Management of Pelvic Organ Prolapse - Full Clinical Guideline

Reference No: UHDB/Gynae/02:23/P4

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1. Introduction

Pelvic organ prolapse (POP) is the descent of the pelvic organs from their normal position into the vagina. These organs can be the bladder, uterus/vaginal vault or the bowel/rectum. Studies have shown an incidence of up to 50% in women on examination, with 10% of women requiring at least one surgical procedure as treatment for their POP. With an ageing population, this number is likely to increase..

The pelvic organs (uterus, bladder and bowel) are supported by pelvic floor muscles, fascia and ligaments. This support can be weakened by pregnancy and delivery as well as, menopause and/or ageing, contributing to the development of POP. Increased intra-abdominal pressure caused by obesity, chronic cough, chronic constipation, lifting heavy loads and large abdominal/pelvic tumours by causing additional pressure on the pelvic floor can also be aggravating factors that play a part in the emergence of POP. Prolapse may arise in the anterior wall of the vagina (cystocele), posterior wall of the vagina (rectocele or enterocoele) or the apical part of the vagina (uterine or vault prolapse). A combination of these could also be concurrently present.

2. Purpose and outcome

To ensure that staff are aware of the management guideline in women with pelvic organ prolapse.

3. Abbreviations

BMI	-	Body Mass Index
BSUG	-	British Society of Urogynaecology
MDT	-	Multidisciplinary Team
NICE	-	National Institute for Health and Care Excellence
OAB	-	Over Active Bladder
POP	-	Pelvic Organ Prolapse
RCOG	-	Royal College of Obstetrics and Gynaecology
SUI	-	Stress Urinary Incontinence
TVL	-	Total Vaginal Length
UTI	-	Urinary Tract Infection

4. Key Responsibilities and Duties

Staff caring for women with POP have a responsibility to ensure that they are aware of appropriate management options available for these women.

5. Pelvic Organ Prolapse

5.1 Definition

Pelvic organ prolapse is the abnormal descent or herniation of the pelvic organs from their normal attachment sites or normal position in the pelvis, into the vagina.

5.2 Diagnosis

Symptoms

POP may either be asymptomatic or symptomatic. Symptoms may include a feeling of a lump or a bulge inside and/or outside the vagina, a heavy dragging sensation in the vagina and discomfort during sexual intercourse. It is expected to obtain a detailed history to include symptoms of prolapse including that of associated urinary, bowel and sexual function. The effect of symptoms on an individual's quality of life should also be noted.

Bladder related symptoms such as slow urinary stream, a feeling of incomplete bladder emptying, urinary frequency, urinary urgency or stress urinary incontinence (SUI) might be present. Bowel symptoms such as constipation, difficulty opening the bowels, incomplete bowel emptying or needing to press on the vaginal wall to empty the bowel (digitation) can be present in patients with POP. If there was associated bowel incontinence alongside POP, it is recommended to address the bowel symptoms primarily prior to addressing the POP, unless the patient wishes otherwise.

Clinical examination

It is important to assess and record the presence and degree of prolapse. If POP cannot be demonstrated despite an explicit history suggestive of it, consider repeating the examination at a different time or with the patient standing or squatting. It is also suggested to consider the option of an examination under an anaesthetic, after discussion with the patient in this situation. Assessing the strength of the pelvic floor musculature as well as an abdominal/bimanual examination to rule out any additional pelvic pathology is recommended.

Staging

Various staging and grading systems have been put forward to quantify pelvic organ prolapse. Porgess' staging system [1963], Baden Walker's halfway system [1972], Beecham's grading system [1980] and the more recent International Continence Society Pelvic Organ Prolapse Quantification System [ICS POP-Q 1996] are the popular ones in clinical use. The ICS POP-Q quantification system is considered by many to be the gold standard as it is standardised, objective and reproducible. It is therefore the recommended staging method of choice for POP during the initial examination as well as during follow up.

- Stage 0: No prolapse is observed.
- Stage 1: The most distal portion of prolapse is more than 1 cm above the level of the hymen.
- Stage 2: The most distal portion of prolapse is found between 1 cm above and below the hymen.
- Stage 3: The most distal part of the prolapse extends further than 1cm below the hymen but no further than 2 cm less than the total vaginal length (TVL).

- Stage 4: Vaginal eversion has taken place.

5.3 Investigations

Urinalysis should be done for women presenting with urinary symptoms to check for blood, glucose, protein, leucocytes and nitrites in the urine.

A vaginal swab is recommended if persistent decubitus ulcers are present or in the presence of abnormal vaginal discharge.

Routine imaging is not recommended in cases with POP and might be considered if a pelvic mass is suspected or if there is unexplained bleeding originating from the uterus.

6.0 Management of pelvic organ prolapse

The management options should be enumerated and discussed at length with all women who have pelvic organ prolapse. These options include no treatment, non-surgical treatment as well as surgical treatment. Several factors should be considered prior to offering any treatment modality:

- patient preference
- site of prolapse
- lifestyle factors
- comorbidities including cognitive or physical impairments
- age
- desire for childbearing
- previous abdominal or pelvic floor surgery
- benefits and risks of individual procedures

6.1 Non-surgical treatment for POP

Lifestyle changes

Consider giving advice on lifestyle to women with pelvic organ prolapse, including information on:

- reducing weight, if the woman has a BMI greater than 30 kg/m^2
- minimizing lifting of heavy weights
- preventing or treating constipation
- treatment of chronic cough

Topical oestrogen

Vaginal oestrogen could be offered to women with pelvic organ prolapse along with signs of vaginal atrophy, in the absence of any contraindications for its use. Oestrogen releasing rings could also be considered in women with pelvic organ prolapse and signs of vaginal atrophy who have cognitive or physical impairments that might make vaginal oestrogen pessaries or creams difficult to use.

Pelvic floor muscle training

A programme of supervised pelvic floor muscle training which may include electrical stimulation should be offered for at least 16 weeks as a first option for women with symptomatic Stage 1 or 2 POP. If the programme is of help, it would be prudent to advise women to continue pelvic floor muscle training, including post surgery.

Pessaries

A vaginal pessary for women with symptomatic pelvic organ prolapse, alone or in conjunction with supervised pelvic floor muscle training, can be offered as an alternative treatment option.

Prior to commencing pessary treatment, it would be prudent to:

- consider treating any associated vaginal atrophy with topical oestrogen
- explain that more than 1 pessary fitting may be needed to find the correct pessary size as not one size fits all
- discuss the effect of different types of pessary on sexual intercourse
- describe complications with pessary usage including vaginal discharge, bleeding, difficulty removing pessary and pessary expulsion
- explain that the pessary should have removed at least once every 4-6 months to prevent serious pessary complications
- ensure that women are followed up in a pessary clinic every 4-6 months if they are at risk of complications (for example, because of a physical or cognitive impairment that might make it difficult for them to manage their ongoing pessary care).

6.2 Surgical management of POP

It is reasonable to offer surgery for POP to women whose symptoms have not improved with or who have declined non-surgical treatment, after discussion in clinic. If a woman is contemplating undergoing a surgical procedure for pelvic organ prolapse, use of a NICE decision aid is recommended to promote informed and shared decision making. All proposed surgical treatment for primary prolapse should be reviewed at a local MDT.

Discussion with the woman should include:

- the different treatment options available for pelvic organ prolapse, including no treatment or continued non-surgical management
- the benefits and risks of each surgical procedure, including potentially irreversible changes in urinary, bowel and sexual function with surgery
- the risk of ongoing pain and recurrence of prolapse
- the uncertainties about the long-term adverse effects for all procedures, particularly those involving the implantation of mesh material
- differences between procedures in the type of anaesthesia, expected length of hospital stay, surgical incisions and expected recovery period
- information about entering patient information into the BSUG national database contemporaneously by the operating surgeon, unless patient declines the same
- the role of intraoperative POP assessment in deciding the most appropriate surgical procedure.

Explain to women considering surgery for anterior or apical prolapse who do not have incontinence, that there is a risk of developing postoperative urinary incontinence and that further investigations and treatment might become necessary post surgery.

There is public concern about the use of vaginal mesh procedures and at present, they are not being used within the Trust and are thus outside the scope of discussion of this guideline.

6.2.1 Surgery for uterine prolapse

Options can be a hysterectomy or uterus-preserving surgeries. The clinician should:

- discuss the possible complications and the lack of long-term evidence on the effectiveness of the various procedures
- use the NICE patient decision aid on surgery for uterine prolapse to discuss the benefits and risks of treatment, including non-surgical options

For women with uterine prolapse, offer:

- vaginal hysterectomy +/- vaginal sacrospinous fixation (unless they wish to preserve their uterus)
- vaginal sacrospinous hysteropexy
- Manchester repair (unless they wish to have children in the future)

Wherever surgery entails the use of a synthetic polypropylene mesh, the following tenets are expected to be adhered to:

- discussion and ratification at local urogynaecology MDT prior to surgical intervention
- explanation given to the woman about the type of mesh that will be used and whether or not it is permanent
- ensure that details of the procedure and its subsequent short and long term outcomes are recorded in a national registry
- give the woman written information about the implant, including its name, manufacturer, date of insertion, and the implanting surgeon's name and contact details
- ensure that the proposed treatment is reviewed by the regional MDT team if the woman wishes to have children in the future.

6.2.2 Surgery for vault prolapse

Discuss the possible complications and the lack of long-term evidence on the effectiveness of the procedures. Use the NICE decision aid to discuss the options for vault prolapse, with a choice of either:

- vaginal sacrospinous fixation with sutures or
- sacrocolpopexy (abdominal or laparoscopic) with mesh

Considering these cases to be recurrent after index surgery, they [especially the ones which involve

use of a mesh] are expected to be discussed and ratified at local MDT prior to surgical intervention.

6.2.3 Obliterative procedures for vault or uterine prolapse

Colpocleisis could be offered to women with vault or uterine prolapse who do not intend to have penetrative vaginal sex in the future and who have medical or physical conditions that may put them at increased risk of operative and postoperative complications.

6.2.4 Surgery for anterior compartment prolapse

Offer anterior repair without mesh to women with anterior vaginal wall prolapse.

6.2.5 Surgery for posterior compartment prolapse

Offer posterior repair without mesh to women with posterior vaginal wall prolapse.

6.2.6 Surgery for recurrent POP

Offer surgical options as per the type of prolapse as highlighted above. All patients with recurrent prolapse should be discussed and ratified at the local MDT prior to any surgical intervention. In select cases the abdominal paravaginal repair via an open route could be considered and offered to patients.

6.2.7 Surgery for women with both SUI and POP

Consider to concurrent surgery for SUI and POP in women with anterior and/or apical prolapse and stress urinary incontinence. When considering concurrent surgery for SUI and POP, discuss the options for treatment using the NICE decision aids, and explain:

- that this cohort of patients should be discussed and decision ratified at the MDT prior to surgery
- that the option of surgery for POP first followed by surgery for SUI, if persistent, at a later date is a viable and reasonable alternative that there is uncertainty about whether the combined procedure is effective for treating SUI beyond a year and that SUI might persist despite surgery
  the risk of complications related to having surgery for SUI at the same time as having prolapse surgery compared with the risk of complications with having sequential surgery

7.0 Follow up after surgery

Post-operative follow up in nurse led/consultant clinic in 3-4 months should be arranged for all patients at the time of discharge.
Ensure that the review includes a vaginal examination and, if mesh was used, check for mesh exposure/complications.
Access to further referral if they have recurrent symptoms, suspected complications or persistent or worsening urinary symptoms should be provided at this stage.
A quality of life questionnaire should be completed at this visit.
BSUG national database follow up entry should be completed at this visit.
A continuous audit of all patients undergoing surgical procedures in urogynaecology should be done, on an annual basis.

8. Monitoring compliance and effectiveness

As per agreed audit forward programme

9. References

Urinary incontinence and pelvic organ prolapse in women; NICE Guidelines on Pelvic Organ Prolapse 2019.

RCOG/BSUG Joint statement on draft NICE Guidance on urinary incontinence and pelvic organ prolapse. Oct 2018

Post-Hysterectomy Vaginal Vault Prolapse -RCOG green-top Guideline No 46. July 2015.

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