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Study of Obstetric Risk Factors for Symptomatic Genital Prolapse in a Secondary Level Hospital in Bangladesh

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ABSTRACT

Introduction: Genital prolapse is still one of the most common cases found in today's gynecological ward in government hospitals in Bangladesh. Although it rarely threatens life of the patient, it causes significant morbidity to the individual and thus conveys burden to family and society. **Aim of the study:** The aim of the study was to describe the obstetric risk-factor profiles and clinical characteristics of women with symptomatic genital prolapse admitted to a secondary-level hospital in Bangladesh. **Methods & Materials:** This retrospective, observational, cross-sectional study was conducted in the Department of Obstetrics and Gynaecology, 250 Bedded General Hospital, Khulna, Bangladesh, from 1 January to 31 December 2025. A total of 100 women with symptomatic genital prolapse were included. Data regarding sociodemographic characteristics, reproductive histories, obstetric factors, and clinical findings were collected through face-to-face interviews using a pretested semi-structured questionnaire. Data were analyzed using SPSS version 27 and expressed as frequencies and percentages. **Results:** Among 100 women, 35 (35%) were aged 51–60 years, and 65 (65%) belonged to the low-income group. First childbirth before 25 years was reported by 70 (70%) women, while 62 (62%) had five or more children. Birth intervals shorter than two years were reported by 59 (59%) women. Antenatal care had not been received by 91 (91%), and 85 (85%) had delivered exclusively at home. Delivery assistance by relatives or a dai was reported by 75 (75%) women. Difficult labor occurred in 36 (36%), while 28 (28%) reported first labor lasting more than 24 hours. Extensive vaginal tears were reported by 55 (55%), and 65 (65%) resumed household work early without adequate puerperal rest. Symptoms had persisted for at least 16 years in 55 (55%) women. Second-degree uterine prolapse was observed in 76 (76%), and cystocele in 83 (83%). **Conclusion:** High parity, early childbirth, home delivery, inadequate antenatal care, and childbirth-related trauma were frequently documented among women with symptomatic genital prolapse. Most patients had longstanding symptoms, with second-degree prolapse predominating. These descriptive findings highlight common obstetric characteristics but do not establish independent risk-factor associations.

Keywords: *Genital prolapse; Obstetric risk factors; Multiparity; Home delivery; Bangladesh*

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INTRODUCTION

Pelvic organ prolapse (POP) is characterized by descent of the uterus, vaginal apex, or vaginal compartments due to deficient pelvic support. Symptomatic prolapse commonly presents as a vaginal bulge, pelvic heaviness, and urinary or bowel complaints [1,2]. The disorder affects physical functioning and quality of life, although anatomical descent and symptom severity do not consistently correspond. Standardized examination and symptom assessment are therefore important for interpreting epidemiological findings [2,3]. Global Burden of Disease estimates indicated that annual incident cases increased from approximately 8.4 million in 1990 to 14.0 million in 2021, despite declining age-standardized incidence (Wang et al., 2025). In a meta-analysis of 22 studies, a pooled POP prevalence of 30.9% was estimated, but extreme heterogeneity (I^2 = 99.8%) limited its generalizability [4]. In China, symptomatic POP prevalence was reported as 9.6% in a nationwide survey [5]. Clinically confirmed prolapse was found in 521 (10.3%) of 5,064 women interviewed in rural Pakistan and 84 of 1,167 examined women in Maharashtra, India [6,7]. Reported prevalence varies according to age, sampling methods, symptom definitions, and pelvic examination criteria. In Ethiopia, symptomatic prolapse was identified in 189 (24.3%) of 779 examined women, whereas anatomical stage II–IV prolapse was present in 241 (30.9%) [3]. In rural Tanzania, anatomical stage II–IV prolapse was found in 64.6%, but severe descent extending at least 1 cm beyond the hymen was identified in 6.7% [8]. These estimates describe different diagnostic thresholds and should not be interpreted as directly comparable. Pregnancy and childbirth contribute to pelvic floor injury alongside aging and constitutional factors [1,9]. In an Ethiopian meta-analysis of 21 studies involving 14,575 women, associations were identified with grand multiparity (pooled OR 5.42), prolonged labor (OR 4.63), perineal tears (OR 4.83), and home delivery (OR 2.93) [10]. Among 393 Ethiopian hospital attendees, parity and place of first delivery were also associated with prolapse [11]. However, these observational associations may reflect confounding by socioeconomic circumstances, healthcare access, and obstetric complications. Additional reproductive and biomechanical exposures have been investigated in resource-limited communities. In rural Nepal, birth intervals shorter than two years were associated with POP (adjusted OR 3.08; 95% CI 1.04–9.19) among 131 women [12]. In an Ethiopian community study, associations involving age at first marriage, delivery setting, and birth attendants were identified [13]. Conversely, no clear association with heavy load carrying was identified in a Nepalese case-control study, although associations with working posture were observed [14]. Thus, obstetric histories require comprehensive assessment rather than reliance on a single exposure. Symptomatic prolapse may remain untreated for years where healthcare access is restricted. In rural Pakistan, 410 (78.7%) of 521 affected women had never consulted a doctor [6]. Similarly, 73.4% of women with POP symptoms had not sought care in an Ethiopian study [15]. In Nepalese research, advanced prolapse was associated with

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poorer quality of life, while stigma and violence were documented among Bangladeshi women with chronic maternal disabilities, including prolapse [16,17]. Bangladesh-specific studies have documented postpartum maternal morbidity and the challenges of prolapse care in resource-limited settings [18,19]. However, these studies primarily addressed postpartum outcomes or surgical services rather than obstetric histories of women admitted with established symptomatic prolapse. Secondary-level hospital data can describe these histories and the associated clinical presentations. So, the present study aimed to describe obstetric risk-factor profiles, reproductive characteristics, and clinical presentations among women with symptomatic genital prolapse admitted to the 250 Bedded General Hospital, Khulna, Bangladesh.

METHODS & MATERIALS

This retrospective, observational, cross-sectional study was conducted in the Department of Obstetrics and Gynaecology, 250 Bedded General Hospital, Khulna, Bangladesh, over a one-year period from 1 January 2025 to 31 December 2025. The study population comprised women with symptomatic genital prolapse who were admitted to the department for treatment during the study period. A total of 100 women were included in the study. Data were collected using a semi-structured questionnaire developed for the study, which was modified following pretesting. Face-to-face interviews were conducted by the investigators to obtain relevant sociodemographic, reproductive, obstetric, and clinical information. The collected variables included age, socioeconomic status, age at first delivery, parity, birth spacing, antenatal care, place and mode of delivery, type of birth attendant, duration of labour, birth weight of the largest baby, history of perineal trauma and episiotomy, complications during delivery, and rest during the puerperium. Information regarding presenting symptoms, duration of symptoms, menopausal status, and pelvic examination findings was also recorded. Following data collection, all completed questionnaires were checked and rechecked to ensure completeness and consistency. Data were analysed using the Statistical Package for the Social Sciences (SPSS), version 27. Descriptive statistical analysis was performed, and categorical variables were expressed as frequencies and percentages. The findings were presented in tabular form. As the study included 100 women, the numerical values of frequencies and percentages were identical.

RESULTS

A total of 100 women with symptomatic genital prolapse were studied. Their ages ranged from 24 to 80 years. The largest group (35%) was aged 51–60 years, followed by 41–50 years (27%) and 31–40 years (25%); only 2% were aged 30 years or below (*Table I*). Sixty-five women (65%) came from the low-income group, 30% from the middle-income group and 5% from the well-off group. The first delivery had taken place between 15 and 19 years of age in 42% of women and between 20 and 24 years in 28%, so that 70% had their first baby before the age of 25 years. No woman was nulliparous: 38% had 1–4 children and 62% had five or more (*Table I*). In 59% of women the interval between births had been shorter than two years.

Table I
Socio-demographic and reproductive characteristics of the women (*n* = 100).

Characteristic	n	%
Age group (years)		
21–30	2	2
31–40	25	25
41–50	27	27
51–60	35	35
61–70	8	8
71–80	3	3
Socio-economic condition		
Low	65	65
Middle	30	30
Well-off	5	5
Age at first delivery (years)		
15–19	42	42
20–24	28	28
25–29	20	20
30–34	8	8
≥35	2	2
Parity		
1–4	38	38
5–9	55	55
≥10	7	7
Interval between births (years)		
<2	59	59
2–3	29	29
>3	12	12

Percentages equal counts because N = 100.

Ninety-one women (91%) had received no antenatal care, and only 9% had attended for antenatal care (*Table II*, *Figure II*). Eighty-five women (85%) had delivered all their babies at home, 12% had delivered some babies at home and some in hospital when complications arose, and only 3% had delivered all babies in hospital. Deliveries had been conducted by relatives in 45%, by a dai in 30%, by a trained birth attendant (TBA) in 10% and by a doctor in 15% of women; thus 75% of deliveries had been conducted by untrained relatives or a dai. With regard to mode of delivery, 52% had normal vaginal delivery, 36% reported a history of difficult labour, 9% had had an instrumental delivery (forceps or ventouse) and 3% had had a lower uterine segment caesarean section (LUCS) for obstructed labour. The duration of labour during the first delivery was more than 24 hours in 28% and 7–24 hours in 46%, so that 74% had labour lasting 7 hours or more. Thirty per cent had delivered a baby weighing more than 4000 g. Extensive vaginal tears were reported by 55% of women, anal sphincter tears by 19%, and episiotomy in any pregnancy by 55%. Complications of delivery were absent in 55%; the remainder reported delivery of a stillborn baby because

of malpresentation (23%), retained placenta (9%), postpartum haemorrhage (7%) and obstructed labour because of a big or twin baby (6%). After delivery, 65% of women had resumed household work early without adequate rest, 29% had taken some rest, and 6% had become more ill in the early puerperium.

Table II
Obstetric and puerperal history of the women (n = 100).

Variable	n	%
Antenatal care		
Received	9	9
Not received	91	91
Place of delivery		
Home only	85	85
Home and hospital	12	12
Hospital only	3	3
Delivery conducted by		
Relative	45	45
Dai	30	30
Trained birth attendant (TBA)	10	10
Doctor	15	15
Mode of delivery / labour history		
Normal vaginal delivery	52	52
Difficult labour	36	36
Instrumental delivery (forceps or ventouse)	9	9
LUCS for obstructed labour	3	3
Duration of labour in first delivery (hours)		
<1	7	7
1–6	19	19
7–24	46	46
>24	28	28
Weight of largest baby (g)		
>4000	30	30
≤4000	70	70
Perineal trauma (ever)		
Extensive vaginal tear	55	55
Anal sphincter tear	19	19
Episiotomy	55	55
Complications during or after delivery		
Stillbirth because of malpresentation	23	23
Retained placenta	9	9
Postpartum haemorrhage	7	7
Obstructed labour (big baby/twins)	6	6
None	55	55
Puerperal rehabilitation		
Early resumption of work without adequate rest	65	65
Took some rest	29	29
Became more ill in early puerperium	6	6

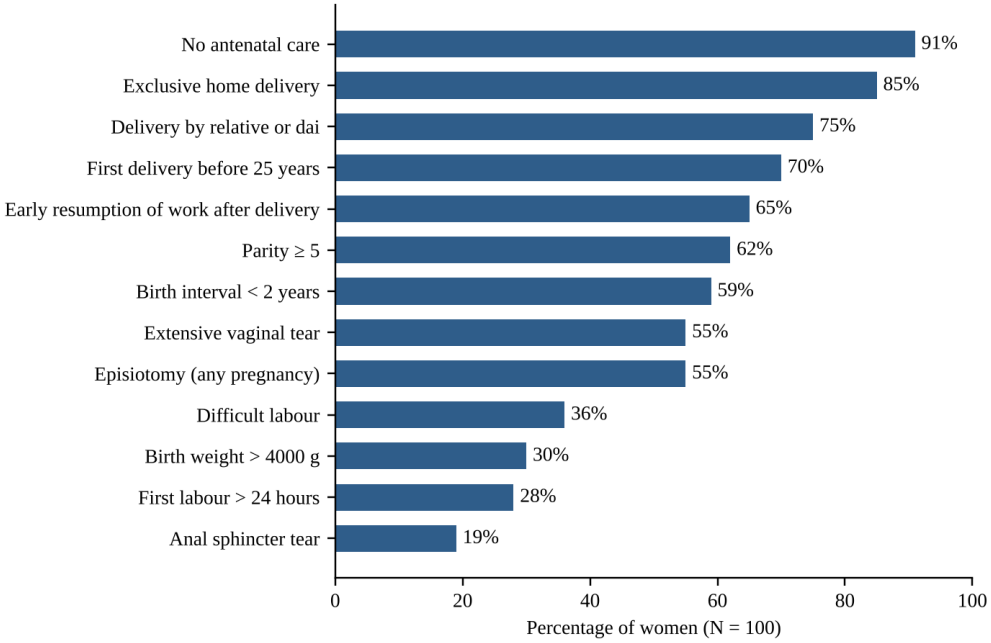


Figure 1 Frequency of key obstetric and puerperal exposures among the women (*n* = 100).

All women presented with something coming down per vagina. Other symptoms (more than one per patient was possible) were urinary incontinence (35%), backache (34%), burning micturition (29%), increased frequency of micturition (27%), difficulty in emptying the bladder (25%) and pelvic heaviness (11%). Symptoms had been present for more than 20 years in 31% and for 16 years or longer in 55% of women (*Table III*, *Figure 2*). On examination, uterine prolapse was first degree in 17%, second degree in 76% and third degree in 7%. Cystocele was present in 83%, rectocele in 33%, urethrocele in 23% and enterocele in 15%; 27% had a hypertrophied cervix, 25% an atrophied uterus and 27% a decubitus ulcer. Forty-nine women (49%) were postmenopausal. Of these, 38 (78%) had developed prolapse before the menopause and 11 (22%) after the menopause; the latter represent 11% of all 100 women (*Table III*).

Table III
Clinical presentation of the women (*n* = 100).

Variable	n	%
Presenting symptoms (multiple responses)		
Something coming down per vagina	100	100
Backache	34	34
Pelvic heaviness	11	11
Increased frequency of micturition	27	27
Difficulty in emptying bladder	25	25
Burning sensation on micturition	29	29
Urinary incontinence	35	35
Duration of symptoms (years)		
≤5	16	16
6–10	18	18
11–15	11	11
16–20	24	24
>20	31	31
Examination findings		
Uterine prolapse, first degree	17	17
Uterine prolapse, second degree	76	76
Uterine prolapse, third degree	7	7
Cystocele	83	83
Urethrocele	23	23
Rectocele	33	33
Enterocele	15	15
Hypertrophied cervix	27	27
Atrophied uterus	25	25
Decubitus ulcer	27	27
Menopausal status		
Postmenopausal	49	49
Prolapse developed before menopause	38	38
Prolapse developed after menopause	11	11

Examination findings are not mutually exclusive, except for the grade of uterine prolapse.

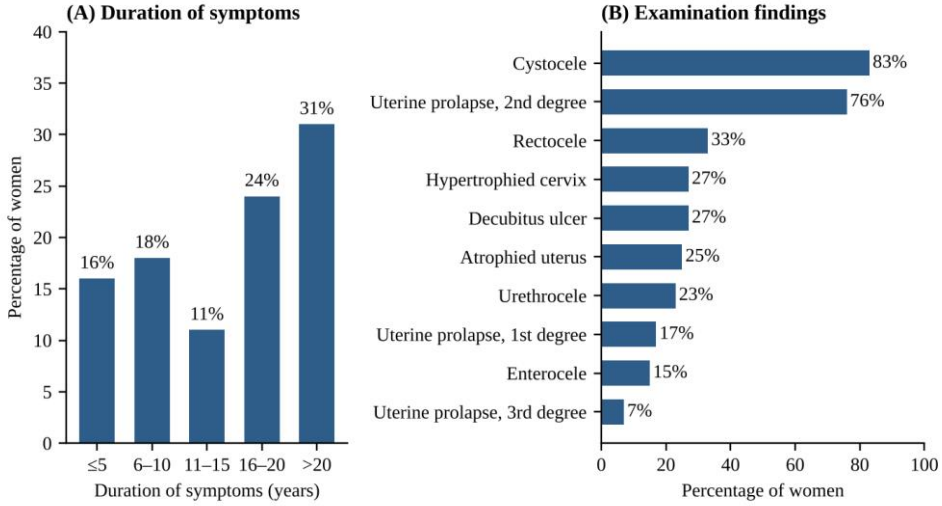


Figure 2 Duration of symptoms (A) and examination findings (B) among the women (n = 100).

DISCUSSION

In the present study, 100 women admitted with symptomatic genital prolapse were assessed. The largest age group was 51–60 years (35%), and 65% belonged to the low-income group. Similar findings were reported in a Bangladeshi hospital series, where 36.1% were aged 51–60 years and 56.9% had poor socioeconomic status [20]. These similarities may reflect the populations served by general hospitals rather than independent effects of age or socioeconomic position. Early childbirth and high parity were prominent findings. First delivery occurred before 25 years in 70%, including 42% before 20 years, and 62% had delivered at least five children. Among Nepalese women with prolapse, first childbirth before 20 years was reported in 31 of 58 (53.4%), and grand multiparity in 29 (50.0%) [21]. In Comilla, 39 of 72 (54.2%) had delivered 5–9 children, compared with 78 of 350 (22.3%) having at least five deliveries in South India (20,22). In a Nepalese case-control study, childbirth before 20 years remained associated with prolapse after adjustment (OR 2.24; 95% CI 1.18–4.25), whereas three or more vaginal births did not [23]. Birth intervals shorter than two years were reported by 59%. In rural Nepal, a minimum birth interval below two years was associated with self-reported prolapse (adjusted OR 3.08; 95% CI 1.04–9.19) [12]. Conversely, no significant birth-spacing association was identified by Paudyal et al [23]. The present questionnaire did not specify whether the interval represented the minimum or usual spacing. So, direct comparison and causal interpretation remain limited. Antenatal care had not been received by 91%, while 85% had delivered exclusively at home and another 12% in both home and hospital settings. Deliveries were reported as attended by relatives in 45% and by a dai in 30%. In South India, home delivery was documented in 162 of 278 (58.3%) available case records [22]. In Nepal, 500 of 519 recorded deliveries (96.3%) occurred at home; this estimate was calculated per delivery rather than per woman [24]. An Ethiopian meta-analysis identified an association between home delivery and prolapse (pooled OR 2.93) [10]. Nevertheless, the independent effect of absent antenatal care was not assessed in the present study. Difficult labor was reported by 36%, and first labor exceeded 24 hours in 28%. Instrumental delivery was recorded in 9%, and cesarean section for obstructed labor in 3%. Prolonged labor was reported by 16 of 72 (22.2%) women in Comilla and 37 of 171 (21.6%) with available histories in South India [20,22]. In an Ethiopian case-control study, labor lasting at least 24 hours at the last delivery was associated with prolapse (adjusted OR 3.30; 95% CI 1.12–9.70) [25]. A longitudinal cohort also identified greater prolapse hazard after operative vaginal delivery than after spontaneous delivery (adjusted HR 1.88; 95% CI 1.28–2.78) [26]. Different labor episodes and outcomes limit comparability. Extensive vaginal tears were reported by 55%, anal sphincter tears by 19%, and episiotomy by 55%. An Ethiopian case-control study found an association between sphincter damage or vaginal tear and prolapse (adjusted OR 3.20; 95% CI 1.44–7.10) [25]. Repeated spontaneous perineal lacerations were likewise associated with examination-defined prolapse (adjusted OR 2.34; 95% CI 1.13–4.86), whereas episiotomy was not significantly associated [27]. Thus, the frequency of episiotomy cannot establish an independent harmful effect. A largest infant birth weight exceeding 4,000 g was reported by 30%, but its contribution could not be determined. Early return to household work without adequate puerperal rest was reported by 65%. Similar histories were documented in 38 of 72 (52.8%) Bangladeshi patients and 66 of 100 (66.0%) Nepalese women who resumed activities within 15 days (20,24). In a Nepalese case-control study, rest shorter than 15 days was associated with prolapse (adjusted OR 3.87; 95% CI 1.90–7.93) [23]. However, inadequate rest was not defined by a fixed duration or workload in the present study. All participants reported a vaginal bulge, and 35% reported urinary incontinence. Symptoms had persisted for at least 16 years in 55%. Second-degree uterine prolapse predominated (76%), and cystocele was present in 83%. In Comilla, second-degree prolapse occurred in 58 of 72 (80.6%) and cystocele in 72 (100%) [20]. By contrast, third-degree prolapse predominated among South Indian patients, occurring in 269 of 350 (76.8%) [22]. This difference may reflect the characteristics of hospital referrals. Among 49 postmenopausal participants, 38 (77.6%) reported onset before menopause. Interpretation is limited by the hospital-based descriptive design and the absence of an unaffected comparison group. Obstetric histories were obtained retrospectively by interview and may be subject to recall error, particularly after decades of symptoms. Definitions of difficult labor, birth spacing, birth-attendant categories, and puerperal rest were not uniformly standardized. Therefore, these findings characterize common exposures and presentations among affected women, but cannot establish independent risk factors or causal relationships.

LIMITATIONS

This study was conducted at a single secondary-level hospital with a relatively small sample of 100 women, which may limit the generalizability of the findings. The retrospective collection of obstetric histories through patient interviews may have introduced recall bias, particularly for events occurring many years earlier. Furthermore, the absence of a comparison group prevented the assessment of independent associations between obstetric factors and symptomatic genital prolapse.

CONCLUSION

The present study showed that high parity, early age at first childbirth, short birth intervals, inadequate antenatal care, and home delivery were commonly reported among women with symptomatic genital prolapse. Difficult and prolonged labor, perineal trauma, and early resumption of household activities during the puerperium were also frequently observed. Most women presented with longstanding symptoms, and second-degree uterine prolapse with associated cystocele was the predominant clinical finding. These findings describe the obstetric and clinical profiles of affected women attending a secondary-level hospital in Bangladesh. However, further analytical studies with appropriate comparison groups are required to determine the independent contributions of these obstetric factors to genital prolapse.

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CONFLICT OF INTEREST

None declared.

ETHICAL APPROVAL

The study was approved by the Institutional Ethics Committee.

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