GAVIN PUBLISHERS

OPEN ACCESS

Archives of Pediatrics

Hanine D, et al. Arch Pediatr 5: 182.

DOI: 10.29011/2575-825X.100182

Case Report

Neonatal Genital Prolapse

Driss Hanine*, Fouad Ettayebi, Hicham Zerhouni

Pediatric Surgery Emergencies Department – Children's Hospital of RABAT, Mohammed V University in Rabat, Morocco

***Corresponding author:** Driss Hanine, Pediatric Surgery Emergencies Department - Children Hospital of RABAT, University Mohamed V Rabat, Morocco.

Citation: Hanine D, Ettayebi F, Zerhouni H (2020) Neonatal Genital Prolapse. Arch Pediatr 5: 182. DOI: 10.29011/2575-825X.100182

Received Date: June 19, 2020; **Accepted Date:** July 03, 2020; **Published Date:** July 10, 2020

Abstract

Neonatal genital prolapse is a rare condition occurring in neonates and is usually associated with spinal cord malformations. Several modalities of treatment have been described. A prolapsed uterus carries increased risk of morbidity with progressing time, and inflammation in a newborn baby having associated with neurological, muscular, and spinal anomalies. There are several options to manage this rare condition. When the prolapse is associated to other anomalies, the treatment can be surgical because of occurrence; but when isolated, the conservative treatment is often sufficient. The prognosis depends on the associated anomalies. Our strategy consists of manually reducing of the prolapsed with a sticking plaster joining the two labia majora to be the most conservative. In the light of this observation and after a review of the literature; we emphasize the rarity of the pathology and the difficulty of treatment, especially in the event of delayed diagnosis.

Keywords: Newborn; Genital Prolapse; Neonatal; Uterine Prolapse

Introduction

Genital prolapse is pathology of postmenopausal women. It is an exceptional Entity in Newborns. It is most often associated with Central Nervous System abnormalities in 82 to 86% (particularly neural tube closure anomalies). [1,2]. Various management options have been suggested by different authors. This work consists of a review of the literature on this exceptional case, with a brief presentation and some reflections concerning the management of this condition.

Materiels & Methods

A female Newborn baby, on the second day of life, admitted for a prolapsed pelvic mass.

Having as background:

- A non-consanguineous marriage of his parents,
- Poorly followed pregnancy completed,
- A vaginal delivery medicalized
- Birth weight of 2Kg300

The Perineal examination objectifying:

- External genitals, female type, a reddish mass prolapsed by the labia majora probably corresponding to the complete course of the vaginal wall and the cervix, below the urethral orifice (Figure 1).

Figure 1: Image showing a genital prolapse with ombilical hernia in a newborn.

- Anus in place with good sphincter tone. (Figure 2).

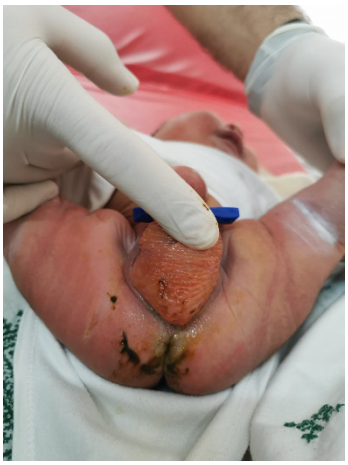

Figure 2: Image of the genital prolapse without anorectal malformation.

Neurological examination is normal: the axial and peripheral tone are present and archaic reflexes preserved.

Clinical malformation examination showed just an umbilical hernia. The rest of the examination is normal, without nor Spina Bifida or other spinal malformation.

The abdominopelvic ultrasound didn't objectify any anomaly, but confirm the absence of visualization of internal genital organs +++.

A spinal and pelvic MRI was performed showing no associated abnormalities.

The treatment adopted was conservative, with the achievement of a manual reduction of the Prolapse. A bladder catheterization was done to reduce abdominal overpressure. (Figure 3).

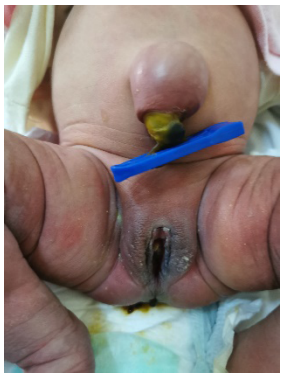

Figure 3: Image showing reduced prolapsed.

- After that, we made a sticking plaster joining the two labia majora. (Figure 4).

Figure 4: Placement of a bladder catheter to relieve abdominal pressure.

The evolution did not show a recurrence with removal of the catheter after 48 hours. With a decline of 3 months, there is no recurrence of the genital prolapsed, but appearance of a right inguinal hernia in addition to umbilical hernia diagnosed at birth.

Discussion

Neonatal genital prolapse is a rare condition. The first case was described by Noyes in 1927 [3]. And since then there have been less than 30 cases published in the literature. On the etiopathogenic level, several hypotheses have been described in the literature. The uterus and vagina are essentially supported by the pelvic muscle diaphragm and the three supports of the endopelvic fascia (cardinal ligaments, uterosacral ligaments and pubo-cervical fascia) [4].

Prolapse results from weakness of the pelvic muscles and these ligaments. This weakness can be congenital or by default of innervation. Cases of neonatal genital prolapsed have been reported in which no spinal defects could be isolated (like our case). The etiology of these has been ascribed to birth trauma and associated increased fetal abdominal pressure and pelvic skeletal deformities [3].

The utero-vaginal junction in adults is angled, while in the fetus or newborn there is little or no angulation, the orientation is almost vertical. Therefore, one hypothesis says that during a prolonged delivery, the intra-abdominal pressure is transmitted in the fetus. So with a failure of the pelvic muscles and ligaments that are stretched, prolapse occurs [5].

The diagnosis is clinical, by visualization of a red or pink mass protruding through the vaginal opening [6], Corresponding to a circumferential course of the entire vaginal wall. The external

cervical os is usually seen on the tip of the prolapsed mass. The urethral opening is most often normal. Genital prolapse can also be associated with rectal prolapse [6,7].

The differential diagnosis of the interlabial mass arises especially before:

- vaginal polyps,
- the urethral prolapse,
- the para urethral cysts and
- rhabdomyosarcoma [7,8].

Although the diagnosis is clinical, imaging is still necessary.

- The abdomino-pelvic ultrasound will confirm the absence of internal genital organs and will look for other associated (renal) anomalies.
- CT and MRI will look for spinal abnormalities including spina bifida, or hydrocephalus [9,10].
- The treatment has two components: a conservative treatment before moving on to surgery.

Conservative Treatment: Digital Reduction of the Prolapse.

Disadvantages: can be repeated several times [11].

Use of Foley catheter in case of reduction failure for 2 weeks [12].

Surgical Treatment: remains exceptional [13].

- Labial Suture
- Sacred Cervicopexy
- Ventro-suspension

Other techniques such as hysterectomy or cervical amputation of the uterus should no longer be seen +++

Its prognosis remains excellent in the event of early management and in the absence of associated severe malformations [13].

Conclusion

Genital prolapse is an exceptional entity in the newborn.

It is most often associated with abnormalities of the central nervous system.

The treatment is most often conservative.

The prognosis is excellent without other abnormalities.

Conflict of Interest

All authors have contributed to the writing of this manuscript and all declare that they have no conflict of interest.

References

1. Chapple C, Zimmern P, Brubaker L, Smith A, Bo K, (Eds) (2006) Multidisciplinary management of female pelvic floor disorders. Philadelphia pp. 384.
2. Johnson A, Unger SW, Rodgers BM (1984) Uterine prolapse inthe neonate. J Pediatr Surg 19: 210- 211.
3. Noyes H (1927) Uterine prolapsed associated with spinal bifida in the newborn with report of the case. Am J Obstet Gynecol 13: 209-213.
4. Ellis H (2006) Clinical Anatomy A revision and applied anatomy for clinical students. (11th Edn) Massachusetts: Blackwell Publishing, pp. 136-149.
5. Hyginus EO, John CO (2013) Congenital uterovaginal prolapse present at birth. J Surg Tech Case Report 5: 89-91.
6. Porges RF (1993) Neonatal genital prolapse. Pediatrics 91: 853-854.
7. Fraser RD (1961) A case of genital prolapse in a newborn baby. Br Med J 1: 1011-1012.
8. Akcakus M, Gunes T, Kurtoglu S (2003) Neonatal uterine prolapse. Pediatr Int 45: 349-351.
9. Zerin JM, Lebowitz RL, Bauer SB (1990) Descent of the bladder neck: a urographic finding in denervation of the urethral sphincter in children with myelodysplasia. Radiology 174: 833-836.
10. Podnar S, Trsinar B, Vodusek DB (2006) Bladder dysfunction in patients with cauda equina lesions. Neurourol Urodyn 25: 23-31.
11. Shuwarger D, Young RL (1985) Management of neonatal genital prolapse: case reports and historic review. Obstet Gynecol 66: 61s-63s.
12. Dixon RE, Acosta AA, Young RL (1974) Penrose pessary management of neonatal genital prolapse. Am J Obstet Gynecol 119: 855-857.
13. Banieghbal B, Fonseca J (1998) Surgical management of uterine prolapse in an infant. Eur J Pediatr Surg 8: 119-120.