National Women & Infants Health Programme

QUICK SUMMARY DOCUMENT

Diagnosis and Management of Pelvic Organ Prolapse

This Quick Summary Document (QSD) is a resource for all clinicians working in healthcare in Ireland who are involved in the care of women with Pelvic Organ Prolapse.

Following a comprehensive literature review a number of evidence-based recommendations for diagnosis and management of Pelvic Organ Prolapse were agreed upon.

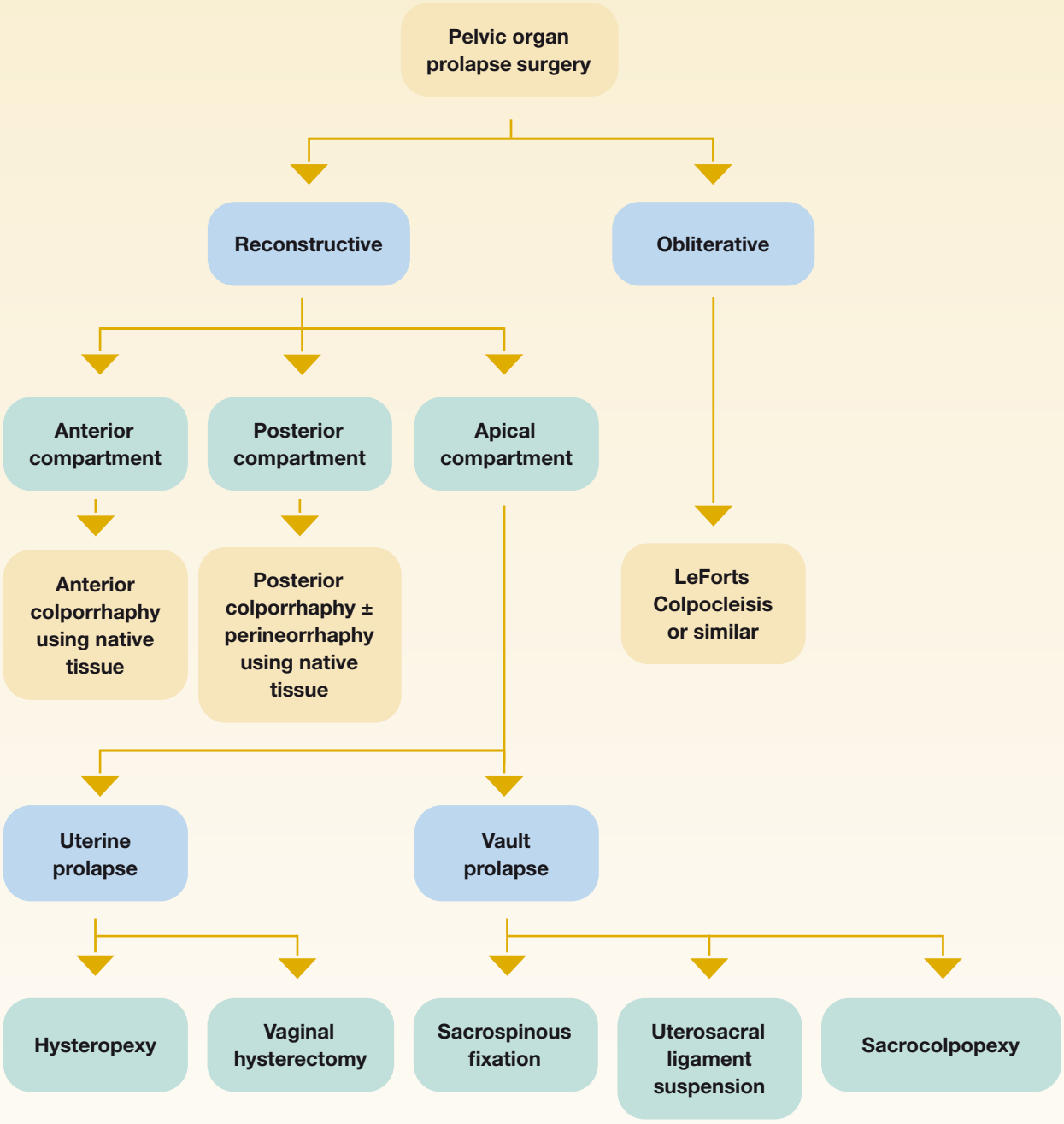
Key Recommendations

1. We recommend that a complete medical, surgical, obstetric, and gynaecologic history should be taken from all women referred with pelvic organ prolapse.
2. We recommend that treatment is indicated only if prolapse is causing bothersome bulge and pressure symptoms, sexual dysfunction, lower urinary tract dysfunction, or defecatory dysfunction.
3. We recommend that lower urinary tract function should be assessed. This includes an evaluation for urinary incontinence and type (stress or urge) and the adequacy of bladder emptying.
4. We recommend that assessment of bowel function should be undertaken to determine if there is a history of straining with bowel movements, laxative use, faecal incontinence, and incomplete rectal emptying.
5. We recommend that symptoms of sexual dysfunction such as dyspareunia, lack of sensation, and anorgasmia should be assessed.
6. We recommend that a physical examination should include an abdominal examination in addition to the pelvic examination to rule out pelvic masses.
7. We recommend that a detailed examination of the pelvic organ prolapse should be performed digitally, or with a split speculum.
8. We recommend that pelvic organ prolapse should be assessed as the woman performs the Valsalva manoeuvre, repetitive coughing, or both.
9. We recommend that the presence and degree of prolapse should be recorded using a standardised quantification system, such as the POP-Q (Pelvic Organ Prolapse Quantification) or Baden-Walker system.
10. We recommend that if the findings during supine physical examination do not match the woman's reported symptoms, repeating the pelvic examination in the standing position may reveal the greatest descent of pelvic organ prolapse.
11. We recommend that pelvic floor muscle activity should be assessed according to a standardised format, such as the modified Oxford grading system. Hypertonicity should be noted if observed by objective assessment.
12. We recommend that the vaginal tissues should be assessed for atrophy.
13. We suggest that pelvic floor ultrasound (translabial, endovaginal, or introital) is not required in the diagnosis and assessment of pelvic organ prolapse without mesh complications.
14. We recommend that observation of symptoms alone by the woman herself for as long as she is happy with this approach is a reasonable option for women who do not wish to undergo treatment for pelvic organ prolapse.
15. We recommend that all women with pelvic organ prolapse should be counselled regarding lifestyle modifications.
16. We suggest that a referral to a specialist pelvic floor physiotherapist should be considered in all women with pelvic organ prolapse.

17. We suggest that a 16-week course of supervised pelvic floor muscle therapy should be considered in all women with Stage 1 or 2 POP.
18. We suggest local oestrogen should be considered for women with hypo-oestrogenic symptoms or evidence of vaginal atrophy who do not have contraindications to vaginal oestrogen.
19. We suggest that women should be offered a vaginal pessary as an alternative to surgery.
20. We recommend a pessary should be considered for a woman with symptomatic pelvic organ prolapse who wishes to become pregnant in the future.
21. We suggest that women in who a ring pessary has failed should be offered a Gellhorn pessary or alternative.
22. We recommend women who are offered a Gellhorn or shelf pessary, or similar, should be advised regarding the contraindication to sexual intercourse.
23. We suggest, if possible, women should be taught to change their pessaries independently. If a woman is unable to remove and replace her pessary, regular follow-up (such as every 3-6 months) is necessary.
24. We suggest an annual follow-up is recommended for women who are able to change their pessaries independently.
25. We suggest that treatment for pessary-related erosion should consist of removing the pessary for 2-4 weeks, local oestrogen therapy, and antimicrobials, if necessary.
26. We recommend that caregivers to patients with dementia should be made aware of the regular pessary changes needed to avoid complications.
27. We recommend that any decisions regarding pessary use in women with diminished mental capacity should be made in line with the HSE National Consent Policy.
28. We recommend that surgical management should be individualised for each woman.
29. We recommend that women who wish to have a procedure that is not performed by their surgeon should be referred to another surgeon who has expertise in this area, if possible.
30. We recommend that obliterative surgery is an appropriate option for women who are older, medically unfit for other surgeries, and are sexually inactive.
31. We recommend that the permanent, irreversible nature of obliterative procedures should be discussed with the woman.
32. We recommend that women who wish to have an obliterative procedure that is not performed by their surgeon should be referred to another surgeon who has expertise in this area, if possible.
33. We recommend that surgical management should be individualised for each woman.
34. We strongly recommend an anterior colporrhaphy is recommended for the treatment of isolated anterior compartment prolapse (cystocele).
35. Posterior colporrhaphy ± perineorrhaphy is strongly recommended for the treatment of posterior compartment prolapse.
36. We recommend those women with combined rectal mucosal prolapse and vaginal prolapse would benefit from colorectal and gynaecologist collaboration.
37. For women with a uterus, we recommend a discussion should be had to determine whether the woman wishes to have her uterus removed or retained.
38. We recommend women undergoing a vaginal hysterectomy should have an apical suspension performed at the same time.
39. We recommend that those women wishing to preserve their uterus should be offered a vaginal sacrospinous hysteropexy.
40. We strongly recommend that women with vault prolapse should be offered a sacrocolpopexy or either a vaginal sacrospinous fixation (SSF) or uterosacral ligament suspension (ULS).

41. We recommend that women wishing to undergo a sacrocolpopexy should be made aware of the risk of mesh erosion with this procedure.
42. We strongly recommend that women should be informed that functional and anatomical outcomes are similar between SSF and USL.
43. We recommend vaginal based native tissue repairs such as SSF or USL may be more appropriate in women with co-morbidities such as obesity or pelvic radiotherapy, or previous pelvic surgery.
44. We recommend that symptoms of SUI should be discussed during the initial consultation.
45. We recommend that concomitant continence procedures should be discussed with women with overt symptoms of SUI.
46. If SUI is elicited once the prolapse is reduced, we strongly recommend concomitant continence procedures should be discussed with the woman.
47. We strongly recommend that women should be counselled that a concomitant continence procedure has a higher risk of adverse events, such as bleeding, urinary tract infection, and bladder injury compared to not performing the procedure.
48. We recommend that a staged approach be discussed with all women with POP who have concomitant SUI.
49. If SUI is not elicited once the prolapse is reduced, we suggest the woman should be counselled that they have a low risk of developing de novo SUI.
50. We recommend women should be offered an in-person return appointment with the operating surgeon within six months of their surgery.
51. We recommend a vaginal examination should be performed by the surgeon at the postoperative clinic visit.
52. We recommend that women with recurrent symptoms and/or complications such as voiding dysfunction or mesh erosion should have access to further referral to another urogynaecologist or urologist.

Algorithm


Pelvic organ prolapse surgery
Reconstructive
Obliterative
Anterior compartment
Posterior compartment
Apical compartment
Anterior colporrhaphy using native tissue
Posterior colporrhaphy ± perineorrhaphy using native tissue
LeForts Colpocleisis or similar
Uterine prolapse
Vault prolapse
Hysteropexy
Vaginal hysterectomy
Sacrospinous fixation
Uterosacral ligament suspension
Sacrocolpopexy

Auditable standards

Audit using the key recommendations as indicators should be undertaken to identify where improvements are required and to enable changes as necessary, and to provide evidence of quality improvement initiatives.

Auditable standards for this guideline include:

- Number of women assessed for POP with a standardised quantification system, such as the POP-Q (Pelvic Organ Prolapse Quantification) system
- Number of women prescribed vaginal oestrogen
- Number of women referred to physiotherapy
- Outcomes of those who has successfully completed a physiotherapy programme
- Number of women offered a pessary
- Number of fittings required in women offered a pessary
- Number of women managing their pessary independently
- Number of women using a pessary treated for vaginal erosions
- Length of time between pessary changes
- Number of women offered a post-operative in-person return appointment
- Post-operative outcomes:
    - Degree of prolapse at postoperative visit (POP-Q or similar)
    - Quality of life score (validated scale used eg. EQ-5D, SF-36, ICIQ)
- Adverse outcomes:
    - Damage to surrounding structures including perforations intraoperatively
    - Post-operative catheterisation for >10 days within 3 months
    - Chronic pain or discomfort at 12 months
    - Dyspareunia/impact on sexual function at 6 and 12 months
    - Overactive Bladder symptoms (new onset) within 12 months

Recommended reading:

1. Full Clinical Guideline – https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/
2. HSE Nomenclature for Clinical Audit – https://www.hse.ie/eng/about/who/nqpsd/ncca/nomenclature-a-glossary-of-terms-for-clinical-audit.pdf
3. HSE National Framework for developing Policies, Procedures, Protocols and Guidelines at https://www.hse.ie/eng/about/who/qid/nationalframeworkdevelopingpolicies/
4. Abrams P, Andersson KE, Apostolidis A, Birder L, Bliss D, Brubaker L, et al. 6th International Consultation on Incontinence. Recommendations of the International Scientific Committee: Evaluation and treatment of urinary incontinence, pelvic organ prolapse and faecal incontinence. Neurourol Urodyn. 2018;37(7):2271-2. https://pubmed.ncbi.nlm.nih.gov/30106223/
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6. Maher C, Feiner B, Baessler K, Christmann-Schmid C, Haya N, Brown J. Surgery for women with anterior compartment prolapse. Cochrane Gynaecology and Fertility Group, editor. Cochrane Database Syst Rev [Internet]. 2016 Nov 30 [cited 2022 Jul 6];2017(11). Available from: http://doi.wiley.com/10.1002/14651858.CD004014.pub6

7. Mowat A, Maher D, Baessler K, Christmann- Schmid C, Haya N, Maher C. Surgery for women with posterior compartment prolapse. Cochrane Database Syst Rev [Internet]. 2018 [cited 2022 Jun 24];(3). Available from: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012975/full

8. Baessler K, Christmann-Schmid C, Maher C, Haya N, Crawford TJ, Brown J. Surgery for women with pelvic organ prolapse with or without stress urinary incontinence. Cochrane Database Syst Rev [Internet]. 2018 [cited 2022 Jun 24];(8). Available from: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013108/full

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O'Leary B, Agnew G, Keane D. National Clinical Practice Guideline: Diagnosis and Management of Pelvic Organ Prolapse. National Women and Infants Health Programme and The Institute of Obstetricians and Gynaecologists. December 2022

https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/

https://www.rcpi.ie/faculties/obstetricians-and-gynaecologists/national-clinical-guidelines-in-obstetrics-and-gynaecology/