

Cervical Elongation in a Young Girl: A Rare Case Report

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ABSTRACT

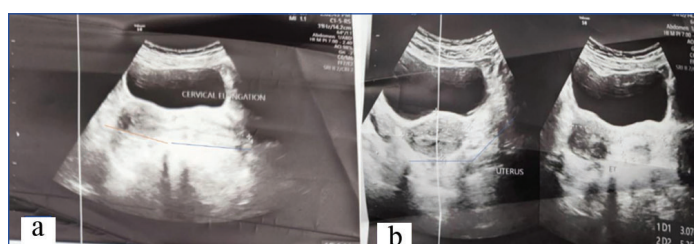
Cervical elongation is a common complaint in perimenopausal and post-menopausal women, often associated with uterovaginal prolapse. However, isolated cervical elongation without uterovaginal prolapse is rare in adolescents and young reproductive-aged women. This case report details a 20-year-old girl presenting with cervical elongation without Pelvic Organ Prolapse (POP). A 2 cm portion of the cervix was protruding from the introitus. The cervix was firm, the uterus normal sized, fornices deep, and cervical length approximately 8 cm. Successful cervical amputation with new cervical lip formation was performed. Management of POP in young girls is challenging, lacking a gold standard surgical approach due to varied presentations across age groups. Counselling regarding surgical pros and cons is crucial.

Keywords: Cervical amputation, Cervical lip formation, Pelvic organ prolapse, Uterovaginal prolapse

CASE REPORT

A 20-year-old girl presented to the gynaecology outpatient department with an eight-month history of a vaginal protrusion, increasing in size and initially present only on straining. She reported difficulty walking. Menarche was at age 14, with regular, average flow, 4-5 day cycles, and no dysmenorrhoea. There was no history of trauma, prior surgery, limb weakness, urinary or bowel complaints, chronic cough, or heavy weightlifting.

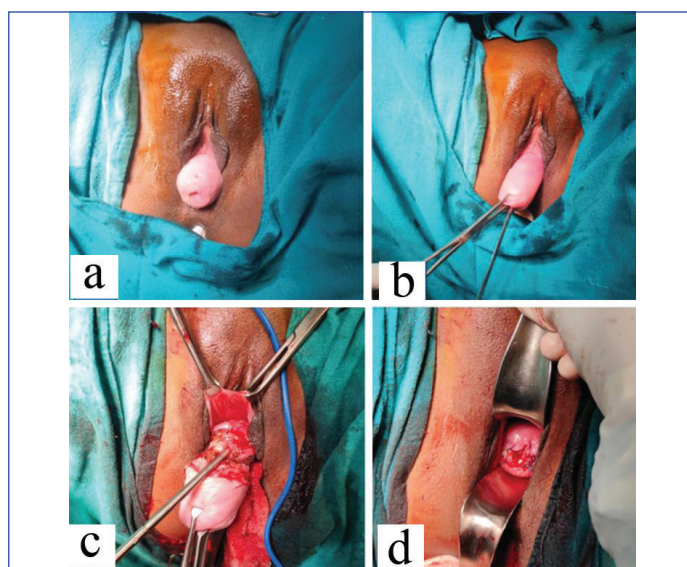
Examination revealed approximately 2 cm of cervix protruding from the introitus. The cervix was firm, the uterus normal sized, fornices deep, and cervical length approximately 8 cm. Ultrasonography showed a 5.3 cm anteverted uterus and a 6.1 cm cervix. The right ovary was normal; the left ovary showed multiple subcentimetric cysts [Table/Fig-1].



[Table/Fig-1]: Ultrasonographic image: a) Uterus with cervix (red line showing uterus cavity and blue line is showing cervical length of 6.1 cm; b) Cervix with uterus marked by blue line.

Operative management was planned. The patient received comprehensive counselling regarding surgical aspects and potential long-term complications (e.g., cervical stenosis, incompetence), albeit rare. Informed consent was obtained. Cervical amputation with new cervical lip formation was successfully performed. Intraoperatively, uterocervical length measured 8 cm via sounding. Hydrodissection of cervical epithelium was performed. A circumferential incision was made on the cervix, a plane created, and separation of epithelium from the cervical stump achieved. The transverse cervical ligament was ligated and divided. A 4 cm section of the cervix was removed, and the cervix covered with epithelium using modified Sturmdorf sutures. Haemostasis was achieved [Table/Fig-2].

The postoperative period was uneventful, and the patient was discharged on postoperative day 3. She received counselling



[Table/Fig-2]: a,b) Preoperative image showing cervix outside introitus; c) Cervical amputation with 6 number Hagar dilator in place and cervical stump was cut; d) Cervix after complete surgical procedure.

regarding antenatal checkups and cervical length assessment at 14-16 weeks gestation should she become pregnant. At the two-month follow-up, menstruation had resumed, and the cervix appeared healthy and well-healed.

DISCUSSION

Cervical elongation is common in perimenopausal and post-menopausal women, frequently associated with uterovaginal prolapse. Isolated cervical elongation without uterovaginal prolapse is rare in adolescents and young reproductive-aged women. In India, genital prolapse affects approximately 40% of women over 45 years and 5-8% of young parous women [1,2].

Normal cervical length is 2.5-4 cm. Cervical elongation is defined as a cervical length >3.38 cm or a cervix-to-corpus ratio >0.79 [3]. Elongation may be supravaginal (commonly associated with uterine prolapse) or vaginal (always congenital, presenting at various ages). In 1.5-2% of cases, it is associated with congenital uterine prolapse due to congenital pelvic floor weakness [3].

Risk factors for POP (the most common cause of cervical elongation) include age, multiparity, congenital pelvic floor weakness, instrumental vaginal delivery, prolonged labour, birth trauma, smoking, chronic cough, genetic factors, prior surgery, and collagen disorders (including myopathies) [4].

Managing POP in young girls is challenging. Conservative management (e.g., pessary insertion) may be considered if surgery is impossible, though effectiveness is questionable in isolated cervical elongation. Various surgical combinations are used due to varied presentations across age groups. Sling surgeries (e.g., sacral cervicopexy, transvaginal sacrospinous fixation) offer support with uterine preservation [5]. Rani V and Pipal DK reported a case of extreme cervical elongation in a 19-year-old nulliparous girl where a Manchester-Fothergill procedure was planned but postponed [6]. In young women with POP and elongated cervix, fertility-sparing surgery (e.g., Manchester-Fothergill procedure) is an option, though pregnancy outcome success rates are not well established [6]. Pramanik A et al., reported conservative management of cervical elongation in a two-day-old neonate [3], while Fadhel JA et al., reported surgical management (cervical amputation and stump coverage) in a 30-year-old woman [7].

Preoperative uterocervical length measurement helps determine the circumferential incision site [7]. Pregnancy related outcomes are not presented due to the patient's young age and unmarried status.

CONCLUSION(S)

Cervical elongation is rare in young women. Management depends on elongation/prolapse severity, presenting symptoms, and patient age. Counselling regarding surgical pros and cons is vital. Intraoperative uterocervical length measurement aids in determining the cervical amputation incision site.

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