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LETTER TO THE EDITOR/EDİTÖRE MEKTUP

TO THE EDITOR

Uterine prolapse is the herniation of uterus into or through the vagina. In UK, the annual incidence of hospital admission with prolapse is 20.4/10000. Confirmed risk factors are older age higher parity, vaginal delivery, race, family history, obesity and constipation (1). Menopause, long second stage of labor, musculoskeletal disease, trauma, smoking and increased intra-abdominal pressure are possible risk factors (2,3). Common complaints and symptoms are feeling of a vaginal bulge and pressure, urinary or fecal incontinence, feeling of incomplete voiding or defecation, weak or prolonged urinary stream, dyspareunia and lack of sexual sensation (4,5).

A 74-year-old woman who was treated due to esophageal variceal bleeding in gastroenterology service was referred to our surgical department for her recurrent umbilical hernia. She was diagnosed with chronic liver disease fifteen years ago and had six vaginal deliveries. On physical examination, recurrent umbilical hernia, massive ascites and uterovaginal prolapse (Figure 1) were detected. Prolapse developed gradually during the last five years whereas formation of ascites had started 10 years ago. Operation for recurrent umbilical hernia and uterovaginal prolapse was proposed but she declined.

Multiparity causes recurrent levator ani injuries and high intraabdominal pressure certainly facilitates uterine prolapsed (6). Nevertheless ascites has the main role in intraabdominal pressure increase. Umbilical hernia secondary to massive ascites is a common pathology with a high recurrence rate (7). We believe that this is the first case in English literature that demonstrates the association between chronic massive ascites and uterovaginal prolapse.

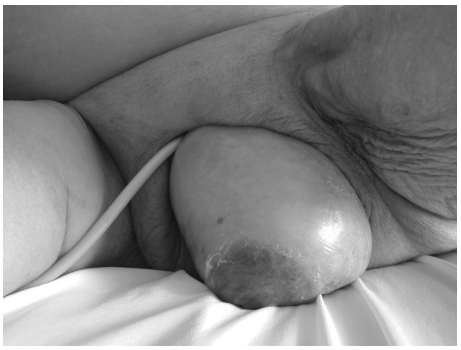

Figure 1— Appearance of massive uterovaginal prolapse.

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