A pregnant woman with long, wavy brown hair is shown from the waist up, sitting on a ledge. She is wearing a vibrant red, sleeveless, form-fitting dress. Her hands are gently cradling her pregnant belly. The background is a bright, out-of-focus window with a view of greenery outside. The overall mood is serene and peaceful.

GYNAECOLOGICAL DISORDERS DURING PREGNANCY

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**MINOR
GYNAECOLOGICAL
DISORDERS DURING
PREGNANCY**



ABNORMAL VAGINAL DISCHARGE:

Abnormal Vaginal Discharge

- Increased cervical secretions and vaginal transudate during pregnancy due to increased vascularity and hyper-estrogenic state.
- Discharge- thick, mucoid ,non-irritating.
- Except improvement in personal hygiene, no treatment is required.



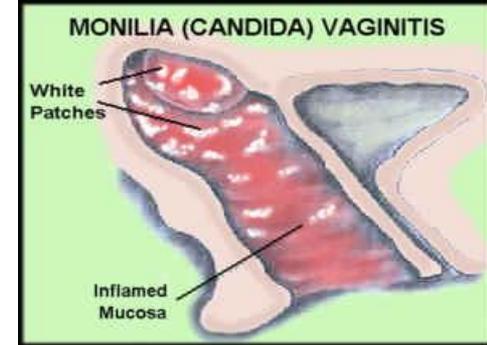


TRICHOMONAS VAGINALIS:

- The infection is not increased during pregnancy.
- Treatment consists of metronidazole 200 mg thrice daily for 7 days.
- Metronidazole should be avoided in the first trimester. The husband should be treated simultaneously.



MONILIA VAGINITIS:



- Vaginitis due to *Candida albicans* relatively more common than *Trichomonas vaginalis*.
- Its growth is favored by the high acidic pH of vaginal secretions and frequent presence of sugar in the urine during pregnancy.
- Treatment is by use of miconazole vaginal cream, one applicator full, high up in the vagina at bedtime for 7 nights.

CERVICAL ECTOPY (EROSION):

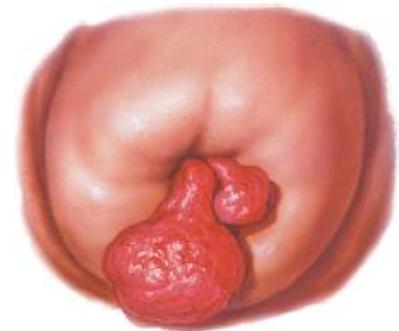


- Hormonal ectopy- During pregnancy as a result of hyperestrogenism.
- This results in the down growth of the columnar epithelium to a variable extent beyond the external os replacing the squamous epithelium producing “pregnancy ectopy”.
- Spontaneous regression occurs usually 6–8 weeks postpartum.

CERVICAL POLYP:



Small polyp



Small and large polyps

- During pregnancy, there is increased vascularity and as a result any pre-existent polyp bleeds, confusing the diagnosis with threatened abortion in early months and constitutes extraplacental cause of APH in later months.
- Diagnosis is confirmed by speculum examination.
- The polyp should be removed as in the non-pregnant state and should be sent for histological examination.

**VARIOUS MAJOR
GYNAECOLOGICAL DISORDERS
DURING PREGNANCY AND
THEIR MANAGEMENT**



1. CARCINOMA CERVIX WITH PREGNANCY

INCIDENCE:

- 1 in 2,500 pregnancies.

DIAGNOSIS:

- Asymptomatic cases — Cytologic screening followed by colposcopic directed biopsy.
- Symptomatic cases — Inspection through a speculum; If suspicion arises, biopsy.



EFFECTS OF PREGNANCY ON CARCINOMA CERVIX:

- Rapid spread following vaginal delivery and induced abortion.

EFFECTS OF CARCINOMA ON PREGNANCY:

Increased incidence of -

- (1) Abortion
 - (2) Premature labor
 - (3) Secondary cervical dystocia
 - (4) Injury to the cervix and lower segment- traumatic PPH
 - (5) Lochiometra and pyometra
 - (6) Uterine sepsis.
- 

CONT...

TREATMENT:

- Depends on the stage of disease
- May vary from conservative management to radical hysterectomy with the fetus in utero.



2. LEIOMYOMAS (FIBROIDS) WITH PREGNANCY:

INCIDENCE:

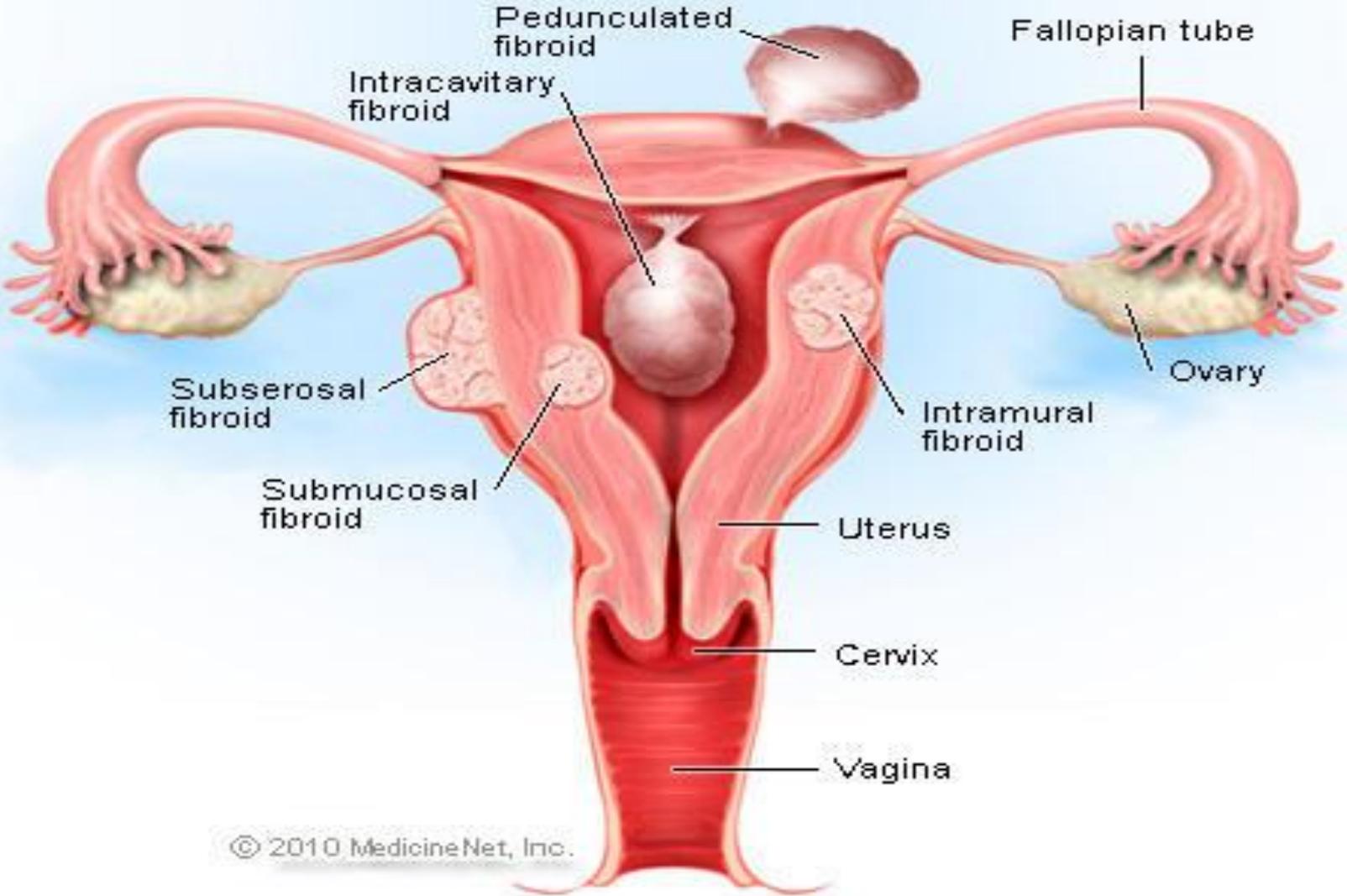
- 1 in 1,000 pregnancy

RED DEGENERATION:

- It predominantly occurs in a large fibroid during the second half of pregnancy or puerperium. The cause is not known but is actually a hemorrhagic infarction.
- Managed conservatively.



Uterine Fibroids



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CONT...

TREATMENT

- Basic principle- not to do anything to the fibroid whenever possible.

Place of elective cesarean section:

- (1) Cervical or broad ligament fibroid
- (2) Associated complicating factors such as elderly primigravida or malpresentation.



3. OVARIAN TUMOR IN PREGNANCY

INCIDENCE:

1 in 2,000 pregnancy



CONT...

DIAGNOSIS:

Patient may remain asymptomatic or presents with the symptoms of:

- (a) Retention of urine due to impaction of the tumor
 - (b) Mechanical distress due to the large cyst
 - (c) Acute abdomen due to complications of the tumor.
- Differential diagnosis of ovarian tumour with pregnancy. (*Hingorani sign*)



TREATMENT: The principle is to remove the tumour as soon as the diagnosis is made.

DURING PREGNANCY

- **Uncomplicated** — The best time of elective operation is between 14th week and 18th week, as the chance of abortion is less and access to the pedicle is easy.
- **Complicated** — The tumor should be removed irrespective of the period of gestation.



DURING LABOR:

- (1) If the tumor is well above the presenting part-watchful expectancy.
- (2) If the tumor is impacted in the pelvis causing obstruction- caesarean section should be done followed by removal of the tumor.

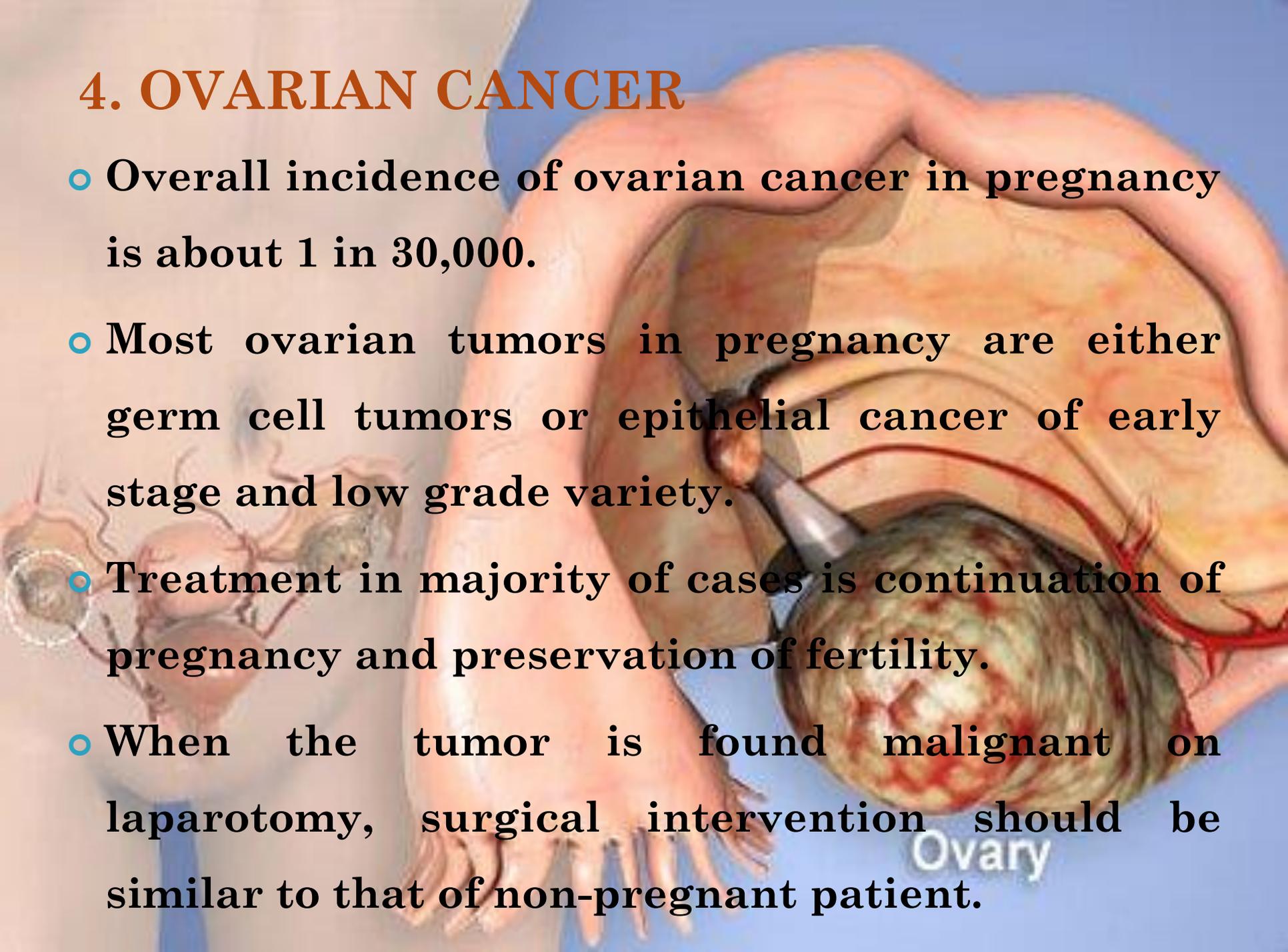
DURING PUERPERIUM:

On occasion, the diagnosis is made following delivery. The tumor should be removed as early in puerperium as possible. Specimen is sent for histological examination.



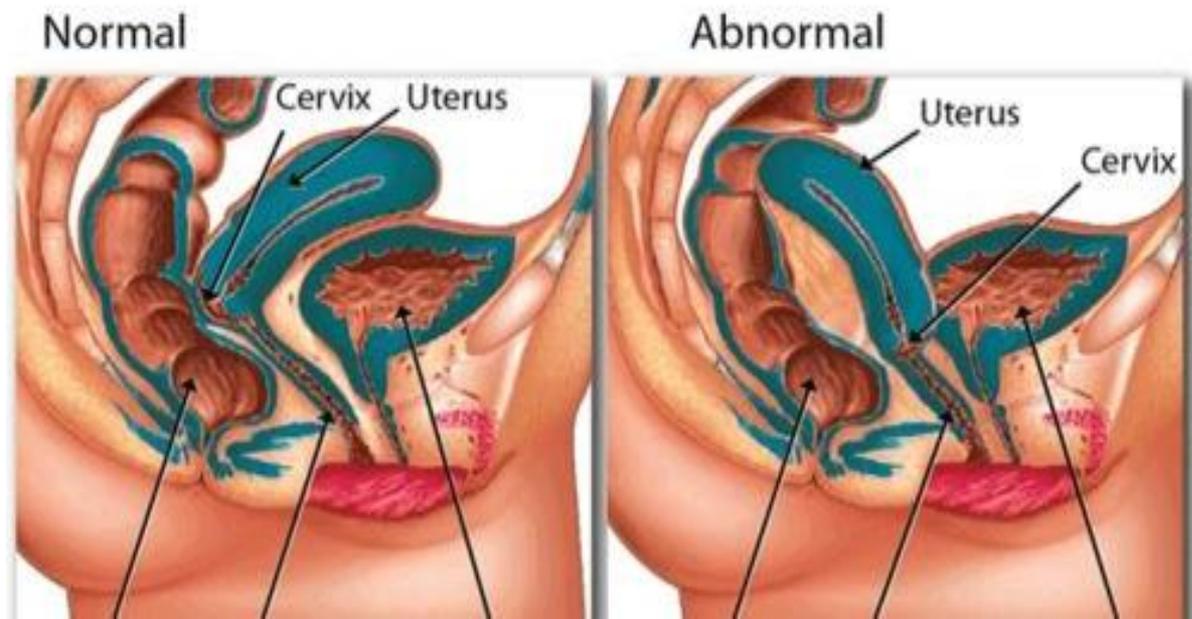
4. OVARIAN CANCER

- Overall incidence of ovarian cancer in pregnancy is about 1 in 30,000.
- Most ovarian tumors in pregnancy are either germ cell tumors or epithelial cancer of early stage and low grade variety.
- Treatment in majority of cases is continuation of pregnancy and preservation of fertility.
- When the tumor is found malignant on laparotomy, surgical intervention should be similar to that of non-pregnant patient.



5. RETROVERTED GRAVID UTERUS

- Retroversion is either pre-existing or may be due to pregnancy. The incidence is about 10% during first trimester of pregnancy.



CAUSES

- Natural variation
- Adhesions
- Endometriosis
- Fibroids
- Pregnancy- in most cases the uterus returns to its normal forward position after child birth, but sometimes it doesn't.
- Symptoms-
- Pain and difficulties in passing urine.
- Uterine incarceration is an obstetrical complication whereby a growing retroverted uterus becomes wedged into the pelvis after first trimester of pregnancy.



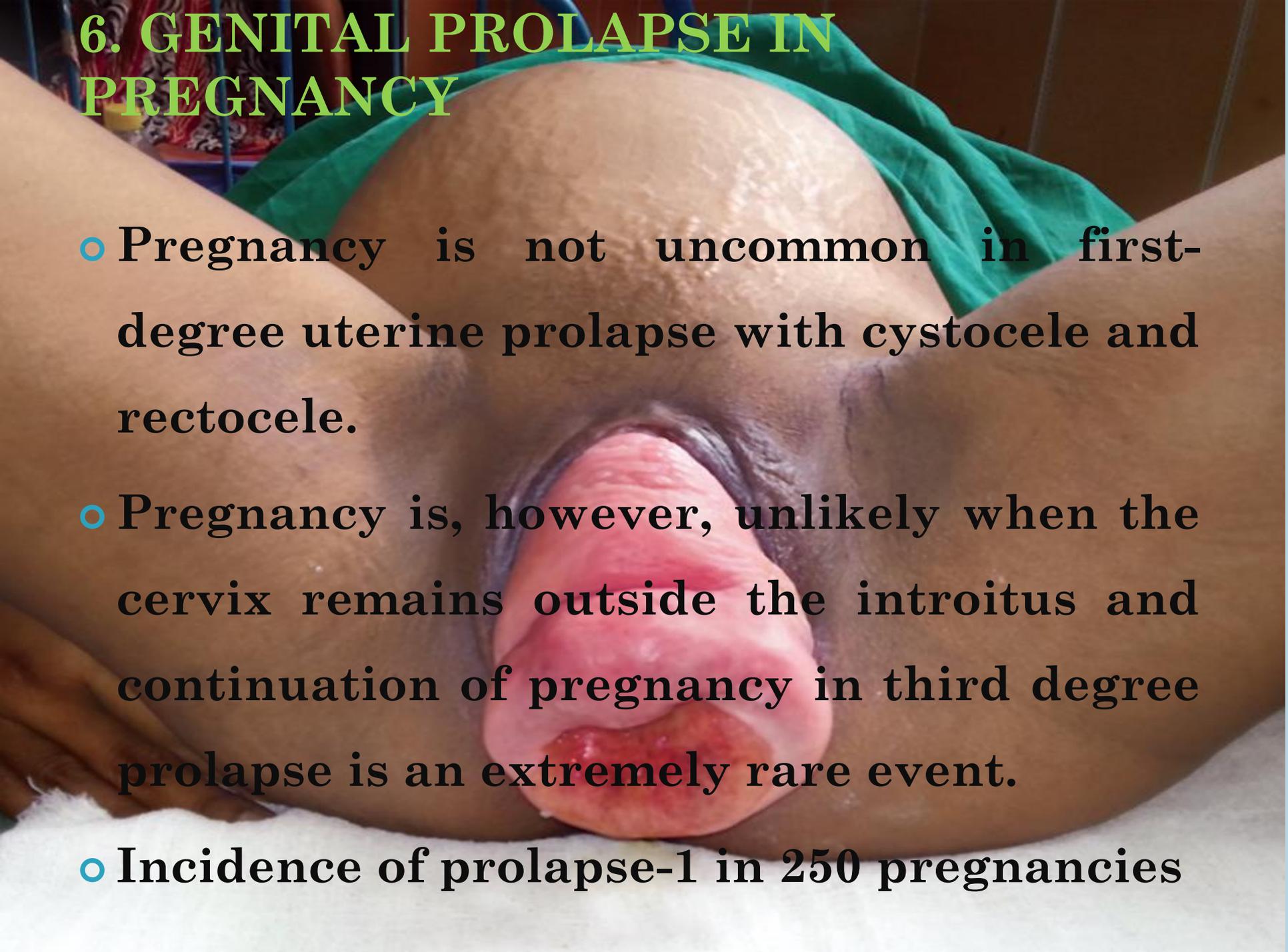
If spontaneous correction fails:

- Manual correction is done with exercises.
- In obstinate cases, when the above method fails due to adhesions, laparotomy/laparoscopy may have to be done. Adhesiolysis is to be done for correction.
- In diagnosed cases of anterior sacculation (sac like) of the uterus, delivery by cesarean section is the method of choice.



6. GENITAL PROLAPSE IN PREGNANCY

- Pregnancy is not uncommon in first-degree uterine prolapse with cystocele and rectocele.
- Pregnancy is, however, unlikely when the cervix remains outside the introitus and continuation of pregnancy in third degree prolapse is an extremely rare event.
- Incidence of prolapse-1 in 250 pregnancies



DEGREE OF PROLAPSE

- First degree- The cervix drops into the vagina.
- Second degree- The cervix drops to the level just inside the opening of the vagina.
- Third degree- The cervix is outside the vagina.
- Fourth degree- The entire uterus is outside the vagina. This condition is also called procidentia.

SYMPTOMS-

A feeling of fullness in pelvis

Low back pain

Feeling that something is coming out from vagina.

Painful sexual intercourse

Difficulty in urination

Discomfort walking



TREATMENT:

DURING PREGNANCY:

- The symptoms are mostly pronounced in early pregnancy.
- If the cervix is outside the introitus— The cervix is to be replaced inside the vagina and is kept in position by a ring pessary. The pessary is to be kept until 18th–20th week of pregnancy
- If the cervix remains outside the introitus even in the later months; it is preferable to admit the mother at 36th week.



DURING LABOR:

- Mother should be in bed.
 - Intravaginal plugging soaked with glycerine and acriflavine (reduces cervical edema and facilitates dilatation), prophylactic antibiotic
 - Manual stretching of the cervix past the presenting part during uterine contractions.
 - If the head is high up and/or the cervix remains edematous, thick or undilated, caesarean section is a safe procedure.
- 

CONT...

PUERPERIUM:

- (1) The mother should lie flat on the bed
- (2) If the mass remains outside, it should be covered with gauze soaked in glycerine and acriflavine.
- (3) If subinvolution is evident, a ring pessary may be put in until involution is completed
- (4) Prophylactic antibiotics.



