

## V. PELVIC ORGAN PROLAPSE

### 1. INTRODUCTION

Pelvic organ prolapse includes vaginal and rectal prolapse. Treatment of pelvic organ prolapse is generally reserved for symptomatic prolapse. Clinicians should recognise that coexistent pelvic floor symptoms are frequently present and that these symptoms may or may not be related to the prolapse. Women with prolapse require a careful and detailed initial assessment not only of the prolapse but associated bladder, bowel and sexual function.

### 2. ASSESSMENT

Symptom assessment preferably with a validated pelvic floor questionnaire that assesses bladder, bowel, vaginal and sexual function and bothersomeness is required. (Grade C).

Physical examination should:

- Report the most distal site of vaginal descent in relation to a fixed point such as the hymen and include an assessment of the anterior posterior and apical vagina. While standardised reporting utilising tools such as the Pelvic Organ Prolapse Quantification (POP-Q) are encouraged. The system used to measure the extent of the prolapse should be documented.
- Be undertaken in the standing position to evaluate the full extent of the prolapse.
- Determine if coexistent pelvic pathology is present on careful bimanual examination. Cytological screening of the cervix should be undertaken if required.
- The prolapse should be reduced to document the presence of occult stress urinary incontinence (see chapter for prolapse and urinary incontinence pathway).
- Assess pelvic floor muscle function (see chapter for full review).
- Determine if epithelial/ mucosal ulceration is present.
- Evaluate anal sphincter tone and or the presence of rectal prolapse in those with bowel symptoms (refer to chapter for pelvic organ prolapse and bowel symptom pathway).

When examination findings of the extent of the prolapse are not consistent with the history the examination can be repeated in a few weeks' time. (GoR C).

Post void residual should be measured; while most elevated post-void residual urines (150mls) resolve with treatment of the prolapse, a specialist consultation is required.

### 3. MANAGEMENT

*Observation* is appropriate when medically safe (GoR C).

Lifestyle interventions include weight loss, treating constipation, avoiding straining at stool and heavy lifting (GoR C).

*Pelvic floor muscle training:*

- Reduces associated pelvic floor symptoms (GoR A).
- May reduce the symptom of vaginal bulge (GoR C).
- Does not reduce extent of prolapse on examination based on POP-Q stage (GoR B).

*Vaginal Pessary:* when successfully fitted

- May reduce prolapse symptoms (GoR B)
- Need to be regularly reviewed (GoR C)
- Have high rates of discontinuation (GoR C)

*Local Oestrogens* are recommended in those with hypo-oestrogenic symptoms and in those with urethral prolapse or vaginal ulceration (GoR B)

*Reconstructive surgery* is reserved for those with symptomatic prolapse and is aimed at correcting the vaginal topography and functional pathology. Please see text for full recommendations.

*Obliterative surgery* is an important and effective treatment option in those who are happy to sacrifice coital activity. (GoR C)

# MANAGEMENT OF PELVIC ORGAN PROLAPSE

(INCLUDING UROGENITAL PROLAPSE AND RECTAL PROLAPSE)

## HISTORY

Bothersome pelvic organ prolapse

Complex or recurrent prolapse

## CLINICAL ASSESSMENT

**Symptoms Screening:** assess bothersomeness, frequency and severity of urinary, ano-rectal, genital and sexual symptoms

- **Urinary:** PVR, cough stress test, urinalysis.
- **Physical Examination:** Sufficient to determine the site and severity of prolapse and detect other significant findings
  - Selective use of urodynamics when results would alter planned treatment.
  - Selective use of upper tract imaging when observation is planned
- **Ano-Rectal:** Endoscopy, lower GI tract imaging

Investigation by specialist

## DIAGNOSIS

UROGENITAL PROLAPSE WITH OR WITHOUT OTHER PELVIC SYMPTOMS

RECTAL PROLAPSE WITH OR WITHOUT OTHER PELVIC SYMPTOMS

## MANAGEMENT\*

- Observation
- Lifestyle interventions
- Pelvic floor muscle training
- Pessary
- Reconstructive surgery
- Obliterative surgery

- Observation
- Lifestyle interventions
- Transperineal surgery
- Transabdominal surgery

Specialist management

\* Consider CONTINENCE PRODUCTS for temporary support during treatment

## PATHWAY FOR THE SURGICAL MANAGEMENT OF PELVIC ORGAN PROLAPSE

The pelvic organ prolapse (POP) surgery pathway was designed to provide an evidence based guide for both clinicians and women for the surgical management of pelvic organ prolapse. Within the pathway green lines highlight the preferred option and yellow lines indicate reasonable options.

An early option in the treatment pathway for women not wanting to preserve sexual function is obliterative surgery (colpocleisis) which is an efficacious intervention that has low morbidity (LoE 3).

The majority of women will enter the reconstructive pathway. Apical suspension procedures should be considered in all cases with 10-year re-operation rates for prolapse being significantly reduced if apical suspensions are performed concomitantly with both anterior and posterior colporrhaphy as compared to those performed without apical support.

In those undergoing anterior and posterior colporrhaphy the evidence is supportive of traditional native tissue suture plications (LoE 1). In the anterior compartment permanent mesh could be considered for recurrent cases when the patient understands the risk benefit profile for these interventions and that the data for their use is scant. Evidence is not supportive of biological grafts in the anterior compartment (LoE 2).

In the posterior compartment, fascial plication is superior to site specific native tissue repair (LoE 2) and levatorplasty should be avoided due to higher rates of dyspareunia (LoE3). Data are not supportive of biological or permanent mesh grafts. Posterior colporrhaphy is superior to transanal repair of rectocele (LoE 1) and there is no data to support ventral rectopexy with or without vaginal graft for rectocele.

With recognition of the importance of apical vaginal support in minimising the risk of subsequent recurrence, the pathway separates those with post-hysterectomy (vault) prolapse from those with uterine prolapse.

Data are supportive of sacral colpopexy as the preferred intervention for vault prolapse with superior anatomical and functional outcomes when compared to a variety of vaginal based interventions with and without transvaginal mesh (LoE1). This preference is highlighted by a green preferred option arrow in the management pathway. In recognition that not all patients are suitable for sacral colpopexy, a yellow reasonable option is included for vaginal based apical support (uterosacral or sacrospinous colpopexy). Both uterosacral and sacrospinous colpopexy are

equally effective vaginal options (LoE 1) and utilisation of transvaginal permanent mesh apical support is not supported by the data (LoE1).

When performing sacral colpopexy the laparoscopic approach is preferred with reduced peri-operative morbidity and cost when compared to both the open or robotic approach (LoE 2). The yellow reasonable option pathway exists for both open and robotic options in recognition of the longer learning curve associated with the laparoscopic approach (LoE3).

Apical support in those with uterine prolapse can be performed abdominally or vaginally and includes options for both uterine preservation (hysteropexy) and hysterectomy, with not insignificant relative contraindications for uterine preservation listed in Table 6. In post-menopausal women undergoing hysterectomy, bilateral salpingo-oophorectomy (BSO) significantly reduces the rate of ovarian cancer without increased morbidity. In those retaining ovaries at hysterectomy, bilateral salpingectomy also reduces rate of subsequent ovarian cancer.

Vaginal hysteropexy is equally effective as vaginal hysterectomy with apical suspension and is associated with reduced blood loss and operating time as compared to hysterectomy (LoE 1). Vaginal hysterectomy with apical support has a lower re-operation for prolapse than abdominal sacrohysteropexy (LoE1). Sacrohysteropexy has a higher re-operation for prolapse than sacral colpopexy with hysterectomy however sacral colpopexy with hysterectomy is not recommended due to the high rate of mesh exposure (LoE2). Supra-cervical hysterectomy at sacral colpopexy reduces the rate of mesh exposure associated with hysterectomy and sacral colpopexy however in a single retrospective study, recurrent prolapse was more common in the supracervical hysterectomy group. Although those data is not complete, vaginal based hysterectomy and hysteropexy with apical support should generally be considered as preferred options for uterine prolapse with sacral colpopexy reserved for vault prolapse.

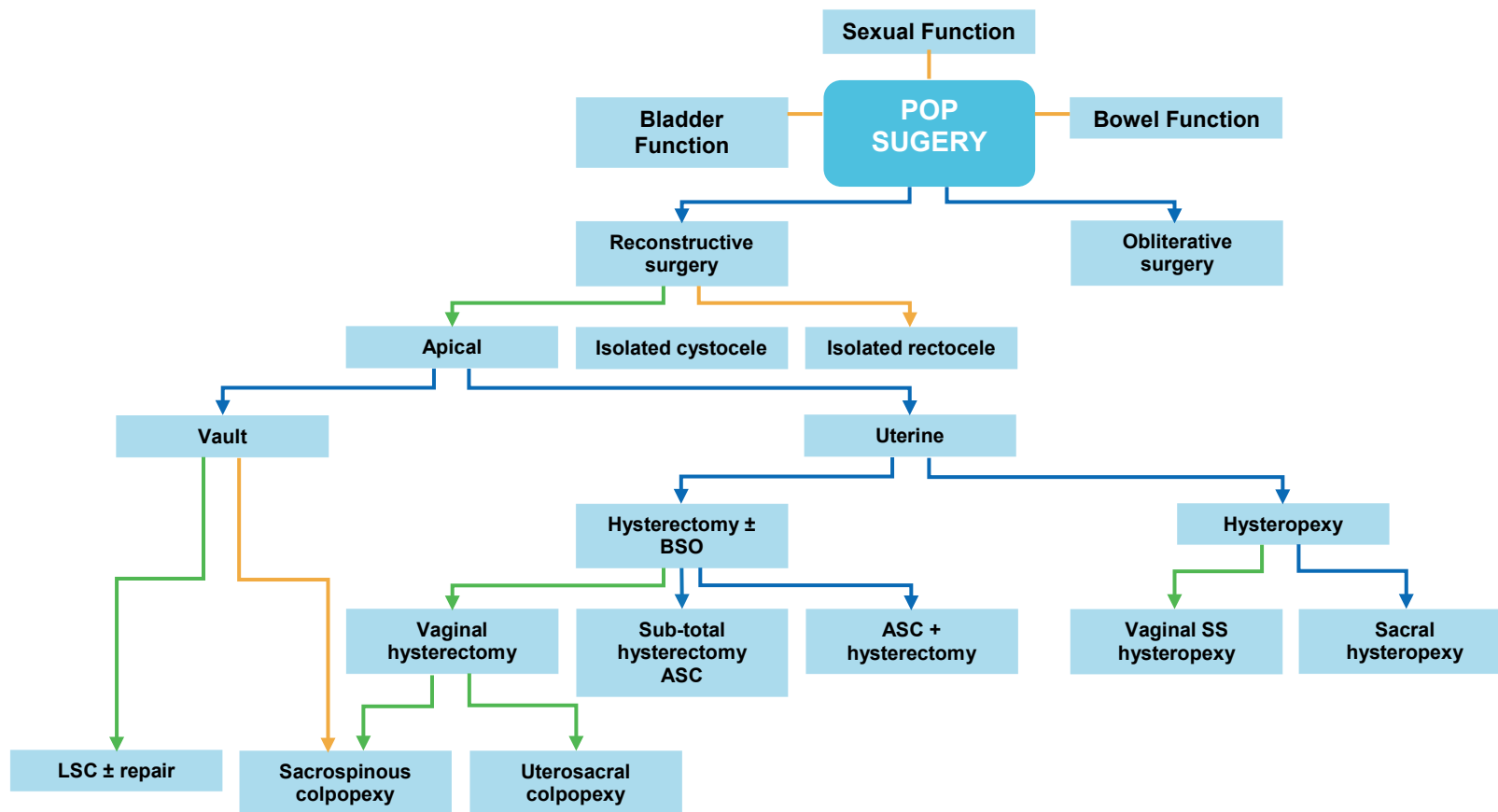
Those undergoing prolapse surgery with stress urinary incontinence (SUI) and occult SUI should generally have continence surgery performed at the time of prolapse surgery (LoE1). Those with prolapse without SUI or occult SUI should not undergo continence surgery at time of prolapse surgery (LoE1).

Based largely upon expert opinion (LoE3) those with prolapse without bowel symptoms and those with impaired defaecation with rectocele should undergo prolapse surgery as per the above pathway. Those with POP and impaired defaecation without rectocele, and those with faecal incontinence require colorectal assessment. If

rectal prolapse exists, these patients may benefit from combined colorectal and gynaecological interventions. Those with significant constipation and prolapse should be approached cautiously and may benefit from gastroenterology assessment prior to entering the POP surgery pathway.

Those undergoing POP surgery generally have improved sexual function post-operatively but a small number undergoing any POP surgery will experience painful intercourse post-operatively that may require subsequent intervention (LoE 1).

## PATHWAY FOR THE SURGICAL MANAGEMENT OF PELVIC ORGAN PROLAPSE



Consider CONTINENCE PRODUCTS for temporary support during treatment