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

**Dr Chin Yong:** And this is regardless of mode of delivery, and you can see it's only one entry actually come forward and ask for help. In terms of faecal incontinence, you can see it's about around one in 10 will have the problem, and this is one of the major cause of admission to aged care facility. Some of those elderly women would have double incontinence, and as you can see, those numbers are really, really staggering and it is so important for us to identify and capture them early, particularly in the community setting, and then we can move them along the pathway. Okay. I always tell the GPs how we can use this opportunity. Every time you see a patient, you can instigate this opportunity screening by asking them whether they have bothersome prolapse symptoms of bulge, or leakage, or faecal incontinence or whatsoever pelvic floor problems. Just by asking simple question. It's a 'yes/no' answer to be done about that, and then we move them along. If we can screen people for cervical cancer, breast cancer, there's no reason why we can't screen people for pelvic floor disorders. As you can see, they're really common problems. And women don't normally disclose this problem because they felt embarrassed and they thought that this is a normal process after childbirth and aging.

So moving on to the management pathway. This is a rather busy slide, but what you can see here on the slide, we start with a screening and the history. I'm not going to go through the details in history, how to take a history for pelvic organ prolapse. The way I divided this pathway is, what can be managed in the community setting, which is on the left side of the slide. If you think that patient have a straightforward isolated problem, isolated prolapse problem with no bladder or bowel symptoms, no voiding difficulty, and then you do the full clinical assessment. I'll run through the slides later to take you through how can we assess the prolapse clinically. When I assess patients in the clinic, I also use some pelvic floor questionnaires that will cover all the four domains. That's also another way of assessing the patient and also a good research tool.

Once we establish the diagnosis, then we move down the conservative management, which is in the orange box here, which can be managed in the community setting, either instigated by the GPs or physiotherapist most of the time. Okay. So the option is either do nothing if it's mild, lifestyle modification, weight reduction, managing constipation. If they have chest problem like COPD, asthma, bronchiectasis, all those should be optimised. In terms of patients who does a lot of strenuous activities or heavy lifting, the gym bunnies people, so they just need to be advised on safe lifting and safe exercise.

Physio has a major role in any form of pelvic floor disorders. They are usually the first point of contact for conservative management, and usually I have a reliable group of physio that I work with and obviously we move them down with a pessary, which is also another conservative management. For postmenopausal women we can offer them topical vaginal oestrogen therapy to treat the vaginal atrophy. Now I want to draw your attention to the right side here, the red box here. This is the time when you should consider referring the patient directly to the specialist for further assessment because of the complexity of the problem and the potential complications that can happen concurrently. As you can see here, advanced prolapse, anyone who has pain, radiation, radical surgery, fistula, mass, all this can just complicate the whole picture and it will be best to send them sooner for assessment and investigation. The list go on, I won't read through the list. These slides will be available for distribution and Tracy will be able to do that at the end.

Now, in terms of prolapse assessment, there are several ways of assessing from urogynaecology perspective. We do this called POP-Q assessment, it's quite detailed, it's a six point assessment. I wouldn't go through this in detail. This is just for a reference. This is a international lingo that we use among the gynaecologists in urogynaecology. So if we write and present it this way, everyone knows what we're talking about in the degree of prolapse. But for primary care setting and physios, usually I use this clinical Baden–Walker, or we call it a 'eyeballing technique'. And the way we develop this staging, so it ranged from stage 0, 1, 2, 3, and 4. Stage zero means no prolapse. Stage one is it's midway of the vagina. The reference point is at the hymen, okay. Hymen is zero, so anything comes above one centimetre above the hymen or below the hymen is considered as stage two.

Anything beyond one centimetre of the hymen is stage three. Stage four means it's completely out i.e. procidentia, or complete vault prolapse, if they have post hysterectomy vault prolapse. An additional clinical assessment when we, it's not just the POP-Q or staging, but we also need to assess for the vulva/vaginal oestrogen status. If they have atrophy, we tend to treat them. Clinical cough stress test, if they have, to elicit whether they have stress, urinary incontinence. Pelvic floor muscle strength, rectal exam to exclude rectal mass. In specialist setting, if patients have advanced prolapse with symptoms of voiding difficulty, we tend to offer them to have a uroflow study in the room, which involves having them to pass urine into commode, and then we can measure how fast the urine flows. And finish up with the bladder scan to check for the postvoid residual. This is a quick way to screen for voiding dysfunction.

Now moving on to management. I can't emphasise more on education. I tend to spend a lot of time educating my patient, what problem they have and it is so crucial for people to understand their problem before they can truly— So I tend to use resources. The most common resource I use is this website, yourpelvicfloor.org which is a website established by the International Urogynecology Association. They have multiple patient information, leaflets. It's also for health professionals without any medical jargon and comes in multiple languages as well. And the other resource is our local resource through the UroGyn Society of Australasia, which is a bit easier, but I prefer the first one. And this is what it looks like. If you go into that patient information website, you can find any form of pelvic floor problems or management and investigation. And the good thing is with this website that it also come in multiple languages. So if you have patients of various ethnic backgrounds, this will be a very good one to use as opposed to having people randomly go in Google or ask Wikipedia.

This is properly developed by various doctors around the world, and putting in this website. Doing nothing if they're not bothered. Even though, for instance, if you see a patient in the clinic and do a cervical screening test and at the same time incidentally found that they have a prolapse but they're not bothered, they're asymptomatic, so they can have the option of doing nothing. Alternatively, you can instigate that pathway and say, 'Look, you've got a second degree prolapse, would you like us to do something to prevent this before things get worse?' Yes/no. Then that's how you move them along the pathway. And obviously if all of the above failed, then surgical management comes in place. In terms of vaginal pessaries, that's the first non-surgical management we tend to offer to patients. However, it does not treat the condition, it does not reverse the stage of prolapse, it will only control the symptoms.

And it comes in various sizes and shape as you can see. And the broad category of pessary includes the support pessary, consists of all the rings and the oval shapes, those with the hollow cavity, those are the supportive pessaries. And then we have another type of group of pessaries called a space occupying pessaries, literally utilising and occupying the whole space in the vagina to stop the prolapse from coming down, such as the Cube, which we don't use a lot because that require daily removal. Donut. I use the Gellhorn a lot, and this is a newer version of the pessary, it's self-inflatable. More recently our unit just completed the randomised control trial comparing the traditional ring pessary against this pessary, what we call an 'irregular hexagonal pessary' or a C-POP.

This pessary was basically developed based on the vaginal cast study that we have previously done. And then the aim is to improve the retention rate and self-care. And this handle here actually helps promote the patient self-care. We have finished analysing the preliminary data. The retention rate is no difference, but subjective pessary because of, it's softer and it's easier to manage and they less likely to get any vaginal discharge from this pessary. So who will be suitable to have pessary? As you can see on the list there, anyone who are frail who are not fit for surgery with multiple medical condition, those who have significant anaesthetic risk, those who doesn't want to have surgery or wishes to delay surgery. We can use pessary in pregnant women or postpartum we use them, or those who just completely don't want to have surgery. So those are the options.

When the patient come to me and requested for pessary, I generally tell them the success rate is about 50/50, it's a trial and error, and the size of the pessary is determined by the clinician on the best fit practice. And obviously whatever we offer, there's always a downside. Common complications with any form of pessaries use including bleeding, ulcerations. Vaginal discharge, which is very common and this is one of the reasons why people stop using them, because of the malodorous discharge. Ulceration, again, if they are postmenopausal with atrophic vagina, have the pessary in place for more than six months or more, it's literally like a pressure, so that's why we recommend the pessary changed every six months. Expulsion of the pessary if it's too small, discomfort is too big, they can't pee or they can't empty the bowel properly. Fistula, I've only seen one over the last 10 years and that was in the context of an elderly aged care patient who had a Gellhorn pessary that was completely forgotten in place for good 10 years.

And then she came in with this passage of Gellhorn pessary. Now moving on to physiotherapies. Again, this is also a recommended first line therapy on top of the pessary. The aim of the physio is mainly to improve the strength and endurance, to reduce the symptoms of the prolapse, but as I said earlier on, it does not reverse stage one and max two, probably might benefit from that. Patients with stage three or more, it's very unlikely to benefit for that, but there's no harm offering them to see the physio and try the pessary. Alright. And it's also a way of delaying the surgery as well. In terms of evidence. Now the only evidence we have, this is the largest randomised trial that was published internationally looking at the effect of supervised one-on-one physiotherapy for controlling prolapse symptoms versus a standard advice on the videos, Pilates videos in dietary control, weight loss.

So they improve the prolapse symptoms, improve their quality of life and patients generally feel better. But the problem with pelvic floor exercise is that the data is only up to 12 months and I haven't seen any patients have, it's really diligent doing physio and pelvic floor exercise for more than 12 months. So this is something that we need to constantly remind patients, particularly in primary care setting. If you see a patient coming back to see you in your room and you say, just check with them, 'How's your bladder doing? How's your prolapse symptom doing? Have you been doing the pelvic floor exercise?' Just a gentle reminder. So, 'Yeah, yeah, yeah, I will do it' most of the patients will say. Sometimes you just need to get them to see the physio again maybe once a year just to refresh and just get a refresher course and see how they do it.

Not just squeezing muscles. It's more than that. When we talk about physio, I always ask the GP practice whether there are any pelvic floor physiotherapists they work along with. And this is extremely important because there are various pelvic floor physiotherapists around and we generally want the physio that particularly focus on pelvic floor specialty only. And this is quite difficult to determine. Within my practice I've got several dedicated group of physiotherapists that I work closely with, but obviously we need to be practical in terms of geographical location. If the patient is in the country, obviously we need to work around that and whatever is available to them. Obviously if the patient felt that it's not getting the benefit, then this can be escalated and I can recommend them my physiotherapist that I work with.

So moving on, when do we consider surgery? When all of the conservative management fail. And every now and then we see patients just come in and say, 'Sorry, I don't want to try any of this, it's a waste of time. It does not treat a problem, it's just delaying the surgery.' Fine. This group of people, when they're adamant to have surgery, you can't change their mind then you just have to work along with them. And as long as they understand that surgery is not risk-free and if they haven't tried a conservative management and ended up having complications, then we need to find a reason to justify, that, 'Look, you have not tried simple stuff and then you have this problem.' So in terms of prolapse surgery, there are various options available here. I'm not going to go through the details of all the options here.

So the basic principles of surgery is that, in the past people always think, when you have a prolapse it means hysterectomy, the patient needs hysterectomy. So there are emerging evidence and more evidence that's actually supporting that, you're trying conservation surgery, the outcomes are equally, have similar outcome as the hysterectomy for treatment of prolapse from short- to medium-term, that is, up to five years. But we haven't got any long-term data. That is applicable provided that patient, they fulfill those strict criteria before we can conserve the uterus. So if they have abnormal uterine bleeding, dysmenorrhea, adenomyotic uterus, big bulky fibroid uterus, history of breast cancer or endometrial hyperplasia, BRCA genes, abnormal cervical screening test, all those are actually contraindications to keep the uterus because the last thing you want to do is to hitch a potentially abnormal uterus and then you require further intervention for the patient in the future, which can be quite trick. And that's why it comes back to counselling and shared decision-making.

Alright. And once the patient has decided whether they want to keep or remove the uterus, then we move them along the pathway, the surgery, whether that can be done vaginally or abdominally. As you can see there are various options, vaginally and abdominally as well. Hysterectomy versus no hysterectomy. Now colpocleisis is an option that means sealing of the vagina. This is usually reserved for patients, elderly, frail, no longer sexually active and doesn't want to retain their sexual function. Then we just seal off the vagina completely by removing the skin of the vagina and pushing the uterus back and close it off, leaving two lateral channel to drain the discharge and blood. The rest are just hitching up the uterus with sutures just using different structures. Vaginal mesh completely gone in Australia since 2018. It's gone in the States and also in UK.

So I know more recently we have all this mesh controversies in the media and this is a hot topic that a lot of people have been talking about, and we see lots of patients coming through asking about, and not wanting to have mesh. Of course. We'll talk a bit more further down the slides, when it comes to mesh. And those are the options for abdominal approach. They come back with a vault prolapse, i.e. with no uterus, the options are similar just without the uterus there. Okay. Now pelvic floor mesh update, as I mentioned earlier on all the vaginal mesh has been removed. Abdominal mesh is still available and we use the mesh for treatment of stress urinary incontinence. Let me give you a brief overview. So mesh is used for treatment of various reasons.

So the mesh is used for treatment of hernia, incisional hernia or umbilical hernia or groin hernia, treatment for pelvic organ prolapse. The one that went on the media about vaginal mesh is no longer available. That's completely gone. Vaginal mesh is inserted vaginally. So you make an insertion and insert mesh vaginally and close it, and that's where the problems come, if the patient has not been adequately counselled and we have not selected the patient appropriately, or the surgeon has not been appropriately trained to insert the mesh, and that's where all the potential disaster came. And also the mesh property is also important. And then we have the abdominal mesh, meaning the mesh is inserted abdominally, like this mesh. It's a wide-shaped mesh that we use to lift up. this is mainly used to treat the apical prolapse, meaning the top of the vagina or the uterus if they have it, by lifting, attaching to the front of the vagina and the back, internally, through the keyhole surgery, and lifting them up and attaching it to the sacral promontory, the ligament of that sacral promontory.

And then of course we have the treatment for stress urinary incontinence, which is a sling. This is unfortunately been clumped together as a vaginal mesh just because it was inserted vaginally, and certainly the retropubic sling that we use for treatment of stress urinary incontinence has the most robust evidence in terms of efficacy and safety. We have 20 years data on that. Our local urogyn society and International Urogyn Society and RANZCOG has endorsed this as a safe treatment, and this is still recommended treatment. However, if the patient is concerned about mesh we don't offer any of the mesh. And then obviously we need to look at alternate management, including the native tissue repair and the non-mesh or mesh-free surgery, which we'll talk a bit more. Okay. So to put things into perspective, do we still offer mesh? Yes, as I said earlier on, it's all back to careful counselling, careful selection.

You want to pick the right patient. Even though the evidence suggests that this mesh procedure is good and durable, but if it's applied on the wrong patient group, it will not work. They end up have more disaster and complication. And when we counsel patient, we need to offer them all the potential options, including doing nothing, conservative, native tissue and mesh surgery, and explain to them all the advantage and disadvantages of each options. Okay. The website from Australian Health and Quality Safety Commission and Safety website has a very detailed information on informed consent and information of each of the options for the patients. So that is also another good website for the patient to go through, which will include all this management pathway as well.

And obviously I tend to provide all the written information to support the discussion. So when do we not use mesh or avoid using mesh? Obviously when they have chronic pelvic pain, that's a no-no. You don't want to put something permanent or prosthesis in someone that has already complained of pain. Fibromyalgia, chronic fatigue syndrome, they're all very difficult to manage from the baseline. And adding on something like mesh is a potential disaster. Immunosuppressed, it's just not mounting the proper immune response, and tissue fibrosis and tissue incorporation. Pelvic radiation just means that patient has terrible tissue quality. They're more likely to end up with mesh complications and mesh exposure in the vagina. So this is another care pathway for patients who have suspected, or with, vaginal mesh complications. This again is a very busy slide, but if you look at the first column on the left here, so you need to establish whether they have a mesh or not.

I have seen so many patients came to me and say, 'Look doc, this is what is written in the news. I've got this symptoms, I've got urgency, I've got this pain, I've got this discharge, I think I have all the symptoms.' And then when you go and ask them, 'Firstly, tell me, what sort of procedure you had. Do you have mesh?' Actually they don't have mesh. So it's very important because of all the things going on in the media, even for people who have successful treatment [–] ... because of all the unnecessary anxiety. There will be another group of people who have good results but they say, 'Look, because of all this stuff going on in the media, I don't want to have them,' and they come forward and seeking for mesh removal. And also there's another group that has no mesh, that they just want to know whether they fit into all this category.

So it is tricky and we just need to spend more time in ascertaining whether they have a mesh. If they have a mesh, what type of mesh they have, when was it inserted and where was it inserted and what specific problems they have. And then again, this is not something that can be managed easily if they truly have a mesh-related complications and will warrant an immediate referral to a tertiary centre or specialist assessment. I won't go through the whole slides here, and, those are the symptoms. And then if they have 'yes' to any of this problem, it's not just pain or mesh. So if they have, sometimes patient complain, or patient husband complain of hispareunia, it means there's only him feeling the mesh prickling and have laceration on his genital and the woman felt nothing. So that is also an indication for us to assess and investigate. So it's not, equally important. Okay. And then we move along the pathway and refer if there is any further concern.

So moving on to prevention. If we want to deal with the prevention, first we need to know, what are the risk factors? And then we can identify the risk factors and manage from that. There are modifiable and non-modifiable one, of course, those, that cannot change, we just have to leave it as it is. The modifiable one, the main risk factors is pregnancy, and that's the biggest problem that we encounter. I mean, wherever there's pregnancy and childbirth, there's always issues with pelvic floor disorders. There's always a complication. Obesity and chest problem, heavy lifting, all this stuff can be dealt with very easily as long as patient comply with all the recommendation. But pregnancy and childbirth, you can't go around and tell people, 'Sorry, I don't think you should be having a baby' or recommending everyone to have a caesarean section. That's not the way to do it.

And obviously it involve multiple disciplines. And at the moment I think the College of Obstetricians and Gynaecologists, we have been talking about this, whether this is something that we should include a informed consent as part of the vaginal birth process, making sure that patient understand the potential pelvic floor implications and also implications for baby as well. What if they have unanticipated shoulder dystocia or ischemic encephalopathy, all those stuff. So it's not just natural, I know most of our midwifery and obstetric colleagues will say, 'Look, you cannot deny a natural process.' Yes, that's true, it is a natural process, but you cannot say it is a normal vaginal birth when you have all the potential implications such as prolapse, urinary incontinence, faecal incontinence, some have double incontinence, sexual dysfunction, obstetric anal sphincter injury. So it's not like a clear cut 'yes/no,' but it needs to be carefully discussed and educate our colleagues as well as the patient.

Alright. I'm seeing a lot of patients who come six months, 12 months, 18 months postpartum after, about pelvic floor disorders. If they have known they would not have gone through that pathway. So perhaps there's something that we can do in the community setting just to provide information and let them know, 'Look, if you want more information, this is the person you can talk to.' I've noticed that a lot of my obstetrician colleagues, they don't talk about this to their patients, which I think, that is actually an opportunity to discuss, but I don't know how to approach them in a long-term, it's an ongoing issues that we need to deal with. In terms of prevention, as you can see, there's actually no evidence that pelvic floor exercise will prevent prolapse. Okay, this is only for prolapse, but there are good evidence that it will prevent urinary incontinence. Alright.

But that doesn't mean there's no point in doing them. So in general, women still benefit from the pelvic floor exercise. Avoiding the forceps of vaginal delivery, you can see how we can reduce those numbers. But again, this is also a very sensitive topic to discuss with our obstetrician and with every colleague. So yeah, perhaps we need to run an education and have a meeting with all the other disciplines and see what can be achieved in longer term. But this is, a lot of work is happening behind the scene and certainly hopefully we will get an answer at some stage. But in short term, instead of approaching our obstetric and midwifery colleague, my approach is to go to the patient, 'These are the information, you are in control, you decide what you want, not what your midwife or your obstetrician tell you what to have.'

And obviously those are the pros and then those are the cons of doing that. Secondary prevention. Again, most of the studies done are non-pregnant subject, and there's only one study have looked at pelvic floor exercise immediately postpartum after 12 months. There's no evidence of benefit whatsoever. However, there's a long-term studies up to 20 years. 12 years and 20 years they show some benefit of improvement in prolapse symptoms. So moving on to the calculator. So this is the recent tool that was developed to identify who are at risk of pelvic floor disorders. So something identical to the cardiovascular risk calculator, and you stratify their risk, how likely they're going to have the problem. And as you can see that's a mnemonic and those are the risk factors. You punch in all the risk factors in the calculator and then they will come up with a risk. So this is what it looks like here.

So I'm giving you an example here. Okay, so this is a young 25-year-old, nulliparous, no risk factors, normal weight, normal height. You're punching all the figures. On the left hand corner here you can see the outcome, prolapse, incontinence, faecal incontinence, any form of pelvic floor disorders, two or more. And the mode of delivery. Average risk, this is a baseline population risk. This is the patient risk. And you can see having as 'first pregnancy, young with no risk factors', her chance of having a pelvic organ prolapse either having a vaginal or caesarean section, there's no difference. Okay. Urinary incontinence, you can see the baseline is already high regardless of the mode of delivery. As I mentioned earlier on on my very first few slides. This is important. If the patient comes and tells you, 'Look, I don't want to have prolapse, I don't want to have leakage.' Elective caesarean section. First, never have any vaginal birth attempt, I think that is reasonable, but I cannot guarantee that you will not have urinary incontinence.

So that is very important. If someone had a vaginal birth or a failed instrumental delivery and it ended up with a caesarean section, that protective effect is gone. Okay. If they have a vaginal birth and then they want to have a caesarean section, that protective effect is already gone. So this figure is applicable to people who have not gone into labour, has not attempted vaginal birth. If I say, 'Look, I want to have a caesarean section', that's my risk. If you have a vaginal birth and then you have a caesar, then that risk will change again. Alright. And that figure will continue to change as you continue to punch in all the risk factors. As I mentioned here, all this, you put it in the calculator and the number will change. So I'm giving you a different scenario here, assuming it's the same patient, she is nine years older and now she had four, and she had one forceps delivery, she remain, she put on even more weight and now she's having leakage.

Can you see how her risk has increased exponentially [–] ... to provide these figures and say, 'Look, those are the chances of you having the urinary incontinence or caesarean section, so that, you already have four, by you having an elective caesarean section of natural vaginal birth, that risk has not reduced, but compared to, your risk has gone up exponentially, that's at least threefold, by just having previous forceps delivery and four vaginal birth. And that's how all this number will continue to change depending on what numbers that you're punching. This is just an extreme example I put in, change from here as a young 25-year-old with no risk factors, nine years down the track, this is her risk, and then she's, by 40 years old or even before 40 years old, I'm pretty sure she will come and see one of us with pelvic floor problems, and any pelvic floor disorders, she literally have any of those pelvic floor disorders, will come to see one of us.

Alright. And this is the example. It is quite difficult to explain in a PowerPoint slide, but if you start putting on the numbers, you play around, you will understand what I'm saying. So this is also a guide for the patients and counselling, for a tool to guide them to make decision. It is not a tool to say, 'You need to have a vaginal birth', 'You need to have a caesarean section.' That is not what it means. It's up to the patient. I always reflect that back to the patient, 'What do you think? Do you think this figure or this risk is acceptable to you to have that?' So we need to individualise the care as well. If someone telling me that, look, I'm going to have one or two max, that's fine. What are the chances of the risk of caesarean section? Of course the surgical risk.

The biggest thing people are concerned, about placenta praevia and accreta, two or less, it's actually less than 1%. Compared to the risk of pelvic flow disorders, just on the baseline alone you can see that that is already trumped the risk of placenta preevia. Okay. If you say she has four, that you cannot contest that and say, 'Yeah, risk of placenta praevia, that's the short term.' This is long-term. They're going to carry this problem the rest of their life. And that's why it's so important to provide this type of information to them and let them make that decision, even though they feel like, look, at the end, the end result, they want to have a natural birth or maybe, 'I don't want to have forceps or instrumental delivery'. So that's all need to be carefully documented, discussed, as long as they understand and then we can prevent the pelvic floor injury to some extent.

So. Take home message. Opportunistic screening for pelvic floor disorder. Whenever you have a chance in patient in front of you, doesn't matter, they come for whatever problem. As long as she's a female. If she has childbirth or pregnant, ask, there's no harm asking, it's other 'yes' or 'no'. Then you move on. For those who have uncomplicated pelvic organ prolapse, they can be managed in the community. If they have the red flags as listed in the red boxes, then just move them along to the specialist care. Conservative management should always be the first line management. And like I said, not all prolapse will require surgery. We need to exhaust all the potential conservative management before we offer them surgery. And specialist input if they have multiple pelvic floor problems. I think I will stop there. We'll encourage some questions.

**Host:** Kate's popped in. Is there a benefit to doing pre-surgery for training?

**Dr Chin Yong:** Yeah, so the pelvic floor training is always beneficial whether they have a surgery or not. But there are strong evidence to say that a perioperative pelvic floor muscle training before the surgery has not altered the outcome of the surgery or quality of life. Okay. So that is the short answer. It will not change the outcome, but I think in long-term there's no harm for patient to do that, but they don't have to go really hard with that.

**Host:** If a patient had surgery many years ago and can't remember if they had mesh or not, is it visible on pelvic ultrasound?

**Dr Chin Yong:** Yes. So imaging is one of the, so transperineal ultrasound scan is been around for years as one of the tool to assess the pelvic mesh placement, the status, whether it is correctly placed or whether it has been contracted, whether it has eroded into other important structures, whether it move with Valsalva and all those things. So it is a good way of assessing. Some people tend to do MRI, but I don't think that offers any good, it is more difficult to get MRI, but transperineal ultrasound is only in selected tertiary centres we do this, and we can do a dynamic scan. We're getting them to do Valsalva and pushings and see the prolapse movements, the anterior, the apical compartment and the posterior vaginal compartment all in relation to the mesh. And we can actually ascertain whether the mesh is actually still being in place. So the answer to your question, whether you can see mesh, yes.

**Host:** Okay, thank you. What is your management approach for women with established chronic pelvic pain?

**Dr Chin Yong:** Okay, that's a very, very good question. Okay. Now anyone with chronic pelvic pain, the most important thing is, don't touch the patient. Okay. Don't do anything, don't rush anything into them. So as you say, chronic pelvic pain will require involvement of the multidisciplinary team, which will involve a urogynaecology if it's a pelvic floor related, if it's endometriosis, you involve the endometriosis gynaecology surgeon. Physiotherapy has a very big role in this multidisciplinary team to down train the pelvic floor muscles. The chronic pain specialists will need to be involved. Clinical psychologists, these are the team members that we tend to work together with, and most of the time some of our colleagues are just very tempted on to say, 'Oh, you have a problem there, we need to rush in and do surgery.' No, that's incorrect. That's not to touch them until we have exhausted all the conservative management.

And obviously when they have pain we need to ascertain, for instance, if this is mesh related or not, or is this something else that's causing the pain or referred pain, is it a nerve pain? So that's why I say fibromyalgia, chronic pain, chronic fatigue syndrome, those are just very vague symptoms. You don't know what is happening until you find out what is going on with them. And the clinical psychologist and physio will be able to deal with a lot of the stuff. If there's anything organic or medical related, then the specialists come in hand, the pain specialist will, kind of, overlooking the whole thing and say, 'Look, we've got some modalities to optimise your pain. And those are the options.' So that's how it should work.

**Host:** Okay, thank you. That's a great answer there Chin. Thank you for that. How long after vaginal childbirth should we wait to see if prolapse persists or recovers?

**Dr Chin Yong:** Very good question. Majority of the pelvic floor issues will settle down within the first 12 months. Even though patients have very pronounced symptoms, I think it's very important just to manage them conservatively and reassure them. If they're six weeks, six months, there's no specific timeframe, it needs to be individualised. But I wouldn't rush in and do anything. If they're fully breastfeeding that's also another different story. If they're fully breastfeeding, means their oestrogen level is low, so the tissue quality is not great, slowly, the recovery is even longer. So it's so important we ascertain those kind of information. If they're hypoestrogenic state, then we offer them a topical vaginal oestrogen replacement therapy to reduce the symptoms. Pessary can be considered, but physio is a key thing. As I said, physio is the gatekeeper of all the pelvic floor problems, and not conservative, until we have sorted out all these issues.

**Host:** And just on that note around pessaries, you've talked about some of the pessaries in your talk tonight, but the role of pessaries and collagen replacement, and, how to upskill in pessary fitting, is there more training?

**Dr Chin Yong:** Alright, now the pessary fitting, okay, there is no specific, there's no guideline whatsoever how you do the pessary. It is best fit basis. So by clinical examination, you examine the patient and you determine what is the best size. So pessaries come in different sizes. In the past we have the pessary sizes that comes in the box, has various sizes, you put it into the patient and ask them, 'How do you feel? Is this good or not?' 'No', then you change to different type and, before you pop in the real pessary. However, the pessary sizer is no longer available because it does not comply with the TGA requirement. You cannot resterilise anything that has been put into vagina, particularly with this sizer.

So, best fit, clinical experience. And obviously sometimes we run some pessary workshops, pre-conference, particularly our UROGYN conference. We do have some of the workshops if you're interested in, and that's how we will teach people, It's best fit, clinical determination. And then we allow up to two fitting, normally, First fitting and I, usually one. So I generally put a smaller size pessary and one size smaller. If it is too small then I always tell them, 'Look, it can be, we can increase one size and make it bigger next time.' That's how I deal with that.

**Host:** Is there a relationship between bladder urgency and grade 2 prolapse?

**Dr Chin Yong:** So any cystocele bladder prolapse, there's always some form of relation. It's either, whether, so firstly we want to know the urgency, is it because the patient is post-menopausal, hypoestrogenic state, or is it because of the prolapse, or is it because they have an underlying neurological condition causing the urinary urgency and frequency, or something else. Or diabetes, all the other conditions that we need to think of the differentials. But prolapse alone, we need to ascertain whether this is just an isolated problem separate from the prolapse. If someone is telling you, she's got a grade 1 bladder prolapse, it's very unlikely. Grade 2, maybe, but 3 and 4 most likely they will have some form of association. So the question from Lisa, 'hearing about special pessary, self-removal, handle please'. So this is a irregular hexagonal pessary, shape of the pessary. Most of the pessaries that are available in market, we don't know even whether that is the right size for the patient.

So in our unit, what we have done in the past is to, we did this vaginal cast study, meaning we examined 60 women with pelvic organ prolapse, random women, with pelvic organ prolapse. And we created this, inserted this vaginal cast, like the dental cast, like dentists use. So we inserted them, form the cast, remove it. So we have 60 different size and shapes of prolapse. And all this went to the bioengineers people, they're really, really clever people, and then they came up with a formula and best determined shape, hence they came up with this shape. The folding point is to promote insertion and self-management and the handle as well. However, more recently we are seeing people finding that handle can be quite annoying. It's not like the tampon string, so it's quite firm. They find it a bit annoying. So we have the options of removing that handle. In fact we have the newer pessaries, which is a similar shape, some of them were manufactured without the handle. So watch this space. We have not actually use it outside the research setting, but once we have more information then this will be able to come into market for use. So at the moment it's for research purpose only.

**Host:** How long should a woman persist with pelvic floor exercises before she can expect an improvement in symptoms? And is there a best vaginal device to help with exercise?

**Dr Chin Yong:** Minimum, three–

**Host:** Yeah. So how long should a woman persist with pelvic floor exercise?

**Dr Chin Yong:** Okay. Minimum, three to six months before–

**Host:** Three to six months. And would that be doing that every day?

**Dr Chin Yong:** So minimum three to six months. Yes, one-on-one supervision to start with, with the physio, to activate the right muscles, and you just need to do it a couple of times a day. Most women will say, 'I'll do it when I remember.' So that's not particularly useful. So minimum three to six months of intensive supervised pelvic floor exercise, you should be able to see some form of results from there.

**Host:** And is that doing it every–

**Dr Chin Yong:** In terms of the device, so the physiotherapist tend to have the– Yeah, every day, and they will say, 'Do a few times a day.'

**Host:** Thank you.

**Dr Chin Yong:** And then in terms of the device, the physiotherapist will have a specific device. they improve the biofeedback like the TENS machine, fingers, anything that improve the biofeedback, some use ultrasound machine to see whether they're activating the right muscles. So those are the tools that the physiotherapist, every physiotherapist is slightly different and they employ various technique, and that's why it's important to have that biofeedback. If you can see what you're doing, you're more likely to do it properly. Pelvic floor muscle is something you cannot see. So that's why it's important to have the guidance. It's not just going to YouTube and see a Kegel exercise on YouTube. It doesn't work like that. So public sector physio. So the public sector physio will need to be referred to the public hospital obviously. And generally they get referred to, so, I work in Royal Women's Hospital, the referral will come in, that will be first point of contact, will be either our continence nurse specialist or a pelvic floor physiotherapist. So by default be the patient will be seeing them first before getting to see any doctors.

So you don't have to worry about where to get the physio by default. That process will need to go to physio and that's how it is. There's no point having patient come and see us and have not instigated any conservative therapy. And then we say, 'Okay, let's go and see the physio.' Let's do and see the physio if you think that the patient has improved after seeing physio, then probably you don't need to see the specialist. Then we just stop there. But if they have not improved after conservative management, that's where we come in and say, 'Look, this is what we need to do for you.' Okay.

**Host:** Thank you. So there's two other questions here. What is the efficacy or use of using vaginal oestrogen for postmenopausal women with uterine prolapse whilst waiting for gyne assessment?

**Dr Chin Yong:** Okay, very good question. The oestrogen therapy is always, always useful. It's not going to reverse the prolapse, but it will improve the tissue quality in case the patient requires some form of intervention, i.e. if they require pessaries, we kind of prepare the tissue [inaudible] in place, and they're less likely to develop complications. In terms of surgery, if you have a healthy vaginal tissues, they're more likely to heal well. They don't tear easily, they don't bleed that easily. So it is very, very useful and I generally offer a topical vaginal oestrogen therapy to all my postmenopausal women unless there are contraindication, particularly active breast cancer, then I tend to avoid that. But in terms of reversing the prolapse or controlling the symptoms, no, it's not going to change that.

**Host:** Okay. And this last question is quite a good one. What management options exist for young women with prolapse who have yet to have children? So what sort of success rates are we also seeing here with different options of conservative and operative management?

**Dr Chin Yong:** Young woman?

**Host:** So a young woman who has not had any children.

**Dr Chin Yong:** Planning to start family?

**Host:** Doesn't say, just says, 'What management options exist for young women with prolapse?' So they've got prolapse, they haven't had any children. What's the best management and what are the success rates that you've seen?

**Dr Chin Yong:** Okay, first, do no harm, I always say. First, do no harm. Don't do surgery. Always start with conservative. Doesn't matter what problem, how bad it is. Particularly in young nulliparous women, if they are planning to start a family at some stage or they have not had any children, I'm very, very cautious in this group of women. And exhaust all the conservative management and the pessary, physio, whatever types of pessary I can offer until I have no options, that is what I will do. And then it depends on the degree of prolapse. It is very, very unlikely to see a young woman with advanced prolapse without having childbirth. So I have not seen one unless they've got really bad connective tissue disorders, like Ehlers Danlos or Marfan or something like that. That is a different story, and you don't want to operate on those people either because they're more likely to end up with the complications.

The next question is, what do we do surgically? If they say, 'Look, we exhausted all the options, they're symptomatic.' So, surgery. We do not remove the uterus, obviously. We keep the uterus, we offer them uterine conservation surgery if possible. Just do the least amount of surgery if possible. Don't use any synthetic or permanent mesh if possible, because you never know, once they meet someone or they want to start a family at some stage in the future, we have no long-term data or whatsoever to support the effect of mesh use in pregnancy, and how is that going to affect your pregnancy, and whatever we offer and fix that potentially will be undone. So this young group, nulliparous, not completed family or have not started family, we need to treat them, we're cautious. And a lot of education, a lot of reassurance, a lot of conservative management, regular point of contact, give them information. Make them understand, why are we doing certain things and why is it this way? Because in no time they'll come back with problems. You do the surgery, we know, the risk factors of prolapse recurrence is when they're less than 60 years old, when they have advanced prolapse or if someone had a previous prolapse surgery, they come back with the same problem. Or if someone had what we call 'levator ani muscle avultion' from childbirth or forceps delivery, that increases the genital hiatus. So if you have a big opening, obviously everything drops out, the gravity will do the work. Alright.

**Host:** Lots of education. And one last question that I think sings to your heart, Chin. Instead of using mesh, can the patient's own tissue be used?

**Dr Chin Yong:** Absolutely. This is a very, very, very good question because this is what we are doing a lot nowadays, because it doesn't matter how good the data on mesh, when the patient comes to you and say, 'Look doc, I don't want any of those plastic stuff or mesh, I don't care how good it is, what can you do? What can you offer me?' So native tissue repair. Native tissue means using their own tissues to fix that. So generally for patient who have primary prolapse surgery, I tend to use their own tissues and just sutures. Selected cases, if they have really advanced prolapse and they're very active and they understood that, like if they're in the thirties, forties or fifties, they're adamant they want that. We want to minimise the risk of recurrence. So that is an option, too, for mesh. But, careful selection. More recently we are doing a lot of stuff, at the moment actually we're doing a research on using a fascia lata, autologous fascia lata, patient's own tissue, meaning you harvest a piece of fascia lata from the lateral thigh, which is identical quality to the rectus sheath. So that fascia lata will be used to reinforce whatever existing defect they have or weakness of their own tissues.

We're doing some cadaver studies on that. We have formulated a couple of study protocol, which is in the pipeline. All these studies will be done through Royal Women's Hospital and Epworth and potentially Monash and some of the international centres. So it will be a multicentre study that we're looking at this. So this is the new thing that we're looking at, because what can we offer if patient do not want to have mesh? So to keep things simple. So basically the principle of using the fascia lata tissue is the same as the mesh. So instead of using mesh, we use their own tissue. The technique of the surgery is exactly the same. Either we are keeping the uterus or lifting up the uterus or do the hysterectomy and put something on top. And we can also use that as a treatment of stress urinary incontinence, which has been around for a long time.

**Host:** Sounds like a good way to head, I think, Chin, with all the mesh controversy that's come out. So using the own tissue.

**Dr Chin Yong:** Yeah. We have a lot of patients just coming in and say, 'Look, sorry no mesh, I don't care what you say.' The first word they heard 'mesh', they just switch off. So we need to take back a bit and say, 'Look, okay, mesh is not the only option, but it is an option to consider if you think that's what you wish.' I still have patients say, first they come in straight, 'I just want to have the most durable procedure. Give me the mesh. I understood. I accept the risk.' But nobody can guarantee, there's no 100% one procedure that can guarantee a patient that a hundred percent have no issues. As long as they manage to balance their concerns and the risk, surgical risk and the risk of prolapse recurrence. So all this needs to be taken into consideration, not just say 'mesh'. Okay, yeah, we are using your own tissues, but they're more likely to come back with another prolapse. You need a repeat surgery. So it is a repeat surgery, the risk is still high still. So as opposed to having a one-off mesh procedure. So there's no right or wrong answer.

It is more of putting it back to the patient and let the patient decide. I have all the options I offer all of the above options. Those are the risks, those are the benefit, and you decide what you want to do and how you want to move forward. My role is to provide information and to support your decision making. So it needs to be individualised. First, do no harm. This is what we need to understand. Though everyone comes to us will have different expectation. The complex patient tend to be difficult to manage, but my principle is 'first, do no harm'. Sometimes the first session, all you need is to break the ice with them. I'm talking about the chronic pelvic pain and mesh-related issues patient. You just break the ice with them and say, 'What do you want to achieve? What are your expectations from today's consultation?' Some of them will come in and just blast, 'You guys have done this to me', and this and this and this, and then I say, 'I'm sorry, I'm just being objective here and see what I can do to help you. Being angry is not going to help with the situation.' So we just need to sometimes break it in a few session and calm them down, see a different people, see the physio. Physio give a different advice and a different approach. Clinical psychologist, different approach.

And the pain specialists have different approach too. So that's why multidisciplinary team is important as well. The simple, straightforward stuff. Physio, GP, and specialist. Okay. One word of advice, whoever, doesn't matter at what level, community level, physio, specialist level, doesn't matter where you are, I think it's so important to maintain the communication among the multidisciplinary team. If the patients see the GP and have a physio input and seeing a urogynaecologist or any other form of specialist, my rule of thumb, I always have this three-way conversation. If we have a clinical psychologist, it's a four-way conversation.

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This podcast series has been made possible by the NSW Government's Menopause Awareness Campaign. For help talking about menopause, download the [Perimenopause and Menopause Symptom Checklist](https://www.jeanhailes.org.au/resources/perimenopause-and-menopause-symptom-checklist) and take it with you to your next medical appointment. For more information visit: <https://www.nsw.gov.au/women-nsw/toolkits-and-resources/perimenopause-and-menopause-toolkit>

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