

Overcoming Vaginal Prolapse



Non-Operative and Operative Solutions

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A variety of factors – some inherent, others modifiable – can lead to anatomic and neuromuscular dysfunction of the female pelvic floor. Pelvic floor dysfunction is responsible for several different types of symptoms, one of which is pelvic organ prolapse.

Pelvic organ prolapse is the protrusion of pelvic structures through the vaginal introitus, causing symptoms of bulging, pressure and/or discomfort. Different types of prolapse represent different levels and compartments of the vaginal vault, involving pelvic structures such as the uterus, bladder, rectum, small intestine or a combination. There are different degrees, or stages, of prolapse, ranging from mild and asymptomatic to complete eversion of the vagina. A complete vaginal vault prolapse associated with an intact uterus is referred to as uterine *procidentia*.

Treatment of pelvic organ prolapse is symptom-based, and can be non-surgical or surgical, depending on many factors, including severity, associated bowel or bladder dysfunction, and patient preferences.

VAGINAL PESSARY

A non-surgical option is a supportive device called a vaginal pessary, which is used to support the uterus (uterine prolapse) and/or vaginal walls (cystocele or rectocele).

It improves certain types of urinary incontinence and aids in bladder emptying. A pessary is often used as a temporary measure to provide symptom relief in anticipation of surgery or as a permanent alternative if surgery is not an option. A pessary may also be used long-term in patients who prefer to avoid surgery.

The size and type of pessary depends on the degree of prolapse or severity of the vaginal “hernia.” Pessary fitting is often a matter of trial and error. The pessary must fit properly for effectiveness. Since every woman is unique, it may take several fittings before the best one is found for a specific problem. If it is too loose, it may move and fall out. If it is too tight, it may be uncomfortable, block the passage of urine or stool, or cause an ulcer or “sore spot” in the vagina.

A proper fit does not always occur immediately. The pessary may require changing more than once for a different size or shape to keep its effective fit. This is not uncommon and may be necessary after extended use.

Instruction on care and use is required. Initially, frequent follow-up examinations are necessary to ensure proper pessary position. However, most women can be instructed to insert and remove their own pessary and manage it independently. Consideration should be given to the use of estrogen cream, ring or tablet to help the tissues soften and accept the pessary.

Upper vaginal wall weakness, with the uterus in place, may lead to uterine descent or complete prolapse, referred to as procidentia.

PELVIC FLOOR RECONSTRUCTION

Prolapse occurs when organs normally supported by the pelvic floor, including the bladder, bowel and uterus, protrude or herniated into the vagina. Weakened pelvic support due to childbirth is the most common cause of pelvic floor prolapse. Previous hysterectomy, insufficient estrogen due to menopause and chronic conditions or activities, such as constipation, coughing and heavy lifting, can also contribute to pelvic floor prolapse.

Pelvic organ prolapse may be repaired vaginally or transabdominally. Types of prolapse operations include reconstructive (using the patient’s own tissue), compensatory (using a synthetic graft), or obliterative (vaginal

shortening). Transvaginal repairs may be performed as an outpatient procedure or with one overnight stay in the hospital. Abdominal surgery involves a longer operative time and recovery period.

Advances in minimally invasive laparoscopic and robotic laparoscopic surgery using the da Vinci robot have made it possible to perform a sacrocolpopexy (abdominal prolapse repair using synthetic graft) without a large abdominal incision. The laparoscopic robotic approach provides a minimally invasive pelvic reconstructive procedure with a shortened post-operative recovery time.

Many women with pelvic floor prolapse also suffer from urinary incontinence. Pelvic reconstructive surgery for pelvic prolapse correction can also incorporate appropriate procedures to treat co-existing urinary incontinence.



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Dr. Knapp has a special interest in female urology, urinary incontinence, and other bladder control problems in men, women, and children. He is a Medical Director of UroPoint Bladder Control Centers and is an instructor in the Female Medicine and Pelvic Reconstructive Surgery Fellowship at Indiana University School of Medicine.



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