Pelvic Organ Prolapse in Female Patients Presenting to Transitional Urology Care Clinic

Rose Khavari,* Molly Colleen Tokaz, Julie N. Stewart and Timothy B. Boone

From the Department of Urology, Houston Methodist Hospital and Baylor College of Medicine (MCT), Houston (RK, JNS, TBB), Texas

Abbreviation and Acronym

CIC = clean intermittent catheterization

POP = pelvic organ prolapse

Accepted for publication July 16, 2015.

Study received institutional review board approval.

Supported by National Institutes of Health Grant K12 DK0083014 (RK) and Multidisciplinary K12 Urologic Research Career Development Program from the National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health (DJL).

* Correspondence: Department of Urology, 6560 Fannin St., Suite 2100, Houston, Texas 77030 (telephone: 713-441-6455; FAX: 713-441-6463; e-mail: rkhavari@houstonmethodist.org).

Purpose: Patients with congenital genitourinary abnormalities are growing into adulthood and their expectations, especially in the areas of sexual function and fertility are creating unforeseen challenges for health care providers. We review the incidence and management of pelvic organ prolapse at our Transitional Urology Clinic.

Materials and Methods: This study is a retrospective chart review of the presentation and treatment of patients with clinically bothersome pelvic organ prolapse seen at our tertiary Transitional Urology Clinic during 2012 to 2015.

Results: Seven patients with a mean age of 22.8 years presented to our clinic with clinically bothersome prolapse. Four patients had myelomeningocele, 2 had sacral agenesis and 1 had bladder exstrophy. All were on self-catheterization. Three patients were sexually active and 1 had an intact uterus and desired fertility. Bothersome symptoms included vaginal bulge in 6 cases, difficult vaginal intercourse in 1 and difficult catheterization in 1. For the leading edge of Bp (anterior compartment) prolapse the median POP-Q (Pelvic Organ Prolapse Quantification System) stage was 3 (range 1 to 3), for Bp (posterior compartment) prolapse it was 1 (range 0 to 3) and for C (vaginal vault or cervical) prolapse it was 2 (range 1 to 3). Management included pessary in 1 case, hysterectomy with bilateral uterosacral ligament suspension in 4, sacrocolpopexy in 1 and observation in 1. Mean followup was 17.6 months (range 1 to 92). One of the 5 patients treated with surgical intervention had recurrence in the anterior compartment and vaginal vault.

Conclusions: Females with congenital genitourinary anomalies present with pelvic organ prolapse at a much younger age and a more advanced stage. There is a paucity of literature on the epidemiology, presentation and management of pelvic organ prolapse in this patient population.

Key Words: abnormalities, female, pelvic organ prolapse, reconstructive surgical procedures, tertiary healthcare

Patients with congenital genitourinary malformations are surviving into adulthood at higher rates than ever before. They pose unforeseen challenges in the fields of urology and urogynecology, specifically in regard to sexual function, fertility and pelvic health. In the past patients with myelomeningocele were largely treated in the pediatric sector due to their foreshortened expected life span. However, with improvements in early care at least 75% of patients with myelomeningocele are reaching young adulthood.[1] This population presents a unique medical challenge

0022-5347/15/1946-1654/0
THE JOURNAL OF UROLOGY®
© 2015 by American Urological Association Education and Research, Inc.
http://dx.doi.org/10.1016/j.juro.2015.07.086
Vol. 194, 1654-1658, December 2015
Printed in U.S.A.

to the provider due to complex anatomy, extensive surgical history, unique emotional and psychological needs, and the lack of consensus and evidence-based research driving best practice.[2,3]

The unique needs of this patient population require specialized knowledge of pediatric urology and the associated congenital malformations as well as treatment goals pertinent to adult urological care, including fertility, sexuality, pelvic health and family planning.[4] Challenges exist to bridge the needs and knowledge of the pediatric and adult urological fields to address the specialized treatment goals and requirements for this unique population in transition. These patients lead increasingly autonomous lives with up to 30% with spina bifida living independently and up to 23% entering matrimony.[5] This increase in societal participation is accompanied by changing expectations about the scope of functionality needed to attain a meaningful life, such as urinary and bowel continence, fertility and sexual options.

POP is a prevalent problem in the field of female urology and urogynecology. More than 41% of women who present to the general gynecologist have underlying prolapse.[6] This condition has profound effects not only on functional status and urinary continence but also on sexual function with many women giving up sexual activity altogether.[7] Little information has been gathered about the prevalence, demographics and effects of POP in the female transitional patient. We retrospectively reviewed the presentation and treatment of female patients with clinically bothersome POP seen at our tertiary care Transitional Urology Clinic.

MATERIALS AND METHODS

This is a retrospective review of the records of female patients who presented to the Transitional Urology Clinic at Houston Methodist Hospital with symptomatic POP from 2012 to 2015. A total of 43 eligible females who presented were identified for the study. Demographics and urological care characteristics were reviewed, including patient age, number of visits per year, neurological and urological diagnoses, previous genitourinary surgeries, number of urinary tract infections per year, sexual activity and parity, mode and method of CIC, coexistence of fecal or urinary incontinence and current management with anticholinergic medication, intravesical injection of botulinum toxin, urodynamic studies and upper tract imaging. Neurological diagnoses included bladder exstrophy, sacral agenesis and caudal regression syndrome, and myelomeningocele.

We reviewed the leading edge of the POP compartments, including Ba, Bp and C prolapse in all patients with the added complaints of urinary incontinence (urge or stress incontinence), recurrent urinary tract infections and incomplete bladder emptying. The degree of prolapse was measured using the accepted POP-Q examination accepted by ICS (International Continence Society), AUGS (American Urogynecologic Society) and SGS (Society of Gynecologic Surgeons).[8] For each compartment the leading edge was measured with respect to the hymen and staged based on POP-Q staging as previously described, including stage 0—no prolapse, stage 1—leading edge less than −1 cm, stage 2—leading edge −1 cm or greater but +1 cm or less, stage 3—leading edge greater than +1 cm but less than +(total vaginal length −2) cm and stage 4—leading edge +(total vaginal length −2) cm or greater. Management plans were identified, and followup, outcomes and complications were recorded.

RESULTS

Currently 77 patients are registered at our Transitional Urology Clinic. Table 1 shows detailed demographics on 40 female patients in our clinic with and without POP followed at the clinic from 2012 to 2015. Seven female patients (21.2%) with an

Table 1. *Patient population demographics*

POP	
No. pts	7
Av age (range)	25 (20–38)
Followup (mos)	6.3
No. visits/yr	3.4
No. neurological diagnosis:	
Myelomeningocele	4
Sacral agenesis	2
Bladder exstrophy	1
No. bladder management at presentation:	
CIC	7
CIC, continent stoma	6
CIC, native urethra	1
Anticholinergic medication (oxybutynin)	3
Botox® injections	3
No. urodynamics	4
No. renal ultrasound or computerized tomography	4
No. sexual history:	
Sexually active	3
Prior pregnancies	2
Prior deliveries	2
Cesarean delivery	1
Spontaneous vaginal delivery	1
No. POP (presenting symptom):	7
Palpable bulge	6*
Dyspareunia	1†
Difficult catheterization	1†
NonPOP	
No. pts	33
Av age (range)	24 (13–61)
No. neurological diagnosis:	
Myelomeningocele	22
Cerebral palsy	3
Bladder exstrophy	1
Tethered cord	1
Other (idiopathic, hypoxic encephalopathy, congenital hypotonia, congenital heart disease)	7
No. CIC at presentation	26
No. fertility (gravida/para):	
0/0	32
3/3	1

* One patient had dyspareunia and vaginal bulge.
† One of 6 patients.

Download English Version:

https://daneshyari.com/en/article/3860335

Download Persian Version:

https://daneshyari.com/article/3860335

Daneshyari.com