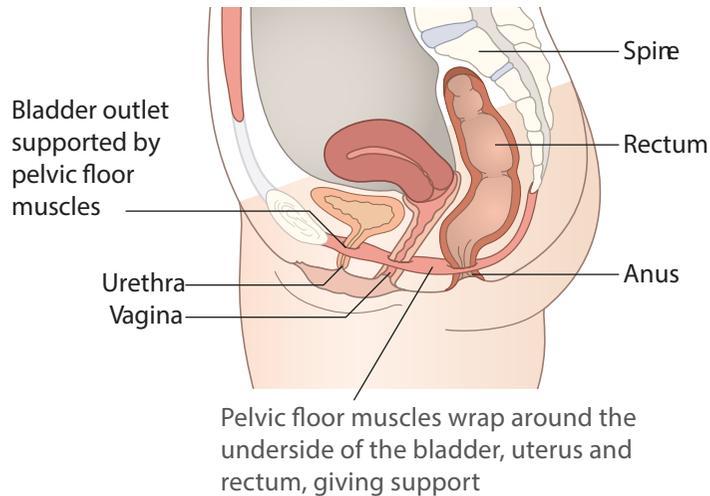


Female Genital Prolapse – Gynaecological Perspective



Pelvic organ prolapse is a state of pelvic relaxation due to a disorder of pelvic support structures – that is, the endopelvic fascia.

Loss of pelvic support can occur through:

- Birth trauma
- Increased intra-abdominal pressure due to a chronic cough, chronic constipation, heavy weight lifting/domestic work, obesity or previous prolapse surgery
- Atrophic changes
- Intrinsic weakness

Definition

Prolapse/Procidentia is the downward descent of the uterus and/or vagina. Procidentia is from the Latin, *procidere*, to fall. It is not life-threatening but can have an adverse effect on quality of life.

Effects of prolapse

The effects of prolapse range widely from no significant symptoms through to local discomfort, loss of sexual function, urinary and bowel problems, discharge, backache, ulceration and infection.

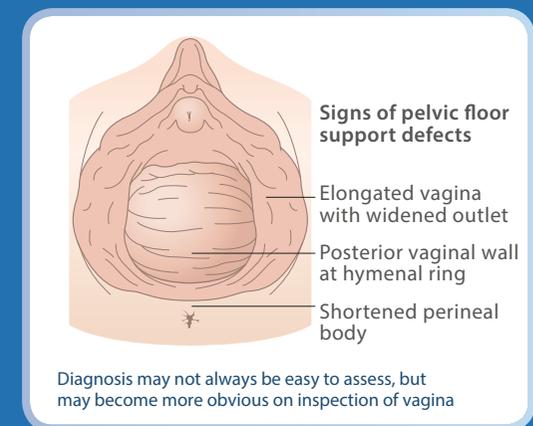
Causes of increased intra-abdominal pressure

There are six main causes ('the six Fs'): Fluid, fibroids (and other tumours), flatus, foetus, faeces, fat.

When to treat

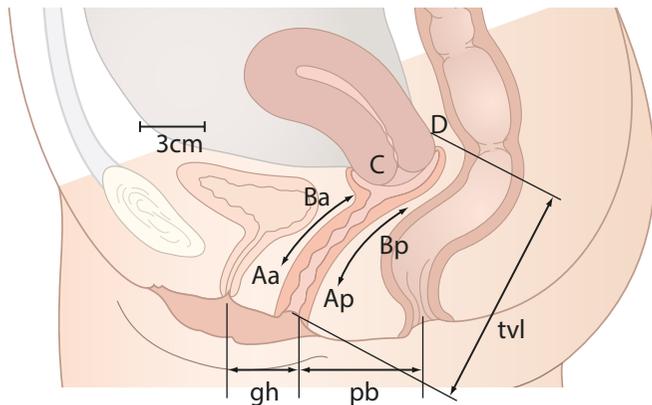
Treatment should be offered only when the condition is symptomatic and once it has been clearly ascertained that symptoms are due to prolapse.

Additional reasons for treatment may be that the condition interferes with a woman's normal activity and that the patient actively seeks treatment.



Female Genital Prolapse – Gynaecological Perspective

Nine Measurement Points for Pelvic Organ Prolapse Quantification (POP-Q)



- Aa Position of distal anterior vaginal wall, 3cm proximal to the external urethral meatus
- Ba The most distal portion of the remaining anterior vaginal wall above point Aa Point at anterior vaginal
- C The most distal edge of the cervix or vaginal cuff
- D The position of the posterior fornix
- Bp, Ap The most distal position of the posterior vagina; wall above point Ap
- gh The genital hiatus
- pb The perineal body
- tvl The total vaginal length

Ordinal staging of pelvic organ prolapse

Stage	Leading edge of Prolapse: Location of the Most Distal Point of the Anterior or Posterior Vaginal Wall (any points Aa, Ap, Ba, Bp)	Leading edge of Prolapse: Location of Apex of Vagina or Cervix (Value of Point C or D)
0	No prolapse: All points are 3 cm above the hymen (value = -3)	No prolapse: Apex of cervix is at a position above the hymen that equals or is less than +/- 2 cm of vaginal length (value $\leq (tvl-2)$)
I	All points are more than 1 cm above hymen (value < -1)	
II	Maximal prolapse point protrudes to or beyond 1 cm above hymen but not more than 1 cm below hymen (value > -1 to > +1)	
III	Maximal prolapse point protrudes beyond 1 cm above hymen but less than 2cm less than the total vaginal length (value > +1 but < +(tvl - 2))	
IV	Maximal prolapse point protrudes the length of the vagina (2 cm) beyond the hymen. Complete eversion of the vagina +/- cervix (value $\geq (tvl-2)$)	

tvl=total vaginal length

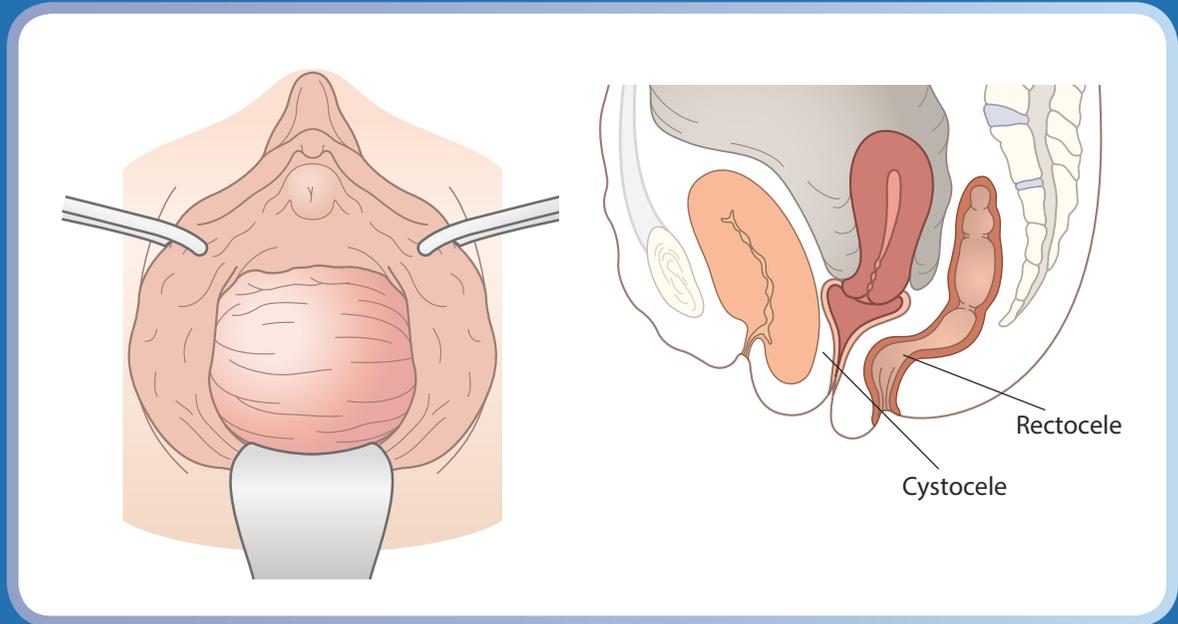
Female Genital Prolapse - Gynaecological Perspective

Treatment

- Pelvic floor exercises
- Prevent and limit injury during childbirth
- Topical Oestrogen Therapy
- Smoking cessation
- Avoid constipation
- Avoid heavy lifting
- Pessaries

Diagnosis

- Examine patient
- Rule out pelvic pathology e.g. pelvic mass



Pessary Treatment

Advantages of Pessaries

Surgery contraindicated / declined
Family not complete
Temporary symptom control for those awaiting surgery
May improve voiding dysfunction

Success Rate

Successful fitting rates are high varying from 74% to 94%. However in 46% of cases refitting within the first week may be required.

Problems

Poor fitting or the inability to retain a pessary may be influenced by the following:

- Deficient perineal body
- Large prolapse
- Wide introitus
- Vagina shorter than 6 cm
- Stenosed / atrophic vagina
- Lower urinary tract symptoms can be made worse with a pessary in situ

A pessary could make stress incontinence worse or unmask stress incontinence

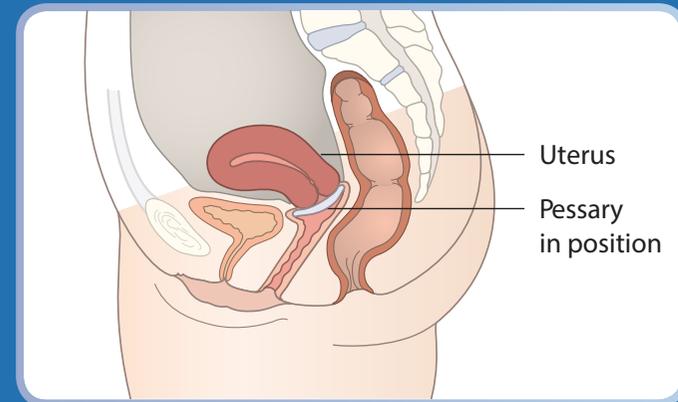
The History of the Pessary

Used in the treatment of genital prolapse for centuries and is one of the oldest medical devices. It reached the peak of popularity in the 19th Century particularly to treat uterine retroversion.

Historical Perspective

Hippocrates mentioned the use of pomegranate to treat prolapse. The earliest written record on the use of pessaries is dated 27 BC and a papyrus from 1500 BC refers to prolapse.

Sizing, fitting and changing



- Examine and evaluate the patient's prolapse and vaginal walls before fitting a ring
- Replace the ring with a new one after a maximum of 6 months' use

Research findings on pessary use

Patient satisfaction with pessaries ranges from 70% - 92%
Discomfort from prolapse reduce from 90% to 3%
May help prevent the progression of prolapse
Can cause a significant improvement in POP-Q score

Farrell 2006