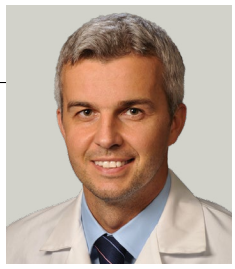
AT THE FOREFRONT
UChicago Medicine

Department of Obstetrics & Gynecology
Physician Connect
WINTER 2020

BEST HOSPITALS U.S.News & WORLD REPORT NATIONAL GYNECOLOGY 2019-20

BRIEFINGS FROM
WOMEN'S HEALTH EXPERTS

Pelvic Organ Prolapse: An Overview



by Juraj Letko, MD
Urogynecology and Pelvic Reconstructive Surgery
Assistant Professor of Obstetrics and Gynecology

What is pelvic organ prolapse and its prevalence?

Pelvic organ prolapse (POP) is a herniation of the pelvic organs to or beyond the vaginal walls. Pelvic organs can herniate through any or all vaginal compartments resulting in anterior compartment prolapse (aka cystocele), posterior compartment prolapse (aka rectocele or enterocele) and apical prolapse (uterine or vaginal vault prolapse).

When women are routinely examined for gynecologic care, 50% of them have stage 0 or 1 POP [1]. The majority of these women, however, are asymptomatic or their symptoms are not bothersome. Overall, a woman's lifetime risk to undergo surgery for POP is 19 percent [2].

How does pelvic organ prolapse develop?

Anatomic support to the pelvic organs is provided by the pelvic floor muscles and a network of connective tissue attachments to the pelvic walls. The levator ani is the key muscle complex supporting the pelvic organs. Connective tissue condensations form ligaments (uterosacral and cardinal) and endopelvic fascia, which together stabilize the pelvic organs. Injury to these structures results in weakened pelvic organ support and increased size of the genital hiatus. Over time, women may accumulate additional risk factors that promote the development and progression of POP.

Delivering vaginally, advanced age, and obesity are established risk factors for developing POP. Other potential risk factors include pregnancy (irrespective of mode of delivery), instrumental delivery, infant birthweight, race or ethnicity, heavy lifting, connective-tissue disorders, constipation, and prior hysterectomy.

What is the impact on women's lives?

POP symptoms are distressing, embarrassing, and many women may be reluctant to broach these topics with their care providers. Asking every woman a general question such as, "Do you have any concerns about your pelvic floor, bladder, or bowel function?" normalizes this common issue.

Women with POP usually become symptomatic once the vaginal bulge reaches or protrudes beyond the vaginal hymen. The symptoms may be specific to the prolapse, such as vaginal bulge or pressure, or can be associated with symptoms including urinary, defecatory or sexual dysfunction [3]. Prolapse has a significant impact on body image and sexuality [4]. Severity of these symptoms, however, does not correlate well with the degree of prolapse.

How is POP diagnosed?

POP is diagnosed using pelvic examination. The recommended staging system for evaluation of POP severity is the Pelvic Organ Prolapse Quantification (POPQ) system [5]. Imaging is not usually necessary for evaluation of POP; however, it may play a role in the planning of surgical treatment if surgery is indicated and desired by the patient.

What are the treatment options for POP?

Treatment of POP is generally reserved for symptomatic cases, and the impact of these symptoms on the patient's quality of life is critical to identify treatment goals.

Women with POP can be managed expectantly or treated by conservative or surgical therapy. Degree of POP, age, and ability to comply with conservative treatment, or to tolerate surgery, play an important role in choosing an individualized treatment plan.

Expectant management by observation is an acceptable option if the patient prefers to avoid treatment and her POP symptoms are tolerable. However, women with advanced stages of POP (stage 3 and 4) may develop worsening urinary and defecatory symptoms and findings. These patients should be thoroughly counseled about the risks and if they opt for expectant management, they should undergo regular surveillance.

Conservative treatment options, including pelvic floor muscle training (PFMT) and trial of pessary, should be offered to every woman with a symptomatic POP.

Surgery is indicated for treatment of POP in women who are bothered by their POP and have failed or declined nonsurgical treatments [6].

(continued from page 1)

What are the surgical options for POP?

A variety of surgeries are available for treatment of POP. Considering the specifics of each type of surgery in combination with the patient's own treatment goals is critical in planning the optimal surgical treatment of POP for each individual.

Surgeries for POP are reconstructive or obliterative. Most women are treated by reconstructive surgeries, which preserve vaginal function and allow penetrative intercourse. These surgeries can be approached vaginally or abdominally. Abdominal surgeries are usually performed in a minimally invasive fashion via laparoscopy or robot-assisted laparoscopy. Reconstructive surgeries for POP include native tissue repairs and surgeries using augmenting materials such as biological grafts or permanent mesh. When uterine prolapse needs to be addressed, this can be done with concomitant hysterectomy or preservation of the uterus.

Obliterative surgeries result in closing off the vaginal canal, hence, they are reserved for women who do not plan to engage in future penetrative vaginal intercourse or cannot tolerate reconstructive procedures. Obliterative procedures have low risk of perioperative morbidity, very low risk of recurrence, and high satisfaction.

Which patients should be referred?

Pelvic organ prolapse is usually a result of a complex pelvic floor dysfunction that is often accompanied by urinary and defecatory symptoms. Symptoms of POP have a great impact on daily activities, body image and sexual function of women, resulting in decreased quality of life. A great variety of management options for symptomatic POP is available ranging from pelvic floor muscle training to surgical repair. Each management option has its own advantages/benefits, disadvantages, and risks in comparison to the alternatives. Careful consideration of these options in combination with individual treatment goals of each woman is critical to plan the most optimal treatment of POP.

Patients with the following symptoms may benefit from an urogynecology evaluation:

- Vaginal bulge
- Urinary complaints
  - Incontinence
  - Feeling of incomplete bladder emptying
  - Frequency or urgency
  - Leaking urine during sex
- Bowel complaints
  - Constipation
  - Inability to completely evacuate bowel
  - Splinting
  - Loss of control of bowel movements or flatus
- Pelvic pain or pressure
- Pain during sexual intercourse or loss of sexual sensation
- Vaginal bleeding

Summary

- 50% of women have POP — most are asymptomatic.
- 1 in 5 women will need surgery for POP over their lifetime.
- Ask all women: "Do you have any concerns about your pelvic floor?" "Have you noticed any vaginal bulge or urinary incontinence?" Many women are embarrassed and reluctant to discuss these topics with their care providers.
- Physical exam is the key to diagnosis.
- Non-surgical options are available for treatment of POP.
- We are happy to discuss individualized treatment plans that address the extent of their POP and their specific goals.

To schedule a patient, e-mail us at womenshealth@uchospitals.edu or call 773-702-6118

Urgent appointments are also available.

UChicagoMedicine.org/womens-health

[1] Swift SE. The distribution of pelvic organ support in a population of female subjects seen for routine gynecologic health care. *Am J Obstet Gynecol.* **2000**;183(2):277. [2] Smith FJ, Holman CD, Moorin RE, Tsokos N. Lifetime risk of undergoing surgery for pelvic organ prolapse. *Obstet Gynecol.* **2010**;116(5):1096. [3] Jelovsek JE, Maher C, Barber MD. Pelvic organ prolapse. *The Lancet.* **2007**;369(9566):1027. [4] Lowder JL, Ghetti C, Nikolajski C, Oliphant SS, Zyczynski HM. Body image perceptions in women with pelvic organ prolapse: a qualitative study. *Am J Obstet Gynecol.* **2011**;204(5):441. [5] Bump RC, Mattiasson A, BøK, Brubaker LP, DeLancey JO, Klarskov P, Shull BL, Smith AR. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. *Am J Obstet Gynecol.* **1996**;175(1):10. [6] Committee on Practice Bulletins—Gynecology and the American Urogynecologic Society. Practice Bulletin No. 176: Pelvic Organ Prolapse. *Obstet Gynecol.* **2017**;129(4):e56.

UROGYNECOLOGY AND PELVIC RECONSTRUCTIVE SURGERY

Referrals and consultations
Call **773-702-6118**
Email **womenshealth@uchospitals.edu**

LOCATIONS

Hyde Park
Duchossois Center for Advanced Medicine (DCAM)
5758 S. Maryland Ave.
Third Floor
Chicago, IL 60637

Hinsdale
12 Salt Creek Lane
Salt Creek Suite 106
Hinsdale, IL 60521

New Lenox
1850 Silver Cross Blvd.
New Lenox, IL 60451

Orland Park
14290 S. La Grange Road
Third Floor
Orland Park, IL 60462

Schererville
222 Indianapolis Blvd.
Schererville, IN 46375

Streeterville
680 N. Lake Shore Drive, Suite 117
Chicago, IL 60611

Sandra Valaitis, MD
Chief, Section of Urogynecology and Reconstructive Pelvic Surgery Professor of Obstetrics and Gynecology

svalaitis@bsd.uchicago.edu

Hyde Park
Hinsdale
Orland Park

Juraj Letko, MD
Urogynecology and Pelvic Reconstructive Surgery Assistant Professor of Obstetrics and Gynecology

jletko@bsd.uchicago.edu

Hyde Park
New Lenox
Schererville

Dianne Glass, MD, PhD
Urogynecology and Pelvic Reconstructive Surgery Assistant Professor of Obstetrics and Gynecology

dianneglass@bsd.uchicago.edu

Hyde Park
Schererville
Streeterville

Shilpa Iyer, MD, MPH
Urogynecology and Pelvic Reconstructive Surgery Assistant Professor of Obstetrics and Gynecology

siyer2@bsd.uchicago.edu

Hyde Park
Hinsdale
Orland Park