Surgical Management for Pelvic Organ Prolapse and Its Impact on Sexual Function

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ABSTRACT

Introduction: Female sexual function is complex, incorporating physical, emotional, and psychological factors. Pelvic organ prolapse, descent of the pelvic organs to or through the vaginal opening, is a common condition that affects quality of life, including sexual function. Symptomatic prolapse is most commonly treated with reconstructive surgery.

Aim: To address the surgical management of pelvic organ prolapse and its impact on sexual function and include recommendations for evaluating sexual function, use of validated questionnaires to assess function, preoperative counseling, and postoperative follow-up.

Methods: A literature search was performed for articles evaluating sexual function after pelvic organ prolapse surgery. Priority was given to larger studies, including systematic reviews, and use of validated questionnaires.

Main Outcome Measures: The main outcome was postoperative sexual function after pelvic organ prolapse repair.

Results: Multiple surgical approaches are used for the treatment of pelvic organ prolapse, including native tissue and grafted repairs. An evaluation of sexual function preoperatively is necessary to decide on type of surgery and to establish appropriate postoperative expectations. Postoperatively, most patients report sexual function as improved or unchanged.

Conclusion: Thorough preoperative counseling allows patients and their physicians to develop appropriate, individualized treatment plans for pelvic organ prolapse that consider women's preoperative sexual function and sexual function goals.

Key Words: Sexual Function; Pelvic Organ Prolapse; Vaginal Surgery

INTRODUCTION

Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality.[1] The interconnection of these factors as it pertains to intimate relationships is sexual function. Pelvic organ prolapse, descent of the pelvic organs to or through the vaginal opening, is a common condition that affects many facets of women's quality of life. In the United States, 2.9% to 7% of women seek medical treatment for prolapse symptoms.[2,3] Typically, patients are most symptomatic when the leading edge of the vaginal protrusion is at or past the level of the hymen.[2] Prolapse is further described as involving the anterior (cystocele), posterior (rectocele), or apical (enterocele) compartment of the vagina, although many women have multiple affected compartments (Figure 1). The pathophysiology of prolapse is not completely understood but is most likely multifactorial, including age, parity, and injury to or weakness of the pelvic floor.[2–4]

Although not dangerous, pelvic organ prolapse can be bothersome to women and negatively affect body image and sexual health.[5,6] Although some women report that prolapse results in feeling more self-conscious or embarrassed, less feminine, and less sexually attractive, others report that their prolapse is not associated with any sexual complaint.[5,7–9] Women's goals in seeking treatment for pelvic organ prolapse include physical resolution of bulge symptoms and improvement in bowel, bladder, and sexual function.[10–12] Although prolapse is most commonly treated non-surgically with the use of a pessary, surgical repair is the mainstay of treatment. Operation on a woman's sexual organs is likely to affect sexual function. This review focuses on the impact of surgical management of pelvic organ prolapse on sexual function. In addition, we make suggestions regarding the counseling of women on sexual function before and after surgery.

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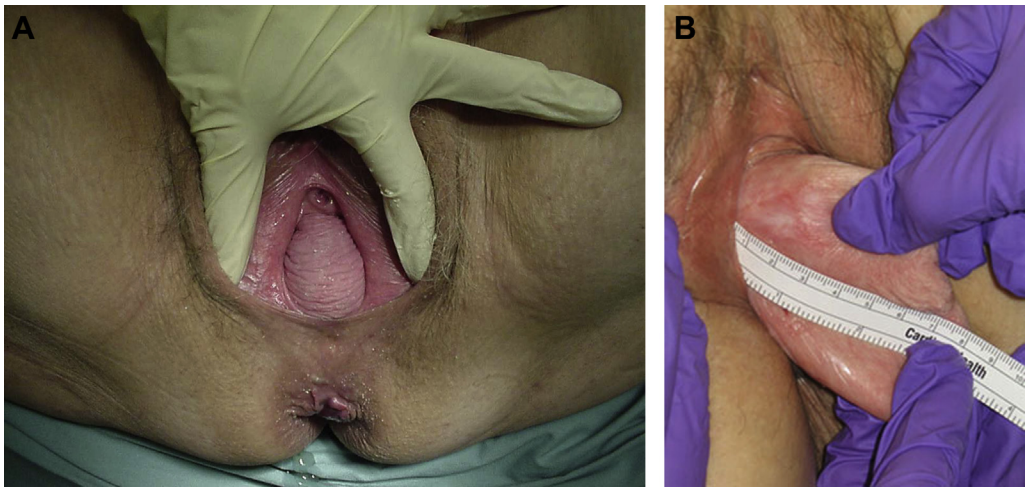

Figure 1. Panel A shows an example of prolapse of the anterior wall of the vagina to the vaginal opening (cystocele). Panel B shows an example of complete prolapse of the anterior (cystocele), posterior (rectocele), and apical (enterocele) portions of the vagina. Figure 1 is available in color online at www.smr.jsexmed.org.

EVALUATION OF SEXUAL FUNCTION IN WOMEN WITH PELVIC ORGAN PROLAPSE

The first step in the assessment of sexual function is to ask the patient. The responsibility is left to the physician to initiate the conversation. When surveyed in a gynecologic clinic setting, only 17% of women with a sexual complaint were forthcoming with their physician about sexual concerns, emphasizing the importance of the physician initiating a conversation about sexual function.[13,14] Open-ended questions can be useful for screening: Are you sexually active? Do you experience any problems such as pain or discomfort with sexual activity?[15] These give patients an invitation to describe any concerns they might have. These same questions can be used to probe the sexual health of women before and after surgery for prolapse. Many women with prolapse abstain from sexual activity because they fear that the prolapse will harm their partner or because they are ashamed of the appearance of the prolapse.[16] Although prolapse is not usually associated with pain, some women with prolapse do experience pain with sexual activity and might have resolution of the pain as a goal of surgery.

Validated questionnaires can be used to measure sexual function in women with prolapse. These questionnaires can be categorized into general and condition-specific assessments of sexual function. A commonly used questionnaire for the general assessment of women with prolapse is the Female Sexual Function Index.[17] In addition, the long and short versions of the Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ and PISQ-12) and the PISQ International Urogynecological Association revised are condition-specific assessments for sexual function designed to measure sexual function in women with prolapse and incontinence.[18–20] These assessments are more commonly used for research purposes, although they can aid in the clinical evaluation of women with prolapse.

In addition to sexual function assessment, the evaluation of women with prolapse includes assessment of the vaginal architecture, which is most commonly assessed with the Pelvic Organ Prolapse Quantification System. This system describes the stage or extent of prolapse by the vaginal compartment with greatest descent—apex, anterior, or posterior vaginal wall—and an assessment of vaginal length.[21] This information not only is critical for surgical decision making but also can help with preoperative and postoperative sexual function counseling. Although rare, vaginal architecture can have an impact on sexual function, particularly if the patient has a history of prolapse repair. If the vaginal is very short or scarred or the vaginal opening is too small, then sexual intercourse can be impeded. Indeed, in the early literature on posterior repair, investigators found that although their repair of prolapse was successful, the small vaginal opening resulting from the repair made intercourse difficult, if not impossible.[22,23]

Although these standardized assessments of sexual function and vaginal anatomy can help evaluate a woman before prolapse surgical repair, preoperative counseling of the patient also should include a discussion of her sexual goals after surgery. The results of this discussion can help guide surgical planning and set realistic expectations for postoperative outcomes.

PELVIC ORGAN PROLAPSE SURGERY AND SEXUAL FUNCTION

Surgical planning for prolapse repair takes into account the severity of prolapse, the patient's health status, prior surgeries, physicians' and patients' preferences, and current and desired sexual function and activity. Options for prolapse repair include abdominal vs. vaginal approaches and native tissue vs. grafted repairs. A native tissue repair is one that uses a patient's own structures to repair the vaginal defect. These surgeries most commonly include anterior and posterior repairs (colporrhaphy), uterosacral vault suspensions, and sacrospinous fixations. Native tissue repairs are typically performed vaginally.[24,25] Grafted repairs use mesh materials or biologic grafts to augment native