Journal of Medical Diagnostic Methods

ISSN: 2168-9784

Onuigbo and Twomey,, J Med Diagn Meth 2015, S2:1
DOI: 10.4172/2168-9784-S2001

Case Report Open Access

Uterine Procidentia in a 15-Year-Old Girl in Nigeria

Wilson IB Onuigbo* and Deirdre Twomey

Medical Foundation and Clinic, Mater Hospital, Afikpo, Nigeria

***Corresponding author**: Wilson I.B. Onuigbo, Medical Foundation and Clinic, Mater Hospital, Afikpo, 8 Nsukka Lane, Enugu, 400001, Nigeria, Tel: 48037208680; E-mail: wilson.onuigbo@gmail.com

Received date: Aug 27, 2015, **Accepted date**: Oct 13, 2015, **Published date**: Oct 20, 2015

Abstract

Uterovaginal prolapse in adolescents is rare. Recently, it was reported in a 17-year-old. Therefore, this case concerning a younger girl is deemed worthy of report.

Keywords: Uterus; Procidentia; Teenager; Hinterland; Missionary hospital

Introduction

Uterovaginal prolapse is a common disease with age dependent increase in incidence [1]. Thus, in a previous report [2] on 78 women in our developing community, the general run of the cases recorded in a 30-year period was to the effect that the youngest was aged 20 years, while 69 patients or 88.5% clustered between 40 and 69 years of age.

Age of early onset of a disease is necessarily of epidemiologic interest. Elsewhere, as regards uterine procidentia, it was put at 17 years in Nigeria [3]. Therefore, our case of a younger age is deemed worthy of publication.

Case Report

A 15-year-old girl in Nigeria had her menarche at 14 years of age. She had menstruated thrice before presenting at a Missionary Hospital with 30 prolapse of the uterus. She had never been pregnant. However, there was a past history of bilateral inguinal hernia operation at another hospital the year before. At laparotomy, a large sized ovarian cyst was found to occupy almost the entire pelvis. Ovarian cystectomy was performed as well as Gilliam's suspension of the uterus by one of us (DT). The operations were undertaken with a mature relation's consent. The removed ovary measured 12 cm across (Figure 1).

Figure 1: Excised specimen of the ovarian teratoma.

On section, it was multiloculated and contained straw coloured fluid. In one area, the solid part contained straight black hairs, greasy matter and bone. Microscopical confirmation of the presence of the three layers characteristic of benign teratoma completed the pathological observations by one of us (WO). Recovery was uneventful.

Discussion

Uniqueness in presentation is of epidemiological interest in terms of a histopathologic data pool [4]. Thus, we found, on checking our Reference Pathology Laboratory records, that teenagers presenting with abdominal masses, which resulted from ovarian teratomas, numbered 23 cases. It was only in the present patient that uterovaginal procidentia occurred. The local age pattern also strengthened the present case's uniqueness. Thus, Table 1 shows that clustering was towards the eldest group rather than the youngest.

Years	No
13	2
14	2
15	1
16	2
17	5
18	5
19	6
Total	17

Table 1: Age pattern of ovarian teratoma in Nigerian teenagers.

A report from France [5], concerning prolapse in the young woman, revealed association with operations for abdominal hernias. Our case qualifies for this etiologic agent. This is bolstered by the size which was not the heaviest, seeing that its recorded 12 cm width was actually the average while the range was from 6 cm to 30 cm.

Candy [6] found in 1976 that uterine suspension had become an infrequent operation on most gynecologic services but that the round ligament fixation to the rectus sheath described by Gilliam was commonly employed because of its ease, effectiveness, and low complication rate. This has been our experience in this hinterland

Missionary Hospital. Undoubtedly, the recent review by Lin's associates [7] noted that the most appropriate surgical approach for uterine preservation still remains the subject of ongoing controversy. They found that there is a paucity of research studies and publications in this field and favored sacral colpohysteropexy.

Conclusion

Ovarian pathology, as far as the teratoma is concerned, is of considerable diversity [8]. Therefore, it is important to document any unusual parameters occurring in pediatric and adolescent patients, especially from developing countries. However, at the hinterland Mater Hospital, where this patient was treated, ultrasound pelvic CT scan was not available.

References

1. Utian WH (1987) The fate of the untreated menopause. Obstet Gynecol Clin N Am 14: 1-11.
2. Onuigbo WIB (2003) A clinico-pathological study of uterine procidentia in Nigerian Igbos. Ghana Med J 37: 137-140.
3. Dim CC, Umeh UA, Ezegwui HU, Ikeme AC (2008) A Case report. Uterine Procidentia in an African Adolescent: An uncommon Gynecological Challenge. J Pediatr, Adolesc Gynecol 21: 37-39.
4. Macartney GT, Rollason TP, Codling BW (1980) Use of a histopathology data pool for epidemiological analysis. J Clin Pathol 33: 351-355.
5. Deval B, Rafil A, Polipot S, Aflack N, Levardon M (2002) Prolapse in the young woman: study of risk factors. Gynecol Obstet Fertil 30: 673-674.
6. Candy JW (1976) Modified Gilliam uterine suspension using laparoscopic visualization. Obstet Gynecol 47: 242-243.
7. Lin LL, Ho MH, Haessler AL, Betson LH, Alinsod RM, et al. (2005) A review of laparoscopic uterine suspension, Procedures for uterine preservation. Curr Opin Obstet Gynecol 17: 541-546.
8. Comerci JT Jr, Licciardi F, Bergh FA, Gregori C, Breen JL (1994) Mature cystic teratoma: a clinicopathologic evaluation of 517 cases and review of the literature. Obstet Gynecol 84: 22-28.

This article was originally published in a special issue, entitled: **"Differential Diagnosis of Loss of Finger Extension"**, Edited by Dr. Alphonso Mejia