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**A BRIEF OVERVIEW OF PROBLEM UTERINE PROLAPSE**

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Pelvic floor defects are created as a result of childbirth and are caused by the stretching and tearing of the endopelvic fascia and the levator muscles and perineal body. Partial pudendal and perineal neuropathies are also associated with labor. Impaired nerve transmission to the muscles of the pelvic floor may predispose them to decreased tone, leading to further sagging and stretching. Therefore, multiparous women are at particular risk for UP. Genital atrophy and hypoestrogenism also play important contributory roles in the pathogenesis of prolapse. Prolapse may also result from pelvic tumors, sacral nerve disorders, and diabetic neuropathy. Other medical conditions that may result in prolapse are those associated with increases in intra-abdominal pressure (eg, obesity, chronic pulmonary disease, smoking, constipation). Certain rare abnormalities in connective tissue (collagen), such as Marfan disease, have also been linked to genitourinary prolapse.

Evaluation: Identification of concomitant pelvic defects before surgery facilitates simultaneous repair of other defects and minimizes the chance for recurrence. Optimally, surgeons should plan the most appropriate procedures necessary to correct all defects at the same surgical etting. When a patient presents with complaints of UP, a detailed history and a site-specific assessment of all pelvic floor defects are critical to the evaluation. Patients are often referred for asymptomatic prolapse. The gynecologist's responsibility is to address the individual needs and wishes of patients.

Assessment of quality of life is also helpful in determining appropriate treatment. A detailed sexual history is crucial, and focused questions or questionnaires should include quality-of-life measures. Voiding difficulties and urinary frequency, urgency, or incontinence are common symptoms associated with POP. If present, these symptoms should be investigated because advanced prolapse may contribute to lower urinary tract dysfunction, including hydronephrosis and obstructive nephropathy. Surgery for the correction of incontinence is less successful in patients with POP.

The staging system for UP consists of stage I, which is defined as descent of the uterus to any point in the vagina up to 1 cm proximal to the hymen; stage II, as descent from 1 cm proximal to the hymen, to the hymen, or up to 1 cm distal to the hymen; stage III, as descent beyond 1 cm distal to the hymen; and stage IV, as total uterine prolapse or uterine procidentia. Evaluate the patient in both the lithotomy and standing positions, during relaxation and maximal straining. To perform the evaluation, place a standard double-bladed speculum in the vaginal vault to visually examine the vagina and cervix. The speculum is removed and taken apart, leaving only the posterior blade, which is then replaced into the posterior vagina, allowing visualization of the anterior wall. The monovalve speculum is then everted to view the posterior wall. Note the point of maximal descent of the anterior, lateral, and apical walls in relation to the ischial spines and hymen. Next, place 2 fingers into the vagina such that each finger opposes the ipsilateral vaginal wall, and ask the patient to bear down. After evaluating the lateral vaginal support system, assess the apex (cervix and apical vagina). Repeat the examination with the patient standing and bearing down in order to note the maximum descent of the UP.

Next, grade the strength and quality of pelvic floor contraction, asking the patient to tighten the levators around the examining finger. Assess the external genitalia, noting estrogen status, diameter of the introitus, and length of perineal body. Perform a careful bimanual examination and note uterine size, mobility, and adnexa. Lastly, perform a rectal examination, assessing the external sphincter tone and checking for the presence of rectocele or enterocele.