

Pelvic Organ Prolapse

Common

Due to failure of pelvic muscle/fascia

Affects 50-100% of multiparous women: 20% symptomatic

Incidence ~ 1:500 female population

Presentation

Prolapse

Dragging sensation

Voiding dysfunction

Defaecation difficulty

Dysparaeunia

Pelvic pain

Occasionally hydronephrosis

Classification

(i) By compartment

Anterior cystocele, urethrocele, combined

Apical cervix/uterus, enterocele

Posterior rectocele, perineal body laxity

(ii) By musculofascial support (DeLancey)

Level 1 Uterosacral and cardinal ligaments

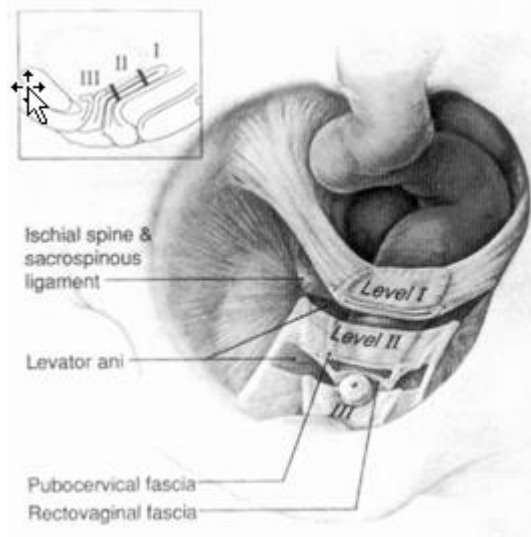
Uterine prolapse, enterocele

Level 2 Pubocervical and rectovaginal fascia

Cystocele, rectocele

Level 3 Urogenital diaphragm, perineal body

Urethrocele, perineal body laxity



(iii) By degree of prolapse

Halfway system (Baden and Walker)

Practical and reasonably reproducible qualitative system

? standardisation of straining/valsalva

Degree of prolapse graded for each pelvic organ

Grade 0 Normal

Grade 1 Halfway to hymen

Grade 2 At introitus

Grade 3 Halfway past hymen

Grade 4 Maximum descent

POP-Q system (Bump et al 1996)

International Continence Society

Quantitative vs. qualitative

Uses anatomical landmarks to standardise halfway system – reference point hymenal ring cf. introitus

Useful for research studies but cumbersome and difficult to remember

Grading similar (grade 2 at hymen etc.)

Grades 1/2

Stress incontinence due to urethral hypermobility. Impaired emptying with cystocele - up to one third of women. Usually few symptoms of OAB or obstructed voiding. Surgical options comprise vaginal or abdominal approach: Vaginal = combined TVT and anterior repair - problems with development of other compartment prolapse. Abdominal = Burch and paravaginal/pelvic floor repair - more invasive. No evidence to favour either approach

Grades 3/4

Predominantly symptoms of OAB and obstructed voiding [70% of patients have objective evidence of BOO, compared with only 6% of patients with grade 1/2. Procidencia associated with hydro-nephrosis in one third of cases]. Digital reduction sometimes required to initiate voiding. Usually no symptoms of stress incontinence. POP repair associated with de novo development of stress incontinence (by relieving urethral kinking) in 22-80% of cases - therefore should have UDS with prolapse reduction, and addition of anti-incontinence repair if positive. Unfortunately no standardised way of performing prolapse-reduction UDS.

Management

(i) Conservative

Reassurance

Weight loss

Pelvic floor exercises

Vaginal pessary (ring, shelf, etc.)

(ii) Surgery

	Primary	Recurrent
Anterior	anterior repair site specific repair	redo repair mesh supplemented? mesh kit (eg Perogee)
Posterior	posterior repair	redo repair mesh supplemented? mesh kit (eg Apogee)
Uterine	hysterectomy sacrospinous hysteropexy sacrohysteropexy colpocleisis	=
Vault	sacrospinous fixation sacrocolpopexy mesh kit (eg Apogee) colpocleisis	=

Anterior colporrhaphy

Recurrence rates 20-30% @ 2 years

Improved outcomes in those with concomitant hysterectomy.

Some evidence that mesh repair of cystocele a/w improved cure rates, but erosion rates 5-17% and significant dyspareunia. Highest erosion rates with microporous (type 2) or mixed (type 3) tapes.

De-novo SUI in ~30%, particularly in those with grade 3/4 prolapse; can be halved with concomitant TVT/TOT

Posterior colporrhaphy

Single RCT showed no benefit for mesh. Case series suggest high rates of erosion and dyspareunia (up to 30% at 3 yrs).

Apical repairs

Mesh (sacrocolpopexy) more effective and less side effects than sacrospinous fixation