Ask an Expert: Pelvic organ prolapse (POP) management pathways

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Overview

- Pelvic floor disorders domain & screening.
- Assessment and management pathways for POP
  - conservative vs surgical management
  - useful education resources for patients.
- Pelvic mesh update & management pathways.

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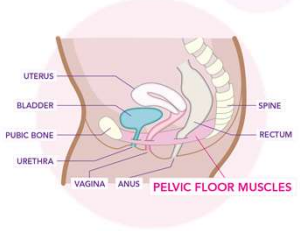
Pelvic floor disorders (PFDs) domain

Pelvic organ prolapse (POP)
Bladder-related issues
- stress urinary incontinence
- overactive bladder
- voiding dysfunction
- bladder pain syndrome/Interstitial cystitis
- recurrent UTI

Bowel-related issues
- obstructive defecation
- faecal incontinence
- rectal prolapse

Sexual dysfunction



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PFD - Why is it important to know?

- POP occurs in up to 50% of women after childbirth
  - 40% will be symptomatic
  - 10-20% lifetime risk of undergoing surgical correction of POP
- Urinary incontinence (UI) affects 37% of Australian women (Australian Institute of Welfare Report 2006)
  - 65% have some type of UI but only 31% seek help from a professional
- Faecal incontinence affects up to 13% of Australian Women
  - one of the 3 major cause of admission to aged-care facility
- Most women believe that it is "normal" to have PFD after childbirth & also part of ageing process
- Most women do not usually disclose the problem unless asked/screened

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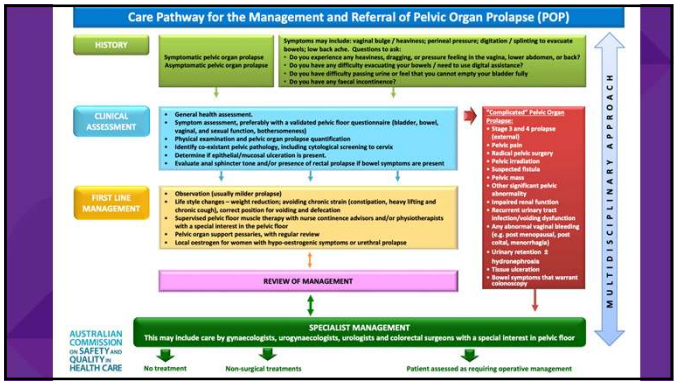

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Prolapse assessment

Clinical staging

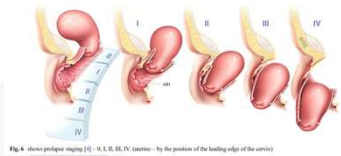

Fig. 6 shows prolapse staging [4] – 0, I, II, III, IV. (uterine – by the position of the leading edge of the cervix)

Stage 0: No prolapse is demonstrated.
Stage I: Most distal portion of the prolapse is more than 1 cm above the level of the hymen.
Stage II: The most distal portion of the prolapse is situated between 1 cm above the hymen and 1 cm below the hymen[3].. See also Appendix.
Stage III: The most distal portion of the prolapse is more than 1 cm beyond the plane of the hymen but everted at least 2 cm less than the total vaginal length.
Stage IV: Complete eversion or eversion at least within 2 cm of the total length of the lower genital tract is demonstrated.

Reference: IUGA/ICS Joint Terminology Report for Female Pelvic Organ Prolapse IUJ 2016

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POP-Q

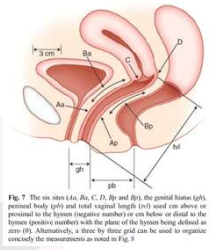

Fig. 7 The six sites (*Aa, Ba, C, D, Bp* and *Ap*), the genital hiatus (*gh*), perineal body (*pb*) and total vaginal length (*tvl*) used cm above or proximal to the hymen (negative number) or cm below or distal to the hymen (positive number) with the plane of the hymen being defined as zero (0). Alternatively, a three by three grid can be used to organize concisely the measurements as noted in Fig. 8

Anterior wall **Aa**	Anterior wall **Ba**	Cervix or Cuff **C**
Genital hiatus **gH**	Perineal Body **pB**	Total Vaginal Length **TVL**
Posterior wall **Ap**	Posterior wall **Bp**	Posterior Fornix **D**

Reference: IUGA/ICS Joint Terminology Report for Female Pelvic Organ Prolapse IUJ 2016

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Additional clinical assessment

- vulva/vaginal estrogen status
- clinical cough stress test
- pelvic floor muscle strength
- digital rectal exam

- uroflow study
- postvoid residual on bladder scan.

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Patient education

- Improve patient's understanding of their underlying condition
- More likely to improve patient's compliance to recommended treatment
- Where to find information for patients?
  https://www.yourpelvicfloor.org/
  https://www.ugsa.com.au/patient-resources/

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IUGA patient info website

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Treatment options

- Do nothing
- Conservative management
- Surgical management.

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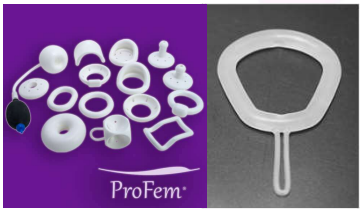
Vaginal pessaries

- 1st line non-surgical mx
- can be used on its own or combined with PMFT
- options:
  - support pessaries - Ring ± support, Hodge, Gehrung
  - space occupying pessaries Gelhorn, Donut, Cube.



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Vaginal pessaries

Who will be suitable?

- frail elderly with multiple comorbidities
- patient with significant anaesthetic risks
- women to wishes to avoid/delay surgery
- pregnant women with symptomatic POP.

Potential complications:

- vaginal bleeding/ulceration
- vaginal discharge
- expulsion of pessary
- pain/discomfort
- voiding difficulty/obstructive defaecation if pessary too large
- fistula formation if pessary left in situ for prolonged period (very rare).

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Physiotherapy

Pelvic floor muscle training (PFMT) aim:

- increase strength & endurance of pelvic floor
- reduce frequency of sx a/w prolapse (bladder, bowel, sexual, backache)
- prevent severity of POP from getting worse
- advert delay for surgery.

Hagen et at Lancet 2014 (POPPY):

- improve prolapse symptoms for stage 1-3 POP
- better QOL at 6m after PFMT
- more patients perceived "better" at 6 @ 12m than no treatment.

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When to consider surgery?

- Failed conservative management.
- Patient declined non-surgical management.

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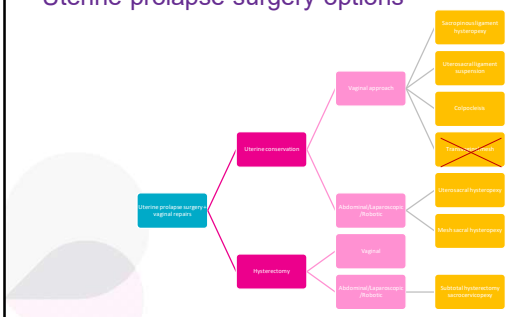
Uterine prolapse surgery options



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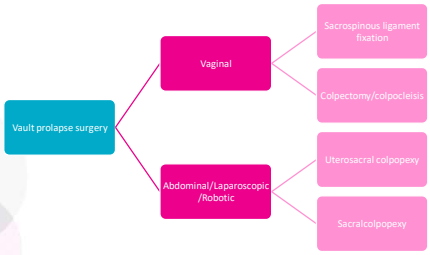
Post hysterectomy vault prolapse surgery options



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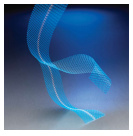
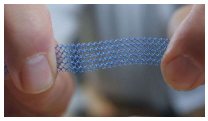
Pelvic floor mesh update

All TVM mesh for POP treatment were withdrawn from Australian market since Jan 2018, more recently withdrawn from UK and USA

Abdominal mesh use for POP treatment remain available

Midurethral sling mesh for treatment of stress urinary incontinence remain available





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Do we still offer pelvic mesh to patients?

- YES.
- Careful selection and counselling on various management options including
  - Conservative therapy
  - Native tissue/mesh-free surgery
  - Mesh augmented prolapse surgery.
- Informed consent and ensure patient understands the proposed procedure.
- Provide written information to support the discussion.

When to avoid mesh use?

- Chronic pain
- Fibromyalgia
- Chronic fatigue syndrome
- Immunosuppressed
- Pelvic radiation
- Chronic smoker

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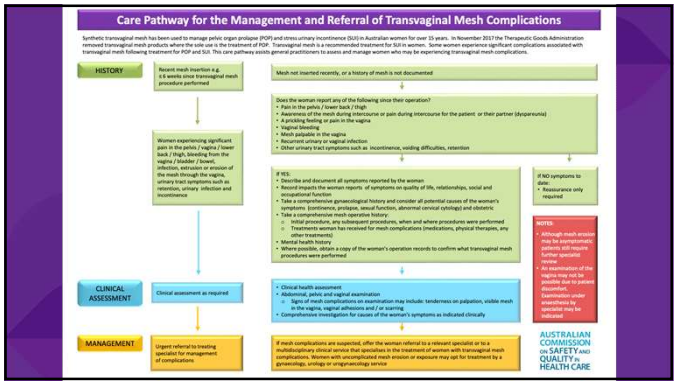

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Prolapse prevention

First identify the risk factors!

Modifiable:

- obesity
- chronic constipation/cough/asthma
- heavy lifting
- pregnancy related complications.

Non-modifiable:

- ageing/menopause
- genetic disorders.

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Evidence on prolapse prevention

Primary prevention:

- PMFT (evidence unclear but no harm)
- avoidance of forceps delivery (risk reduction by 20-40%)
- avoidance of vaginal delivery (risk reduction by 60-80%)

Secondary prevention:

- no benefit during immediate (up to 6m) postpartum period (*Bo et al BJOG 2015*)
- improvement in POP sx with PMFT long term (PREVPROL 12 years postpartum) – Hagen et al Lancet 2017

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Pelvic floor disorder risk calculator

- **U** UI during pregnancy
- **R** Race/ethnicity
- **C** Childbearing started at what age?
- **H** Height: maternal height < 160 cm
- **O** Overweight and obesity
- **I** Inheritance: family history
- **C** child number
- **E** estimated fetal weight

http://riskcalc.org/UR_CHOICE/

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25 yo, nulliparous with no risk factors, weight 50kg, height 160cm

12-Year Risk for Women with One or More Previous Births

Outcomes	Route of Delivery	Any	Bothersome	Treatment	Bothersome or Treatment	Average Risk of Bothersome or Treatment
Pelvic Organ Prolapse	Vaginal	16%	4%	2%*	7%	9%
	C-Section	16%	4%	2%*	7%	7%
Urinary Incontinence	Vaginal	41%	14%		17%	28%
	C-Section	32%	14%		17%	24%
Fecal Incontinence	Vaginal	9%	>10%	2%*	2%	5%
	C-Section	9%	>10%	2%*	2%	5%
Any Pelvic Floor Disorder	Vaginal	52%	12%			37%
	C-Section	43%	12%			32%
Two or More Pelvic Floor Disorders	Vaginal	13%	2%		3%	5%
	C-Section	13%	2%		3%	5%

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34yo, para 4, 1 forceps delivery, height 160cm, weight 80kg, history of UI

12-Year Risk for Women with One or More Previous Births.

Outcomes	Route of Delivery	Any	Bothersome	Treatment	Bothersome or Treatment	Average Risk of Bothersome or Treatment
Pelvic Organ Prolapse	Vaginal	32%	15%	3%*	63%	9%
	C-Section	32%	15%	4%*	63%	7%
Urinary Incontinence	Vaginal	90%	67%		76%	28%
	C-Section	85%	67%		76%	24%
Fecal Incontinence	Vaginal	>30%	>10%	1%*	>15%	5%
	C-Section	>30%	>10%	4%*	>15%	5%
Any Pelvic Floor Disorder	Vaginal	93%	67%			37%
	C-Section	90%	67%			32%
Two or More Pelvic Floor Disorders	Vaginal	54%	18%		30%	5%
	C-Section	54%	18%		30%	5%

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Take home messages

- Opportunistic screening for pelvic floor disorder.
- Uncomplicated pelvic organ prolapse can be managed in community.
- Conservative therapy should be the first line management.
- Not all prolapse require surgery.
- Specialist input if patient presented with multiple pelvic floor symptoms, pelvic mesh complications or failed conservative management.

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Questions?

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References

Patient & health care provider information resources
International Urogynaecology Association (IUGA): https://www.yourpelvicfloor.org/
Urogynaecology Society of Australasia (UGSA): https://www.ugsa.com.au/patient-resources/

Australian Commission on Safety & Quality in Health Care
https://www.safetyandquality.gov.au/our-work/health-conditions-and-treatments/transvaginal-mesh

URCHOICE calculator
http://riskcalc.org/UR_CHOICE/

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Resources

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Health Professional education

E-learning modules

Webinars

Premature menopause

Managing sexual pain: a multidisciplinary approach

Common vulval conditions: all that itches is not thrush

Menopause after cancer

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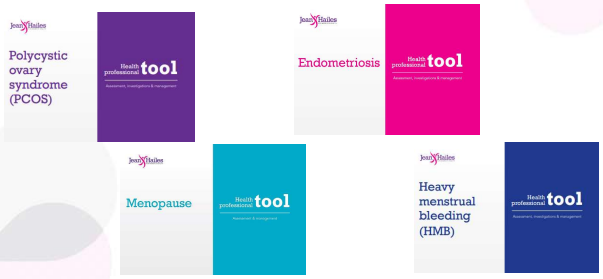
Health Professional tools



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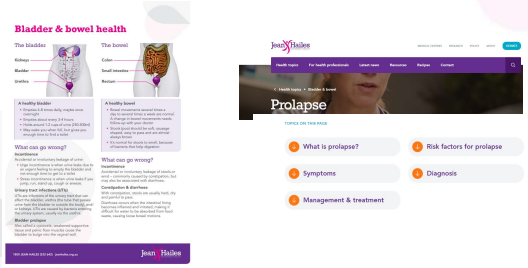
Consumer resources



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Consumer resources

- Magazine (yearly)
- Email update (for women & health professionals)
- Facts sheets & booklets
- Tools for health professionals
- Videos & recipes

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