

## Surgery for Pelvic Organ Prolapse

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### Article info

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### Abstract

**Context:** Pelvic organ prolapse is a common condition affecting at least a half of adult women. Most women are asymptomatic, but a significant proportion of women choose to have an operation.

**Objective:** The aim of this paper is to review the various surgical procedures for the correction of pelvic organ prolapse.

**Evidence acquisition:** Guidelines from professional organizations, meta-analysis, reviews, and high-quality studies were referred to collect the evidence for the various surgical techniques.

**Evidence synthesis:** Management of pelvic organ prolapse is considered under anterior vaginal wall prolapse, apical prolapse, and posterior vaginal wall prolapse to help the reader organize the information to counsel women in a systematic way.

**Conclusions:** Surgical management of prolapse can be challenging, and various factors affect the procedure of choice and the outcomes. Providing information, careful counseling, and informed choice are crucial to deliver patient expectations. All these factors should be considered when deciding on the surgical procedure. Crown Copyright © 2018 Published by Elsevier B.V. on behalf of European Association of Urology. All rights reserved.

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### 1. Introduction

Pelvic floor dysfunction, including urinary incontinence, anal incontinence, and pelvic organ prolapse (POP), is extremely common, affecting at least one-third of adult women [1]. POP is the herniation or bulging of the pelvic organs to or beyond the vaginal introitus. Prolapse is a common condition affecting more than half of parous women [2,3], but it is difficult to determine the true prevalence as symptoms vary in women. A USA-based epidemiological study found a prevalence of 12.9%, while a Swedish study reported an 8.3% prevalence rate in women reporting a symptom of a bulge in the vagina [4]. Examination of women increases the prevalence to 40% of women having stage 2 or more [5]. The evidence on the natural

history of POP is not clearly understood. The reported annual incidences of cystocele (anterior compartment), rectocele (posterior compartment), and uterine prolapse (middle compartment) were 9.3, 5.7, and 1.5 cases per 100 women years, respectively, and progression rates for grade 1 POP (per 100 women years) were 9.5 for cystocele, 13.5 for rectocele, and 1.9 for uterine prolapse [2]. The annual rates of regression (per 100 women years) were 23.5, 22, and 48, respectively [2]. The lifetime risk of a woman needing an operation for prolapse is 11–19% [6–8]. Up to one in three women need a reoperation for prolapse [9].

Risk factors for POP include pregnancy, childbirth, congenital or acquired connective tissue disorders, age, and body mass index [10]. POP significantly affects a woman's quality of life, and surgical interventions can

improves the quality of life [11]. Conservative therapies including pelvic floor exercises and vaginal pessaries should be offered and tried in women with POP prior to surgical options. These measures are not considered in this article. “Bulging” is the principal symptom that correlates with the severity of prolapse, and POP is not shown to be associated with pelvic pain or back pain [12,13]. POP is generally considered to be symptomatic (implying a need for treatment) when the leading edge of the prolapse is at or beyond the level of the hymen (>stage 2 prolapse) [13]. Another study has suggested prolapse to become symptomatic if it descends lower than a point 0.5 cm above the hymenal reference plane [14].

There is paucity of data on the impact of pelvic organ surgery on sexual function outcomes [15]. The economic costs of pelvic organ surgery are also significant and is expected to double in the next decade due to the aging population [16]. There is some evidence to suggest that vaginal reconstructive surgery and pessary use were more cost effective than expectant management, and abdominal sacrocolpopexy incurs less cost than laparoscopic or robotic surgery [16].

This article will address the surgical management of POP.

## 2. Assessment of POP

Any protrusion of the vaginal wall or the pelvic organs should be assessed during straining, and the patient can be asked to confirm the size of the prolapse. Every attempt should be made to demonstrate the maximum protrusion in various positions. Factors such as the position of the patient, type of chair or table used, speculum, fullness of the bladder or bowel, and maneuvers used should be documented along with the findings. Although various classification systems are available, the International Continence Society and the International Urogynaecological Association recommend the use of the Pelvic Organ Prolapse Quantification system to describe POP [1]. This is used clinically both pre- and postoperatively and in research. Another classification that is used is the Baden–Walker classification.

## 3. Outcomes of POP surgery

Although anatomical and subjective outcomes are critical in the evaluation of the outcomes, patient-reported outcomes measures and health-related quality of life questionnaires have been developed for use pre- and postoperatively to assess the outcomes of POP surgery. As POP predominantly affects a patient’s quality of life, use of these outcome measures are advisable. The International Consultation on Incontinence Modular Questionnaires are one such set of questionnaires specifically developed for pelvic floor problems (<http://icq.net/structure.html>).

## 4. Anatomical considerations

The vaginal walls derive support from strong fascia and ligaments in the pelvis. DeLancey [17] described three levels of support to the vagina (Fig. 1):

Level 1: The cardinal and uterosacral ligaments provide support to the apical attachment—the uterus and the vaginal vault.

Level 2: The arcus tendinous fascia pelvis and the fascia overlying the levator ani muscles provide support to the middle part of the vagina.

Level 3: The urogenital diaphragm and the perineal body provide support to the lower part of the vagina.

Disruption to any of these structures will result in a POP, and surgical correction aims to correct these defects and restore anatomy.

## 5. Surgical procedures

POP may present with various symptoms and may not be compartment specific, and increasing severity may be associated with several specific symptoms related to urinary incontinence, voiding difficulties, defecatory symptoms, and sexual dysfunction [4]. There is poor evidence to suggest that POP surgery will consistently alleviate all these symptoms [5]. Feeling of a bulge in the vagina is the principal symptom that correlates with the severity of the prolapse [12]. POP is unlikely to be the cause of pelvic or back pain, and there is no evidence to suggest that this will improve with surgery [13]. Women with POP with the leading edge of the prolapse at or beyond the hymenal remnants (stage 2 or above) have been shown to have more symptoms that may define a symptomatic prolapse [14]. It may hence be reasonable to offer surgery to these women. Individual patients’ risk of surgery, risk of recurrence, previous treatments, and surgical goals should be considered in deciding on the surgical management of POP [18].

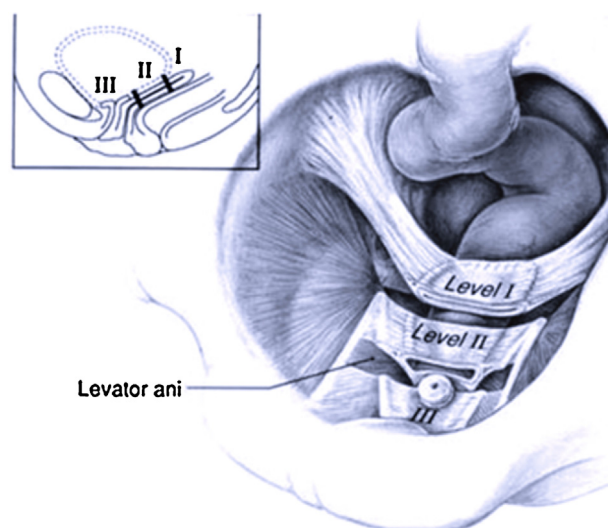


Fig. 1 – Levels of uterovaginal support. Reproduced from DeLancey [17].

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