

Correlation Between Joint Laxity and Genital Prolapse

To the Editor: Genital prolapse can belong to one of 2 types: uterine, displacing both the uterus and vagina, and vaginal, which can be of the anterior wall (cystocele) or posterior vaginal wall (rectal prolapse); it constitutes one of the most frequent gynecological problems and multiparous women are more likely to present it. In spite of a reduction in the birth rate, genital prolapse is still a gynecological problem of the first order, responsible for approximately 20% of gynecological surgical interventions.¹ Although joint laxity associated to genital prolapse has already been described in the literature,² there are no publications that have studied such an association in our country.

The objective of the following study was to investigate the prevalence of joint laxity in a series of women affected by genital prolapse by the outpatient clinic of a hospital gynecology department, prospectively analyzing the data of 33 women who attended a hospital gynecological dispensary for 18 months. The variables recorded were age, weight, height, body mass index, parity (term pregnancies, preterm pregnancies, abortions, and live births), uterine prolapse, years since the prolapse, cystocele or rectal prolapse, and whether Valsalva-associated urinary incontinence was present.

The joint laxity evaluation was carried out using the criteria published by Beighton.³ Descriptive statistics of the data obtained was carried out. Of the 33 patients who were included, 16 fulfilled the criteria for joint laxity. Both groups were comparable regarding anthropometric variables: age, weight, and height. Although the patients in the present study generally had a short stature and were overweight, the body mass index was similar in both groups.

The uterine prolapse variable was present in 8 patients with no joint laxity versus 13 of the patients with joint laxity; these differences were statistically significant between both of the groups analyzed. For the cystocele variable there were no differences between the groups; it was present in 14 patients with joint laxity and in 16 patients without it. There also were no statistically significant differences for rectal prolapse, registered in 12 patients with joint laxity and in 13 patients without it. The variable of urinary incontinence was present in 7 patients with joint laxity and in 3 patients without it; these differences were not statistically significant. The relationship between the number of term or preterm pregnancies and joint laxity was not statistically significant; the mean number of pregnancies for the group with joint laxity was 2.44, and 2.06 in the group with no joint laxity.

Table presents the characteristics of the series. The association between joint laxity and genital prolapse has already been described in the literature.² The present study, even though the scarce number of patients confirms such an association in our country. The mean age of our patients, both in those fulfilling the criteria for joint laxity as in controls, was superior to that described up until now in the literature.^{4,5} Genital prolapse in these women can be explained by the lack of adequate obstetric care at the moment of parturition, the frequent use of forceps that was prevalent some years ago and especially the lack of exercise to reinforce the muscles of the pelvic floor during pregnancy, commonly used in current obstetrics.

One of the characteristics of the joint laxity syndrome is the degree of clinical overlap with other congenital diseases of connective tissue, including Marfan's syndrome external habitus,⁶ skin hyperelasticity, and the tendency to osteopenia.⁷ Therefore there are enough arguments to propose new diagnostic criteria for the joint laxity syndrome which are not exclusively based on the hypermobile joint count. A provisional group of new criteria for the diagnosis of joint laxity syndrome was originally presented in London to the British Society of Rheumatology.⁸ This group of new criteria incorporated extra-articular manifestations to the known and accepted Beighton evaluation system of 9 points. The following year, data validating these criteria was presented. The proportion of cases which were positively identified was 93%, while the proportion of negative cases correctly identified was also of 93%. For the first time, extra-articular manifestations of the joint laxity syndrome were included for their diagnosis, among them, genital prolapse.

Epidemiological Characteristics of the Series^a

Variables	Lax (n=16)	Non Lax (n=17)	P
Age, y ^b	61.75	63.29	NS
Weight, kg ^b	66	68.88	NS
Height, cm ^b	152.75	155.47	NS
BMI ^b	28.32	28.56	NS
Uterine prolapse ^c	13	8	.041
Years since prolapse ^b	3.81	7.82	NS
Cystocele ^b	14	16	NS
Rectal prolapse ^b	12	13	NS
Urinary Incontinence ^c	7	3	NS

^aBMI indicates body mass index; NS, not significant.

^bMean.

^cNumber of cases.

Statistical significance was established at $P \leq .05$.

The inclusion of extra-articular manifestations in the new criteria for the diagnosis of the joint laxity syndrome can be very useful for the diagnosis not only for rheumatologists, but also for general internal medicine specialists or primary care physicians, allowing for a better comprehension and definition of this disease, which is rich from a clinical standpoint, usually ignored or mistaken for fibromyalgia.

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