SEMICONSERVATIVE MANAGEMENT OF NEONATAL VAGINAL PROLAPSE

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Abstract
Neonatal genital prolapse is uncommon when present at birth or during the first few days of life. The majority of reported cases are associated with congenital spinal defects. Several conservative and surgical treatments have been advocated. The authors report a case of a baby with meningomyelocele presented with total vaginal prolapse causing urinary retention, which was treated successfully and permanently by partial labial fusion.

Key words: neonate, vaginal prolapse

Case report
A full term 3100 g female baby was born by caesarean section. The antenatal history and obstetric course were unremarkable. At delivery, she presented a ruptured lumbosacral meningomyelocele. Physical examination revealed a ruptured meningomyelocele, paraplegia with bilateral clubbed feet, urinary and faecal incontinence, hydrocephalus and recurrent total vaginal prolapse (Fig. 1.a). The urethral orifice was normal. Radiological investigations (spine X-ray, brain USS and CT) showed a wide spinal bony defect from L2 to sacral segment and marked symmetrical ventricular dilatation. The meningomyelocele was closed on day 2, a ventriculo-peritoneal shunt was inserted later for her hydrocephalus. Subsequently her total vaginal prolapse resulted in urinary retention necessitating an indwelling catheter. On day 4 of life, the vaginal prolapse was reduced under general anaesthesia and the labia majora partially fused with interrupted 2.0 Prolene sutures (Fig. 1. b). The urinary catheter was removed 2 weeks later and sutures left in place for 2 months (Fig. 1. c). No further vaginal prolapse was noted during 3 years of follow up (Fig. 1. d).

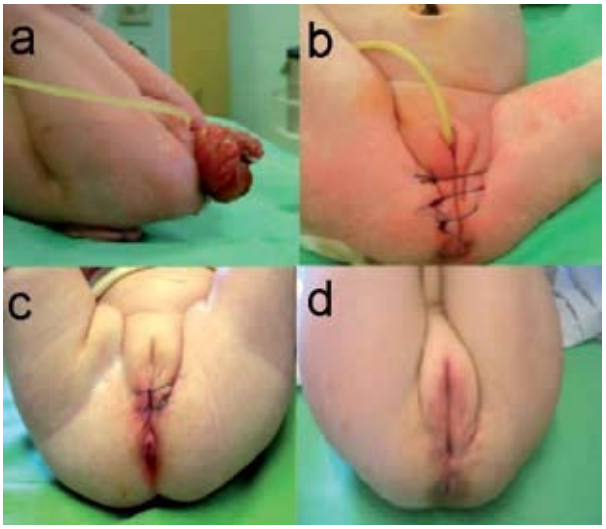

Figure 1. a. *Total vaginal prolapse with lumbosacral meningomyelocele, indwelling Foley catheter (yellow) and a catheter passed into the vagina (white),*
b. *Labial fusion,*
c. *At two months,*
d. *Three years follow up, normal looking genitalia*

Discussion
Neonatal genital prolapse is rare and usually occurs in association with spina bifida (meningomyelocele and spina bifida occulta), 82-86%. In 1917, Findley suggested that 85% of cases of neonatal genital prolapse were associated with congenital abnormalities of the spine, resulting in pelvic floor weakness as a consequence of disturbed sacral innervation [1]. However, neonatal genital prolapse can also occur in the absence of an underlying spinal defect, for example prolonged labour with a breech-presenting fetus or intrapartum trauma. Malpas subdivided neonatal genital prolapse into primary with spinal malformation and secondary such as abnormal labour [2].

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Differential diagnosis of a neonatal intralabial mass includes vaginal polyps, urethral prolapse, paraurethral cysts, ureteroceles and rhabdomyosarcoma. Treatment modalities should be tailored to the severity of genital prolapse. In mild forms, conservative treatment is advocated such as single or repeated digital reduction, use of hypertonic saline pads, vaginal pessary and insertion of a Foley catheter into the vagina [3,4]. Surgical interventions is indicated when conservative treatment fails such as recurrent prolapse despite of repeated reduction, evidence of vaginal mucosal ulceration or hypertrophy and urethral orifice obstruction. Several operative methods including uterine ventrosuspension, sling or sacral cervicopexy have been described. In 1976, Ajabor and Okojie reported partial labial fusion following decompression of local oedema with the application of hypertonic saline pads [5]. In our case we used this unique technique for the treatment of total vaginal prolapse. Following failed repeated digital reduction and urinary retention, partial labial fusion proved to be a successful and permanent method of treatment for this condition.

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