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Pelvic organ prolapse

Patient information

The purpose of this leaflet is to provide the patient with information on the risk factors, nature and treatment of pelvic organ prolapse.

Pelvic organ prolapse is a condition in which one or more organs in the pelvis have moved out of their normal position and lapsed into or out of the vagina. This is due to the weakening and loosening of the connective tissue structures and muscles that keep the pelvic organs in the correct position. Prolapse can involve the uterus, intestines, bladder and, after removal of the uterus, the cervix or the vaginal stump.

The risk of developing pelvic organ prolapse increases with age, with more than half of women over the age of 50 being likely to have prolapse-related complaints.

Seeing a doctor about this problem can help you find solutions for your complaints.

Risk factors

The causes of prolapse are usually combined. These include the following:

- Hereditary predisposition to connective tissue loosening
- Pregnancy and vaginal delivery, which are the most common causes of connective tissue loosening. The risk is increased by the high birth weight of the child, vacuum birth, prolonged birth as well as each subsequent birth
- Age, menopause
- Being overweight
- Constipation, weight lifting or chronic cough – tightening of the abdominal muscles increases the pressure on the pelvic floor

Types of prolapse

The prolapse may involve one or more pelvic organs simultaneously.

The most common types of prolapse are:

- anterior vaginal wall prolapse or cystocele or bladder hernia – arching of the bladder into the anterior vaginal wall or, in the case of a more severe depression, out of the vagina;
- prolapse of the posterior wall of the vagina or rectocele or rectal hernia – arching of the rectum into the posterior vaginal wall or, in the case of a more severe depression, out of the vagina;
- uterine prolapse – lapsing of the uterus into the vagina or, in the case of more severe depression, out of the vagina;
- prolapse of the cervical/vaginal stump – the lapse of the stump into the vagina after the removal of the uterus or, in the case of a more severe depression, out of the vagina;
- cervical elongation – the cervix is elongated and extends into the distal part of the vagina or out of the vagina.

Lapses are divided into degree of severity (using the POP-Q scale) according to how much the pelvic organs have shifted from their normal position.

Complaints of prolapse

Complaints depend on which organs are involved as well as the severity of the prolapse. Mild pelvic prolapse often does not cause any complaints and does not require treatment.

The most common causes of prolapse include:

- the feeling of heaviness, the feeling of something pulling in the vagina or the feeling that something is coming out of the vagina – often the symptoms may get worse when standing/sitting or at the end of the day and get better while lying down or by the next morning;
- increased frequency of urination, difficulty emptying the bladder or feeling that the bladder is not emptying completely. In the case of bladder involvement, urine leaking when coughing/jumping/laughing;
- constipation in the case of colon involvement, difficulty defecating, lower back pain;
- pain, discomfort during sexual intercourse.

To diagnose a prolapse, the doctor asks the patient about their health, complaints and lifestyle and performs a vaginal examination. In some cases, the patient will be referred for further investigation, in particular to clarify complaints related to urination.

Treatment options

Mild pelvic organ prolapse that is asymptomatic for the patient does not require treatment; the patient may be monitored. Partial tissue loosening after childbirth and with increasing age is to be expected.

If the condition is symptomatic, the most appropriate treatment will be selected in cooperation with the doctor and the patient, according to the severity of the prolapse and the pelvic organs affected. The patient’s lifestyle and sexual activity are important in the choice of treatment.

Non-surgical as well as surgical treatment options are available.

To prevent the prolapse from worsening, the doctor may recommend lifestyle changes for the patient: weight loss and keeping the weight within a normal range, reducing or giving up smoking, preventing constipation and avoiding lifting heavy weights.

Regular pelvic floor muscle training can also help reduce symptoms; it is more effective to do the exercises under the guidance of a specially trained physiotherapist.

Non-surgical treatment options

A pessary or vaginal ring is a device made of silicone that is placed into the vagina to support the

pelvic organs. There are different types and sizes of pessaries, the most suitable for the patient is chosen during an appointment with a gynaecologist. Pessaries must be cared for regularly: removed from the vagina, washed and put back in the vagina. In some cases, topical use of a female sex hormone (oestrogen) is required to ensure the elasticity of the vaginal mucosa.

A pessary is well-suited for patients who do not require surgery or are at high risk for surgery.

Surgical treatment options

The purpose of surgical treatment is to support the pelvic organs, to at least partially restore the organs to their original position in the pelvis and to alleviate complaints caused by the prolapse. It is not always possible to completely eliminate the problem with surgical treatment.

Several types of surgery can be performed in the case of prolapse, and a gynaecologist will advise you in choosing a suitable technique. In general, surgeries to treat pelvic organ prolapse are divided into:

- vaginal surgeries (performed in the vagina or through it);
- surgeries performed through the abdomen. During the latter, the abdominal cavity is filled with carbon dioxide and a camera and instruments are inserted through small incisions in the skin for performing the surgery.

In the case of prolapse surgery, the patient's own tissue may be used for the support or the prolapsed organs may be supported with a prosthetic mesh.

Most common surgical techniques

Corrective surgery of the anterior and posterior vaginal wall with the patient's own tissue– a surgery performed in the case of prolapse of the anterior vaginal wall (cystocele or bladder hernia) or the posterior vaginal wall (rectocele or rectal hernia), during which supportive sutures on the connective tissue of the vaginal wall are placed.

Lateral suspension is a surgery performed through the abdomen, usually for the prolapse of the anterior wall of the uterus and vagina: a supporting mesh is attached to the cervix and the upper part of the vagina, the arms of the mesh are placed under the peritoneum in the anterior abdominal wall and the uterus is lifted to the anterior side.

Colposacropexia is a surgery performed through the abdomen in which a prolapsed vaginal or cervical stump is fixed to the sacrum with a mesh.

Vaginal hysterectomy is a surgery performed through the vagina to remove the uterus. Sometimes the surgery is performed with vaginal plastic surgery.

Sacrospinous fixation is a surgery performed through the vagina in which a prolapsed vaginal stump is fixed to the sacrospinous ligaments.

Colpocleisis is a vaginal surgery in which the front and back walls of the vagina are sutured together.

None of the above surgeries guarantee that the problems associated with prolapse are completely eliminated, but they usually significantly improve the patient's quality of life. However, there is a risk of recurrence of the problem after surgery: according to literature, the risk of recurrence ranges from 5-50%. Recurrent prolapse may involve a pelvic organ that was supported during the surgery or another pelvic organ. Patients with persistent risk factors after surgery are at increased risk of recurrence: obesity, chronic cough and constipation, heavy weight-lifting. Therefore, adherence to the postoperative regimen is very important.

Risks associated with treatment

Both the use of pessaries and surgical treatment may be associated with complications that patients must be aware of.

When using a pessary or vaginal ring, there may be an unpleasant odour from the vagina, irritation of the vaginal walls, vaginal discomfort and problems with urinating.

The risks associated with surgical treatment come from both anaesthesia and the surgery itself.

To reduce the risk of anaesthesia, it is important to follow your doctor's instructions, including not eating for six hours prior and not drinking for two hours prior the surgery. The anaesthesia leaflet should also describe as accurately as possible the chronic diseases, the medications used and any reactions to medications that have occurred in the past.

Complications can occur with any surgery. The most common risks related to surgery are:

- injury to neighbouring organs – injuries to the intestines, bladder and ureters are more often and may require repeated surgical intervention;
- infection or inflammation – mainly the risk of developing wound inflammation, less often the development of intra-abdominal inflammation or peritonitis. Inflammation is usually solved with antibacterial treatment;
- bleeding – some bleeding is expected during surgery. However, sometimes heavier bleeding than expected may occur and a blood transfusion may be needed;
- recurrence of the prolapse – even after successful surgery, recurrence may develop, especially if the postoperative instructions are not followed;
- postoperative pain – usually, all patients receive painkillers after surgery. In some cases, the discomfort or pain may persist for a longer period of time or occur during intercourse or defecation, for example.

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