AP183, October 2013

Surgery for Pelvic Organ Prolapse

One in four women will have a ***pelvic floor disorder*** during their lifetimes. ***Pelvic organ prolapse*** is a pelvic floor disorder in which one or more of the pelvic organs drop from their normal position. Most women with prolapse have few or no symptoms. About 2–6% have symptoms ranging from mild to severe.

With proper treatment, symptoms can be reduced or eliminated. Nonsurgical treatment options usually are tried first. If these options do not work and if your symptoms are severe, you may want to consider surgery.

This pamphlet explains

- types, causes, and signs and symptoms of pelvic organ prolapse
- nonsurgical treatment options
- when to consider surgery
- surgical treatment options

Pelvic Organ Prolapse: Types, Causes, and Signs and Symptoms

Pelvic organ prolapse is caused by a weakening of the normal support provided by muscles and tissues of the ***pelvic floor***. The main cause of pelvic organ prolapse is pregnancy and childbirth, especially vaginal childbirth. Other factors include prior pelvic surgery, ***menopause***, and aging. Activities or conditions that increase pressure in the abdomen, such as a long-lasting cough, obesity, or straining with bowel movements due to constipation, can play a role in pelvic organ prolapse. Prolapse also runs in families.

Pelvic organ prolapse usually involves more than one organ. The organs that can be affected include the following:

- ***Uterus***
- Top of the ***vagina*** in women who have had a ***hysterectomy*** (the ***vaginal vault***)
- Front (anterior) wall of the vagina (usually with the ***bladder***, which is called a ***cystocele***)
- Back (posterior) wall of the vagina (usually with the ***rectum***, which is called a ***rectocele***)
- The pouch between the rectum and back wall of the uterus (usually with a part of the small intestine, which is called an ***enterocele***)

In severe prolapse, the woman can see or feel a bulge of tissue at or past the vaginal opening. Most women have mild prolapse—the organs drop down only slightly and do not protrude from the opening of the vagina—and do not have any signs or symptoms. Some women with mild prolapse and women with severe prolapse do have symptoms, which can include the following:

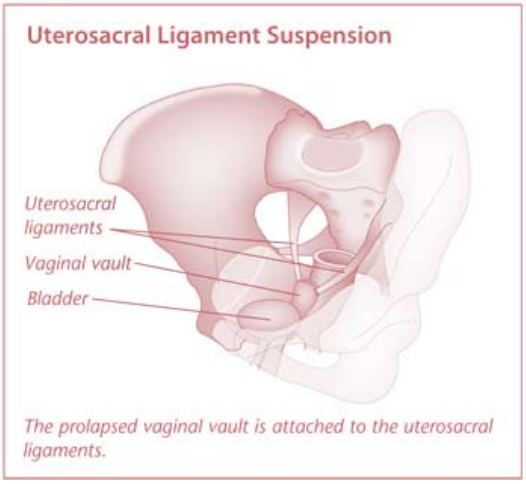
- Feeling of fullness or heaviness in the pelvic region
- Pulling or aching feeling in the lower abdomen or pelvis
- Painful or uncomfortable sex
- Difficulty urinating or having a bowel movement

Nonsurgical Treatment Options

If you do not have any symptoms or if your symptoms are mild, you do not need any special follow-up or treatment beyond having regular checkups. If you have symptoms, prolapse may be treated with or without surgery.

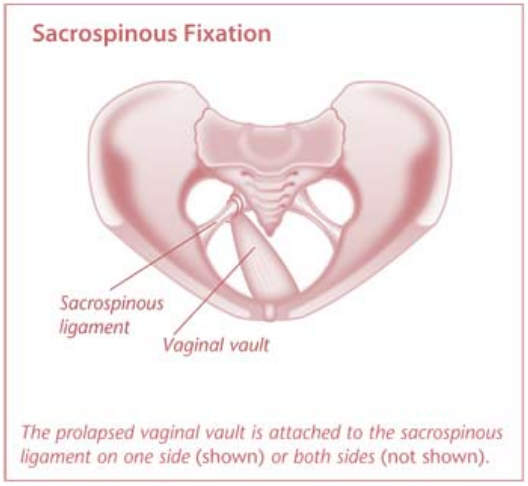
Nonsurgical treatment options usually are tried first. Often the first nonsurgical option tried is a ***pessary***. This device is inserted into the vagina to support the pelvic organs. There are many types of pessaries available. A health care provider can help you find the right pessary that fits comfortably. Targeting specific symptoms may be another option. For example, bowel problems can be addressed with behavioral changes, dietary changes (such as adding more fiber to the diet), and stool softeners. ***Kegel exercises*** may be recommended in addition to symptom-related treatment to help strengthen the pelvic floor. Weight loss can decrease pressure in the abdomen and help improve overall health.

Deciding to Have Surgery



If your symptoms are severe and disrupt your life, and if nonsurgical treatment options have not helped, you may want to consider surgery. Having surgery is a major decision. An important factor in this decision is the severity of your symptoms. The following additional factors should be considered when deciding whether to have surgery:

- Your age—If you have surgery at a young age, there is a chance that prolapse will recur and may possibly require additional treatment. If you have surgery at an older age, general health issues and any prior surgery may affect the type of surgery that you have.
- Your childbearing plans—Ideally, women who plan to have children (or more children) should postpone surgery until their families are complete to avoid the risk of prolapse happening again after corrective surgery.
- Health conditions—Any surgical procedure carries some risk, such as infection, bleeding, blood clots in the legs, and problems related to ***anesthesia***. Surgery may carry more risks if you have a medical condition, such as diabetes, heart disease, or breathing problems, or if you smoke or are obese.



You also should be aware that there is no guarantee that any treatment—including pelvic prolapse surgery—will relieve all of your symptoms. Pelvic prolapse of the same site can come back after surgery. Prolapse also can occur at a new site after surgery. Depending on whether you have symptoms, additional treatment with nonsurgical options, such as a pessary, or surgery may be needed.

Surgery also may cause new problems, such as pain during sex, pelvic pain, or urinary ***incontinence***. Urinary incontinence occurs because before surgery, the prolapsed part prevents urine leakage while laughing, coughing, or sneezing by kinking the ***urethra***. Fixing the prolapse may unkink the urethra, and symptoms of stress urinary incontinence can occur. To prevent this complication, a stress urinary incontinence procedure often is done during some types of prolapse surgery.

Overview of Pelvic Organ Prolapse Surgery

In general, there are two types of surgery: 1) ***obliterative surgery*** and 2) ***reconstructive surgery***. Obliterative surgery narrows or closes off the vagina to provide support for prolapsed organs. Sexual intercourse is not possible after this procedure. Obliterative surgery has a high success rate and may be a good choice for women who do not plan to have sex in the future and who want an easily performed procedure.

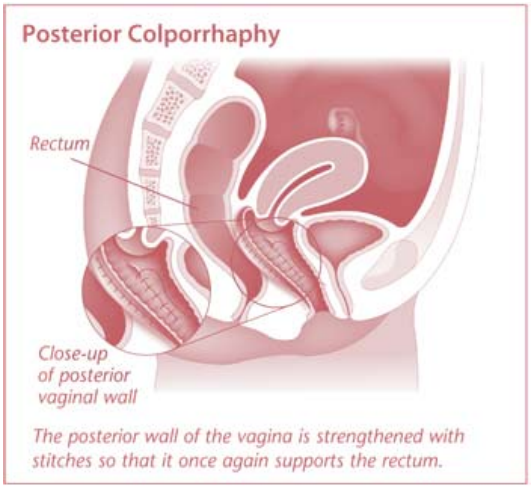
Most women who have surgery to treat pelvic organ prolapse have reconstructive surgery. Reconstructive surgery reconstructs the pelvic floor with the goal of restoring the organs to their original position. Some types of reconstructive surgery are done through an incision in the vagina. Others are done through an incision in the abdomen or with ***laparoscopy***. A surgical robot may be used to assist with laparoscopy.

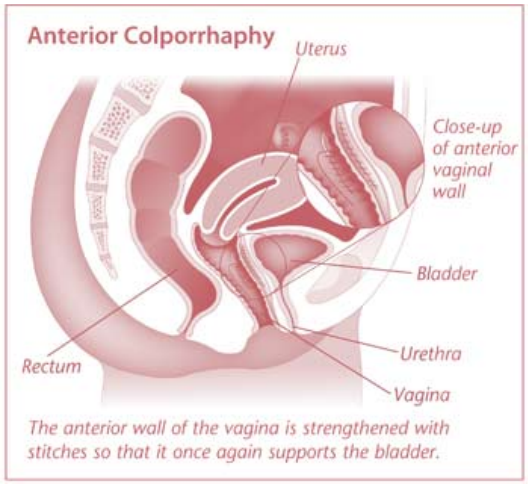
If the uterus is prolapsed, another option is hysterectomy (removal of the uterus). When hysterectomy is performed to treat prolapse, an additional procedure may be done to help prevent vaginal vault prolapse in the future.

Types of Reconstructive Surgery

There are many types of reconstructive surgical procedures. Often, more than one type of surgery is done at the same time to fix multiple problems. The type you and your health care provider choose depends on your specific problem and your individual situation. Lifestyle issues, such as your weight, whether you smoke, or whether you have a physically demanding job that requires heavy lifting, also influence the type of procedure you will have.

Fixation or Suspension Using Your Own Tissues





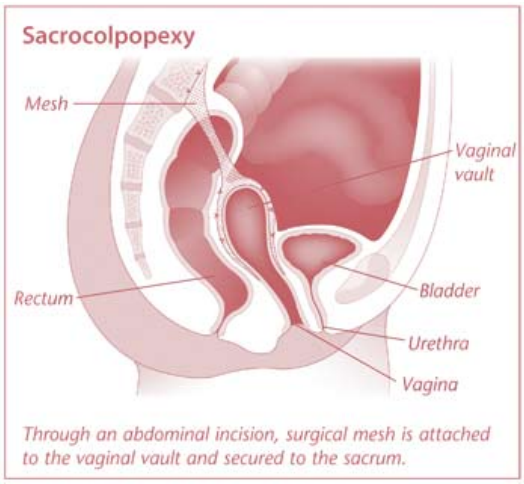
This type of surgery often is referred to as "native tissue repair" because it uses your own tissues to treat uterine or vaginal vault prolapse. It is performed through an incision in the vagina. The prolapsed part is attached with stitches to a ***ligament*** or to a muscle in the pelvis.

Because it is performed through the vagina, this type of surgery takes less time to perform than surgery performed through an incision in the abdomen. The recovery time usually is shorter.

Complications include injury to the ureters, bowel, or bladder; pain with intercourse; and urinary incontinence. A procedure to prevent urinary incontinence may be done at the same time. Buttock pain may occur for the first few weeks in about 1 in 10 women. Heavy bleeding is rare but can be life threatening.

Colporrhaphy

Colporrhaphy is used to treat prolapse of the anterior wall of the vagina and prolapse of the posterior wall of the vagina. This type of surgery is performed through the vagina. In anterior colporrhaphy, stitches are used to strengthen the anterior wall of the vagina so that it once again supports the bladder. In posterior colporrhaphy, stitches are used to strengthen the posterior wall of the vagina so that it once again supports the rectum. Risks include pain during intercourse and damage to the bladder, ureters, or rectum.



Sacrocolpopexy

Sacrocolpopexy is used to treat vaginal vault prolapse and enterocele. It can be done with an abdominal incision or with laparoscopy with or without robotic assistance. Surgical mesh is attached to the front and back walls of the vagina. A special kind of mesh shaped like a Y can be used. The ends of the mesh then are attached to the sacrum (tail bone). This lifts the vagina back into place. A similar procedure, also performed with an abdominal incision, is called ***sacrohysteropexy***. This procedure is used to treat uterine prolapse when a woman does not want a hysterectomy. Surgical mesh is attached to the front and back of the ***cervix*** and the top of the vagina and then to the sacrum, lifting the uterus back into place.

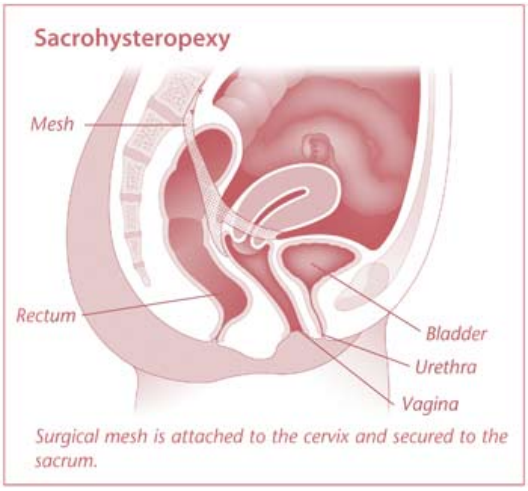
A benefit of this type of surgery is that women may have less pain during sex than after procedures performed through the vagina. However, with an abdominal incision, there is a risk of damage to the intestines and a risk of complications from ***adhesions***. There is a small risk (3%) that the mesh will erode (wear through the tissues) into the vagina. Mesh erosion can cause scarring and pain that can be long lasting. Additional surgery may be needed to remove the mesh. Other complications include pelvic pain, pain during intercourse, and damage to the bladder, bowel, ureters, or blood vessels.

Surgery Using Vaginally Placed Mesh

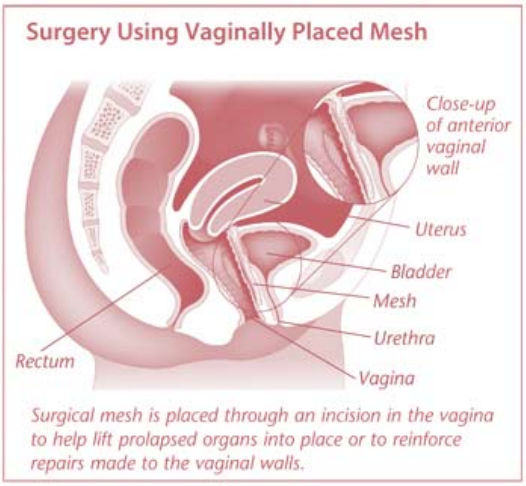
Some prolapse procedures involve the use of surgical mesh placed through a vaginal incision to help lift prolapsed organs into place or to reinforce repairs made to the vaginal walls. This type of mesh can be used to treat all types of pelvic organ prolapse, but it most often is used to treat bladder prolapse.

Vaginal mesh surgery can be used to repair prolapse in women whose own tissues are not strong enough for native tissue repair. For women in whom this is not the case, there is debate about whether vaginally placed mesh gives better results than other types of surgery for bladder prolapse. There is not enough information about vaginally placed mesh for vaginal vault prolapse, uterine prolapse, or rectocele to say whether these procedures are better or worse for relieving symptoms of pelvic organ prolapse than procedures that do not use mesh.

Vaginally placed mesh also has a significant risk of severe complications. These complications include erosion of the mesh into the vagina, bladder, or bowel; pain that interferes with daily life; infection; pain during sexual intercourse; and bladder



or bowel injury. Some of these complications may require that you have more surgery. The overall risk of mesh-related complications occurring from surgery using vaginally placed mesh is as high as 15%. Although the mesh often can be removed, it may take more than one surgical procedure to do so. Complete removal of mesh may not be possible. If this happens, pain and other complications may never go away completely.



Because of the high risk of complications, it is currently recommended that procedures involving the use of vaginal mesh be reserved for women in whom the benefits may justify the risks. This may include women with anterior prolapse that has come back after previous surgery or who have a medical condition that prevents them from having a lengthier operation done through an incision in the abdomen.

Prolapse can be treated successfully without mesh in many cases. If you are considering a surgical procedure using vaginally placed mesh, ask your health care provider for detailed information about its risks, benefits, and potential complications (see box).

Follow-up After Surgery

Recovery time varies depending on the type of surgery. You usually need to take a few weeks off from work. For the first few weeks, you should avoid vigorous exercise, lifting, and straining. You also should avoid sexual intercourse for several weeks after surgery.

It is not known whether anything can be done to keep prolapse from coming back after surgery. Avoiding activities that increase pressure inside the abdomen may be helpful, such as controlling your weight, avoiding constipation, and not lifting heavy objects. Stopping smoking may control a long-lasting cough and has many other health benefits as well. If you have new symptoms, let your health care provider know.

Finally…

Many women have some type of pelvic organ prolapse, but most have no symptoms and do not need treatment. If you have symptoms, and they interfere with your normal activities, you may need treatment. Nonsurgical treatment options are available that work for many women. If they do not work for you and you feel that your quality of life is not what it should be, you may want to consider surgery. It is important to understand the risks, benefits, and possible complications before making a decision to have surgery. There are many types of surgical procedures available. Talk with your health care provider about all of your options.

Glossary

Adhesions Scarring that binds together the surfaces of tissues.

Anesthesia: Relief of pain by loss of sensation.

Bladder: A muscular organ in which urine is stored.

Cervix: The lower, narrow end of the uterus at the top of the vagina.

Colporrhaphy: A type of surgery performed through the vagina to repair anterior vaginal prolapse and posterior vaginal prolapse by reinforcing (or repairing) a woman's own tissues.

Cystocele: Bulging of the bladder into the vagina.

Enterocele: Bulging of the intestine into the upper part of the vagina.

Questions to Ask About Vaginally Placed Mesh

When considering mesh surgery for prolapse, it is important to balance the risks and benefits of the surgery as well as consider other treatment options. Questions to ask your health care provider about the use of mesh in pelvic organ prolapse surgery include the following:

- What are the pros and cons of using surgical mesh in my particular case? Can my repair be successfully performed without using mesh?
- If mesh is to be used, what has been your experience with implanting this particular product? What experience have your other patients had with this product?
- What has been your experience in dealing with the complications that might occur?
- What can I expect to feel after surgery and for how long?
- Are there any specific side effects I should let you know about after the surgery?
- What if the mesh does not correct my problem?
- If I have a complication related to the mesh, can the mesh be removed and what could the consequences be?
- If mesh is to be used, is there patient information that comes with the product, and can I have a copy?

From U.S. Food and Drug Administration, Medical Devices, Medical Device Safety. Alerts and Notices. Surgical mesh. July 13, 2011.

Hysterectomy: Removal of the uterus.

Incontinence: Inability to control bodily functions such as urination.

Kegel Exercises: Pelvic muscle exercises that assist in bladder and bowel control as well as sexual function.

Laparoscopy: A surgical procedure in which an instrument called a laparoscope is inserted into the pelvic cavity through a small incision. The laparoscope is used to view the pelvic organs. Other instruments can be used with it to perform surgery.

Ligament: A band of tissue that connects bones or supports large internal organs.

Menopause: The time in a woman's life when menstruation stops; defined as the absence of menstrual periods for 1 year.

Obliterative Surgery: A type of surgery for pelvic organ prolapse in which the vagina is narrowed or closed off to provide support for prolapsed organs.

Pelvic Floor: A muscular area at the base of the abdomen attached to the pelvis.

Pelvic Floor Disorder: Any disorder affecting the muscles and tissues that support the pelvic organs; these disorders may result in loss of control of the bladder or bowels or cause one or more pelvic organs to drop downward (prolapse).

Pelvic Organ Prolapse: A condition in which pelvic organs, such as the uterus or bladder, drop downward. It is caused by weakening of the muscles and tissues that support these organs.

Pessary: A device inserted into the vagina to support sagging organs that have dropped down (prolapsed) or to help control urine leakage.

Reconstructive Surgery: Surgery to repair or restore a part of the body that is injured or damaged.

Rectocele: Bulging of the rectum into the vaginal wall.

Rectum: The last part of the digestive tract.

Sacrocolpopexy: A type of surgery to repair vaginal vault prolapse in which the vaginal vault is attached to the sacrum with surgical mesh.

Sacrohysteropexy: A type of surgery to repair uterine prolapse in which the cervix is attached to the sacrum with surgical mesh.

Ureters: A pair of tubes, each leading from one of the kidneys to the bladder.

Urethra: A tube-like structure through which urine flows from the bladder to the outside of the body.

Uterus: A muscular organ located in the female pelvis that contains and nourishes the developing fetus during pregnancy.

Vagina: A tube-like structure surrounded by muscles leading from the uterus to the outside of the body.

Vaginal Vault: The top of the vagina after a hysterectomy.

This Patient Education Pamphlet was developed by the American College of Obstetricians and Gynecologists. Designed as an aid to patients, it sets forth current information and opinions on subjects related to women's health. The average readability level of the series, based on the Fry formula, is grade 6–8. The Suitability Assessment of Materials (SAM) instrument rates the pamphlets as "superior." To ensure the information is current and accurate, the pamphlets are reviewed every 18 months. The information in this pamphlet does not dictate an exclusive course of treatment or procedure to be followed and should not be construed as excluding other acceptable methods of practice. Variations, taking into account the needs of the individual patient, resources, and limitations unique to the institution or type of practice, may be appropriate.

ISSN 1074-8601

Requests for authorization to make photocopies should be directed to the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923.

To reorder Patient Education Pamphlets in packs of 50, please call 800-762-2264 or order online at sales.acog.org.

The American College of Obstetricians and Gynecologists
409 12th Street, SW
PO Box 96920
Washington, DC 20090-6920

12345/76543

409 12th Street SW, Washington, DC 20024-2188 | Mailing Address: PO Box 70620, Washington, DC 20024-9998