Pelvic Organ Prolapse

What is Pelvic Organ Prolapse?

Pelvic organ prolapse (POP) occurs when the tissue and muscles of the pelvic floor no longer support the pelvic organs resulting in the drop (prolapse) of the pelvic organs from their normal position. The pelvic organs include the vagina, cervix, uterus, bladder, urethra, and rectum.

Types of Pelvic Organ Prolapse

Different types of pelvic organ prolapse affect different parts of the vagina (see illustrations):

**Cystocele (Anterior Vaginal Prolapse)** This type of prolapse occurs when the wall between the vagina and the bladder stretches or detaches from its attachment on the pelvic bones. This loss of support allows the bladder to prolapse or fall down into the vagina.

**Urethrocele.** A similar defect, known as urethrocele, develops when the urethra presses into the front vaginal wall.

**Rectocele.** (Posterior Vaginal Prolapse) Weakening and stretching of the back wall of the vagina allows the rectum to bulge into and out of the vagina, sometimes causing difficulty with defecation.

**Enterocoele.** Part of the small bowel pushes through into the vagina. An enterocoele usually develops after a hysterectomy, when the small bowel herniates into the vagina due to lack of normal support.

**Uterine prolapse.** The supporting ligaments and muscles of the pelvic floor that keep the uterus in the pelvis are damaged. The cervix and uterus descend into and eventually out of the vagina. Often, uterine prolapse is associated with loss of vaginal wall support (cystocele, rectocele). In women who have undergone a hysterectomy, a similar condition known as vaginal vault prolapse can occur: the top of the vagina protrudes into the lower vagina.

Pelvic organ prolapse conditions

Depending on where weak spots occur, the bladder, urethra, rectum, or uterus may protrude into the vagina.

What causes pelvic organ prolapse?

Pelvic support comes from pelvic floor muscles, connecting tissue (fascia), and thickened pieces of fascia that serve as ligaments. When pelvic floor muscles are weakened, the fascia and ligaments have to bear the brunt of the weight. Eventually, they may stretch and fail, allowing pelvic organs to drop and press into the vaginal wall.

Women who have had multiple vaginal births are at greatest risk for pelvic organ prolapse, particularly after menopause. Other risk factors include surgery to the pelvic floor, connective tissue disorders, and obesity.

Hysterectomy and other surgical procedures to treat pelvic organ prolapse can also be associated with future development of prolapse. Some other conditions that promote/cause prolapse include: constipation and chronic straining, smoking, chronic coughing and heavy lifting. Obesity, like smoking, is one of the few modifiable risk factors. Women who are obese have a 40 to 75% increased risk of pelvic organ prolapse. Aging, menopause, debilitating nerve and muscle diseases contribute to the deterioration of pelvic floor strength and the development of prolapse.

**Symptoms?**

Women with mild prolapse discovered during a routine pelvic exam may have no symptoms at all. But others experience considerable discomfort and a range of symptoms, including:

**Pressure and pain.** The most common complaints are a feeling of pelvic pressure, or bearing down, leg fatigue, and low back pain.
Urinary symptoms. Cystocele, urethrocele, and uterine prolapse can cause stress incontinence, difficulty in starting to urinate and possible incomplete bladder emptying.

Bowel symptoms. A rectocele may cause problems with defecation by forming a pocket just above the anal sphincter. Stool can become trapped, causing pain, pressure, and constipation.

Sexual problems. A prolapse can cause irritated vaginal tissues or pain during intercourse, as well as psychological stress.

Treatment.

Women with no or very mild symptoms do not need treatment, although they should avoid anything that might worsen the prolapse, for example, losing weight if necessary, avoiding lifting heavy objects, and quitting smoking all prevent prolapse from progressing. Prolapse doesn’t necessarily worsen over time, so there’s no need to seek aggressive treatments, unless your symptoms are really bothersome.

If you’re experiencing major discomfort or inconvenience, surgery is the only definitive way to relieve symptoms and improve your quality of life (see “Surgical treatment,” below). But if your symptoms are mild or you want to delay or avoid surgery, less invasive treatments can help:

Pelvic Floor Exercises (PFE’s). A woman with prolapse but no symptoms should be encouraged to practice pelvic floor exercises to reduce the chance of her condition progressing. PFE’s are a series of contractions that strengthen the pelvic floor.

Pessary. For women who are not suitable for surgery or want to delay surgery (eg, planning to have more children), one alternative is a vaginal pessary. (See illustration).

Surgical treatment

Not every woman with POP will need surgery. Surgery may be recommended for women with significant discomfort or pain from POP that impairs their quality of life. If surgery is recommended, factors to consider include: which organ(s) have prolapsed, severity of prolapse, desire for future children, age, sexual activity, and severity of symptoms.

Surgical techniques.

Pelvic reconstruction surgery may be performed through the vagina or abdominally; both procedures are equally effective. A newer option is laparoscopic surgery, in which repairs are made with instruments, including a camera, inserted through a few tiny abdominal incisions. The prolapsed organ will be repositioned and secured with stitches to the surrounding tissues and ligaments. The vaginal defect will be repaired, sometimes using a piece of synthetic material, called a graft or mesh. Hospital stay is usually within one to three days.

Complications. The consultant will discuss any possible complications of pelvic reconstructive surgery.

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