Obsessive-compulsive disorder and pelvic organ prolapse

Trouble obsessionnel compulsif et prolapsus genital

Keywords  Pelvic organ prolapse; Obsessive compulsive disorder; Sacrohysteropexy; Laparoscopy
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Obsessive-compulsive disorder (OCD) is a psychiatric condition affecting 2–3% of the population, most frequently in young people. It is defined as follows: intrusive obsessions, such as cleanliness, dirt and germs, order, symmetry or the feeling of being excessively responsible for the safety of others. This obsession leads to a lot of anxiety that the patient tries to reduce by performing repetitive compulsive rituals. Typical compulsive acts are tidying up, washing, counting or checking and can take up to several hours each day. The patient is aware that his obsessions come from his own mental activity, which leads to a feeling of shame and delay in seeking help from a healthcare professional. Diagnosis is therefore often late, with a chronic disabling disorder and physical damage caused by the disease [1]. Pelvic organ prolapse (POP) affects 30 to 50% of parous women of whom 10% are symptomatic (vaginal bulge) [2]. POP in young nulliparous women is very rare. Li et al. reported that only 0.42% of women affected by symptomatic POP were nulliparous [3]. We present the case of a 24-year-old nulliparous woman who consulted for POP and OCD consisting of repetitive straining efforts. The patient’s history revealed an anxiety disorder that continuously worsened during 2 years, following a psychological shock (she had to resuscitate one of her parents who experienced a myocardial infarction). This anxiety disorder (involved in post-traumatic stress disorder) primarily manifested by an OCD which resulted in her spending time contracting her abdomen as if she was making abdominal pushing/straining efforts. These abdominal pushing/straining movements occurred permanently, throughout the day. Despite management of OCD, including cognitive behavior therapy, the first reported symptom of POP was pelvic discomfort and occurred 6 months after the beginning of the OCD. One year after, the patient was greatly bothered by vaginal bulge and so sought medical advice. Pelvic examination revealed stage 3 hysteropostosis without cystocele or rectocele. The cervix was healthy, but showed incipient lengthening of the portio vaginalis cervix. ICS-POP-Q classification scoring was as follows: Ba = –3; C = –2; Bp = –3. No rectal prolapse was noted. Pelvic ultrasound examination revealed no abnormality. The patient also reported dyspareunia and overactive bladder symptoms with frequency and nocturia (7 urinations per night), without urinary incontinence. She had no bladder outlet obstruction symptoms and no stress urinary incontinence symptoms. This nulliparous woman presented no family history of POP or of stress urinary incontinence. No connective tissue disease was noted in her family. She presented no sign of joint hypermobility and the diagnosis of Ehlers–Danlos syndrome was ruled out on the basis of the patient’s personal and family history and of clinical examination carried out by a referral team for this disease. The neurological examination and the spine MRI were also normal. Medical questioning identified several risk factors of POP: primarily chronic abdominal pushing/straining efforts related to the OCP, but also a 10kg weight gain in one year (current BMI of 24.4kg/m²), constipation (one bowel movement per week), with obstructive defecatory syndrome (ODS) with dyssynergic defecation. Treatment initially consisted in pelvic floor muscle training and ano-rectal reeducation by biofeedback therapy for the dyssynergic defecation, and psychological and psychiatric management of the anxiety disorder and the obsessive-compulsive abdominal pushing efforts with initiation from her psychiatrist of serotonin reuptake inhibitor therapy (added to cognitive behavior therapy). Furthermore, the use of a vaginal pessary was initiated. Five months of treatment enabled the patient to control OCD pushing/straining efforts and to correct dyssynergic defecation. Surgery was not considered as a first-line treatment in this young nulliparous woman at risk of recurrence (future pregnancies, chronic abdominal pushing efforts associated with OCD and dyssynergic defecation). However, since discomfort because of POP increased and after failure of pelvic floor muscle therapy and pessary use (despite trying different sizes and shapes of pessaries), the patient finally requested surgical treatment. Minimally invasive treatment was performed: anterior laparoscopic promontory sacrohysteropexy using a monofilament polypropylene suture. Surgery proceeded without complications. Follow-up examinations four weeks after the operation and 6 months later showed the absence of prolapse. POP-Q classification was Ba = –3; C = –7; Bp = –3. The patient reported no postoperative urinary incontinence. Her psychiatric and psychological follow-up allowed her to have better control of OCD abdominal pushing/straining efforts, although OCD did not completely disappear. The patient was satisfied with the surgical treatment concerning vaginal bulge. No de novo urinary stress incontinence occurred. However, overactive bladder symptoms with frequency and nocturia symptoms remained after POP surgery. Postoperative urethra-cystoscopy and cystomanometry revealed no bladder suture exposure, no obstructive micturition and no overactive detrusor. ODS symptoms persisted. A new ano-rectal manometry showed no ano-rectal asynchronism, but non-specific anal sphincter hypertonia associated with rectal sensitivity disorders that required specific management. The patient continued psychiatric follow-up and ano-rectal management, and was informed of the absolute necessity of the correction of these factors in order to prevent POP recurrence.

This case is interesting from a pathophysiological point of view. Several risk factors have been associated with POP (obesity, aging, genetic factors, obstetrical history), all leading to a weakening of pelvic floor connective tissues (including collagen), ligaments, muscles and fascia. According to epidemiological studies, aging and vaginal deliveries are the two major risk factors of POP [4]. Hysteropostosis is very infrequent in young nulliparous women. Connective tissue disorder and neuromuscular disease were ruled out. The particularity of this patient is her OCD, which resulted in her spending time making abdominal pushing/straining efforts. Increased abdominal pressure is a well-known risk factor for prolapse [4]. The chronology of appearance of POP symp-
toms after the exacerbation of OCD suggested that these excessive abdominal pushing/straining movements were the main etiology of POP in this case. However, rapid weight gain and ODS may also have contributed to the development of POP. The presence of only hysteroscopy and no associated cystocele or rectocele suggests a failure of uterosacral ligaments and/or cardinal ligaments, with an effective support of anterior and posterior compartments by fascias and ligaments (pubocervical fascia, tendinous arch of the pelvic fascia, tendinous arch of the levator ani and rectovaginal fascia). Two hypotheses might explain this clinical presentation. First, the abdominal pushing/straining efforts exerted by the patient may be mainly applied on ligaments responsible for the apical support of the vagina and of the uterus. The second hypothesis is the possibility of histological changes or abnormalities of the ligamentous connective tissue, and not of the connective tissue of the fascia.

Severe obsessive-compulsive behaviors may often result in physical complications. Conversely, OCD should be considered when patients present uncommon or atypical physical complaints. Similar cases of somatic pelvic and perineal complications as a result of OCD have occasionally been described in the literature. In one case, a 39-year-old patient, who feared the idea of keeping stools in the bowels, used to defecate 10 times a day. This required massive abdominal pressing and caused inguinal hernias and prolapsed hemorrhoids once complicated by massive hemorrhoidal bleeding [5]. In another case, a 47-year-old woman who feared developing bowel cancer evacuated feces five times a day by a 90-minute ritual that included forced defecation and manual stool evacuation. Finally, rectal prolapse appeared, and spontaneously disappeared after appropriate treatment for OCD [6].

The present case stresses the importance of an early diagnosis and management of OCD, before the onset of physical complications, which may be irreversible. Effective therapeutic measures are available, including cognitive behavioral therapy, possibly associated with antidepressant treatment, with serotonin reuptake inhibitor first line.

Disclosure of interest

The authors declare that they have no competing interest.

References


A. Tsilanzara a,b, L. Karila b,c, C. Sallee a,b, P. Denys b,d, A. Fechner e,f, K. Benistan f,g, V. Cardot h, X. Deffieux a,b,*

a Assistance publique—Hôpitaux de Paris, Groupe hospitalier universitaire Paris Saclay, hôpital Antoine-Béclère, Service de gynécologie obstétrique, 92140 Clamart, France
b Université Paris Saclay, 94270 Le Kremlin-Bicêtre, France
c Assistance publique—Hôpitaux de Paris, Groupe hospitalier universitaire Paris Saclay, hôpital Paul-Brousse, UR PSYCOMADD, 94800 Villejuif, France
d Assistance publique—Hôpitaux de Paris, Groupe hospitalier universitaire Paris Saclay, hôpital R.-Poincaré, Service de neurologie, 92380 Garches, France
e Assistance publique—Hôpitaux de Paris, Groupe hospitalier universitaire Paris Saclay, hôpital Antoine-Béclère, Service de radiologie, 92140 Clamart, France
f Centre de référence des syndromes d’Ehlers-Danlos non vasculaires, Assistance publique—Hôpitaux de Paris, Groupe hospitalier universitaire Paris Saclay, hôpital R.-Poincaré, 92380 Garches, France
g Université Paris Saclay, UMR 1179 Inserm-Université de Versailles-Saint-Quentin, France
h Pôle de santé du plateau—Meudon, service d’urologie, clinique de Meudon, 3, avenue de Villacoublay, 92360 Meudon-La-Forêt, France

* Corresponding author at: Service de gynécologie obstétrique et médecine de la reproduction, hôpital Antoine—Béclère, AP—HP, 157, rue de la Porte-de-Trivaux, 92140 Clamart, France.

E-mail address: xavier.deffieux@aphp.fr
(X. Deffieux)

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Un cas de volumineuse hypertrophie bénigne de la prostate compliquée de perforation rectale

A case of voluminous benign hypertrophy of the prostate complicated by rectal perforation

Mots clés Adénome ; Anémie ; Colostomie ; Rectorragie ; Prostate

Keywords Adenoma; Anemia; Colostomy; Rectal bleeding; Prostate

Introduction

La complication sur les organes à voisinage liée au volume prostatique est rare. Nous rapportons un cas d’une perforation rectale.