle for 3 months. If it is associated with menorrhagia then you treat her as for menorrhagia.

19.3.3 Metrorrhagia

Metrorrhagia or the intermenstrual bleeding is mostly due to lesions of the genital tract. Some times there is slight bleeding at the time of ovulation that does not require any treatment. If the bleeding is post coital it may be due to cervical erosion, polyp or cancer, or due to fibromyomatous polyp arising from the uterus and protruding through the cervix or rarely from cancer vagina or trichomonas vaginitis. In these cases you must do speculum examination, and visualize the vagina and cervix, take smear for cytology and biopsy if there is any growth. The benign polyps with thin pedicle can be twisted off. Large fibromyomatus polyp requires polypectomy. Cervical erosion is best treated by cryosurgery. Cases of carcinoma cervix or vagina are referred to cancer centres.

19.3.4 Amenorrhoea

You will at times see women who come with amenorrhoea. Besides the pregnancy or lactation, there are other conditions responsible for amenorrhoea. You have to think of cystic glandular hyperplasia if the amenorrhoea is less than 3 months. Long periods of amenorrhoea may be due to tubercular endometritis which is quite common in our country specially in infertile women. Other endocrine disturbances like polycystic disease of ovary, hyperprolactenemia, thyroid dysfunction, and adrenal hyperplasia may occasionally cause amenorrhoea. Milk discharge from nipple (galactorrhoea) suggests hyperprolactenemia. Anorexia nervosa sometimes occurs in younger woman, she rejects food, looses weight and stops having periods. Male hormone producing tumours may also cause amenorrhoa.

You must take an endometrial biopsy in all married women with amenorrhoea of more than 3 months who are not pregnant to exclude tubercular endometritis. If it is negative and if there is any suggestive feature of endocrine disturbance, you refer her to endocrinologists.

If you do not find any cause, you must inquire regarding any psychological or emotional stress or anxiety or any change of environment. Usually women with these disturbances get all right as soon as this phase is over. Sometimes women on oral contraceptive pills also develop amenorrhoea which spontaneously reverts itself after variable time period after stopping the pills. Any severe general illness may also cause amenorrhoea. All these women need reassurance.

Treatment

If there is no obvious pathology and you suspect pituitary-ovarian disturbance, you give progestogen 10 mg twice daily for 10 days. Withdrawal bleeding after a couple of days after stopping progestrogen will indicate: presence of endogenous oestrogen. If there is no withdrawal bleeding it means that either there is end organ failure or there is deficiency of endogenous oestrogens. You should then prescribe sequential oestrogen and progestogen. Failure of withdrawal bleeding will indicate end organ failure, these women you must refer to senior specialists for hysteroscopy and further management. You must refer all women who do not revert back with 3 cycles of progestogen therapy for specialized investigations like serum, FSH/LH and prolactin to rule out premature ovarian failure or hyperprolactenemia.

Check Your Progress 2

1) Fill in the blanks:

   a) Serum Prolactin assay is indicated in women .....

b) Polymenorrhoea is when the menstrual cycle is .....

c) Dysfunctional bleeding in young women is best treated by .....

d) Menstrual cycle is controlled by .....

e) Cervical polyp can cause symptom of .....

2) Write short notes on:

a) Cystic glandular hyperplasia

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b) Causes of secondary amenorrhoea

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19.4 DYSMENORRHOEA

You will find two distinct types of clinical pictures in women complaining of painful periods. It may be of congestive or spasmodic type.

19.4.1 Congestive Dysmenorrhoea

Congestive dysmenorrhoea is the more common type in interconceptional period. The pain usually starts about a week before the onset of menstruation and persists during menstruation. It may be dull ache or moderate or very severe in intensity, in the lower abdomen and back sometimes extending to the thighs. It is usually due to some pathological condition like pelvic inflammatory disease, fibromyoma uterus, adenomyosis or endometriosis, which cause pelvic congestion. In endometriosis it is worse and progressive. In submucus fibromyoma spasmodic type of pain may also be associated. Congestive dysmenorrhoea is usually associated with other symptoms like dyspareunia, menorrhagia or infertility. You will be able to arrive at the probable diagnosis by taking a careful history and doing a bimanual examination. You must prescribe antibiotics along with analgesics to women in whom you suspect pelvic inflammatory disease. If they do not respond or have fibromyoma or adenomyosis, you must refer them for investigations and treatment. If endometriosis is diagnosed, you treat her with Danazol 200 mg to 800 mg daily in divided doses for 6-9 months. If patient can not take Danazol, you can give her progestogen 10 mg daily in divided doses and gradually increasing up to 30 mg/24 hrs. for 6-9 months.

19.4.2 Spasmodic Dysmenorrhoea

It usually occurs before child birth. The pain is spasmodic or colicky.in nature, in the hypogastrium and low back and sometimes radiating to thighs. It usually lasts for 1 or 2 days. It may be very severe impairing the daily activities. Sometimes there may be vomiting with pain. It is important that you find out the family background and if there is any emotional stress. Proper guidance, rest, relaxation, local heat and exercises or psychotherapy may help. You can prescribe analgesic drugs like aspirin, codeine,

dextropropoxyphene hydrochloride or acetaminophen along with anti prostaglandin drug like mefanamic acid 500 mg or indomethacin 50 mg three times a day till the pain lasts.

If the patient is not relieved you try ovulation suppression by prescribing combined hormonal pills from 5th to 25th day of cycle. This may be helpful.

Check Your Progress 3

1) Describe the clinical features differentiating spasmodic from congestive dysmenorrhoea.

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2) How will you treat a case of congestive dysmenorrhoea?

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19.5 BACKACHE

You will observe that backache is a common complaint in multiparous women and in most of them you do not find a gynaecological cause. A detailed history of the exact site, character and duration of pain and its antecedent factor will give you some idea of the cause. A chronic low backache specially arising after a pelvic intervention, child birth or abortion is likely to be of gynaecological origin. History suggestive of trauma, an operation in lithotomy position, spinal anaesthesia, urinary infection with acute onset will suggest a non-gynaecological cause. Again if there is an associated symptom, like menorrhagia, dysmenorrhoea or dyspareunia you must look for a gynaecological cause. In all women besides doing a pelvic and abdominal examination, you must examine the back, spine, sacro-iliac joints and pelvic bone for any deformity or tenderness.

19.5.1 Gynaecological Conditions

Gynaecological causes are:

a) **Prolapse of uterus:** It is a referred pain due to the stretch and pull on the uterosacral ligaments. It is less in the morning, gradually increases with standing and walking and is worse in the evening, gets relieved on lying down and resting.

b) **Retroverted uterus:** It is associated with pelvic inflammatory disease or endometriosis. Pain is due to involvement of uterosacral ligaments with the disease process, retroverted uterus as such does not cause back pain.

c) **Pelvic inflammatory disease:** The pain is due to increased pelvic congestion and is usually associated with congestive dysmenorrhoea, menorrhagia and increased vaginal discharge.

d) **After delivery:** Pain and tenderness over the coccygeal region is due to trauma to the sacrococcygeal joint and ligament. Low back pain may occur due to strain on the sacroiliac or lumbosacral joints if heavy work has been undertaken soon after delivery.

e) **Chronic cervicitics:** Chronic cervicitis may be associated with infection of uterosacral ligament which causes backache.

f) **Injudicious positioning:** Injudicious positioning of the patient in lithotomy position on the operating table may cause strain of muscles and ligaments and causing back pain.

g) **Advanced malignancy:** Advanced malignancy may also cause backache and sciatica like pain by involvement on pressure on the pelvic nerves.

Treatment

Pinpointing the exact cause is important. Analgesic and nonsteroidal anti-inflammatory drugs will bring symptomatic relief but unless the disease causing backache is treated it will not be a sustained relief.

If a retroverted uterus is thought to be a cause of backache, a pessary test is done. The retroverted uterus is corrected under general anaesthesia, and a Hodge's pessary is inserted. If the pain disappears, it indicates that the cause is due to retroverted uterus. You can then refer her for corrective surgery (ventrisuspension). If the pain is not relieved there is no point keeping the pessary in or operating. If you find an abnormal discharge, on pelvic tenderness or adnexal thickening, you must think of pelvic inflammatory disease. Give a full treatment for pelvic infections along with anti-inflammatory and analgesic drugs.

If you think of ligaments and muscle strain, then physiotherapy will be helpful.

Cases with prolapse uterus, endometriosis, and persistent cervical infection should be referred for advice and treatment to specialists where treatment facilities are available.

19.5.2 Non-gynaecological Conditions

Non-gynaecological causes include:

- subluxation of sacroiliac joints which are tender,
- muscle and ligamentous strain due to wrong position,
- disease of spine and intervertebral disc,
- trauma to coccyx,
- beumbomyositis of lumbar region,
- urinary infection, and
- psychological upset.

Besides the clinical examination mentioned before, it is advisable to do an X-ray of lumbosacral region and urine culture. This will be helpful in the diagnosis of any spinal disease or urinary infection respectively. Urinary infection is treated with antibiotics and those with spinal disease are referred to Orthopaedic surgeon.

Last of all you must remember that there may be no organic cause and the backache may be a manifestation of a psychological disturbance and besides symptomatic treatment psychotherapy will help.

Check Your Progress 4

1) Mention the examination or investigation required to detect the cause of backache.

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2) What are the differences in the character of backache in different gynaecological conditions ?

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19.6 UTEROVAGINAL PROLAPSE

You must revise pelvic anatomy before you start reading this section. Prolapse of uterus is descent from it's normal position in pelvis and is usually associated with descent of vaginal walls. You must have read that the main ligamentous supports are uterosacral, transcervical (Mackenrodt's) and pubocervical and the main muscle supports are Levator ani and perineal muscles as well as perineal body. Vagina is mainly supported by the fibrous sheath around it known as vaginal sheath. The anterior position of the uterus itself prevents descent of uterus as in that position it is at an angle to the axis of vagina.

There are two main types of prolapse: (a) Nulliparous in which there is congenital weakness of all supports with the result that the whole uterus with the vault descends. It is usually seen in young women, nulliparous or with one or two children or at menopause when deficiency of oestrogen precipitates already existing general weakness. (b) Acquired in which the lower supports i.e. perineal muscle and lower fibres of levator ani and the lower part of uterosacral and transcervical ligaments get damaged during the child birth, gradually dragging down the lower part and ultimately the whole of uterus. There is usually elongation of supravaginal portion of cervix. It is associated with anterior and posterior vaginal wall prolapse.

There are three degrees of prolapse: 1st degree when the cervix descends uptil introitus, 2nd degree when the cervix descends below the introitus and 3rd degree or procidentia when even the fundus of uterus is below the level of introitus.

19.6.1 Predisposing Factors

The most important predisposing factor is child birth. If the second stage of labour is prolonged and the presenting part remains in vagina for a long time, it over stretches and lacerate the vaginal sheath, damages the lower fibres of the uterosacral and transcervical ligaments and the muscles of the pelvic floor. If there is a big baby on a tight perineum, pelvic floor will get torn and if not properly repaired, it will cause weakness of pelvic floor muscles. If forceps are applied when cervix is not fully dilated, it would drag the cervix down along with the head damaging the supporting ligaments.

Other predisposing factors are inadequate puerperal rehabilitation, that is pregnancies in rapid succession when the tissues get exposed to softening effect and strain of pregnancy and child birth before they get back their tone. In addition if the patient gets chronic cough or increase in intra-abdominal pressure due to any cause like abdominal tumours, ascitis and even chronic constipation in which the patient has to strain to pass stool, will aggravate the prolapse if she has any.

19.6.2 Prevention

Most important preventive measure is the care which you can take during child birth and puerperium. Avoid prolonged second stage, take care to prevent perineal tear, give timely episiotomy to prevent overstretching of perineum, suture perineal tear and episiotomy meticulously. Give good perineal care to aid good healing, prevent sepsis and break through. You must encourage the patient to be ambulatory and breast feed the child. It will help involution of uterus. You must advice her to lie on her abdomen for some time every day to encourage antiversion of uterus. Counselling is done to use family planning methods to space and limit her family. Give treatment if there is any factor causing increase in intra-abdominal pressure.

19.6.3 Diagnosis

Earliest symptom which the patient has is dragging sensation in vagina associated with some discomfort. As the degree of prolapse increases she has difficulty in walking, develops backache which is worse towards the evening. Prolapsed cervix may develop a decubitus ulcer due to improper venous drainage and friction and may get infected. Patient may start having vaginal discharge which may be mucopurulent or blood stained. If she has a big cystocoele and rectocoele she may have difficulty in initiation of micturition or defaecation. She will give a typical history that she has to push in the prolapsed part and then only she can pass urine or stool. She may have a feeling of incomplete evacuation of bladder bowel.

In long standing prolapse the whole prolapsed tissue may get oedematous and congested and becomes irreducible, then she develops retention of urine and severe pain.

19.6.4 Treatment

In a young woman with 1st degree prolapse and a desire to have more children, you must teach perineal exercises and avoid surgery. Treat aggravating factors if present. This would to some extent prevent further descent and improve patient's symptoms. For a woman with 2nd or 3rd degree prolapse surgery is necessary. Procedure varies with the age, desire for further pregnancy and type and degree of prolapse. Before you refer her for surgery improve local condition of the tissues. Give glycerine acriflavin tampons or pack to keep the cervix in the vagina and help healing of decubitus ulcer. In post menopausal women local or systemic oestrogen will hasten healing. Treat urinary infection if there is any. If the woman has irreducible prolapse, admit her, raise the foot end of bed, cover the prolapsed tissue with gauze soaked in glycerine acriflavin till the oedema and congestion subsides, and then only reduce it under general anaesthesia. Do continuous bladder drainage if she has retention of urine.

If the patient is pregnant or if she is medically unfit for surgery, then give her a ring pessary and teach her pessary care. She should take daily vaginal douche with an antiseptic solution and get the pessary changed every three month.

19.6.5 Association with Pregnancy

During the first trimester of pregnancy, the degree of prolapse increases because the uterus becomes heavier and the pelvic tissues become soft and relaxed. As the pregnancy grows and uterus becomes an abdominal organ, cervix gets pulled up and prolapse gets reduced. During early labour if the patient starts pushing down early, cervix comes out, becomes oedematous and may have problem in dilating. In the first trimester if patient is uncomfortable you can give her ring pessary. The diameter of the pessary is measured by the index and middle fingers in the vagina as the distance between the posterior fornix and the inner margin of the lower border of symphysis pubis.

During labour you encourage her not to bear down prematurely, nurse the patient with foot end raised, cut short second stage of labour if necessary. Deliver the patient with forceps if she has a big cystocele which otherwise will come in the way of descending head.

Check Your Progress 5

1) a) Mention supports of uterus.

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b) What are the predisposing factors for prolapse of uterus?

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c) Write treatment of decubitus ulcer.

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2) Fill in the blanks:

a) Backache due to prolapse is maximum during ..... of the day.

b) 2nd degree prolapse is when cervix comes .....

c) Treatment of 2nd degree prolapse if felt necessary in 1st trimester ofpregnancy is .....

19.7 LET US SUM UP

In this unit you have learnt the common gynaecological problems seen in the interconceptional period and their relevance in MCH care. These are vaginal discharge, menstrual irregularities, dysmenorrhoea, backache and prolapse of uterus. You have read the significance of the different types of discharges. Abnormal discharge may be due to bacterial vaginosis; chlamydia trachomatis, trichomonas vaginalis, candida albicantis and gonococcal infection of cervix and vagina. Simple methods of diagnosis are speculum examination of cervix and vagina, inspection and wet smear examination of discharge and if possible gram staining of the vaginal discharge. You have learnt how to treat each type of infection.

The commonest cause of menstrual irregularity is dysfunctional uterine bleeding. Dilatation and curettage some times is curative. In others, combined hormone pills or oral progestogens are used to control excessive bleeding. A few cases may require specialized investigations and treatment, these should be referred to higher centres. Other bleeding irregularities are polymenorrhoea, metrorrhagia and amenorrhoea. These may be due to tumours, psychological upsets or other endocrine disorders. Most women with metrorrhagia and amenorrhoea require specialized investigations and treatment.

You have also learnt that there are two types of dysmenorrhoea with distinct clinical characteristics. The type commonly seen in interconceptional period is congestive dysmenorrhoea which is often due to some associated condition like pelvic infection, fibromyoma and endometriosis which require specific treatment. You have learnt that the backache is due to gynaecological as well as non-gynaecological conditions, and to a certain extent you can prevent backache due to gynaecological causes by taking care during delivery, puerperium, and vaginal operations, by proper counselling and physiotherapy. You have learnt the predisposing factors for prolapse uterus which is mostly due to child birth. You can give timely family planning advice. The treatment of prolapse in stage 2 and 3 is surgery, but very early cases can be treated conservatively. Those cases who are not suitable for surgical therapy are given ring pessary.

19.8 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) a) normal discharge during ovulatory and preovulatory phase

   b) trichomonas vaginalis infection

   c) trichomonal infection

   d) tetracyclines for 3 weeks

   e) cervical lesions bleeding on touch

2) a) vaginal epithelial cells coated with bacilli seen in bacterial vaginosis.

   b) — Vaginal and cervical infection due to bacteria, Trichomonas Monilia, Chlamydia. Rarely amoebic or Tuberculosis

   — Cervical cancer, cervical eorison, polyp, vaginal lesions, trauma to perineum and vagina

   — Pelvic congestion due to psychosexal causes, emotional upsets, pelvic tumours, infection and sometimes chronic constipation.

   — General causes, anaemia, debilitating condition, any illness.

   c) Diagnosis of vaginal and cervical lesions, identification of infection.

Check Your Progress 2

1) a) with galactorrhoea.

   b) less than 21 days.

   c) hormonal therapy.

   d) hypothalomo-pituitary-ovarian axis.

   e) metrorrhagia.

2) a) A type of dysfunctional bleeding, 6-8 weeks amenorrhoea followed by prolonged bleeding. Swiss cheese appearance for endometrium— Microscopically cystic dilatation of glands—Responds to progestogen therapy.

   b) T.B. endometritis, policystic ovaries, thyroid dysfunction, adrenal hyperplasia, hyperprolactenemia, psychological, sexual and emotional stress, severe illness, premature ovarian failure, male hormone producing tumour, anorexia nervosa, contraceptive pills (hormonal).

Check Your Progress 3

1) Congestive dysmenorrhoea

   — older women

   Spasmodic dysmenorrhoea

   — young women

— married	— Unmarried or nullipara
— may start after child birth or abortion	— relieved after child birth
— starts a week before and lasts during period	— 1st or 2nd day of period
— dull, discomfort, mild, moderate or severe pain almost continuous	— colicky pain may be severe
— usually due to some pathology	— no pathology, rarely submucus fibroid

2) Careful history and bimanual examination will be helpful in the correct diagnosis of the condition causing congestive dysmenorrhoea. The treatment will depend on the condition diagnosed. You give antibiotics and analgesics for pelvic infection, Danazol/Progestogens for endometriosis—Refer the cases not responding, or if they have prolapse uterus, fibroid, adenomyosis or ovarian tumour.

Check Your Progress 4

1) Examination — Speculum examination for cervicitis, Bimanual pelvic examination for prolapse and pelvic inflammatory disease, spine, Sacroiliac joints for any bony problem.

   Investigations — Urine culture, X-ray lumbosacral region, high vaginal swab for culture (if necessary).

2) Back plain due to pelvic inflammatory disease, more during premenstrual and menstrual period, in low back.

   Malignance — Sciatica like pain

   Cervicitis — low back pain

   Prolapse — pain increase towards evening, lying down and relieved by rest

Check Your Progress 5

1) a) Ligaments — uterosacral, transcervical and pubo-cervical

      Muscle — levaton ani, perineal

      Perineal body

      Anteverted position of uterus

   b) Child birth, Pregnancy in quick succession, early bearing down, forceps application in cervix not fully dilated, prolonged second stage, inadequate suturing of perineam tear or episiotomy, poor perineal care.

   c) Glycerin acriflavin tampons or packs daily with local or systemic oestrogen in menopausal women.

2) a) end

   b) out of introitus

   c) ring pessary

19.9 FURTHER READINGS

Bhargava, V.L. (ed.), *Text Book of Gynaecology*, Galgotia Publishers, New Delhi.

Padubidri, V. (ed.), *Shaw's Text Book of Gynaecology*, B.I. Churchil, New Delhi.