Pelvic Organ Prolapse

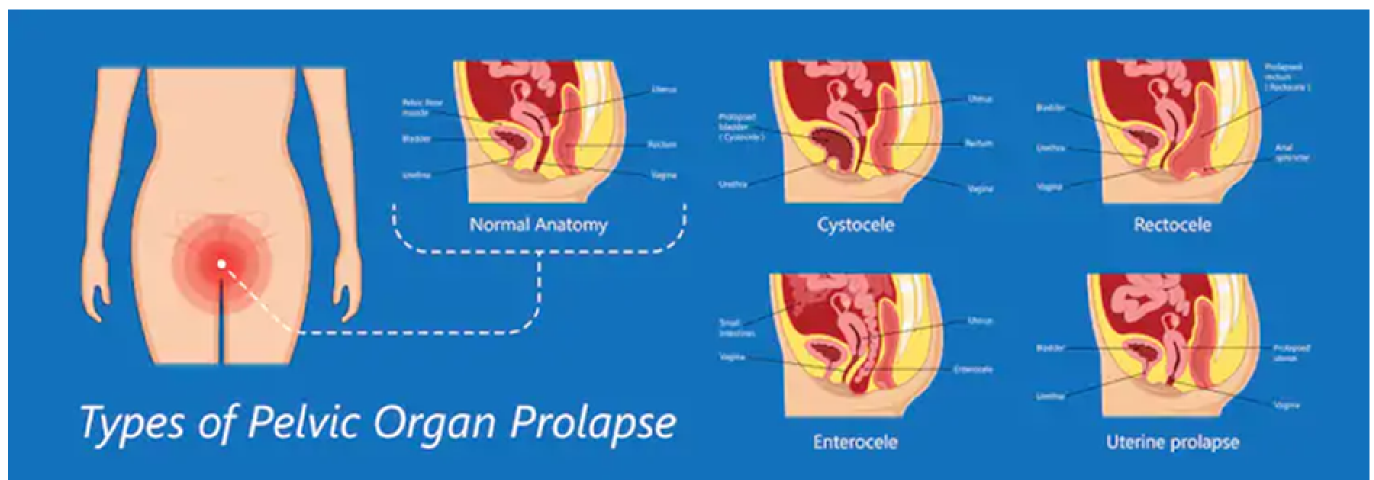
Pelvic organ prolapse is often simply known as vaginal prolapse or utero vaginal prolapse.

This is a condition when the ligaments in the pelvis that normally hold up the internal female organs become relaxed. This is a type of hernia. As a result, one or more of the pelvic organs (cervix, uterus, vagina) drop from their normal position, often dragging the surrounding organs such as the bladder and bowel to create a bulge in the vagina.

A prolapse is not a life-threatening condition but can affect quality of life.

What are the different kinds of pelvic organ prolapse? (see image)

- Bladder prolapse (cystocele or anterior prolapse as the bladder bulges into the front vaginal wall)
- Bowel prolapse (bowel pushing into the posterior vaginal wall: rectocele or enterocele)
- Uterine prolapse with cervical descent (The uterus and cervix bulge down to varying degrees, including procidentia when the entire womb is outside the vaginal opening)
- Vault prolapse which is top of the vagina coming down, especially after a hysterectomy (see separate leaflet)
- Cervical elongation or nulliparous prolapse where the cervix elongates and drops without the womb dropping down (not common)



Depending on the degree, pelvic organ prolapse is classified into 4 grades, with Grade 4 being the most severe or mild, moderate and severe (older classification). It is common to have more than one type of prolapse at the same time. (for example, the womb may drop along with an anterior or posterior prolapse)

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What are the symptoms of prolapse?

This depends on the kind of prolapse. Most prolapse remains the same or gets worse over time. Sometimes, symptoms may improve over time. However, surgical operations should be offered because of current symptoms and not to prevent future problems.

- Asymptomatic: This means the woman may notice no symptoms at all and it may be first mentioned when she goes for a smear test or some other gynaecological issue.
- Pain: A prolapse is usually not painful but may cause discomfort, heaviness or a dragging or pulling sensation especially on standing for long periods.
- Feeling a lump down below, sometimes the size of a golf ball or bigger.
- Feeling a lump that becomes smaller on passing urine, or after a bowel motion
- Noticing a vaginal lump at the end of the day, or on prolonged standing or after strenuous exercise or heavy lifting that often disappears or reduces on lying down.
- Difficulty in passing urine, frequency, urgency, urinary urge or stress incontinence (leaking of urine) (anterior prolapse).
- Needing to push the vaginal lump to empty bladder, a feeling of incomplete emptying or needing to go after emptying bladder (residual urine) (anterior prolapse).
- Difficulty in opening bowels or incomplete emptying with a feeling of needing to go again or having to push the lump inwards to help with bowel motions. (posterior prolapse)
- Low back ache.
- Difficulty in walking because of lump coming in the way (vault prolapse, procidentia or Grade 4 prolapse).
- Difficulty with sexual intercourse because of the prolapse coming in the way.
- Bleeding from friction from rubbing to the vaginal skin or cervix if prolapsed outside.

What is the cause of prolapse?

There are several reasons why a woman may develop pelvic organ prolapse. The underlying reasons in individual situations are often hard to define and can have more than one reason.

The following risk factors can increase a woman’s risk of developing prolapse:

- Pregnancy
- Childbirth especially long or difficult labours, vaginal instrumental delivery, big babies
- Very quick vaginal deliveries

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- Being overweight or obese
- Heavy lifting
- Connective tissue disease (Ehler Danlos syndrome, Marfan’s, joint hypermobility for example)
- Genetic predisposition
- Family history of prolapse
- Caucasian race increases risk
- Age: getting older and going through menopause
- History of hernias elsewhere
- Chronic cough or chronic constipation
- Hysterectomy increases the risk, including vault prolapse

What is the management for pelvic organ prolapse?

An internal pelvic examination including a speculum examination, initially by your GP and then by your specialist to determine the exact type and degree of prolapse so you can be offered the correct management. You may be examined on your side or standing up. You should request a chaperone if you wish.

Tests that may be arranged by your GP or your specialist:

A urine examination may be requested to rule out infections as these may need treatment, especially before any planned surgery.

A pelvic ultrasound scan may be indicated to ensure there are no underlying reasons for the prolapse such as a large fibroid or ovarian cyst.

Specialised tests to check your bladder called urodynamic studies.

Treatment of pelvic organ prolapse:

> It is important that all options are discussed with you so you can make an informed choice.

Lifestyle modifications: The above interventions may be all that are needed for many women who have mild prolapse and will be helpful for every woman, even if she needs further treatment.

- Losing weight in a healthy and sustainable way is important as being overweight or obese increases the intra-abdominal pressure on your pelvic organs and can increase the risk of developing pelvic organ prolapse*. See nutrition leaflet.*
- Regular exercise, focusing on core strength exercise including Pilates and yoga can strengthen the pelvic floor muscles.
- Avoiding heavy lifting and high impact exercises as this may worsen symptoms.
- Preventing or treating constipation by adopting a fibre rich whole foods plant based diet.
- Stopping smoking as cigarette smoke has chemicals that can damage tissues and increase risk of prolapse in susceptible women.
- A chronic cough can increase the risk of prolapse, so it is important to address this with your doctor.
- Oestrogen treatment; Topical vaginal oestrogen treatment in the form of tablets or cream can help with vaginal soreness and improve the vaginal skin texture, reducing discomfort.
- Using vaginal cones, electrical stimulation and other treatments can not be recommended as the scientific evidence is not strong.

Pelvic physiotherapy: Pelvic floor exercises can be very helpful and a trained physiotherapist specialising in women's health will teach you these exercises, which you should ideally continue to do on your own. Adopting these exercises early may help prevent prolapse in the future and reduce the severity. You may be recommended a programme of supervised pelvic exercises for 4-6 months, before definitive surgical treatment is offered.

Pessary: Some women, especially those who are older, do not wish to have surgery, are pregnant or wish to have children or cannot have surgery for medical reasons may benefit from using a latex or silicone pessary to help support the vaginal walls and womb. There are several types of pessaries and a ring pessary is the most common. Your specialist will guide you to the one that will suit you best. Pessaries need to be cleaned or changed every few months. Most women find this treatment very suitable, but some may notice vaginal discharge or bleeding from ulceration or infection or may notice difficulty with intercourse or leaking of urine. You should seek medical advice if you have concerns.

A vaginal vault prolapse does not usually respond to pessary treatment.

Surgical treatment: Depending on your symptoms and your wishes as well as taking into consideration, the type and degree of prolapse, your general health and your fertility wishes, your specialist will guide you to the best surgical option for you. You may wish to delay surgery until your family is complete and try other options first.

The different surgical options include a combination or on its own of the various techniques. The aim is to lift and support the vagina or uterus and cervix and neighbouring organs. Incontinence surgery may be indicated and offered at the same time.

Common risks (> 1 in 100) include bleeding, blood transfusion, organ damage, thrombosis, anaesthetic risks and the need for an open operation (laparotomy) in the event of a complication. Dissatisfaction with the results of the operation or long-term sexual pain or discomfort may be possible unwanted outcomes. Recurrent prolapse and needing further surgery can be a risk for a third of women undergoing surgery. It is important to ask the surgeon their own success and complication rates.

Hospital stay after an operation for prolapse is usually 48-72 hours and you may have an indwelling catheter to rest your bladder and a vaginal gauze pack for about 24 hours to reduce the risk of oozing. Most operations are done under a general anaesthetic and most women need a 4-8-week recovery period. You should also receive post-operative advice including advice regarding lifting, pelvic floor exercises and avoiding coughing and constipation before you leave the hospital. You will have a follow up after your surgery 6 weeks to 6 months to review your symptoms and for an examination. *See pre and post op surgical leaflet.*

Anterior pelvic floor repair: Repair of the anterior vaginal wall is performed vaginally, lifting the bladder up with the help of stitches and strengthening the neighbouring tissues.

Posterior pelvic floor repair: Repair of the posterior vaginal wall is performed vaginally, strengthening the tissues and replacing the bowel to its original position with the help of stitches. Avoiding constipation is advised and bowel softeners may be used.

Vaginal or keyhole hysterectomy: Usually performed along with one or both the above procedures. *See hysterectomy leaflet.*

Vaginal Vault prolapse repair (sacrospinous fixation through the vaginal route or sacrocolpopexy, abdominal route) to lift and support the top of the vagina*. See separate leaflet.*

Vaginal mesh surgery (not offered on the NHS as there have been both short-term and long-term complications)

Closing the vagina (Colpocleisis or Le Fort’s operation) Rarely offered, usually only to the elderly who are not suitable for pessary or other surgical options. Part or all the of the

vagina may be closed off.

Cervical amputation (Fothergill operation): may be an option for women with just cervical elongation (nulliparous prolapse). It is rarely performed nowadays.

Links that may help you include information from the British Society of UroGynaecology. (BSUG)

https://bsug.org.uk/budcms/includes/kcfinder/upload/files/Anterior%20repair%20BSUG%20Oct%202018.pdf

https://bsug.org.uk/budcms/includes/kcfinder/upload/files/Posterior%20repair%20BSUG%20Oct%202018.pdf

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