

Pelvic Organ Prolapse FAQs

What is prolapse?

Prolapse is a hernia of the vagina that a woman may feel as a bulge or pressure. This is referred to in many different ways, including “dropped bladder,” “dropped uterus,” “dropped vagina,” or “dropped rectum.” Your doctor may have also called this a cystocele, rectocele, or enterocele.

Prolapse, which is caused by a weakening of the vaginal tissues, is often associated with pregnancy and childbirth; however, prolapse can happen in women who have never had children. Prolapse is also associated with repetitive heavy lifting, chronic constipation, chronic cough, and poor tissue.

Prolapse symptoms may be worse at different times in the day. Some women notice that they feel more pressure after walking or standing for long periods of time.

My doctor told me I have a “dropped bladder.” What is this?

Sometimes the vaginal tissue under the bladder becomes weak and causes a hernia. This is called prolapse. You may feel a bulge outside the vagina, or pressure. Your doctor might also have called this condition a “cystocele.”

Is prolapse serious?

Prolapse can be uncomfortable, especially if you can feel the bulge after walking or standing for long periods of time. The good news is that prolapse is generally not life-threatening, and many treatment options are available. For most women, the treatment they choose depends on how much they are bothered by their symptoms. Many conservative treatment options are available, including dietary changes, pelvic floor muscle exercises, and physical therapy. One treatment for

prolapse is a device inserted into the vagina called a *pessary*. Finally, some women are bothered by the prolapse enough to decide to have surgery.

What are the risk factors for prolapse?

By studying large numbers of women with and without prolapse, researchers and urogynecologists have identified certain risk factors that predispose, cause, promote, or worsen pelvic organ prolapse.

The overall strength of human bones, muscles, and connective tissue is influenced by our genes and our race. Some women are born with weaker tissues and are therefore at risk to develop prolapse. Caucasian women are more likely than African-American women to develop pelvic organ prolapse. Loss of pelvic support can occur when any part of the pelvic floor is injured during vaginal delivery, surgery, pelvic radiation, or back and pelvic fractures during falls or motor vehicle accidents.

Hysterectomies and other procedures that treat pelvic organ prolapse also are associated with future development of prolapse. Some other conditions that promote 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 40-75 percent increased risk of pelvic organ prolapse. Aging, menopause, and debilitating nerve and muscle diseases contribute to the deterioration of pelvic floor strength and the development of prolapse.

Is prolapse common?

We do not know exactly how common pelvic organ prolapse is because research is limited to women who seek health care. It is estimated that nearly 50 percent of all women between the ages

of 50 and 79 have some form of prolapse. The lifetime risk that a woman will have surgery for the correction of prolapse or urinary incontinence in the United States is about 11 percent. We also know that only one-third of these women will undergo repeat corrective surgery for these conditions. Approximately 200,000 procedures for correction of pelvic organ prolapse are performed each year in the United States. We believe that is just the tip of the iceberg, as many women manage their prolapse without surgery.

What are the symptoms?

Some loss of support is a very common finding upon physical exams in women, many of whom do not have bothersome symptoms. Those women, who are often uncomfortable, describe the very first signs as subtle, such as an inability to keep a tampon inside the vagina, dampness in underwear, or discomfort due to dryness during intercourse.

As the prolapse worsens, some women complain of:

- A bulging, pressure, or heavy sensation in the vagina that worsens by the end of the day or during bowel movements;
- A feeling that they are “sitting on a ball”;
- Needing to push stool out of the rectum by placing their fingers into the vagina during bowel movement;
- Difficulty starting to urinate, or a weak or spraying stream of urine;
- Urinary frequency or the sensation that they are not emptying their bladder well;
- The need to lift up the bulging vagina or uterus to start urination;
- Urine leakage with intercourse.

What are the different types of prolapse and how can they be managed?

There are several types of prolapse, each with their own set of characteristics and treatment options.

ANTERIOR VAGINAL PROLAPSE

(also known as *cystocele*)

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.

Most women do not have symptoms when the anterior vaginal prolapse is mild. As it progresses outside the opening of the vagina, the prolapsed bladder may not empty well, which can lead to urinary frequency, night-time voiding, loss of bladder control, and recurrent bladder infections. Strengthening pelvic muscles may improve the support to the bladder and neighboring organs and reduce symptoms. In addition, women can get temporary support by wearing a device called a *vaginal pessary*. It works much like a knee or ankle brace would support a weak joint. When these efforts are inadequate, surgery is available to elevate the bladder and other internal organs to their proper position.

POSTERIOR VAGINAL PROLAPSE

(also known as *rectocele*)

Weakening and stretching of the back wall of the vagina allows the rectum to bulge into and out of the vagina. Most often, the damage to the back wall of the vagina occurs during vaginal childbirth, although not everyone who has delivered a child vaginally will develop a rectocele. Mild rectoceles rarely cause symptoms. However, straining with constipation puts significant pressure on the weak vaginal wall and can further thin it out. Avoiding constipation may prevent progression and also reduce symptoms from the rectocele. Some women might find benefit from pelvic floor muscle strengthening and vaginal pessaries. When these low-risk interventions are insufficient to relieve symptoms, surgery is performed to reinforce the posterior vaginal wall.

UTERINE PROLAPSE

When the supporting ligaments and muscles of the pelvic floor 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*). When the cervix protrudes outside the vagina, it can develop ulcers from rubbing on underwear or

protective pads. There is a risk that these ulcers will bleed and become infected.

As with other forms of prolapse, it is not until the uterine descent is bothersome that treatment is necessary. Women who have uterine prolapse often report pelvic pressure, the need to sit or lay down to relieve the discomfort, a sensation that their insides are falling out, difficulty emptying their bladder, and urine leakage. Strengthening the pelvic muscles with Kegel exercises and avoiding heavy lifting, constipation, and weight gain may reduce the risk of progression of uterine descent. Additional treatment options include pessary devices, which provide support when worn, and surgery.

VAGINAL PROLAPSE AFTER HYSTERECTOMY

If a woman has already had a hysterectomy, the very top of the vagina (where the uterus used to be) can become detached from its supporting ligaments. This can result in the tube of the vagina turning inside out. This condition is also known as vaginal “vault” prolapse. Depending upon how extensively the top of the vagina is turning inside out, one or several pelvic organs (such as the bladder and the small and large bowels) will prolapse into the protruding bulge. Symptoms depend on which organs are prolapsing. When the bladder is involved, women report difficulty in starting to urinate and emptying their bladder well. If it is the bowel, then many report the need to push up the vaginal bulge and strain to have a bowel movement. Skin sores may develop if the bulge is rubbing on pads or underwear. A pessary may provide support for the bulge; otherwise, surgery is recommended.

RECTAL PROLAPSE

The rectum is the name given to the last six inches of the colon. Like the vagina and uterus, the rectum is normally securely attached to the bony pelvis by ligaments and muscles. Infrequently, the supporting structures stretch or detach from the rectal wall, which results in the rectum relapsing through the anus. This looks like red, often donut-shaped soft tissue coming through the anus. Early

on, it is most often noticed on the toilet after a bowel movement and can be confused with a large hemorrhoid. Conditions associated with straining, such as chronic constipation or diarrhea, nerve and muscle weakness (paralysis or multiple sclerosis), and advancing age, are risk factors for rectal prolapse.

Women with rectal prolapse often report the following symptoms:

- Pain during bowel movements;
- Mucus or blood discharge from the protruding tissue;
- Loss of control of bowel movements;
- Soft, red tissue protruding from the anus.

It is very important to be clear in describing where the bulging tissue is coming from (opening of the anus or the vagina) when you seek help, as both conditions may be present simultaneously.

Treatment for a rectocele and a rectal prolapse are different.

How can I prevent pelvic organ prolapse?

Because vaginal and uterine prolapse have several different causes, there is no single way to prevent these problems. Currently, a woman cannot change her genetic risk profile, which influences the strength of her connective tissue. She can, however, make wise choices that influence those risks, which are modifiable.

In general, avoid increased pressure inside the abdomen and on the pelvic floor. This can be done by:

- Maintaining a normal weight or losing weight if overweight, as overweight women are at a significantly increased risk of developing prolapse;
- Following a diet with plenty of fiber and fluids, as well as regular exercise to help maintain regular bowel function. Constipation and chronic straining during bowel movement increase a woman’s chance of developing prolapse, especially a rectocele. If constipation persists despite diet and exercise measures, further evaluation and treatment is recommended;

- Seeking medical attention to evaluate and treat a chronic cough, which increases abdominal and pelvic pressure;
- Avoiding heavy lifting and learning how to lift safely by using leg and arm muscles as much as possible.
- Not smoking—or kicking the habit;
- Avoiding repetitive strenuous activities;
- Learning and performing pelvic floor muscle (Kegel) exercises regularly to improve the strength of the pelvic floor, and limit the likelihood of developing prolapse. Once prolapse has developed, pelvic floor exercises will not correct the prolapse, but they may limit the development of worsening prolapse and may diminish some of the symptoms.

What will happen if I just ignore this problem? Will it get worse?

Most likely. Prolapse, left untreated, often gets worse over time, but this is usually a gradual change. One exception to the rule: “New” prolapse (noticed by a patient or doctor in the early postpartum period) will often get better within the first year after the delivery.

Treatment of prolapse should be based on your symptoms. In rare cases, severe prolapse can cause urinary retention (inability to empty the bladder), which progresses to kidney damage or infection. When this occurs, prolapse treatment is mandatory. In most other cases, patients should be the ones to decide when to have their prolapse treated, based on the symptoms they are having.

What is a pessary?

A *pessary* is a plastic device that can be used to help support prolapse. It is used for women who do not want surgery. Pessaries come in different shapes and sizes and can be fitted to help women with different degrees and types of prolapse. Pessaries are safe to use and are latex-free.

Once you decide you would like to try a pessary, you will be fitted for the correct size and shape to help support the prolapse without causing any discomfort or pain. The pessary that fits best

will be able to support the prolapse, feel comfortable, and allow you to urinate and have bowel movements without difficulty.

Pessaries should be removed and cleaned on a regular basis. Most pessaries are easy to remove/clean/replace daily or weekly. However, some pessaries are difficult to remove and require you to be seen in the doctor’s office for removal, cleaning, and replacement. A pessary can be used for any woman who is bothered by her prolapse but who does not want to have surgery, or for women with other medical conditions that make surgery riskier. Pessaries can be used for as long as the woman desires.

What types of surgeries are done to fix prolapse?

Many times, surgery is chosen when a vaginal pessary is either not desired or cannot be retained comfortably. There are several different surgical techniques that are effective. Often the choices offered to a woman depend upon her anatomy, her overall health, her prior surgeries and current medical conditions, her desire to retain sexual function, and the experience and training of her surgeon. Deciding whether or not to have surgery for prolapse is an individual decision. The success or failure of someone else’s operation should never be the deciding factor for you. Every woman’s situation is different. There is no single operation that is right for every patient. You and your urogynecologist must decide the best option together.

Pelvic reconstructive surgery can be performed through an incision in the vagina, through an incision in the abdominal cavity, or through a series of small incisions in the abdomen through which the surgeon places a laparoscope and instruments. Recently, it is even being performed with the assistance of a robot. The advantages and disadvantage of each of these approaches should be discussed with your urogynecologist.

The goal of all reconstructive pelvic floor procedures is to restore normal pelvic floor anatomy and to give the patient her best chance at

maintaining a normal quality of life, including sexual intercourse, if desired.

Apical Suspensions

The most important aspect of a prolapse repair (when maintaining sexual function is desired) is restoration of the support of the top of the vagina, which is also called the vaginal apex or vault.

Common procedures that do this are:

- *Abdominal Sacral Colpopexy (ASC)*: The ASC is performed through an abdominal incision (about 3-4 inches long), done laparoscopically (through four half-inch incisions) or robotically. In this procedure, straps of graft material are used to reinforce the front and back walls of the vagina. These straps are then attached to a strong ligament overlying the sacrum. The end result is that the vagina is suspended over the pelvic muscles to the back bone. The mesh graft straps replace the original natural support provided by the uterosacral ligaments.
- *Uterosacral or Sacrospinous Ligament Fixation*: When a vaginal incision is preferred, the top of the vagina is most often suspended to a woman's own uterosacral ligament or the sacrospinous ligaments. Traditionally these procedures did not use graft material. But recently, some surgeons are adding graft reinforcement to the natural ligament suspensions in an effort to improve the durability of the prolapse repair, when surgeons find the vaginal wall to be weak. Research studies are being conducted to determine if this desired benefit will result in superior outcomes.

ANTERIOR VAGINAL PROLAPSE REPAIR

A cystocele or bulge of the front wall of the vagina usually results in loss of support to the bladder that rests upon this part of the vagina. The goal of a cystocele repair is to elevate the anterior vaginal wall back into the body and support the bladder. This can be done either vaginally, called "anterior

colporrhaphy," or through an abdominal approach at the time of a sacral colpopexy.

POSTERIOR VAGINAL PROLAPSE REPAIR

A rectocele, or bulge of the back wall of the vagina, is most often repaired by a vaginal procedure called *posterior colporrhaphy*. If the muscles at the opening of the vagina have been stretched or separated during childbirth, the repair may include a *perineorrhaphy*. A rectocele may also be fixed abdominally at the time of a sacral colpopexy.

Perineorrhaphy is surgical reconstruction of the muscles of the perineum, the area between the vagina and the rectum. This procedure involves reattaching a number of small muscles that normally connect in this area.

OBLITERATIVE PROCEDURES

For those women who do not need to maintain sexual function, an obliterative procedure may be the quickest and least risky method to correct prolapse. Obliterative operations correct prolapse by narrowing and shortening the vagina. These procedures support the pelvic organs with the patient's own pelvic muscles in such a way as to make the vagina too small to accommodate a penis for sexual intercourse. The skin overlying the vaginal bulge is removed, and the front and back walls of the vagina are sewn to each other. A woman who has undergone this surgery will look the same on the outside of her genital area and she will be able to have bowel movements and urinate normally. Her ability to have an orgasm with clitoral stimulation is similar to before her surgery.

There are two main types of obliterative surgery: partial (colpocleisis) and complete (colpectomy). Both are very effective and durable in correcting prolapse. Prior surgeries often influence which procedure is offered to women. The benefit of obliterative surgery is that it is very durable, does not involve the risks of graft materials, tends to be less invasive, and is therefore associated with a quicker recovery.

Do I have to have a hysterectomy as a part of my surgery?

No. All of the operations for prolapse and incontinence can be performed with or without a hysterectomy. However, a hysterectomy is often performed along with these operations for a variety of reasons. In some cases, removing the uterus first makes the rest of the surgery easier to perform. In other cases, there is another reason besides prolapse or incontinence (such as cancer or excessive bleeding) to remove the uterus. Whether or not to remove the uterus should be discussed between the patient and her surgeon, and the decision should be individualized from patient to patient.

Recently, there has been renewed interest in the possibility of repairing the prolapse without taking the uterus out (uterine preservation). Reasons to consider uterine preservation include the following:

- Potentially decreasing the operative time and risk of surgery, because the hysterectomy part is not required;
- Reducing vaginal incisions, which might in turn reduce some kinds of complications like erosions, and leave more of the support structures intact;
- Individual patient preference;
- The desire to become pregnant, although most surgeons discourage prolapse surgery until childbearing is complete.

However, there are reasons to be cautious about leaving the uterus in place, which include the following:

- Presence (or development) of abnormalities, such as fibroids or cancer;
- Continued need for Pap smears, especially if there have been abnormal Pap smears in the past;
- As always, these issues require a careful conversation that addresses the experience and recommendations of the surgeon, along with the values and preferences of the patient.

I have prolapse, but I don't leak urine. Do I still need bladder testing?

Most likely. If you are going to have surgery to correct the prolapse, bladder testing (called *urodynamics*) usually is done first. That's because the prolapsed portion of your vagina may be pushing on your urethra and preventing urine leakage. If that is the case, having the prolapse corrected can give you a new problem—urinary incontinence. The best way to tell whether a continence procedure is needed at the time of prolapse surgery is to perform urodynamics while holding the prolapse up in its normal position.

If my surgery is successful, how long will it last?

The goal of continence or pelvic reconstructive surgery is to re-create normal anatomy permanently. However, none of these procedures are successful 100 percent of the time. According to the medical literature, failures occur in approximately 5–15 percent of instances (perhaps higher for anterior repair type surgery) of women who have prolapse surgery. In these cases, it is usually a partial failure requiring no treatment, pessary use, or surgery that is much less extensive than the original surgery. Patients who follow the recommended restrictions after surgery give themselves the best chance for permanent success.

What are the risks with using graft material?

The graft material most often used for prolapse repair is a medical grade polymer or plastic called *polypropylene*. This graft material is also used for abdominal and groin hernia repairs. Approximately 90 percent of patients do very well with this material. However, 5–10 percent of patients may experience an exposure of the material into the vagina, causing vaginal discharge or spotting, and these patients may require removal of the exposed mesh material. This can either be done in the office or as an outpatient procedure.

Another less common complication associated with the mesh grafts is infection, which is treated with antibiotics and surgery to remove the graft.

Women who smoke tobacco products carry a greater risk for mesh exposure. Currently, women with severe or recurrent prolapse who prioritized retaining sexual function, gain the greatest benefit from mesh reinforcement procedures. Every woman has a different risk/benefit profile regarding graft repairs.