

# A Cook's Tour of Pelvic Organ Prolapse

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# Learning Points

- Types/Classification of prolapses
- What can a GP do?
- When to refer?
- How do gynaecologists treat them?
- Does well does it work?
- What is the story about mesh?

# Conservative Management

- **Lifestyle adjustments- No RCTs**
  - weight loss
  - avoid heavy lifting
  - improve bowel function
- **Vaginal Estrogen or Hormone Therapy**
  - Cochrane: Ismail et al 2010
  - Limited evidence from RCTs
- **Pelvic Floor Muscle Training (PFMT)**
  - Cochrane Hagen et al 2011

# **Cochrane Review- Conservative management of pelvic organ prolapse- Hagen et al 2011**

- 4 studies compared PFMT to no intervention
  - PFMT increased the chance of improvement in anatomical prolapse stage by 17% (2 Studies)
  - Bladder symptoms improved (2/3 trials)
  - Bowel symptoms improved (1 Study)
- 2 studies compared Surgery to Surgery plus PFMT (opposite findings)

# **Cochrane Review- Conservative management of pelvic organ prolapse**

## **Conclusion**

Some benefit for PFMT compared to no intervention but no information on the different regimens, cost-benefit analysis or long terms effects

# When to Refer

- Asymptomatic Women DO NOT need treatment
- Only exception is a procidentia
  - Risk of ureteric obstruction
  - Risk of ulceration
- Symptomatic Women (only if it is bothersome)
  - Bulge
  - Heaviness or dragging sensation
  - Backache
  - Vaginal irritation or dryness
  - Need to push the vagina back especially after straining

- **Bladder Symptoms**

- Urinary frequency and urgency
- Stress incontinence
- Voiding difficulties
- Inability to pass urine without reducing the prolapse back into the vagina

- **Bowel symptoms**

- Incomplete bowel emptying
- Obstruction at defecation due to faeces lodging in the rectocele
- Constipation may be caused by the rectocele
- The need to reduce prolapse to empty the bowel

- **Consider a pelvic/KUB ultrasound**

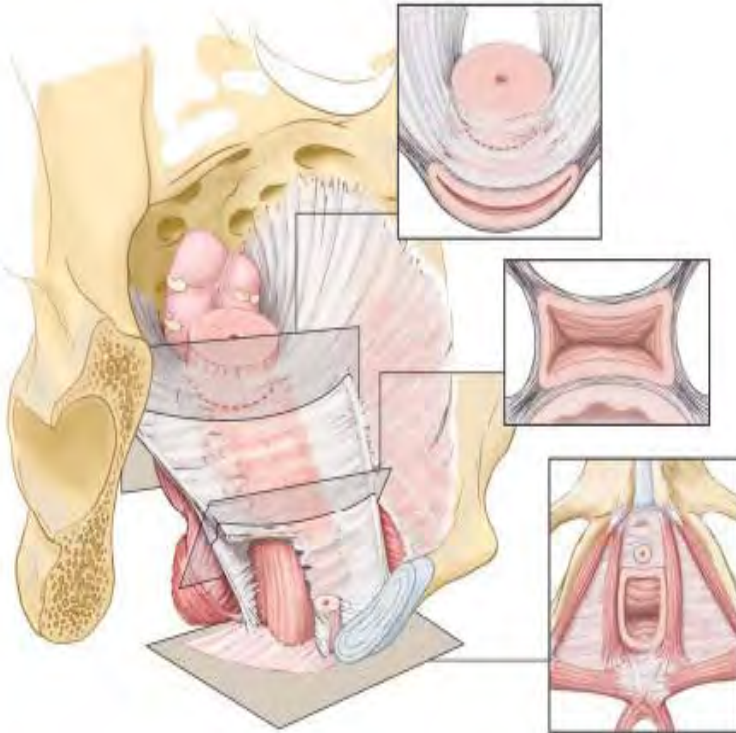
- **PROLAPSE IS NOT USUALLY PAINFUL**

# De Lancy's Classification

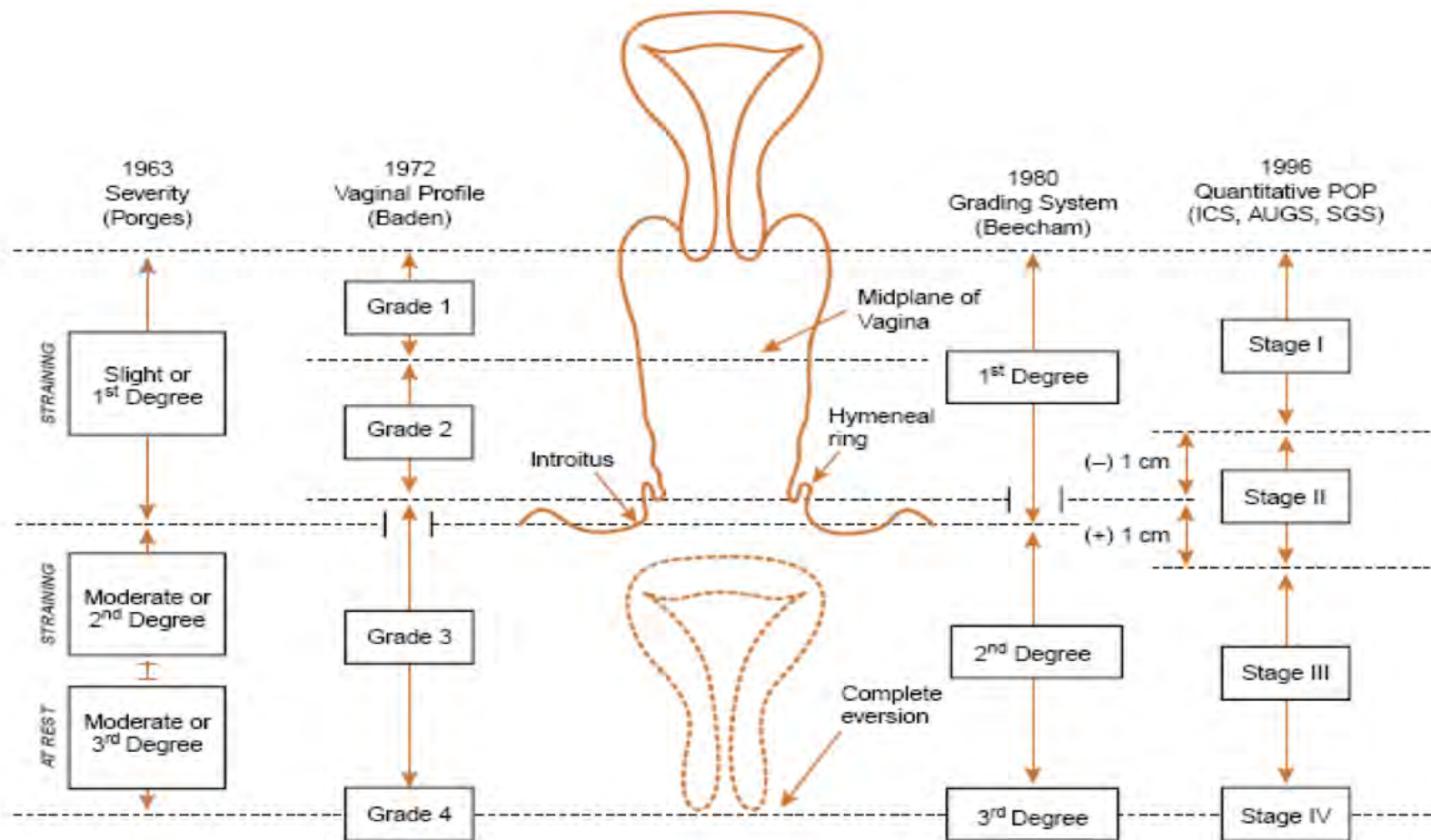
Level 1

Level 2

Level 3



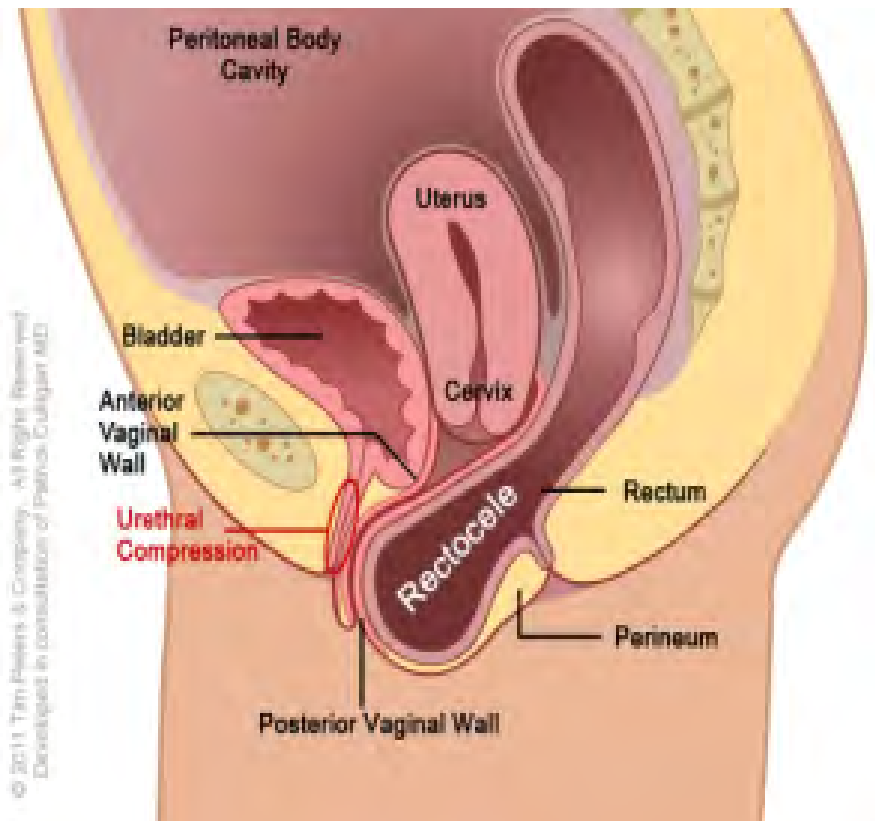




# Cystocele



# Rectocele





# Gynaecologists Treatment of Prolapse

- May not do anything
- Vaginal pessaries
- Surgery
  - Vaginal
  - Abdominal
    - Laparoscopic or open
  - Augmented
    - Mesh
    - Biological



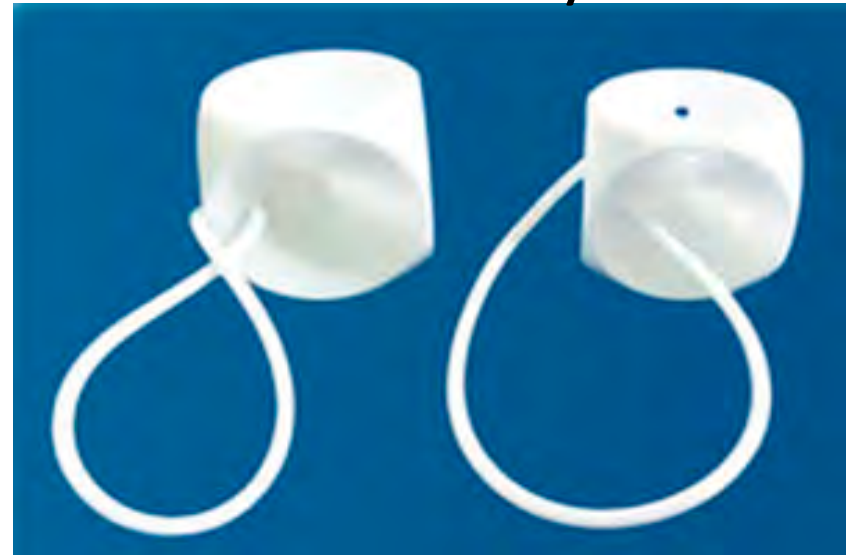
# Vaginal Pessaries



Gellhorn Pessary



Cube Pessary



# Indications for a pessary

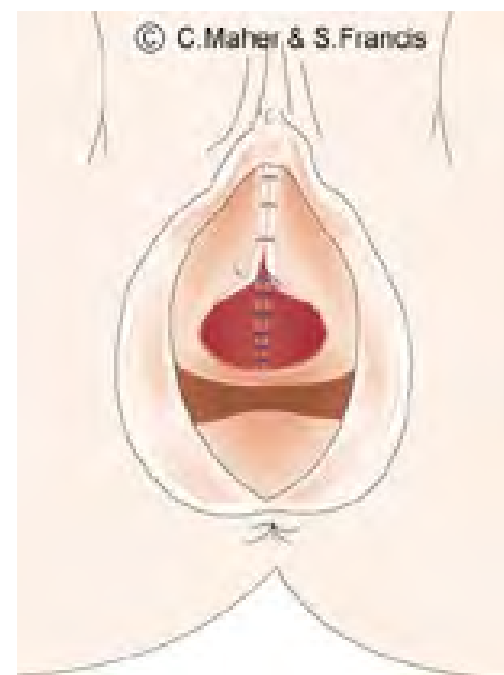
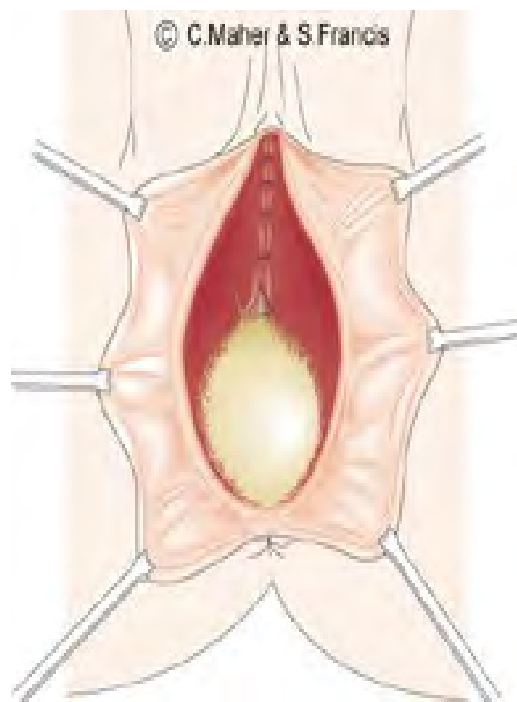
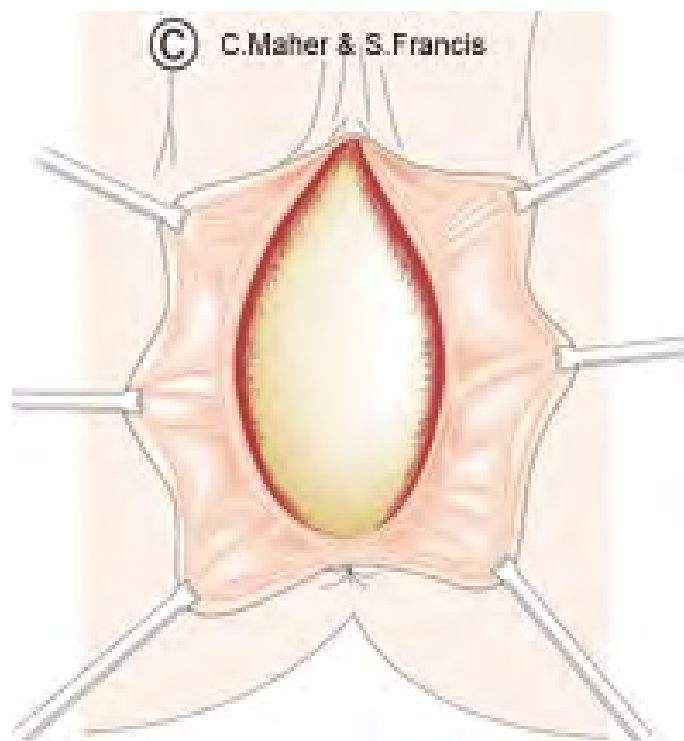
- the patient has significant comorbid risk factors for surgery
- the patient prefers a nonsurgical alternative
- a goal is to avoid reoperation
- POP or cervical insufficiency is present during pregnancy
- the patient desires future fertility
- Cochrane-Bugge et al 2010
  - Ring vs Gelhorne
    - 60% continuation rate
    - Whatever works

# Factors that negatively impact success rates

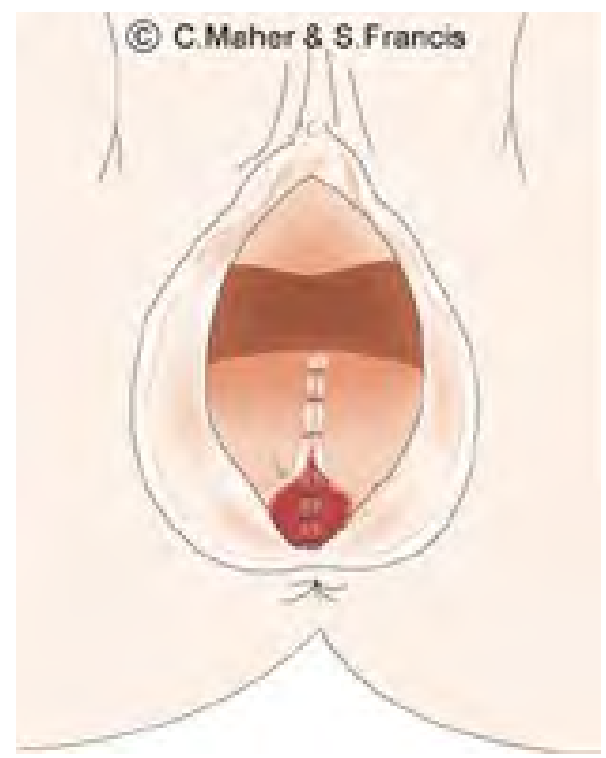
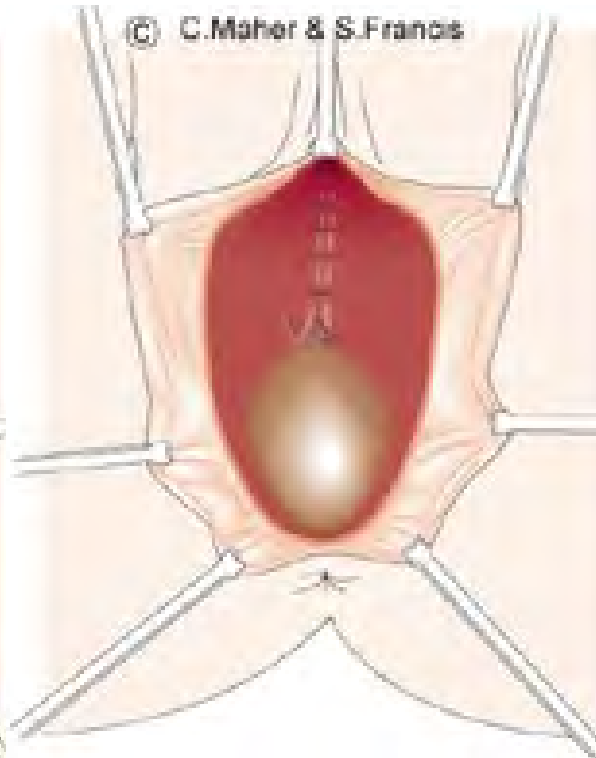
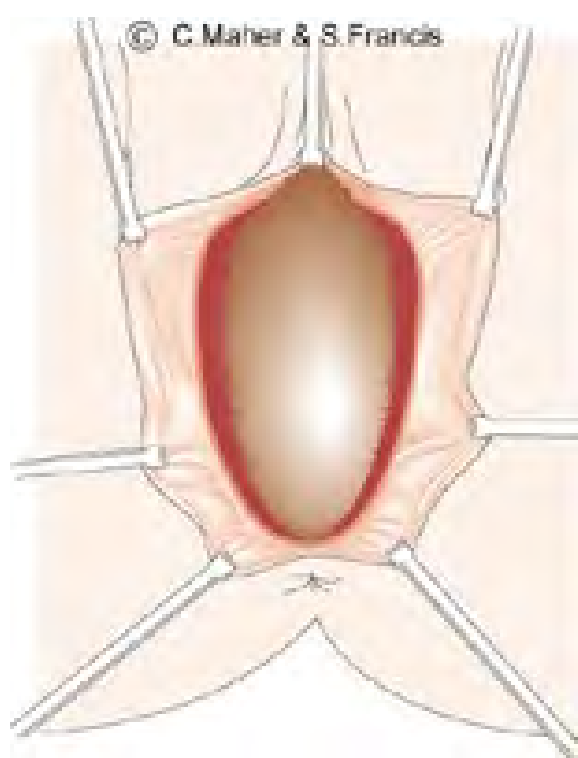
- prior pelvic surgery
- multiparity
- obesity
- SUI
- short vaginal length (<7 cm)
- wide vaginal introitus (>4 fingerbreadths)
- significant posterior vaginal wall defect



# Fascial Plication-Anterior repair



# Fascial Plication-Posterior



# Sacrospinous colpopexy



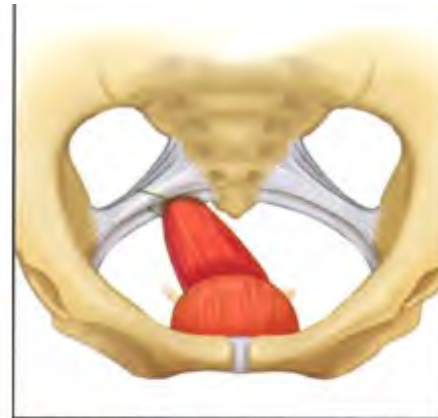
**Figure 3:** For proper device placement, the dissection finger is placed adjacent to the suture site



**Figure 4:** To maintain device position, the dissection finger is placed firmly on the tip of the device

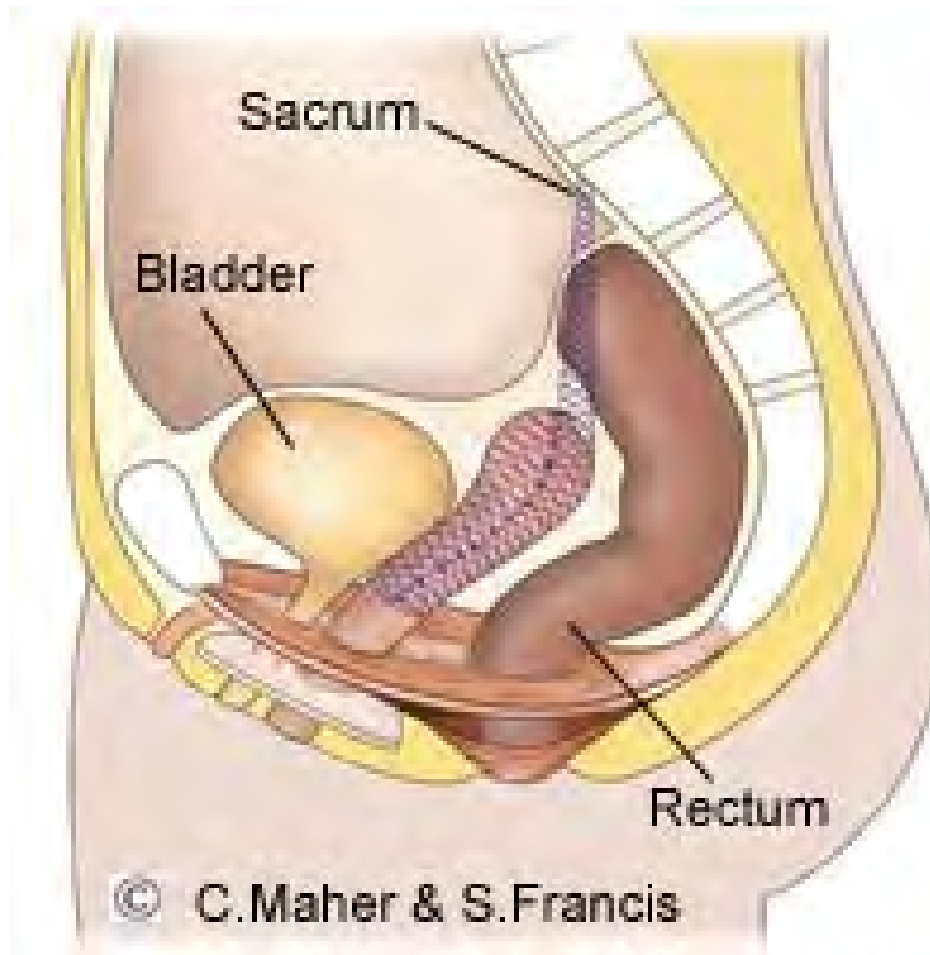


**Figure 6:** Once suturing is confirmed, the Capiro device is carefully withdrawn and reloaded



**Figure 8:** The upper vaginal vault is secured to the sacrospinous ligament, restoring vaginal wall support and correcting prolapse

# Sacrocolpopexy (or Hysteropexy)



# Does Surgery work?

- Accepted Rate 30% reoperation rate in lifetime- for different or same compartment
- Subjective recurrence lower than objective recurrence
- Reoperation rates lower than recurrence rates
- Most Studies, especially RCT short to medium term

# Cochrane Reviews

- Anterior native tissue repair-Maher et al 2016
  - 27-42% Recurrence
- Apical prolapse-Maher et al 2016
  - Abdominal Sacrocolpopexy vs Vaginal Sacrospinous Colpopexy
    - Repeat surgery more common after vaginal procedure
      - 4% vs 5-18%
    - Stress incontinence and dyspareunia more common after vaginal procedures
    - Abdominal procedures: longer operating time longer return to ADLs, higher cost

# Colpocleisis



# Colpocleisis

- Closes the vagina by suturing anterior and posterior walls together
- Inhibits a patient from future sexual intercourse
- 90-95% cure rate
- Can be performed using local anesthesia, epidural or spinal
- Takes 45 minutes or less to perform



# What is the story with mesh

- Suburethral slings developed in 1990's
- Vaginal mesh sheets started to be used in the early 2000's
- Mesh has evolved from microporous, multifilament to macroporous light weight monofilament mesh
- Hand crafted meshes, to mesh kits with arms to single incision mesh kits
- ?light weight mesh has less adverse effects and erosion than the heavier meshes
- Litigation and reports of adverse events
- Scotland withdrew all vaginal mesh from use in 2014  
INCLUDING SUBURETHRAL SLINGS

# **Cochrane Review-Transvaginal Mesh compared with Native tissue Repair for Prolapse (Maher et al 2016)**

- Awareness of prolapse at 1-3 years was less likely after a mesh repair (RR 0.6)
- Lower rates of repeat surgery for prolapse after mesh repair (RR 0.53)
- Recurrent prolapse on examination less after mesh repair (RR 0.4)

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# Cochrane Review-Transvaginal Mesh compared with Native tissue Repair for Prolapse

- No difference in rates of de novo dyspareunia
- No difference in surgery for incontinence
- Higher rate of de novo stress incontinence in mesh group (RR 1.39)
- 8% of women in mesh group required repeat surgery for mesh exposure

# **Cochrane Review-Transvaginal Mesh compared with Native tissue Repair for Prolapse**

## **Conclusion**

**The risk-benefit profile means that transvaginal mesh has limited use in primary surgery. While it is possible that in women with a higher risk of recurrence the benefits may outweigh the risks, there is currently no evidence to support this position.**

# **Prospect Trial Glazener et al**

**Lancet Dec 2016**

**Mesh, graft, or standard repair for women having primary transvaginal anterior or posterior compartment prolapse surgery: two parallel-group, multicentre, randomised, controlled trials- 2 Year Followup**

- **Mesh vs Fascial Repair (865 women)**
- **Biologic Graft vs Fascial Repair (735 women)**

# Prospect Trial- Results

- Serious events did not differ between groups
  - Infection
  - Urinary retention
  - Dyspareunia
  - Other pain
- Cumulative rate of mesh erosion was 12%



# Prospect Trial Conclusion

- Augmentation with mesh or graft did not improve outcomes of
  - Effectiveness
  - Quality of life
  - Adverse Events
  - Short term outcomes
- 1 in 10 women had an erosion
- Long term follow up required

# Mesh Erosion Before and After



# AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

## Vaginal Mesh Reference Group

Members of the reference group are supporting the Commission over the next 6 to 12 months to develop guidance in relation to:

- Treatment pathways for pelvic organ prolapse and stress urinary incontinence
- Service models for mesh complications and mesh removal
- Training and credentialing of clinicians who implant and remove mesh for treatment of pelvic organ prolapse and stress urinary incontinence
- Data collection and reporting of device use and adverse events
- Patient decision support tools
- Information for general practitioners



# Take Home Messages

- Prolapses are not life threatening, they are quality of life threatening
- Surgery is not always necessary
- Try conservative treatments first, or institute conservative treatments after referral
- Pessaries will work in about 60% of women
- Around 30% of women who have surgery for a prolapse will need more surgery for a prolapse
- Mesh is not necessarily evil