Step-by-step approach to managing pelvic organ prolapse

Information for physicians

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Definition of pelvic organ prolapse

Descent of pelvic organs into the vagina

- Anterior: cystocele (bladder most common), urethrocele (urethra)
- Middle: uterus, vault (after hysterectomy)
- Posterior: rectocele (rectum), enterocele (small bowel, omentum)

Grades of uterine prolapse

I Descent of the uterus to above the hymen
II Descent of the uterus to the hymen
III Descent of the uterus beyond the hymen
IV Total prolapse

Step 1: Presentation and history

Prevalence: The prevalence of pelvic organ prolapse among parous women is 50%. Most women are asymptomatic.

History: Physicians should ask about urinary frequency and urgency, bulges or lumps in the vagina, pelvic pressure or heaviness, incontinence of urine or stool, difficulty with defecation or constipation, dyspareunia, and whether patients insert their fingers in the vagina to void or defecate.

Risk factors: Childbirth, constipation, age, pelvic surgery, chronic cough, raised intra-abdominal pressure, and obesity.

Step 2: Physical examination and investigations

Physical examination: Bimanual, including speculum examination at rest and with straining. If prolapse is not obvious, repeat with patient standing with 1 foot on a chair. To help with speculum examination, turn the regular speculum 90° (watch the urethra) to see the anterior and posterior walls or remove 1 blade from a double speculum and apply the single blade anteriorly and posteriorly.

Investigations: Urine culture. If you are unsure of the diagnosis, use pelvic ultrasonography or cystography.

Step 3: Treatment principles

Most women are asymptomatic so no treatment is needed. A trial of lifestyle modification might be beneficial: Kegel exercises, weight loss, smoking cessation, treatment of constipation, electrical stimulation, or biofeedback.

Step 4: Medical therapy

Use estrogen (oral or vaginal) for mild cystocele. Consider a pessary.

- A pessary is a shaped device usually made of silicone and left in the vagina.

Tips on pessaries

- There are 2 types: supportive for milder prolapses and space-occupying for more serious prolapse.
- Cost is $88 (Canadian) delivered to your office.
- For women with atrophic changes, the vagina can be prepared with topical estrogen 2 to 3 times a week for a month before insertion.
- Aim for the largest pessary that fits comfortably.
- Examiner's fingers should pass easily between the pessary and the vagina wall.
- After fitting the pessary in the office, have patients walk around and then try to urinate or defecate.
- Women can remove, wash with mild soap and water, and replace the pessary weekly or monthly (or it can be cleaned by a health care professional every 3 to 6 months).
- There is no evidence or consensus on which pessary is best, how often to clean it, or how often to visit a health professional.
- You can try to keep the vagina lubricated with estrogen or Trimo-San vaginal jelly.
- Adverse effects include discharge, odour, pain, bleeding, failure to reduce prolapse, and expulsion.
- Long-term use carries a risk of vaginal erosion, so vaginal examinations should be done every 3 to 6 months.
- If forgotten, pessaries might become fixed in place. To loosen fixed pessaries before removal, apply 2 g of estrogen cream every second day for 2 weeks.
- Change a pessary after about 5 years or when it wears out.

Pessary companies

Milex (Cooper Surgical), 800 243-2974, **www.coopersurgical.com**
Mentor, 800 668-6069, **www.mentorcorp.com**
Superior, 800 268-7944, **www.superiormedical.com**

Steps to manage:

Pelvic Organ Prolapse

Bottom Line: Women are often reluctant to discuss prolapse symptoms. While no RCT's exist for treatment, pessaries are a good option for those who wish to remain fertile or avoid surgery.

Definition: Descent of pelvic organs into the vagina.

- Anterior: cystocele (bladder, most common), urethrocele (urethra)
- Middle: uterus, vault (post hysterectomy),
- Posterior: rectocele (rectum) enterocele (small bowel, omentum)

1 Presentation/History

Prevalance ≈ 50% of parous women. Most asymptomatic.

History

- Urinary frequency, urgency
- Bulge/lump in vagina
- Pelvic pressure/heaviness
- Incontinence of urine or stool
- Difficulty with defecation/ constipation
- Dysparunia
- Inserting fingers in vagina to void/defecate

Risk factors

- Childbirth
- Constipation
- Aging
- Pelvic surgery
- Chronic cough
- Obesity
- Raised intraabdominal pressure

2 Physical Exam/Initial Investigations

- Bimanual + speculum exam at rest and with straining
- If prolapse not obvious: repeat with patient standing with one foot on chair
- Urine culture
- If unsure of diagnosis pelvic u/s or cystography

Tips for speculum exam for proplapse:

- Turn regular speculum 90° (watch urethra) to see anterior/posterior
- Remove one blade from the double speculum and use single blade applied anteriorly and posteriorly

3 Treatment Principles

- Most asymptomatic and no treatment needed
- Trial of lifestyle modification may be beneficial
  - Kegel exercises
  - Weight loss
  - Stop smoking
  - Treat constipation
  - Electical stimulation/biofeedback

OHIP billing code for pessary fitting **G398** (per 12 months)

4 Medical Therapy

- **Estrogen** (oral,vaginal) for mild cystocele
- Consider a pessary
- Shaped device usually made of silicone and left in the vagina
- Different types for cystocele, stress incontinence, uterine prolapse, rectocele or combinations (not as good for post hysterectomy vault prolapse)
- Fit by trial and error with fitting rings similar to diaphragm fitting
- Most common is **ring with support** (treats Grades I and II uterine prolapse and cystocele)
- Removed regularly for cleaning by patient or health care professional
- See patient every 3 - 6 months to check for vaginal erosions

Grades of Uterine Prolapse:

1. Descent of uterus above the hymen
2. Descent to the hymen
3. Descent beyond the hymen
4. Total prolapse

5 Further Evaluations/Surgical Treatment

- Pelvic organ prolapse surgeries have a success rate 65-90%, re-operation rate 30%
- When more than one compartment involved, need a combination of surgeries
- Correcting cystocele can unmask stress incontinence (unkink bladder→easier to leak)
  - can check for this prior to surgery by correcting prolapse with a pessary
- Some operations may predispose to prolapse in another compartment
- Can use fascia/mesh/tape/suture to suspend organs through abdomen, vagina or laparoscopic approach
- For uterine prolapse, vaginal hysterectomy is treatment of choice
  - to conserve uterus: Sacrohysteropexy uses Y-shaped graft to attach uterus to sacrum
- Complications include hemorrhage, hematoma, nerve damage, voiding difficulties, recurrence of prolapse, dysparunia, mesh erosion

- Different pessaries are used for cystocele, stress incontinence, uterine prolapse, rectocele, and combinations of these (pessaries are not as good for vault prolapse after hysterectomy).
- Fit by trial and error with fitting rings, similar to diaphragm fitting.
- The most used pessary is the *ring with support* (treats grades I and II uterine prolapse and cystocele).
- Pessaries should be removed regularly for cleaning by patient or health care professional.
- Patients should be seen every 3 to 6 months to check for vaginal erosions.

Step 5: Further evaluations and surgical treatment

- Pelvic organ prolapse surgery has a success rate of 65% to 90%; repeat operation rate is 30%.
- When more than 1 compartment is involved, patients need a combination of surgeries.
- Correcting cystocele can unmask stress incontinence (unkinking the urethra makes it easier to leak). You could check for this before surgery by correcting the prolapse with a pessary.
- Some operations predispose patients to prolapse in another compartment.
- Surgery can be via the abdomen (open or laparoscopic) or the vagina using fascia, mesh, tape, or sutures to suspend the organs.
- To conserve the uterus, sacrohysteropexy uses a Y-shaped graft to attach the uterus to the sacrum. Complications include hemorrhage, hematoma, nerve damage, voiding difficulties, recurrence of prolapse, dyspareunia, and mesh erosion.

Bottom line

Women are often reluctant to discuss prolapse symptoms. While there are no randomized controlled trials of treatment, pessaries are a good option for those who wish to remain fertile or avoid surgery.

Resources

An Approach to Diagnosis and Management of Benign Uterine Conditions in Primary Care is available on-line with patient handouts and other useful resources at **www.benignuterineconditions.ca**. Printed copies can be obtained from the Ontario College of Family Physicians on their website at **www.ocfp.on.ca**, by e-mail at **cme_ocfp@cfpc.ca**, and by telephone at 416 867-8646.

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