UTERINE PROLAPSE: AN OVERVIEW

Presented by

DR. SHAMA A.H. KHAN
Professor,
Department of Amraze -Atfal
GUMC, Glocal University
Objectives

• Define Uterine prolapse
• Identify the causes
• State the signs and symptoms
• Explain the diagnosis
• Describe methods of treatment
Uterine prolapse is the herniation of the uterus into or beyond the vagina as a result of failure of the ligamentous and fascial supports. It often coexists with prolapse of the vaginal walls, involving the bladder or rectum.
Risk factors for the development of prolapse

- Confirmed risk factors
  - Older age
  - Race
  - Family history
  - Increased body mass index
  - Higher parity vaginal delivery
  - Constipation
- Possible risk factors intrapartum variables
  - Macrosomia, long second stage of labour,
  - Episiotomy
  - Epidural analgesia) increased abdominal pressure
- Menopause
Why does prolapse occur

Anatomy Some knowledge of normal vaginal support is needed to understand the pathophysiology of pelvic organ prolapse. Delancey’s three levels of support are now accepted worldwide.

Level 1: The cardinal-uterosacral ligament complex provides apical attachment of the uterus and vaginal vault to the bony sacrum. Uterine prolapse occurs when the cardinal-uterosacral ligament complex breaks or is attenuated.

Level 2: The arcus tendineous fascia pelvis and the fascia overlying the levator ani muscles provide support to the middle part of the vagina. Level 3: The urogenital diaphragm and the perineal body provide support to the lower part of the vagina.
Symptoms attributable to uterine prolapse

- Vaginal symptoms
- Sensation of a bulge or protrusion
- Seeing or feeling a bulge
- Pressure
- Heaviness
- Urinary symptoms
  - Incontinence, frequency, or urgency
  - Weak or prolonged urinary stream
  - Feeling of incomplete emptying
  - Manual reduction of prolapse needed to start or complete voiding (“digestion”)
  - Change of position needed to start or complete voiding
Bowel symptoms

- Incontinence of flatus, or liquid or solid stool
- Feeling of incomplete emptying
- Straining during defecation
- Digital evacuation needed to complete defecation
- Splinting (pushing on or around the vagina or perineum)
- Needed to start or complete defecation ("digitation")

Sexual symptoms

- Dyspareunia (painful or difficult intercourse)
- Lack of sensation
The five stages of prolapse

Stage 0: No prolapse

Stage I: The most distal portion of the prolapse is $>1$ cm above the level of the hymen

Stage II: The most distal portion of the prolapse is $\leq 1$ cm proximal or distal to the hymen

Stage III: The most distal portion of the prolapse is $>1$ cm below the hymen but protrudes no further than 2 cm less than the total length of the vagina

Stage IV: Complete eversion of the vagina
**UTERINE DESCENT:**

1° ↔ Descent of the Cervix in the Vagina.

2° ↔ Descent of the Cervix to the Introitus.

3° ↔ Descent of the Cervix outside the Introitus.

**Procidentia** - All of the Uterus outside the Introitus.
Classification of Vault Prolapse

- **1st degree** – vaginal apex is visible when perineum is depressed.
- **2nd degree** – apex extends just through the introitus.
- **3rd degree** – upper 2/3rds of the vagina is outside the introitus.
- **4th degree** – entire vagina is outside the introitus
DIAGNOSIS

• A complete medical history and physical examination, your doctor will perform a complete pelvic examination to look for signs of prolapse.
• An imaging study (ultrasound or MRI) of your pelvis to better delineate the prolapse.
• POP is diagnosed by physical examination of the pelvis, usually with the patient in dorsal lithotomy position or occasionally in standing position. The patient should cough or perform valsalva manoeuvres to recreate the maximal protrusion that she has experienced. Each compartment should be evaluated separately. Anterior, apical and posterior compartment prolapse are respectively synonymous to cystocele, uterine prolapse or colpocele (or vaginal vault prolapse, in a post-hysterectomy patient), and rectocele.
CLINICAL EXAMINATION AND DIAGNOSIS

- Anterior and posterior vaginal walls and cervical descend should be assessed with the patient straining in the left lateral position, using a Sim’s speculum.
- Combined rectal and vaginal digital examination can be an aid to differentiate rectocele from enterocele.
Primary prevention of prolapse

- Pelvic floor muscle exercises (unclear status, no harm)
- Perineal massage (unclear status, no harm)
- Epi-No perineal trainer (no effect)
- Epidural analgesia (possible protection)
- Avoidance of forceps (risk reduction by about 20–40%)
- Avoidance of vaginal delivery (risk reduction by 60–80%)

Secondary prevention

Pelvic floor muscle training (PFMT) is effective in reducing prolapse symptoms and signs.
Management

Observation
The extent of the prolapse does not correlate well with the symptoms. Watchful waiting is most appropriate if the prolapse is minimal (stage I). Some women may prefer observation for advanced prolapse—they should be examined periodically to look for development of new symptoms or disorders (such as obstructed urination or defecation, vaginal erosion).
In cases where the prolapse is minor or not bothersome to the patient, no treatment may be necessary.
• Pelvic floor muscle exercises (Kegel exercises) strengthen

Conservative treatment
Pelvic floor muscle training Pelvic floor muscle training is an effective treatment for urinary incontinence, but its role in managing prolapse is unclear.
4 Must-Know Facts about Kegel Exercises

1. Commonly prescribed to improve many conditions.

2. How to
   - Lift pelvic floor and contract muscles.

3. They can be done at any location: at home, office, or in the car.

4. They have been proven effective in reducing urinary incontinence.
Key points for fitting pessaries and their subsequent management

**Pessaries**
Vaginal pessaries are the only currently available non-surgical intervention for managing women with prolapse

**Fitting**
- Ensure that the patient’s bladder and bowel are empty
- The pessary fits well if a finger can be swept between the pessary and the walls of the vagina. The goal is to fit the largest pessary that does not cause discomfort
- Ask the patient to walk around, bend, and micturate to ensure that the pessary is retained
Current trends in reconstructive surgery for POP

- Transvaginal mesh versus native tissue repair
- Apical suspension during vaginal prolapse repair: sacrospinous ligament fixation versus uterosacral ligament suspension
- Laparoscopic/robotic versus open abdominal sacrocolpopexy
- ASC versus vaginal mesh repairs
- Uterus sparing versus hysterectomy at the time of prolapse repair
- Biosynthetic and coated transvaginal mesh
- Autologous tissue
- Laser therapy for POP
Unani treatment

- Majoon Mochras 5g- 5g
- Majoon Supari Pak 5g- 5g
- Majoon Muqawwi Reham 5g- 5g
- Mazu
- Phitkri
- Kaththa
- Gul fufhal equal dose
- Powder FORM at night as P/v
When to refer and to whom Referral to a gynaecologist or urogynaecologist is indicated if

- Conservative treatment fails
- There are voiding problems or obstructed defaecation
- There is recurrent prolapse after reconstructive surgery
- There is ulceration or the prolapse is irreducible
- The patient prefers surgical treatment.
JazakAllah & Thank You