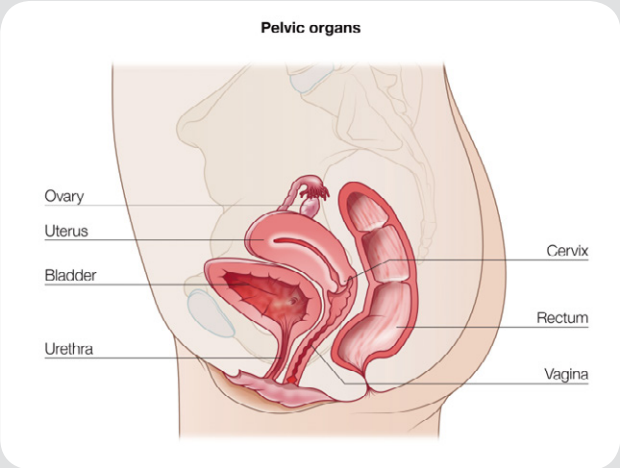
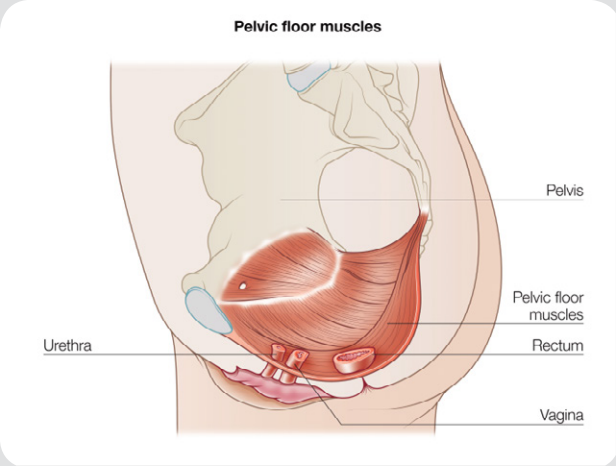
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

Pelvic Organ Prolapse

The organs within a woman's pelvis consist of the uterus (womb), vagina, bladder and bowel.



Normally they are held in place by a supportive hammock of muscles, ligaments and tissue that lie across your pelvis known as the pelvic floor. When this supporting tissue is weakened, it no longer holds these organs in the correct position, causing the pelvic organs to prolapse.



Pelvic organ prolapse (POP) is a bulge or lump in the vagina, which may affect your quality of life. Symptoms may include a heavy, dragging feeling or lump in the vagina, bladder or bowel problems and discomfort with sexual intercourse.

It is difficult to know exactly how many women are affected by prolapse since many do not go to their doctor about it. However, it does appear to be very common, especially in older women. Half of women over 50 will have some symptoms of POP and by the age of 80 more than one in ten will have had surgery for prolapse.

What causes POP?

The main cause is injury to the ligaments and muscles, which make up the natural supporting tissue, which cradles the pelvic organs. It is more likely to result from:

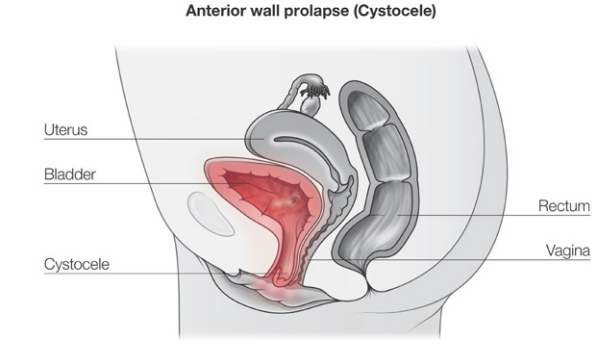
- **Pregnancy and childbirth.** During pregnancy, the changes to your hormones and extra weight weaken your pelvic floor muscles. Pregnancy & birth are the most common causes of weakening of the pelvic floor, particularly if your baby was large, you had an assisted birth (forceps/ventouse) or your labour was prolonged. The more births a woman has, the more likely she is to develop a prolapse in later life; however, you can still get a prolapse even if you have not been pregnant or given birth.
- **Menopause and age.** Prolapse is more common as you get older, particularly after the menopause. After menopause, your body makes less of the female hormone oestrogen that helps keep vaginal tissue healthy and your pelvic floor strong.
- **Constipation.**
- **Being overweight.**
- **Smoking and/or a chronic cough.**
- **Inherited risk.** Some women may have inherited a condition which increases the likelihood of developing POP.

What are the different types of POP?

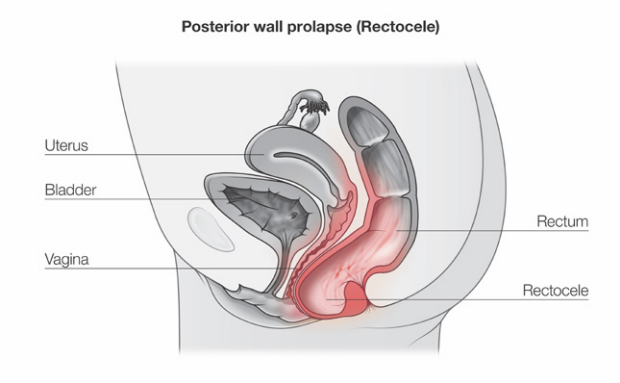
There are different types of POP depending on which organ is bulging into the vagina. It is common to have more than one type of organ prolapse at the same time.

The most common types of prolapse are:

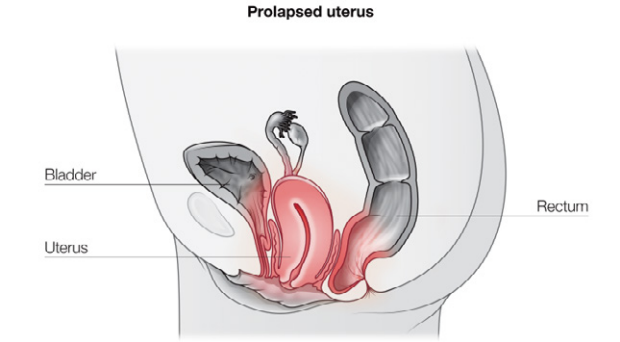
Anterior wall prolapse (Cystocele)
– when the front wall of the vagina bulges.



Posterior wall prolapse (Rectocele) – when the back wall of the vagina bulges.



Uterine prolapse – when the uterus bulges down into the vagina. Eventually the uterus may protrude outside the body. There are different degrees of prolapse depending on how far the organ(s) have bulged.



Vault prolapse – after a hysterectomy has been performed, the top (or vault) of the vagina may bulge down. This happens to one in ten women who have had a hysterectomy as part of the surgery to treat their original prolapse.

How is POP diagnosed?

Your doctor will ask you questions about your medical history, including childbirth. Your doctor would normally perform a vaginal examination, including a speculum (a plastic or metal instrument to separate the walls of the vagina) to assess and measure the stage of prolapse There are different degrees or stages of severity of prolapse. Symptoms and treatment options may differ between the various types and degrees of pelvic organ prolapse.

If you have any bladder symptoms, your doctor may recommend special bladder studies, known as a urodynamic assessment, to help diagnose the cause and determine the best treatment options for you.

What treatments are available?

If you only have a mild prolapse or have no symptoms from your prolapse, you may choose or be advised to take a 'wait and see' approach.

Depending on your degree of POP, you may be recommended to consult a pelvic floor physiotherapist, and/or continence nurse advisor as first line of treatment. For a large POP (beyond the vaginal opening) physiotherapy alone will not correct the prolapse, Treatment options that may ease your symptoms and possibly prevent your prolapse from becoming worse include:

- **General life style changes.** This may include maintaining a healthy weight, reducing / quitting smoking, avoiding constipation, avoiding heavy lifting or high impact exercise.
- **Physiotherapy to assist with pelvic floor exercises:** These exercises can be a very effective way of improving the symptoms of mild to moderate prolapse when they are carried out regularly over a period of time.
- **Vaginal pessary.** The pessary is a plastic or silicone device that fits into the vagina to help support the vaginal walls (usually the front wall) and uterus and less likely to help a posterior (back) wall prolapse.

Surgical treatments

How severe your symptoms are and whether you choose to have surgery will depend on how much your prolapse affects your daily life. Not everyone with prolapse needs surgery but you may want to consider surgery if other options have not adequately helped.

Surgery for prolapse aims to support the pelvic organs and restore them to their natural position and to help ease your symptoms. It cannot always cure the problem completely. There are a number of possible operations and approaches. Surgery for prolapse can be performed either through the vagina or through the abdomen. Your gynaecologist will advise you regarding the surgical options. This will depend on your type of prolapse and your symptoms, as well as your age, general health and your gynaecologist's training and experience with different procedures and your own preferences.

Vaginal approach : This usually involves making an incision (cut) in the vagina so you do not need a cut in your abdomen, separating the prolapsed organ from the vaginal wall and using stitches to suspend the uterus or top of vagina and repair the vaginal walls.

Abdominal approach: This involves making an incision in the abdomen and using sutures and / or graft materials to support the vagina walls, top of vagina or uterus.

Laparoscopic and robotic and robotic approaches: These procedures offer repairs similar to the open abdominal approach but often with quicker recovery time and smaller scars.

Possible operations include:

A vaginal repair. In the case of the anterior (front) wall prolapse (cystocele), the tissue between the vagina and the bladder is sutured and reinforced. Where the prolapse involves the posterior (back) wall of the vagina (rectocele), the tissue between vagina and rectum is sutured .

Sacrospinous fixation. Slowly dissolving or permanent stitches are placed into the top of the vagina or the cervix, and attached to one or both strong ligaments in the pelvis to provide support to the uterus or vaginal vault. The alternative fixation point for vaginal suspension is the uterosacral ligament and this ligament is also able to be sutured via the abdomen.

Sacrocolpopexy. A prolapsed cervix or vaginal vault is supported using mesh attached to the sacrum. This procedure may be approached abdominally or laparoscopically / robotically.

A vaginal hysterectomy (removal of the uterus). This procedure is sometimes performed as part of the surgery to treat uterine prolapse. Your gynaecologist might recommend that this be performed at the same time as a pelvic floor repair. Information about hysterectomy can be found on the RANZCOG website under Patient Information.

It may be possible to treat urinary incontinence at the same time as surgery for prolapse and your doctor will discuss this with you if relevant.

What are the risks of surgery?

Remember that while surgical procedures are generally safe and effective, every operation is different and no two patients are alike. It is important that you are satisfied that the potential benefit from your procedure outweighs the small but real potential risks. Make sure that you discuss your own individual risks, and how they might affect your surgery and outcome, with your gynaecologist.

Anaesthetic risks: surgical procedures are carried out under an anaesthetic. Your anaesthetist will discuss the type of anaesthetic and associated risks with you prior to the procedure. Information about the risks of anaesthesia during surgery can be found at http://www.anzca.edu.au/Patients

Surgical risks: All surgical procedures carry a small amount of risk. The potential risks of any surgery for POP include:

Recurrent POP: Your symptoms of POP or the prolapse itself may not completely resolve or may recur over time.

Injury to other organs: As with all surgery, injury can occur to the surrounding organs (bladder, ureters or bowel). Your gynaecologist may check for bladder injury at the time of the operation by using a camera that is passed into your bladder (known as a cystoscopy). If recognized, an injury can be repaired and a catheter is placed into the bladder to allow the bladder to rest and any small injuries to heal without any further need for treatment. However, in a very small number of cases (less than 1 in 100), further treatment including surgery may be required.

Bladder function: Initially after surgery, you may experience unusual bladder function that may range from difficulty passing urine to incontinence. Difficulty passing urine and incontinence following prolapse surgery frequently resolve, but may require further treatment or surgery and should be discussed with your gynaecologist.

Infection: Infection may occur after any surgical procedure, and this may be noticed after you leave hospital. Infection is usually managed with antibiotics, and should resolve quickly.

Bleeding: Any surgical procedure will cause a small amount of bleeding. Rarely, bleeding can be heavier than expected and in rare cases, a transfusion with blood (or blood products) may be necessary. The risk of major bleeding is less than 1 in 100.

Pain: Temporary pain is common after any surgery. After the procedure you will be uncomfortable for a few days but this can be managed well with medications. The anaesthetist will provide you with a number of options to help control your pain. Taking regular pain relief is very important to your recovery. Ongoing pelvic pain or discomfort during sexual intercourse occurs in 1 – 5 in 100 women. This pain is highly variable for each person and may require treatment from a multidisciplinary team that includes a pain management specialist.

Surgical mesh

To support pelvic tissues and repair prolapse, a polypropylene net-like implant known as mesh has been used to provide permanent support to the weakened organs and to repair damaged tissue for over 50 years via an abdominal approach, and almost 20 years via a vaginal approach just as it has been used for hernia repair. There are some advantages to using mesh as compared to the traditional approach of using a woman's own tissue to repair prolapse. These may include a reduction in prolapse symptoms and less need to have a repeat operation for prolapse.

While many women who have transvaginal mesh experience no difficulties, a number do. This has led to some government and medical authorities concluding that the risks of mesh placed via the vagina, outweighs the benefits. The risks and benefits of transvaginal mesh for prolapse remain unclear and it is currently recommended that operations using mesh be only performed as part of an approved clinical trial or by special access. Your gynaecologist will be aware of recent recommendations, developments and possible adverse effects in relation to the use of surgical meshes.

The use of mesh placed through the abdomen (sacrocolpopexy or sacrohysteropexy) does however have robust studies to show that it is more successful than surgery using your own tissue alone. This mesh continues to be approved for use in this way by the Therapeutic Goods Administration. This surgery is however, more complex than vaginal surgery alone and only performed by some surgeons.

Remember that even though your procedure will be carried out with care and skill, sometimes the expected result may not be achieved. Your individual needs and preferences should be taken into account and you should be given adequate opportunity to make informed decisions in partnership with your health care professionals about the range of treatment options that best suit your needs.

Further information on care pathways, surgical procedures and credentialing of medical practitioners can be found at the Australian Commission on Safety and Quality in Health Care website at:

www.safetyandquality.gov.au/our-work/transvaginal-mesh/resources/

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