

Pelvic Organ Prolapse

THE UROGYNAECOLOGICAL SOCIETY OF AUSTRALASIA

What is prolapse and what causes it?

Prolapse occurs when the supports of the vagina and pelvic organs fail, allowing the vaginal walls to sag and, as a result, creating a bulge in the vagina. These supports are the pelvic ligaments, the pelvic connective tissue and the pelvic floor muscles. A number of factors can contribute to the failure of pelvic organ support. Probably the most important is vaginal childbirth, but other factors such as ageing, menopause, genetics and chronic increased pressure on the pelvic floor (obesity, chronic cough, chronic constipation), also likely play an important role.

Symptoms of Pelvic Organ Prolapse

Symptoms of POP include:

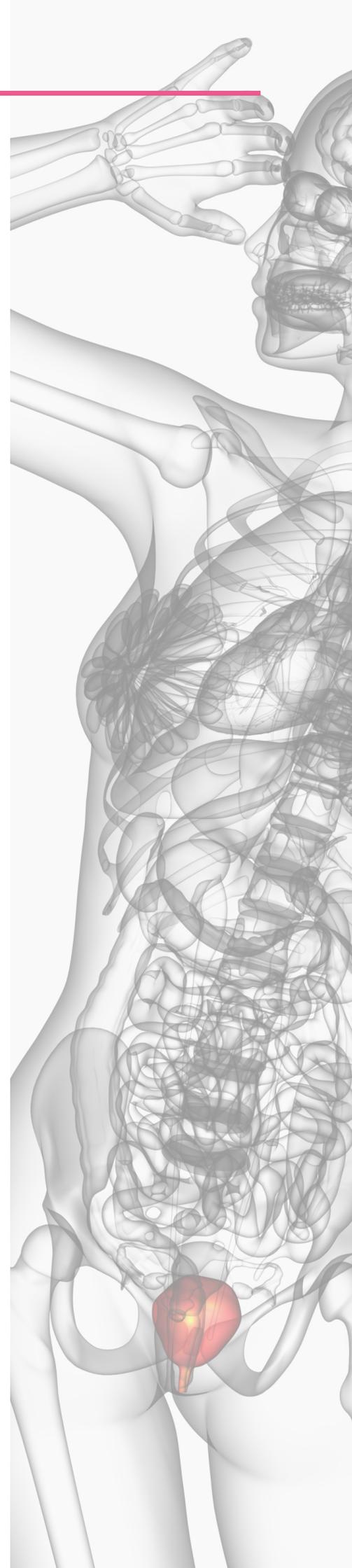
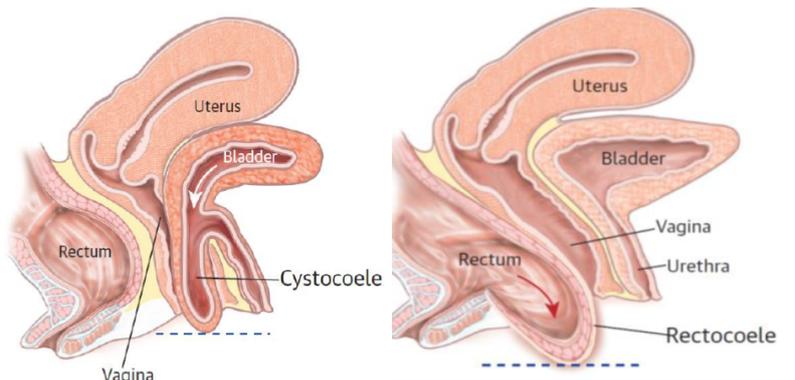
- Bulge, pelvic heaviness or dragging discomfort
- Bladder symptoms: including increased urinary frequency, urine leakage or difficulty passing urine
- Bowel symptoms: including difficulty emptying the bowel, needing to push the lump back into the vagina to empty the bowel or less commonly faecal leakage
- Sometimes sexual function can also be altered by the presence of prolapse.

Pain is not usually attributed to prolapse, so if this is a dominant symptom other causes of the pain should be investigated.

Types of prolapse

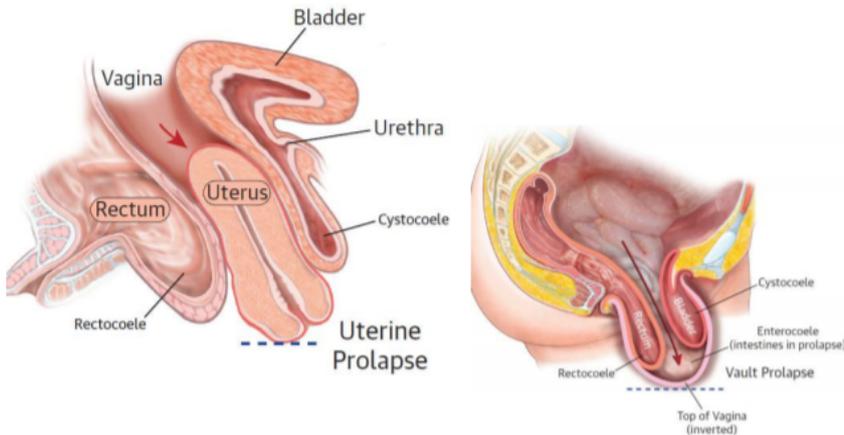
To understand prolapse, it is useful to think of the vagina divided into 3 separate compartments – anterior (front), posterior (back) and apex (top). In reality, prolapse often occurs in more than 1 compartment.

The front wall of the vagina is closely associated with the bladder and this type of prolapse is often referred to as a bladder prolapse or cystocele. The back wall of the vagina is closely associated with the rectum and prolapse of the back wall is referred to as a bowel prolapse or rectocele.



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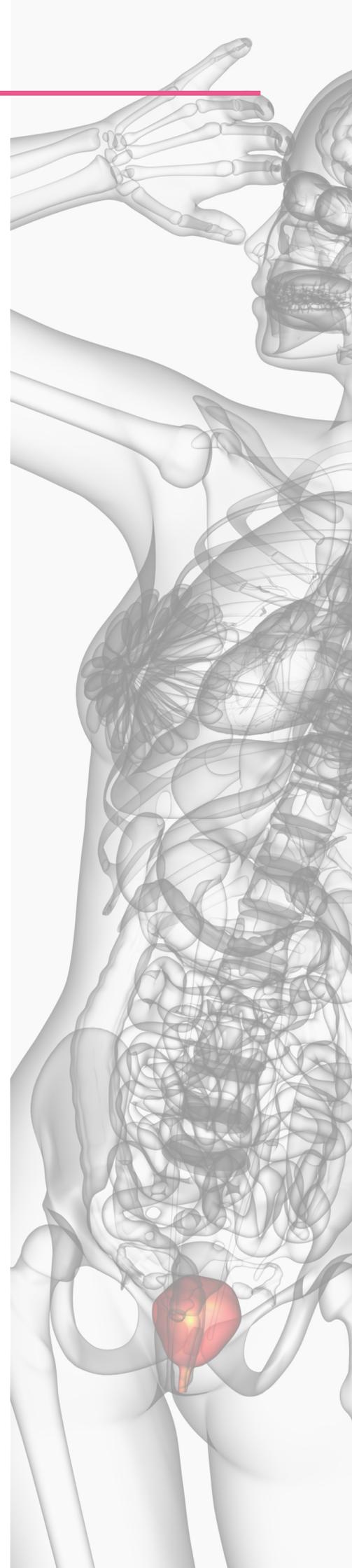
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The top of the vagina is made up of the uterus/cervix and this type of prolapse is referred to as uterine prolapse. If you have already had a hysterectomy (had your uterus/cervix removed) the top of the vagina can still prolapse and this is called a vault prolapse.

How do I know if I have prolapse?

Mild prolapse may be completely asymptomatic and only picked up at a pelvic examination, for example at the time of your pap smear. As prolapse progresses, you may feel a lump at the vaginal opening. In the early stages of prolapse, the lump may come and go depending on your level of activity. The lump often disappears when lying down and becomes apparent again once you are up and on your feet. You may be more aware of the prolapse if you are constipated. With more severe prolapse, the lump may protrude from the vagina all of the time and impact more significantly on bladder, bowel and sexual function.



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If you are concerned that you may have prolapse, the best person to assess this is a gynaecologist. An abdominal and pelvic examination will be performed, often with the use of a speculum (a similar examination to having a Pap smear). Your gynaecologist will then be able to confirm whether a prolapse is present, the site of the prolapse and also the degree or severity of the prolapse.

How is prolapse managed?

Prolapse is managed according to the degree of bother you are experiencing. Maintaining regular bowel habits, treating chronic cough and avoiding heavy lifting are some of the strategies that may help minimise symptoms in the future. If, however, you are bothered by bulge symptoms or have bladder/bowel problems as a result of the prolapse there are a number of management options available to you:

- Pelvic floor muscle training for minor prolapse - See information sheet - *Pelvic Floor Muscle Training*.
- Vaginal pessary - See separate information sheet - *Vaginal Pessaries*.
- Surgery - See separate information sheets - *Hysterectomy, Vaginal Repair and Apical Suspension, Sacrospinous Hysteropexy, Sacral Colpopexy, and Colpocleisis*.

This statement has been developed by the Urogynaecological Society of Australasia (UGSA).

Disclaimer: This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

