# Vaginal Hysterectomy with Perineorrhaphy In 45-Year-Old Female with Cervical Elongation: A Case Report

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***Abstract*—Cervical elongation refers to an abnormal increase in the length of the uterine cervix and is frequently encountered alongside different stages of pelvic organ prolapse. The condition is predominantly seen in multiparous and perimenopausal women, largely because of age-related and obstetric weakening of the pelvic support mechanisms. Women affected by cervical elongation commonly report symptoms such as a protruding vaginal mass, a sensation of pelvic heaviness, lower back discomfort, painful intercourse, and urinary complaints. Diagnosis is primarily based on a thorough pelvic examination, which reveals an elongated cervix that may occur with minimal or marked uterine descent. Prompt identification of this condition is important to reduce the risk of symptom progression and prevent further pelvic floor dysfunction. Treatment strategies should be individualized according to the extent of prolapse, the patient's age, symptom severity, future fertility preferences, and overall health status. Non-surgical management options include pelvic floor muscle training and the use of vaginal pessaries. Surgical correction remains the definitive treatment for many women, particularly those who have completed childbearing, and may involve procedures such as the Manchester-Fothergill operation or vaginal hysterectomy. Early diagnosis coupled with appropriate intervention can markedly improve functional outcomes and overall quality of life. Increased clinical awareness is essential to ensure accurate evaluation and tailored management of perimenopausal women presenting with pelvic floor disorders.**

**A 45-year-old female patient came to our department with C/O - something coming out of vagina since 5 years**
**O/E – vitally stable All lab investigations done.**
**USG suggestive of - Valsalva maneuver - there is descend of uterus suggestive of prolapse.**

**Vaginal Hysterectomy with Perineorrhaphy is done after physician fitness. Improved quality of life and prevention of progression of pelvic organ prolapse achieved.**

***Index Terms*—Cervical elongation, Pelvic organ prolapse, Perineorrhaphy, Vaginal hysterectomy.**

## I. INTRODUCTION

Cervical elongation is a unique gynecological disorder defined by excessive lengthening of the cervix that can occur either independently with little or no uterine descent or in association with pelvic organ prolapse (POP). The condition is most frequently encountered in multiparous and perimenopausal women, primarily because of gradual deterioration of pelvic floor support, persistent elevations in intra-abdominal pressure, and hormonal changes related to aging. Reliable epidemiological data specific to isolated cervical elongation remain limited. However, available evidence indicates that nearly 40% of women diagnosed with pelvic organ prolapse demonstrate varying degrees of cervical elongation. The prevalence of pelvic organ prolapse itself varies considerably across populations and diagnostic methods, with global estimates ranging from approximately 3% to over 40%. Community-based studies conducted in India have reported prolapse rates of up to 20% among adult women.

The most common presenting symptoms include a protruding vaginal mass, pelvic heaviness, lower back pain, and limitations in routine daily activities, all of which can adversely affect physical, psychological, and social well-being. While conservative measures

may provide symptomatic relief in carefully selected patients, surgery remains the treatment of choice for women with symptomatic cervical elongation who have completed their families. Vaginal hysterectomy is widely accepted as an effective, minimally invasive, and economically feasible surgical option, particularly when combined with reconstructive pelvic floor procedures such as perineorrhaphy. While conservative measures may provide symptomatic relief in carefully selected patients, surgery remains the treatment of choice for women with symptomatic cervical elongation who have completed their families. Vaginal hysterectomy is widely accepted as an effective, minimally invasive, and economically feasible surgical option, particularly when combined with reconstructive pelvic floor procedures such as perineorrhaphy.

This case report describes the clinical features, operative management, and postoperative outcome of a perimenopausal woman with cervical elongation who underwent vaginal hysterectomy.

## II. CASE REPORT:

A 45-year-old female came to Prasutitantra evum Striroga department with complaint of something coming out of vagina since 5 years.

LMP – 30/01/2026

Menarche - at the age of 13

Menstrual history – Regular and healthy menstrual cycle

Obstetric history –

G1P1L1 – 16 years male FTND (home delivery)

G2A1 – 6 months IUD vaginally expelled (14 years ago)

G3A2 – 3 months spontaneous complete abortion (12 years ago)

G4P1L1 – 12 years male FTND at private hospital

O/E – Pulse – 84/min

BP – 110/70 mmHg

P/A – soft

P/V – Uterus – bulky

Cervix – hypertrophied, elongated

P/S – 2nd degree uterine prolapse noted

Cervix – hypertrophied, elongated, mild blackish discoloration noted on anterior lip.

USG findings – Uterus mild bulky. Valsalva maneuver - there is descend of uterus suggestive of prolapse. Focal adenomyosis changes in anterior and posterior wall. 13x11 mm posterior wall intramural fibroid seen. Endometrial thickness – 7.2 mm.

Laboratory investigation –

HB% - 12 gm%

BT - 1 min 50 sec

CT – 5 minutes

PT – 15.1 sec

INR – 1.23

Physician fitness taken for Vaginal Hysterectomy procedure.

## III. MANAGEMENT

Following comprehensive counseling regarding the available treatment modalities, the patient elected to undergo definitive surgical management, having completed her family. A vaginal hysterectomy combined with perineorrhaphy was therefore scheduled.

The surgery was performed under spinal anesthesia. Intraoperative assessment demonstrated significant cervical elongation measuring approximately 5 inches in length, along with a bulky uterus measuring around 3 inches. Both adnexa appeared normal intraoperatively and both ovaries were conserved.


The vaginal hysterectomy was completed successfully without any intraoperative complications. Perineorrhaphy was subsequently performed to

reconstruct the perineal body and enhance pelvic floor support. Adequate hemostasis was achieved throughout the procedure, and intraoperative blood loss was minimal.

The postoperative course was uneventful. The patient received standard postoperative care, including antibiotic therapy and analgesics, and was encouraged to ambulate early. She recovered well and was discharged in stable condition. Histopathological examination of the surgical specimen confirmed uterine prolapse with associated Grade I adenomyosis and an intramural leiomyoma. No evidence of cervical dysplasia or malignancy was identified. During follow-up visits, the patient reported complete resolution of her presenting symptoms, and clinical examination confirmed satisfactory wound healing.

## IV. DISCUSSION

Cervical elongation is a recognized but relatively underreported condition, often associated with pelvic organ prolapse. It is commonly seen in multiparous and perimenopausal women due to weakening of pelvic support structures and hormonal changes affecting connective tissue integrity. Patients usually present with a sensation of mass per vaginum and pelvic pressure, which can significantly impair quality of life.

In Ayurveda, cervical elongation is correlated with Prasramsini Yoni Vyapat (laxity or downward descent). For cervical inflammation or erosion (often associated with elongation), the condition is correlated with Karnini Yonivyapad. Treatment focuses on pacifying Vata-Kapha doshas, restoring muscle tone, and localized tissue healing. Clinical examination remains the cornerstone of diagnosis.

Management depends on age, severity, and reproductive wishes. Conservative options such as pelvic floor exercises and pessary use may be considered in mild cases. However, in women who have completed childbearing and present with significant symptoms, surgical management remains the definitive treatment. Vaginal hysterectomy offers advantages including minimal invasiveness, reduced hospital stays, lower morbidity, and faster recovery compared to abdominal approaches. Concomitant perineorrhaphy strengthens pelvic floor support and reduces recurrence risk.

Summary

This case report presents a 45-year-old multiparous woman with symptomatic cervical elongation accompanied by perineal laxity. Following a detailed clinical assessment and discussion of available treatment options, the patient elected to undergo definitive surgical management with vaginal hysterectomy and perineorrhaphy. The surgery was performed successfully, with no intraoperative or postoperative complications observed. Histopathological analysis of the excised specimen revealed benign pathology, with no evidence of premalignant or malignant changes. The patient's postoperative recovery was smooth and uneventful. At follow-up, she reported complete resolution of her symptoms along with significant improvement in daily functioning and overall well-being. This case underscores the effectiveness and safety of vaginal hysterectomy combined with perineorrhaphy as a definitive treatment strategy for cervical elongation in women who have completed childbearing. In addition to alleviating symptoms, this surgical approach helps restore pelvic floor integrity and contributes substantially to improved quality of life.

## V. CONCLUSION:

Cervical elongation is an important etiology of vaginal bulge symptoms in perimenopausal women and should be considered when evaluating patients with suspected pelvic organ prolapse. In patients who have completed their families, vaginal hysterectomy combined with perineorrhaphy offers a definitive, reliable, and effective therapeutic approach. Timely identification of this condition and appropriate surgical management can result in substantial symptom relief, restoration of pelvic floor support, and marked improvement in overall quality of life.

## REFERENCES

[1] B. L. Hoffmann, J. O. Schorge, K. D. Bradshaw, L. M. Halvorson, J. I. Schaffer, and M. M. Corton, *Williams Gynecology*, 4th ed. New York, NY, USA: McGraw Hill, 2020.

[2] J. S. Berek, Berek & Novak's Gynecology, 16th ed. Philadelphia, PA, USA: Lippincott Williams & Wilkins, 2020.

[3] J. A. Rock and H. W. Jones III, Te Linde's Operative Gynecology, 12th ed. Philadelphia, PA, USA: Wolters Kluwer, 2020.

[4] C. Maher, K. Baessler, M. Barber, L. Brubaker, R. DeTayrac, P. Dwyer, et al., "Surgical Management of Pelvic Organ Prolapse," International Urogynecology Journal, vol. 24, no. 11, pp. 1781–1794, 2013.

[5] H. P. Dietz and K. P. Mann, "Cervical Elongation and Pelvic Organ Prolapse," International Urogynecology Journal, vol. 22, no. 3, pp. 1–6, 2011.

[6] T. F. M. Vergeldt, M. Weemhoff, J. IntHout, and K. B. Kluivers, "Risk Factors for Pelvic Organ Prolapse and Its Recurrence: A Systematic Review," International Urogynecology Journal, vol. 26, no. 11, pp. 1559–1573, 2015.

[7] World Health Organization, WHO Recommendations on Prevention and Management of Pelvic Floor Disorders. Geneva, Switzerland: World Health Organization, 2018.

[8] J. O. L. DeLancey, "Anatomy and Biomechanics of Genital Prolapse," Clinical Obstetrics and Gynecology, vol. 36, no. 4, pp. 897–909, 1993.

[9] S. E. Swift, P. Woodman, A. O'Boyle, M. Kahn, M. Valley, D. Bland, et al., "Pelvic Organ Support Study (POSST): The Distribution, Clinical Definition, and Epidemiologic Condition of Pelvic Organ Support Defects," American Journal of Obstetrics and Gynecology, vol. 192, no. 3, pp. 795–806, 2005.

[10] J. Mant, R. Painter, and M. Vessey, "Epidemiology of Genital Prolapse: Observations from the Oxford Family Planning Association Study," BJOG: An International Journal of Obstetrics & Gynaecology, vol. 104, no. 5, pp. 579–585, 1997.

[11] A. L. Olsen, V. J. Smith, J. O. Bergstrom, J. C. Colling, and A. L. Clark, "Epidemiology of Surgically Managed Pelvic Organ Prolapse and Urinary Incontinence," Obstetrics & Gynecology, vol. 89, no. 4, pp. 501–506, 1997.

[12] M. D. Barber, "Pelvic Organ Prolapse," BMJ, vol. 354, p. i3853, 2016.

[13] American College of Obstetricians and Gynecologists, "Pelvic Organ Prolapse," ACOG Practice Bulletin No. 214, Obstetrics & Gynecology, vol. 134, no. 4, pp. e126–e142, 2019.

[14] S. H. Cruikshank and S. R. Kovac, "Randomized Comparison of Three Surgical Methods Used at the Time of Vaginal Hysterectomy to Prevent Posterior Enterocele," American Journal of Obstetrics and Gynecology, vol. 180, no. 4, pp. 859–865, 1999.

[15] H. P. Dietz, "Pelvic Floor Ultrasound in Prolapse: What's in It for the Surgeon?" International Urogynecology Journal, vol. 22, no. 9, pp. 1085–1097, 2011.

[16] R. Kearney, R. Sawhney, and J. O. L. DeLancey, "Levator Ani Muscle Anatomy Evaluated by MRI in Women with and Without Prolapse," Obstetrics & Gynecology, vol. 104, no. 2, pp. 168–173, 2004.

[17] P. S. Manasi, S. Jalihal, and B. K. Kavitha, "Ayurvedic Management of Congenital Elongation of Cervix: A Single Case Study," International Journal of Ayurveda and Pharma Research, vol. 9, no. Suppl. 1, pp. 67–69, 2021, doi: 10.47070/ijapr.v9iSuppl1.2124.