

Case: Mrs. POP

- 65 yr woman G3 3003
- works as a Delivery Room nurse
- vaginal pressure
- vaginal bulge (“egg size”)

What else do you want to know?

Case, con't

- urgency
- urge incontinence
- 2 yrs ago had stress incontinence, none now
- nocturia,
- urinary frequency
- sensation of incomplete emptying

Case, con't

- some fecal urgency
- no fecal incontinence
- some constipation
- sometimes pushes on perineum to pass bowel movement

Case, con't

- groin pain
- backache
- difficulty with intercourse
- vaginal spotting

Case, con't

- very uncomfortable to walk or exercise
- unable to golf
- uncomfortable to sit
- worse at the end of the day
- better in the morning
- embarrassed of urinary symptoms
- stays home

Case, con't

- Medical History:
 - HTN
 - hypothyroid
 - hypercholesterolemia
 - quit smoking 12 yrs ago

Case, con't

- **Surgical History:**
 - cholecystectomy
 - appendectomy
 - T + A

Case, con't

- **Obstetrical History:**
 - 3X vaginal deliveries at term
 - last one midforceps vaginal delivery with 4 hr second stage
 - largest BW 9 lbs 12 oz



Case, con't

- **What is your assessment?**
- **Any investigations?**
- **What are her options?**

Pelvic Organ Prolapse

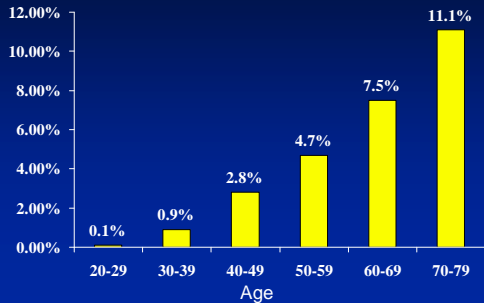
Pelvic Organ Prolapse and Stress Incontinence Requiring Surgery

Olsen AI et. al. Obstet Gynecol 1997;89:401-6

- Kaiser Permanente Northwest
- 149,554 women 20 years and older
- Lifetime risk of surgery 11.1%
- Reoperations occurred in 29.2%

Cumulative Incidence of Surgery for Pelvic Floor Problems

Olsen, Obstet Gynecol 1997;89:401-6

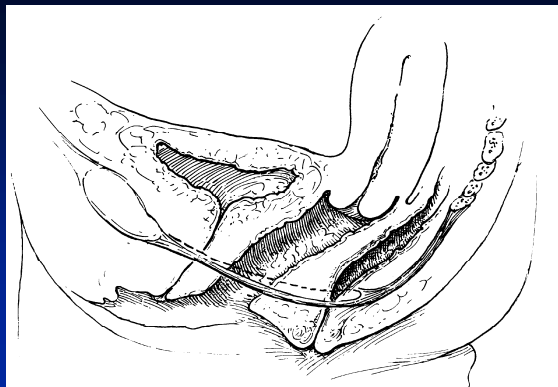
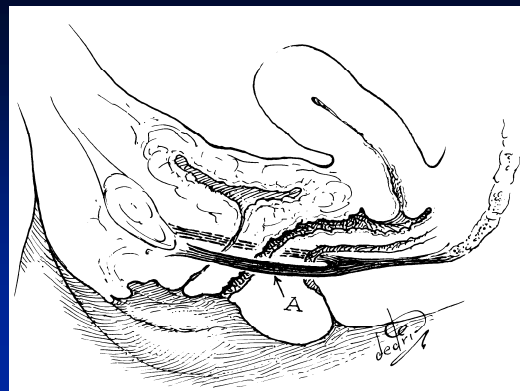
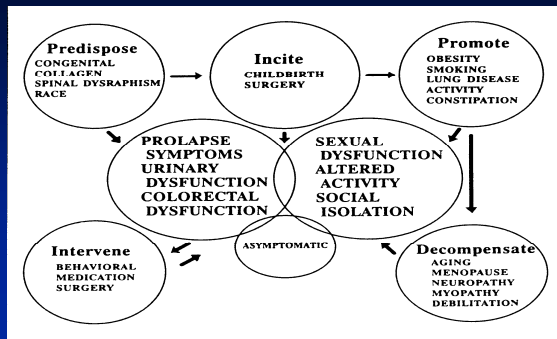


Is Prolapse Related to Childbirth?

Mant J, et al. Br J Obstet Gynecol. 1997;104:579-85

- **Woman with 2 X SVD:**
8.4 X more likely to have prolapse than nullipara
- **Woman with 4 X SVD:**
1.3 X as likely to have prolapse than a woman with 2 X SVD

Pelvic Organ Prolapse: The Paradigm



Evaluation of Pelvic Support

- **Anatomic : Clinical**
 - Baden-Walker/POP-Q
- **Functional**
 - Multi-channel urodynamics

Clinical Classification of Pelvic Organ Prolapse

- Anterior
 - Cystourethrocele
 - Cystocele
- Apical
 - Vaginal vault (posthysterectomy)
 - Uterovaginal
- Posterior
 - Enterocele
 - Rectocele

Clinical Grading of Descent in Pelvic Organ Prolapse (Baden Walker)

Grade 0	No descent
Grade 1	Descent between normal position and ischial spines
Grade 2	Descent between ischial spines and hymen
Grade 3	Descent within hymen
Grade 4	Descent through hymen

Multi-channel Urodynamics

- Latent or Occult or Potential Urinary Incontinence: The presence of stress urinary incontinence with correction of pelvic organ prolapse.



Treatment Options

- ? Observation vs Medical vs Surgical
- ? Abdominal vs Vaginal

Medical Treatment

Behavioural

- Bowel care
- Weight loss
- Pelvic floor exercises
- Vaginal cones
- Biofeedback

Pharmacologic

- Estrogen

Mechanical Devices

- Pessaries

Pessary

- Mechanical Device
- Supports prolapse
- Conservative Therapy
- Should be comfortable, able to void, able to defecate, not fall out
- Temporary relief or longterm alternative to surgery

Abdominal versus Vaginal

Benson et al (1996 AJOG): n=88
Prospective randomized trial
48 bil SSLS (vag); 40 ASC (abdo)
1 to 5.5 yr F/U
Success: Vag 29%; Abdo 58%
Reoperations: Vag 33%; Abdo 16%
RR satisfaction abdo = 2.11 (0.90-4.94)
RR dissatisfaction vag = 2.03 (1.22-9.83)

Abdominal approach provides a better anatomic and functional outcome when compared with a vaginal approach.

Conclusions

- A trial of conservative therapy should be considered prior to surgical therapy.
- It is questionable whether long-term conservative therapy is effective in comparison to surgery.
- Surgical repair needs to be individualized depending on surgical risk, vaginal defects present, functional goals and patient preference.