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NEONATAL PROLAPSE NOT ASSOCIATED WITH CNS DISORDER

Hypothesis / aims of study

Neonatal prolapse is a rare condition occurring at birth or the first few days after birth. More commonly as much as 82% is associated with neural tube defects (1). The first case of neonatal prolapse was reported in 1723 by Conovius. (2) We seek to perform a literature search due to the birth of a term neonate by elective Cesarean section for breech position at our local institution with stage 3 uterovaginal prolapse without neurological defect and a follow up period of 3 years. (Fig 1)

Study design, materials and methods

A review of the English literature with regards to risk factors and management has been performed. The literature search included the data base of Pubmed, (Medline search), and the Cochrane data base with the following nomenclature: “Neonatal Uterine prolapse, Neonatal genital prolapse”.

Results

To date no Cochrane meta-analysis re Neonatal prolapse has been performed. In the English literature very few case reports were identified. As from 1954 until present, 11 cases were reported. (1) Only 7 abstracts and articles could be identified. Of the 11 cases only three cases were not associated with central nervous system malformations.

Interpretation of results

The pathophysiology is based on the associated findings in the case reports where 82% is associated with spina bifida. In the neonates with genital prolapse not associated with CNS disorders, raised intra-abdominal pressure and in utero malnutrition were associated findings. For the differential diagnosis interlabial masses in the female fetus should be considered to include: urethral prolapse, ureterocoele, vaginal introital cyst, urogenital sarcoma and genital prolapse. (3) The diagnosis in our case was difficult initially due to swelling and eversion of the uterus was considered as part of the differential diagnosis. However, until present no eversion of the uterus in the neonate has been described. Different treatment options are available. Most commonly conservative treatment with reduction of the prolapse is adequate. Other conservative options which were reported include a small pessary with the use of a Penrose drain and Foleys catheter with a 4 cc bulb. Surgical options can be considered with failed conservative treatment and is more reserved for cases with coexistent neurological deficit. Surgical options described include ventrosuspension and previous amputation of the cervix where amputation is purely of historical interest. (4)

Concluding message

Neonatal genital prolapse in the absence of neurological defects are rare. Once the diagnosis has been made conservative manual reduction should be adequate treatment.

Fig 1

References

1. McGlone L, Patole S. Neonatal genital prolapse. J Peadiatr. Child Health(2004)40;156 - 157
2. De Mola J. Ricardo Loret; Carpenter Sue E. Management of genital prolapse in neonates and young women. Obstet and Gynecol Surv.1996Apr;(51):253-260
3. Cheng P.J, Shaw S.W, Cheuh H.Y, Soong Y.K. Prenatal diagnosis of fetal genital prolapse. Ultrasound Obstet Gynecol 2005; 26; 204-206

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What were the subjects in the study?	**HUMAN**
Was this study approved by an ethics committee?	**No**
This study did not require ethics committee approval because	**This is a review of the world literuture on neonatal genital prolapse after a rare case presentation**
Was the Declaration of Helsinki followed?	**Yes**
Was informed consent obtained from the patients?	**Yes**