

Uterovaginal prolapse

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Pelvic organ prolapse refers to the protrusion or displacement of the pelvic organs from their normal anatomical position into or through the vagina to varying degrees (Figure 87.23). It is said to affect up to 40% of women at some point in their lifetime. A prolapse can have a detrimental impact on normal organ performance, including anorectal, urinary and sexual function. A prolapse is more common in certain groups, including: /uni25CF older women; /uni25CF parous women, increased parity , prolonged labours, vaginal deliveries; /uni25CF obese women; /uni25CF women who have chronic constipation; /uni25CF women with occupations that involve heavy lifting; /uni25CF women with oestrogen deficiency; /uni25CF women with a family history or genetic risk; /uni25CF women with connective tissue disorders, e.g. Ehlers–Danlos syndrome, Marfan syndrome. (a) (c) (e) Women with minor prolapses may be asymptomatic, but those with more significant degrees may present with a sensation of ‘something coming down’. A cystocele (bladder prolapse) and a cystourethrocele (prolapse of the bladder and urethra) can lead to the sensation of a lump in the vagina and may be associated with urinary urgency (OAB symptoms) and recurrent urinary tract infections. Uterine descent can lead to a lump in the vagina or a dragging sensation; with complete prolapse of the uterus (procidentia) there may be associated vaginal discharge, ulceration of the vaginal mucosa and bleeding. A rectocele (prolapse of the rectum into the vagina) may cause difficulties with defecation or a sensation of incomplete emptying, which can be relieved by digital reduction of the prolapse. The degree of prolapse is graded in terms of descent. Currently , the commonly used grading system is the Pelvic Organ Prolapse Quantification System (POP-Q): /uni25CF grade 0: no prolapse is demonstrated; /uni25CF grade 1: the most distal portion of the prolapse is >1 /uni00A0 cm above the level of the hymen; /uni25CF grade 2: the most distal portion of the prolapse is ≤ 1 /uni00A0 cm (b) above or below the level of the hymen; /uni25CF grade 3: the most distal portion of the prolapse is >1 /uni00A0 cm below the level of the hymen but 2 /uni00A0 cm less than the total vaginal length; /uni25CF grade 4: maximal descent. Non-surgical management of a uterovaginal prolapse includes: lifestyle changes (avoidance of constipation); physio - therapy to help strengthen the pelvic floor muscles for at least 16 weeks for those with grade 1 or 2 organ prolapse; topical oestrogen replacement for oestrogen deficiency to help increase tissue strength and elasticity; and vaginal pessaries . There are a number of different pessaries available and they are replaced every 3–6 months, with the ring pessary being the most frequently used. It is inserted between the posterior fornix - and the pubic bone. The main complications are of vaginal ulceration and infection leading to discharge and bleeding; it is advisable, therefore, to replace the ring frequently . Surgical management aims to correct the prolapse. The surgical procedures are intended to restore the uterovaginal anatomy and position. They may be carried out using a vaginal or abdominal (open or laparoscopic) approach (Table 87.12).

(c) (e) (d) Figure 87.23 Uterovaginal prolapse: (a) urethrocele/cystocele (arrow); (b) uterine prolapse (arrow); (c) enterocele (arrow); (d) vaginal vault prolapse (arrow); (e) rectocele (arrow).

/uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF Approximately 30% of women in their lifetime report a recurrence of their symptoms following surgical treatment. This figure increases with subsequent procedures.

Condition Treatment Urethrocele/cystocele An anterior vaginal wall repair (anterior colporrhaphy) (Figure 87.23a) without the use of mesh Uterine prolapse If the patient's family is complete, a vaginal (Figure 87.23b) hysterectomy with or without vaginal sacrospinous /f_i xation can be performed Uterus-preserving surgery includes: amputation of the cervix with suturing of the transverse cervical ligaments vaginally (Manchester repair); laparoscopic plication of the uterosacral ligaments (McCall suture); or hysteropexy, which may be vaginal (attaching the cervix to the sacrospinous ligaments using non- absorbable sutures) or laparoscopic/abdominal (sacrohysteropexy using a polypropylene mesh to suspend the uterus to the sacral promontory) A colpocleisis can be considered in women who no longer wish to have penetrative intercourse Enterocoele A similar technique to repair of a hernia is used. The (Figure 87.23c) vaginal mucosa is opened and the hernial sac repaired Vaginal vault prolapse Sacrospinous /f_i xation performed vaginally: the (Figure 87.23d) vault is attached to the right sacrospinous ligament using a non-absorbable suture/mesh, avoiding the rectosigmoid colon on the left Sacrocolpopexy performed abdominally or laparoscopically: the vaginal vault is attached to the sacral promontory using a mesh A colpocleisis can be considered in women who no longer wish to have penetrative intercourse Posterior colpoperineorrhaphy without mesh: the Rectocele posterior vaginal wall is opened, the rectum returned (Figure 87.23e) to its normal position and redundant vaginal mucosa excised SUI, stress urinary incontinence.

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