Primary Care
Women's Health Society

Further reading

Pelvic organ prolapse

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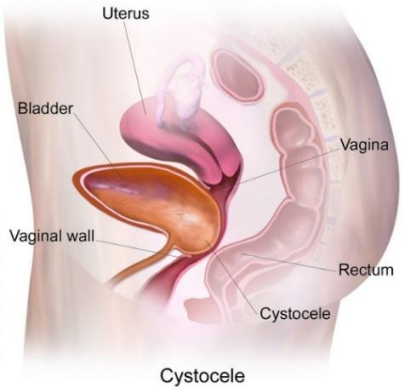
Pelvic organ prolapse occurs when one or more pelvic organs descend from their normal anatomical position into the vagina. It is caused by weakened pelvic support structures and can affect up to 40% of women[1]. Common symptoms of a prolapse are a heaviness or bulge in the vagina, which may be associated with bladder or bowel symptoms such as difficulty passing urine, frequency, urgency and incontinence[2].

Classification

Anterior vaginal wall prolapse/cystocele

The bladder and or urethra bulge into the anterior wall of the vagina. Symptoms include a sensation of bulge/dragging/heaviness in the vagina, urinary frequency, urgency, incomplete emptying, recurrent UTIs, sexual dysfunction.

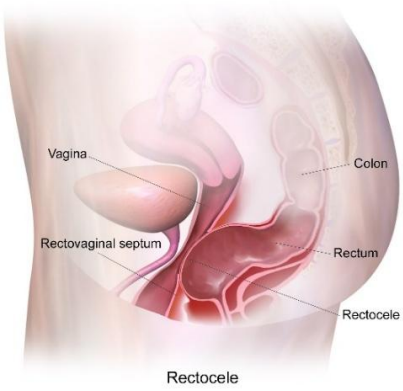


Cystocele

Medical illustration of an anterior prolapse, or a cystocele by BruceBlaus, used under the Creative Commons Attribution-Share Alike 4.0

Posterior vaginal wall prolapse/rectocele

The rectum bulges into the posterior wall of the vagina. Symptoms include a sensation of bulge/dragging/heaviness in the vagina, difficulty emptying bowels, sexual dysfunction. When severe, the patient may need to digitate (put a finger into the vagina to empty the bowel).

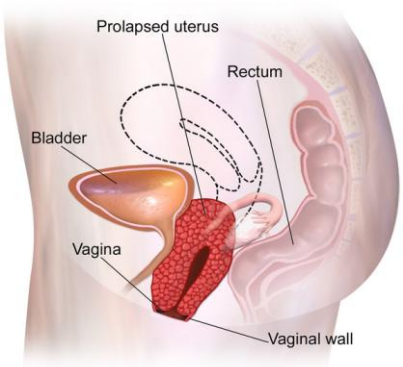


Rectocele

An illustration depicting a rectocoele by Bruce Blaus, used under the Creative Commons Attribution-Share Alike 4.0 International license.

Uterine/vault prolapse

Uterine prolapse is when the uterus descends into the vagina. There will typically be associated cystocele and rectocele. Descent of the womb below the vaginal introitus is defined as a procidentia.
Vault prolapse is when vaginal vault/top of the vagina bulges down into the vagina after a hysterectomy.



Uterine Prolapse

A medical illustration depicting a uterine prolapse by Bruce Blaus, used under the Creative Commons Attribution-Share Alike 4.0 International license

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Aetiology

Pelvic organ prolapse occurs when the pelvic floor weakens. The most common reasons for developing a prolapse are[3]:

- Pregnancy and childbirth.
- Overweight and obesity.
- Menopause - reduction in oestrogen causes the connective tissues supporting the pelvic floor to weaken.
- Chronic constipation.
- Chronic cough.
- Heavy lifting.
- Family history of a prolapse.
- Connective tissues disorders such as Ehlers-Danlos syndrome or hypermobility syndrome.

Management

Conservative

- Weight loss.
- Minimise heavy lifting.
- Avoid constipation - preventing constipation and associated straining can help to stop prolapse worsening. Eating a high fibre diet can help with this as well as sitting on the toilet correctly. Advise patients to sit with a straight back, leaning forward, with their elbows on their knees and their knees higher than their hips. A footstool may help with this last point.
- Pelvic Floor Exercises (PFE):
    - NICE suggest that these should be considered for at least 16 weeks as a first line option for those presenting with a stage 1 or stage 2 prolapse with the aim of strengthening the pelvic floor.
    - Women presenting with symptoms of prolapse should be referred to a pelvic health physiotherapist[3], who will ensure they are doing pelvic floor exercises correctly and support them to do so. Apps such as 'squeezy' are available for patients to download.

Non-surgical - vaginal oestrogen and moisturisers

- Women with menopause associated genitourinary syndrome generally have more pronounced symptoms of prolapse. The tissues of the vulva and vagina are thinner, drier and less elastic[4].
- If a pessary is used in this situation, it can cause discomfort, abrasion and ulceration which in turn can lead to vaginal bleeding. Benefits of using topical vaginal oestrogen may not be noticed for a few months; symptoms can recur when treatment stops[4].
- Oestrogen pessaries, creams and rings are all acceptable, alongside a pessary used to manage a prolapse. Choice of formulation is very much patient dependent. In some circumstances it can be helpful to place an oestrogen releasing ring in front of or behind the pessary. These need to be changed every three months.
- Vaginal moisturisers are available for those who are unable to use topical vaginal oestrogen.

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Non-surgical - vaginal pessaries

- Vaginal pessaries support the pelvic organs and can be used alone or in conjunction with PFE. They are typically made of plastic or silicone and are available in a range of different shapes and sizes depending on the type of prolapse.
- Fitting a pessary is trial and error- patients must are warned that the first pessary may fall out, most commonly when they open their bowels, but that they should return to try a larger size or different type of pessary if it has helped their symptoms.
- Pessaries can be used for long term management of prolapse or as a holding measure whilst awaiting surgery,[5] or until the woman's family is complete. The 4-6 month check may be in secondary care, or at the GP if this is resourced[6].
- Many women opt to manage their own vaginal pessaries. They can remove and reinsert them as they wish, for example prior to intercourse or exercise if this is wanted. Self-managing pessaries increases independence and should be encouraged where possible. Women who manage their own pessaries report less pessary related complications and are more likely to perceive an improvement in their symptoms[9].
- Pessaries aren't suitable for all patients and should not be used if:
    - Regular follow-up is not possible.
    - There is active pelvic infection or unexplained vaginal bleeding.
    - Post brachytherapy.
    - In severe atrophic vulvovaginitis (however, this is eminently treatable).
    - The vagina is too short/narrow to hold the pessary.
- The most common complications with a vaginal pessary are[7]:
    - Increased vaginal discharge.
    - Erosion of vaginal skin.
    - Vaginal bleeding.
    - Discomfort.
    - Expulsion of the pessary.
    - New bladder/ bowel symptoms.
- Types of pessary:
    - Ring pessaries are the most common pessary used. They work most effectively for 1st and 2nd degree uterine prolapse or mild to moderate cystocele but are not as effective at managing a rectocele. They are commonly used in primary care and are easy to self-manage if the patient wishes to remove for sexual intercourse or otherwise.
    - Space occupying pessaries are used for larger prolapses, typically when a ring does not provide sufficient support or falls out. They have a stem which sits in the vagina to aid removal but means that intercourse is not possible. This must therefore be addressed in the assessment when considering a pessary.
        - Shelf and Gellhorn pessaries are the most common space occupying pessaries and work via suction. They can be left in situ for 6 months and are typically managed in secondary care.
        - Cube pessaries can be used to manage third degree uterine prolapse and rectocele; these are also held in with suction but must be removed every night, so before considering this type of pessary, it is important to ensure that the patient is motivated and able to remove it.

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Surgical

Some women prefer to consider more definitive surgical management, with the aim of restoring utero-vaginal anatomy, however the recurrence rate is around 30%[10].

- Operations may include:
  - Anterior repair (repair of cystocele).
  - Posterior repair (repair of rectocele).
  - Hysterectomy +/- repair.
- The British Society of Urogynaecology provide an excellent set of patient information leaflets about all surgeries performed for prolapse management.

Resources

- NICE. NG123. June 2019. Urinary incontinence and pelvic organ prolapse in women: management.
- NICE. NG210. Dec 2021. Pelvic floor dysfunction: prevention and non-surgical management
- POGP. March 2021. Best practice in the use of vaginal pessaries.
- The British Society of Urogynaecology (BSUG) Patient information leaflets

References

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