Urology Consultants, Ltd.
Center for Continence Care and Pelvic Medicine

PELVIC ORGAN PROLAPSE

What is Pelvic Organ Prolapse?

Pelvic organ prolapse is a condition in which the pelvic organs (bladder, uterus, or rectum) descend or "fall" onto the vaginal wall and in some patients bulge outside the vagina. In essence pelvic organ prolapse is a type of "hernia" in which the pelvic organs dip into the vagina due to weakening of the muscles and connective tissues of the pelvis. Prolapse affects 50% of women who have had a vaginal birth, however only 20% of those women have significant symptoms. Unfortunately, only about half of these women seek medical help despite a significant impact on their quality of life. Factors that contribute to pelvic organ prolapse include: vaginal deliveries, a family history of prolapse, post menopausal state, activities that cause repetitive pressure on the pelvis (constipation, chronic cough, obesity) and prior pelvic surgery such as hysterectomy.

What are the symptoms of Pelvic Organ Prolapse?

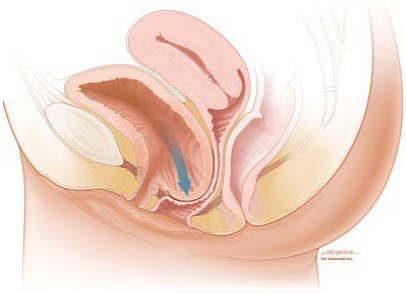
As the pelvic floor muscles weaken and stretch they can no longer hold the bladder, bowel, or uterus in the proper position. Many women may have no symptoms, however those with more advanced prolapse may experience some or all of the following:

- Vaginal or rectal pressure
- You may feel or see a bulge protruding from the vagina
- Difficulty emptying the bladder
- Inconsistent urinary stream
- Trapping of stool in the rectum
- The need to place a finger in the vagina to empty the bladder or bowel
- Discomfort with intercourse
- Leakage of urine
- Dribbling of urine after urination
- Vaginal irritation
- Low backache
- Spotting of blood on the underwear
- Recurrent bladder infections

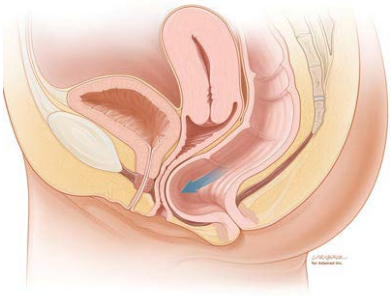
What are the types of Pelvic Organ Prolapse?

Pelvic organ prolapse is named for the organ prolapsing or "falling" into the vagina (bladder, bowel, etc). Many people may have more than one type of prolapse and it may be classified as mild, moderate, or severe. The main types of prolapse are pictured on the following page.

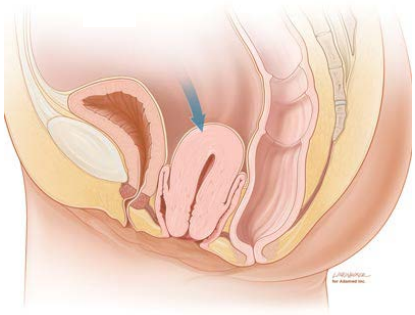
If the bladder falls into the vagina it is called a **CYSTOCELE**



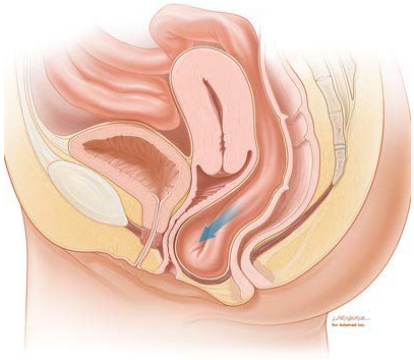
If the rectum bulges into the vagina it is called a **RECTOCELE**



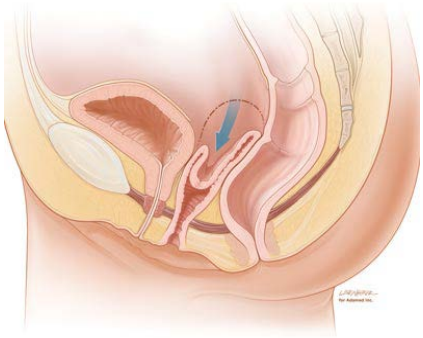
When the uterus sags into the vagina it is termed **UTERINE PROLAPSE**



An **ENTEROCELE** is when the small intestine bulges in to the vagina



After a hysterectomy, the walls of the vagina can fall in on themselves. This is called **VAGINAL VAULT PROLAPSE**



Non-Surgical Treatment of Pelvic Organ Prolapse

The majority of women with pelvic organ prolapse are minimally symptomatic and require no treatment; however when symptoms become significantly bothersome some form of treatment may be required. Non-surgical treatment options for pelvic organ prolapse include:

- Behavioral changes for treatment of pelvic organ prolapse include weight loss, avoiding heavy lifting, correcting a chronic cough (quitting smoking), or preventing constipation that contributes to straining to have a bowel movement.
- Although not proven, pelvic floor exercises (Kegels) done on a consistent basis may also help treat prolapse. Exercises cannot reattach vaginal support and reverse the prolapse, but contracting strong pelvic floor muscles when lifting or bearing down may prevent pelvic organ prolapse from becoming worse or help relieve symptoms.
- A pessary is the most common non-surgical treatment for prolapse. It is a device worn in the vagina to help support the prolapsed organ. It is specially fitted to the vagina by your doctor or nurse practitioner and must be removed periodically for cleaning.

Surgery for Pelvic Organ Prolapse

One in 9 women will undergo surgery for pelvic organ prolapse during their lifetime. Surgery may be performed through a vaginal incision, laparoscopic/robotically, and rarely with via an open abdominal incision.

Depending on the type and severity of the prolapse some patients undergo vaginal surgery for the correction of prolapse. These types of surgeries are commonly known as cystocele and rectocele repairs. These procedures do not involve abdominal incisions, but historically may have lower long-term success rates as compared to other types of surgeries.

Another vaginal procedure is called a Colpocleisis. In this procedure, the prolapse is repaired by making the vaginal opening smaller so that the prolapse will no longer protrude. This surgery is minimally invasive and long lasting, but often narrows the vagina to a point were sexual intercourse is no longer possible.

Sacral colpopexy is another procedure for the correction of prolapse of the pelvic organs. During this surgery, the vagina is suspended to the inside of the tailbone using a thin piece of surgical mesh. It is possible to perform the procedure laparoscopically using the da Vinci Surgical System, also known as the “robot”. The advantage of this approach over an open incision is significantly less pain, less scarring, a shorter hospital stay, and a quicker recovery. Additionally, this procedure offers long-term success of greater than 80 percent.

The choice of a specific surgical procedure depends up many factors such as your age, health status, type of prolapse, severity of prolapse and your desire to maintain your ability for sexual activity. Your physician will discuss the surgical choices with you.

What are the risks of surgery?

- *Recurrence* – Just as with any hernia repair, there is a chance the prolapse may recur or that by fixing one prolapsed organ another may be worsened.
- *Bleeding* – You will be asked to stop aspirin, Coumadin, Plavix, and other medicines that interfere with blood clotting a week before the procedure. After the procedure, you may experience bleeding similar to a light period for a week or two and may want to use a pad to protect your clothing. You should not have heavy vaginal bleeding or blood in the urine. The chance of requiring a blood transfusion is low.
- *Infection* – This risk is low and you will be given antibiotics following the procedure.
- *Mesh exposure* – Rarely, the vaginal skin may not heal well and your partner may feel the mesh during sexual relations. This may require a second procedure to remove the exposed mesh. There is also a very small chance that the mesh could become exposed in the bladder or urinary tract. This may also require another procedure to remove the mesh.
- *Injury to the bladder, urethra, bowel or ureters (tubes that drain the kidneys)* – This risk is small. A cystoscopy will be performed at the time of the procedure to visualize the bladder and urethra.
- *Injury to blood vessels or nerves of the pelvis* – This risk is also small.
- *Hip and leg pain* – You may experience some soreness lasting a few weeks.
- *Urinary urgency/urge incontinence* –A minority of women may have new onset urgency following the procedure. This resolves in most people, but in some medication or other therapies may be required.
- *Urinary retention* –If the tissues around the urethra swell, or if the effects of the anesthesia do not wear off right away, then you may have difficulty emptying your bladder. The majority of patients are sent home without a catheter. If you can't void easily you may go home with a catheter for a few days.
- *Stress Incontinence* – Once the prolapse is repaired you may experience leakage of urine with coughing, sneezing, or activities. If this does not resolve on its own it can be corrected in a short outpatient procedure. In some cases a procedure may be performed at the time of your prolapse repair to prevent this problem.
- *Discomfort with intercourse* – Some women may have a slight shortening of the vagina and intercourse may be painful temporarily. Occasionally this pain may persist.

What are the restrictions following the procedure?

You will be asked to limit your activity for 6 weeks following the procedure so that the repair can become secure. This means no exercise, no lifting anything over 15 pounds and nothing in the vagina (no intercourse or tampons) for 6 weeks. You may shower, but no baths, pools, or hot tubs for 2 weeks. You will be given a prescription for pain pills, and you should not drive or make important decisions while you are taking these medications. Most women are able to return to work (with lifting restrictions) in 2-3 weeks.