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Christchurch Women’s Hospital, Oxford Women's Health, Christchurch

Sunday, August 14, 2016

(Room 4)

8:30 - 9:25 WS #142: Peeling Back the Layers - The Pelvic Floor Uncovered

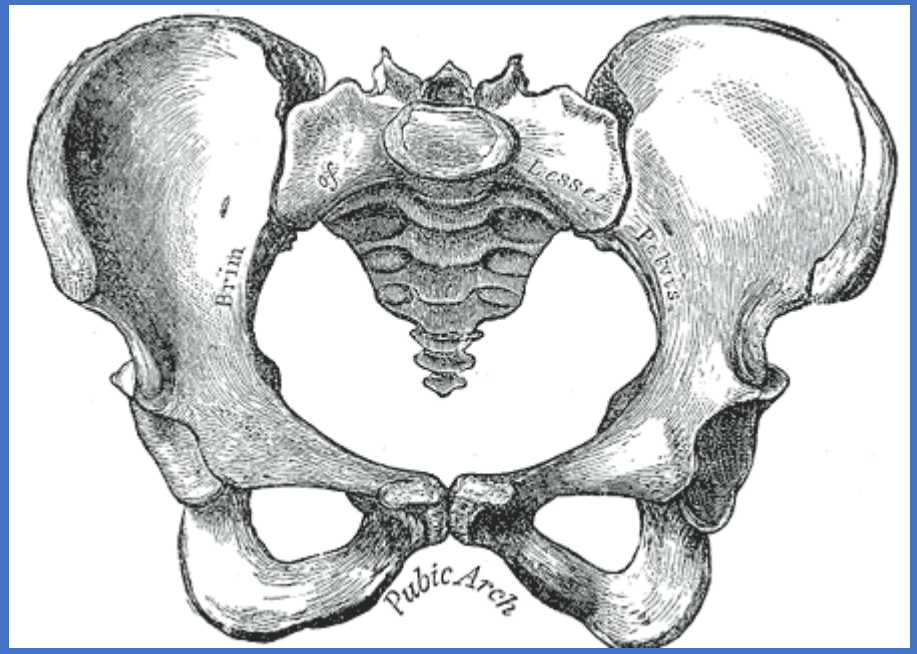
9:35 - 10:30 WS #152: Peeling Back the Layers - The Pelvic Floor Uncovered (Repeated)

Peeling back the layers- the pelvic floor uncovered

- Relevant anatomy
- Key concepts of pelvic organ support
- What constitutes significant prolapse
  - Symptoms
  - Expectations
  - treatment success
- Conservative treatment options
- Current surgical trends

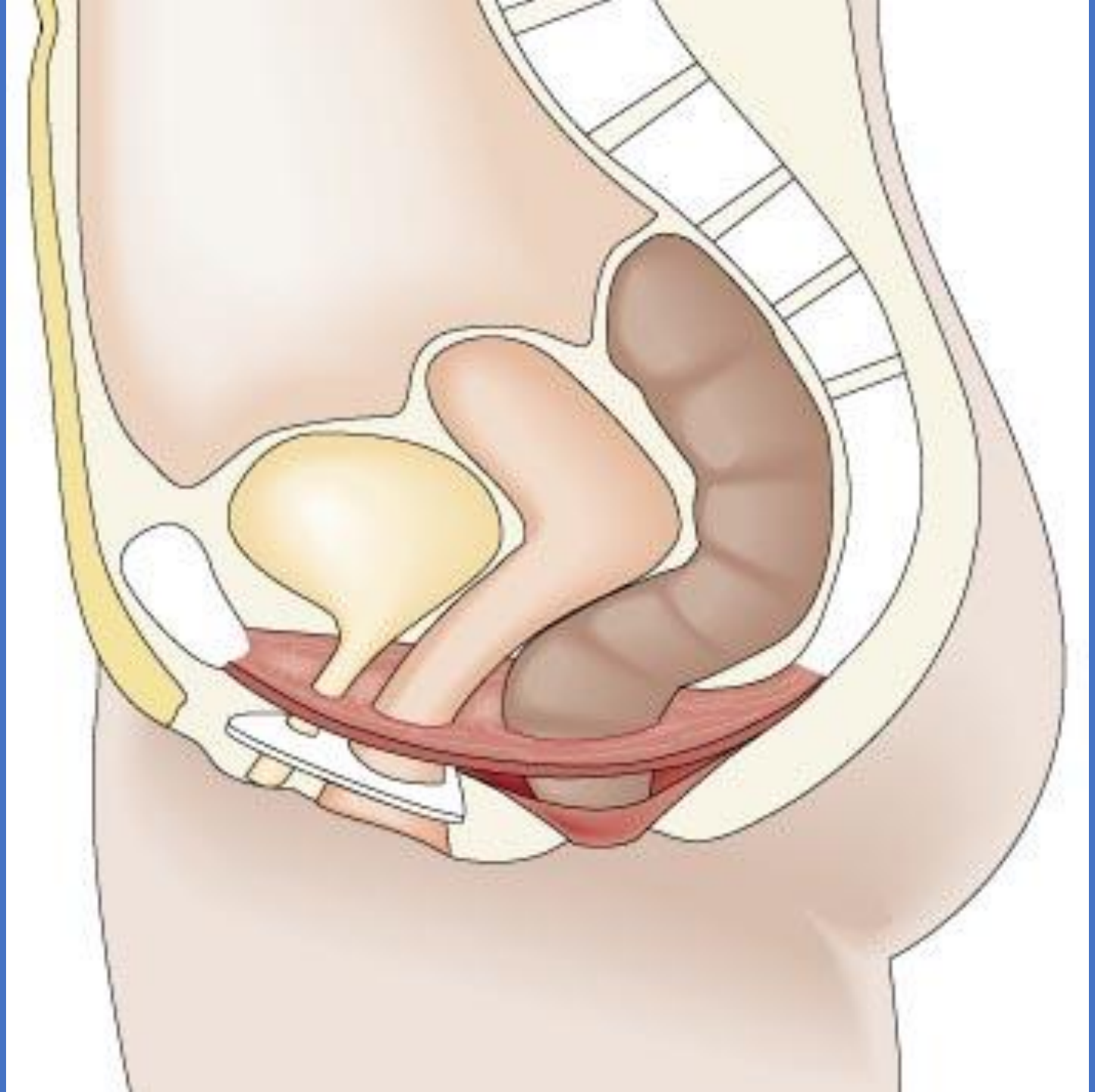
What’s going down there?

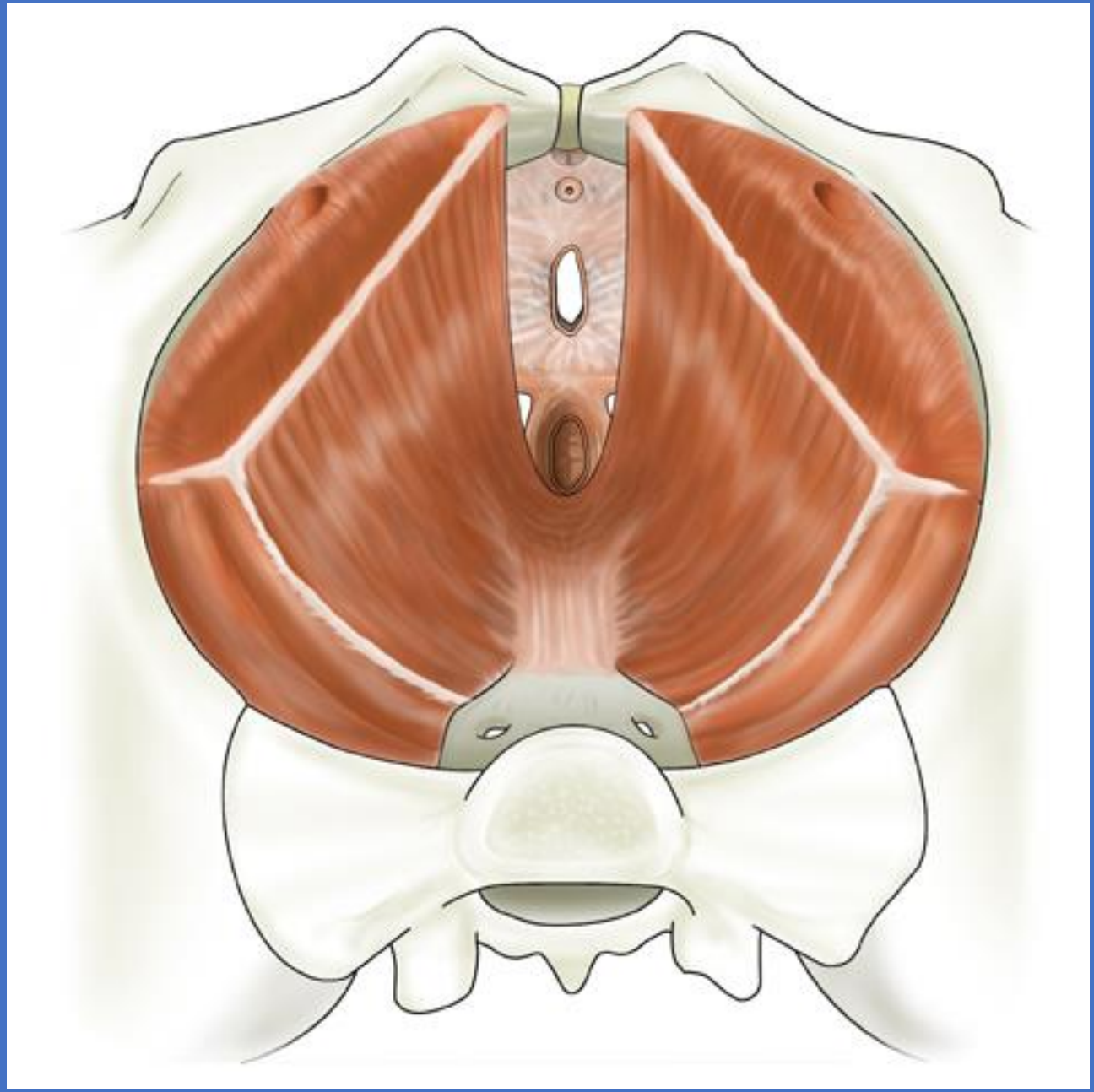
The pelvis

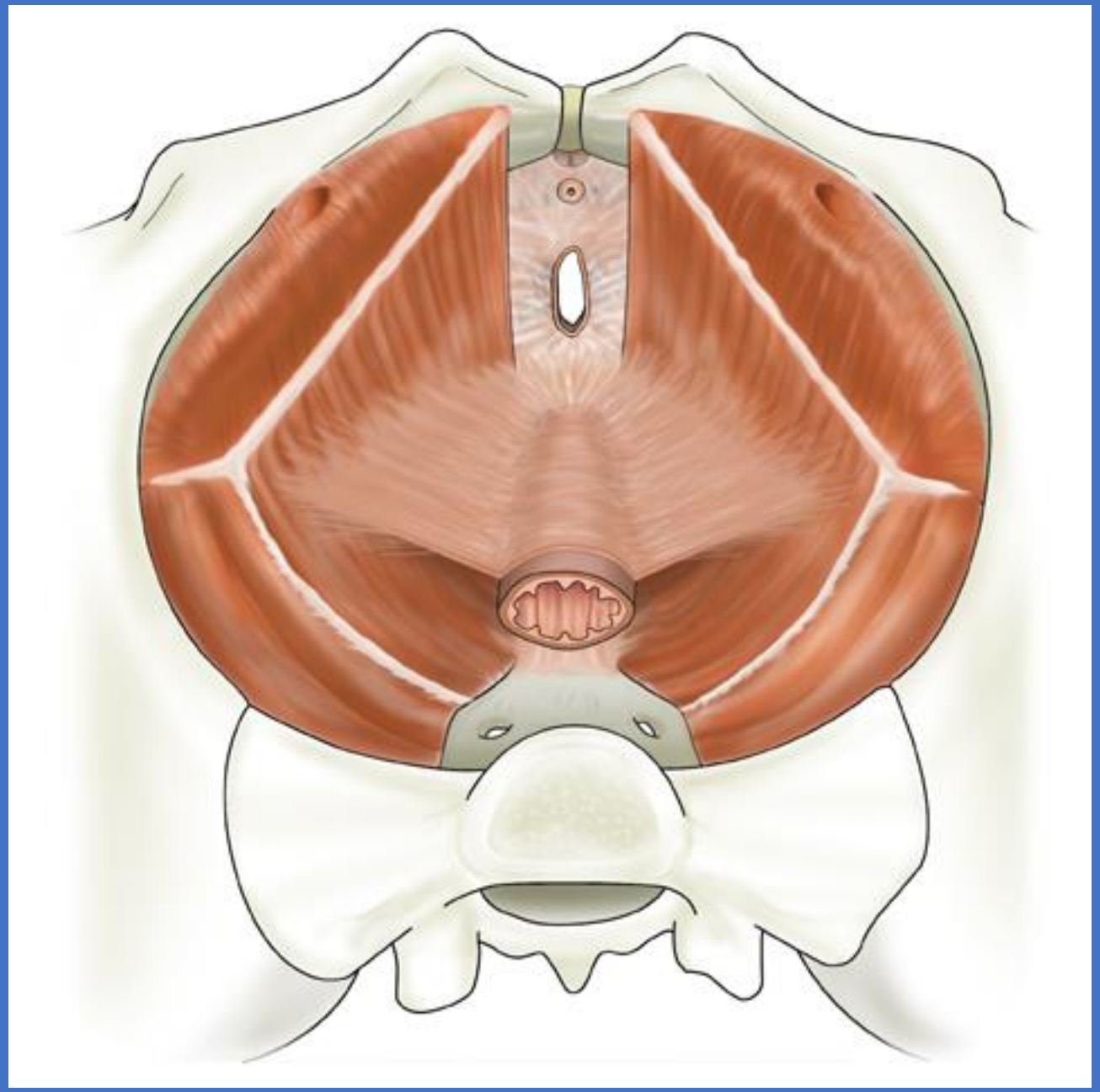


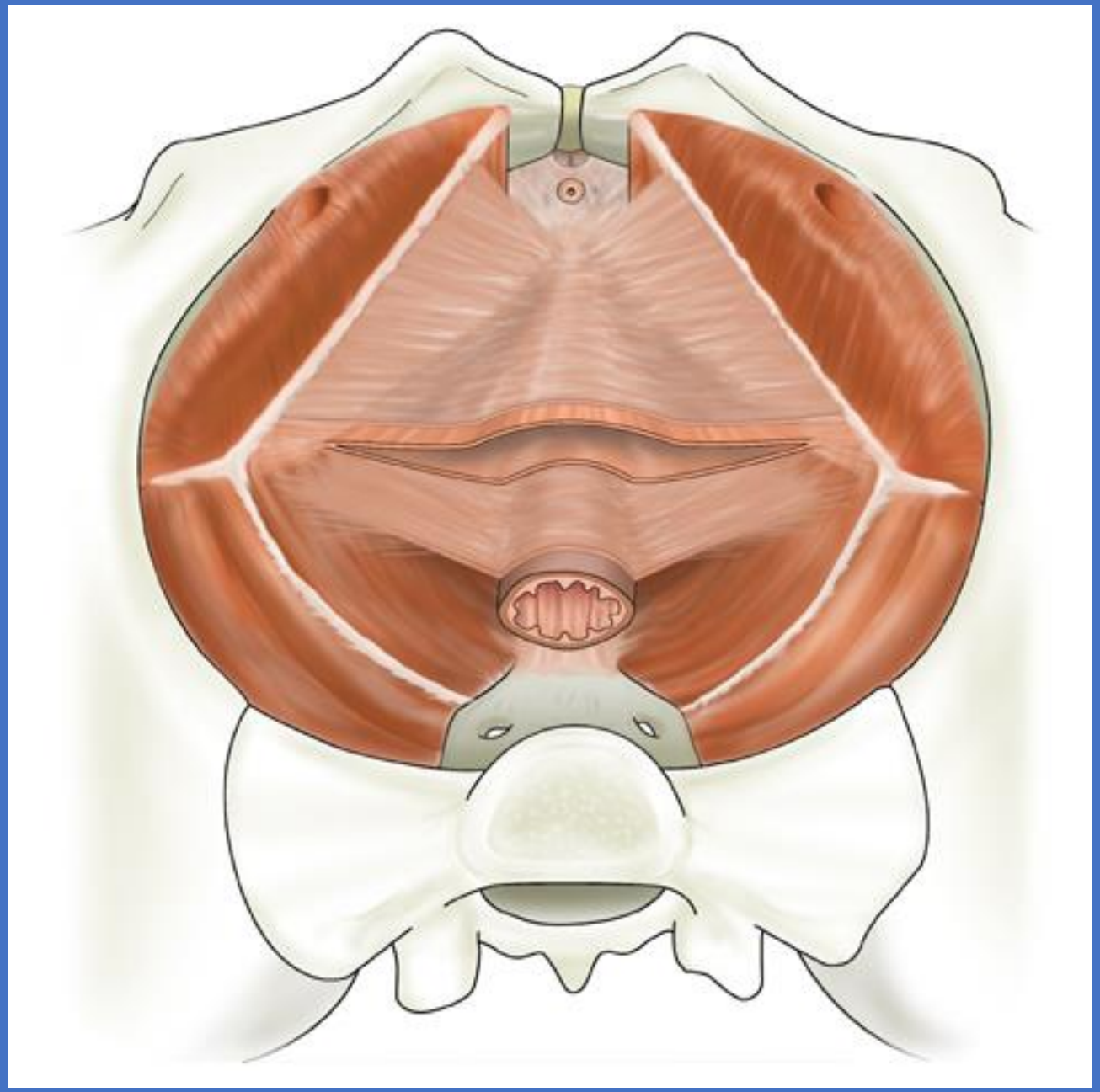
The Pelvic Organs

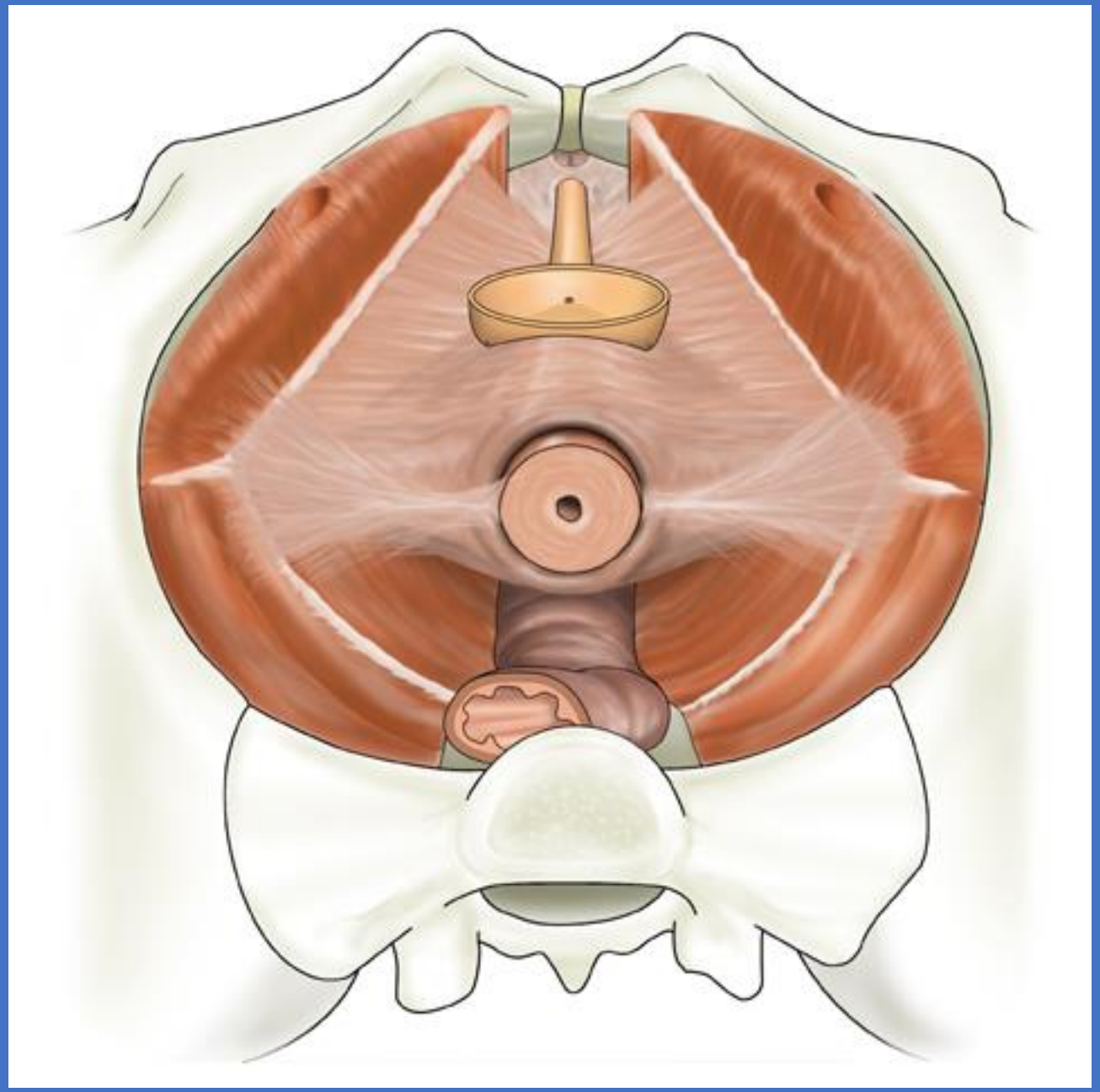
- Uterus
- Bladder
- Rectum
- Small bowel

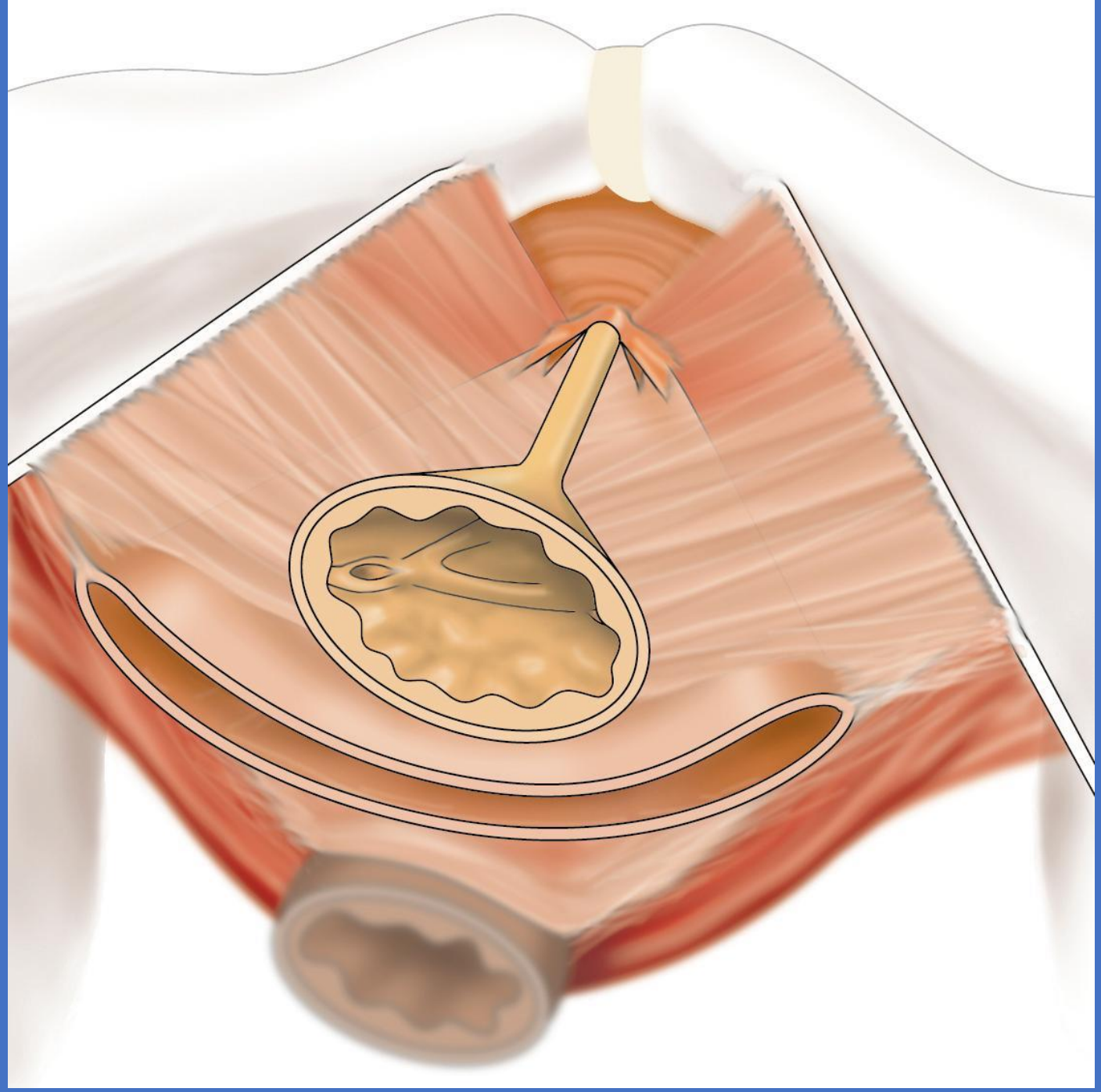




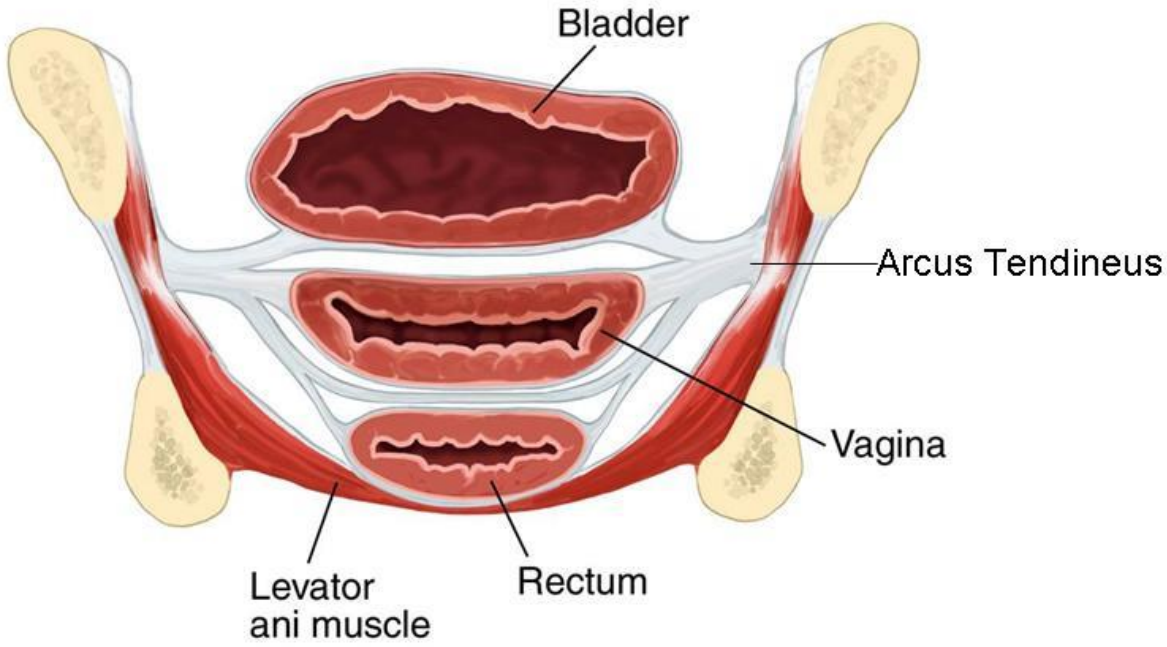


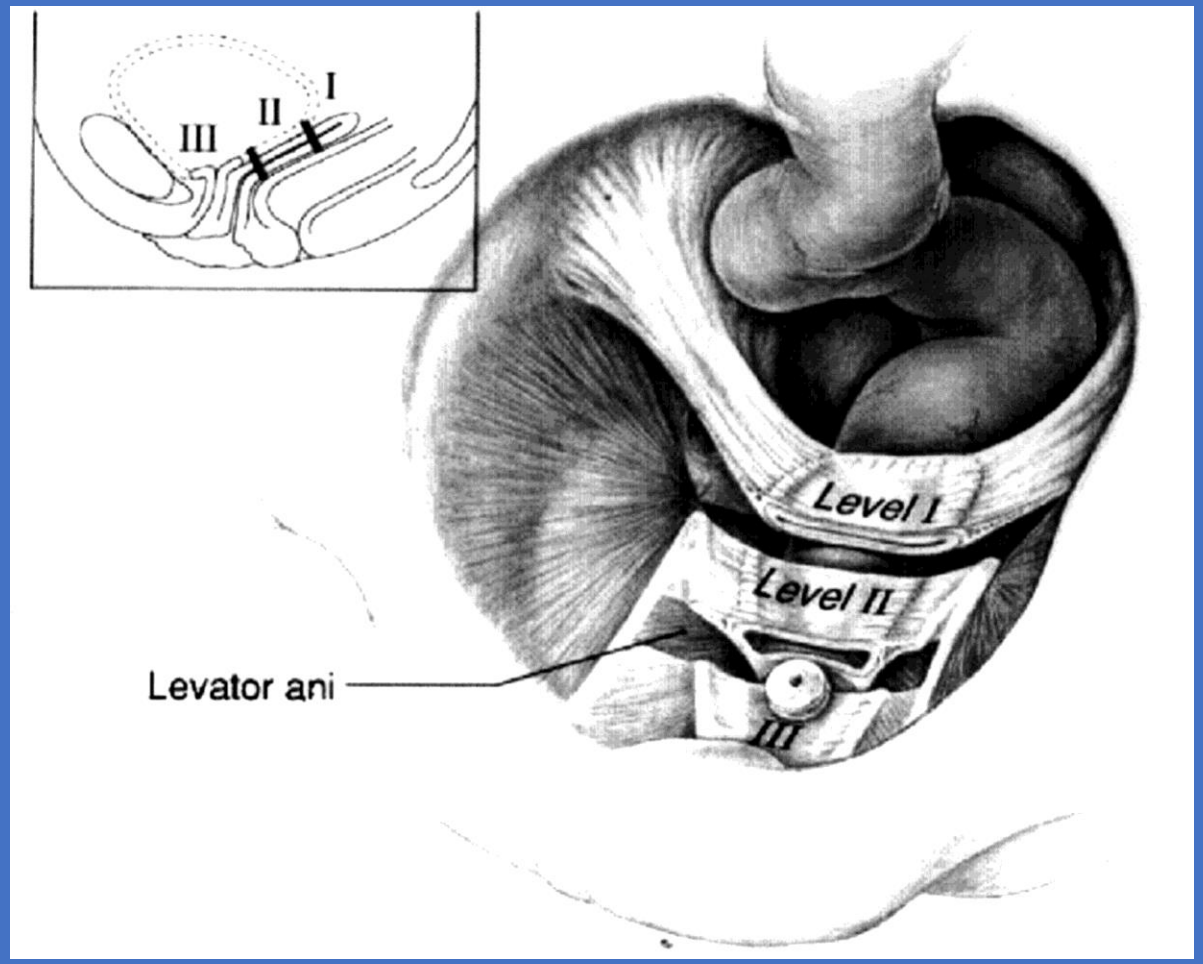


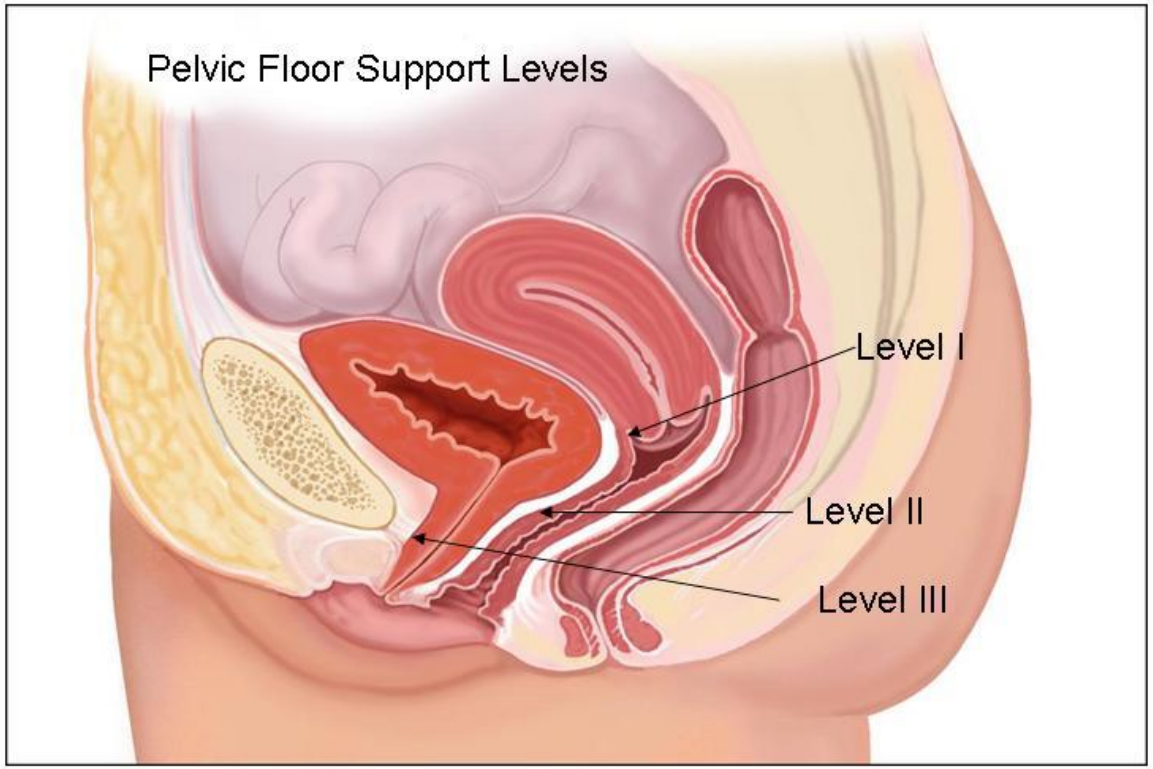




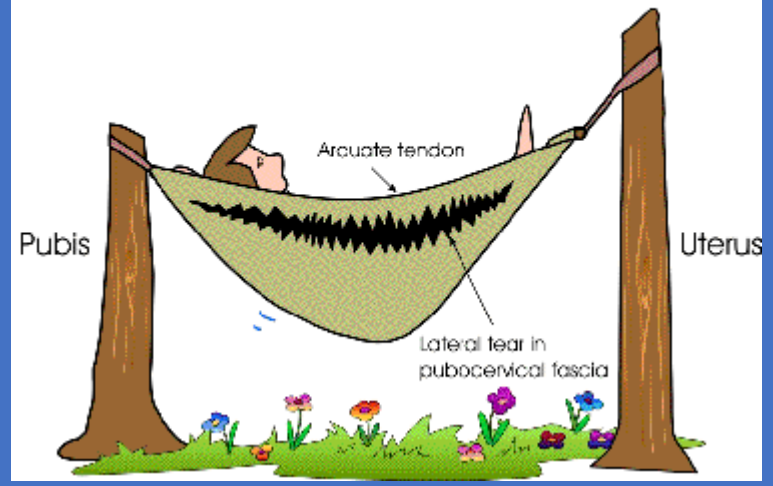
Normal Pelvic Floor Fascia Structures




I
II
III
Level I
Level II
III
Levator ani


Pelvic Floor Support Levels
Level I
Level II
Level III

Cystocele, (anterior vaginal wall prolapse) due to lateral defects in the pubocervical fascia



Assessment

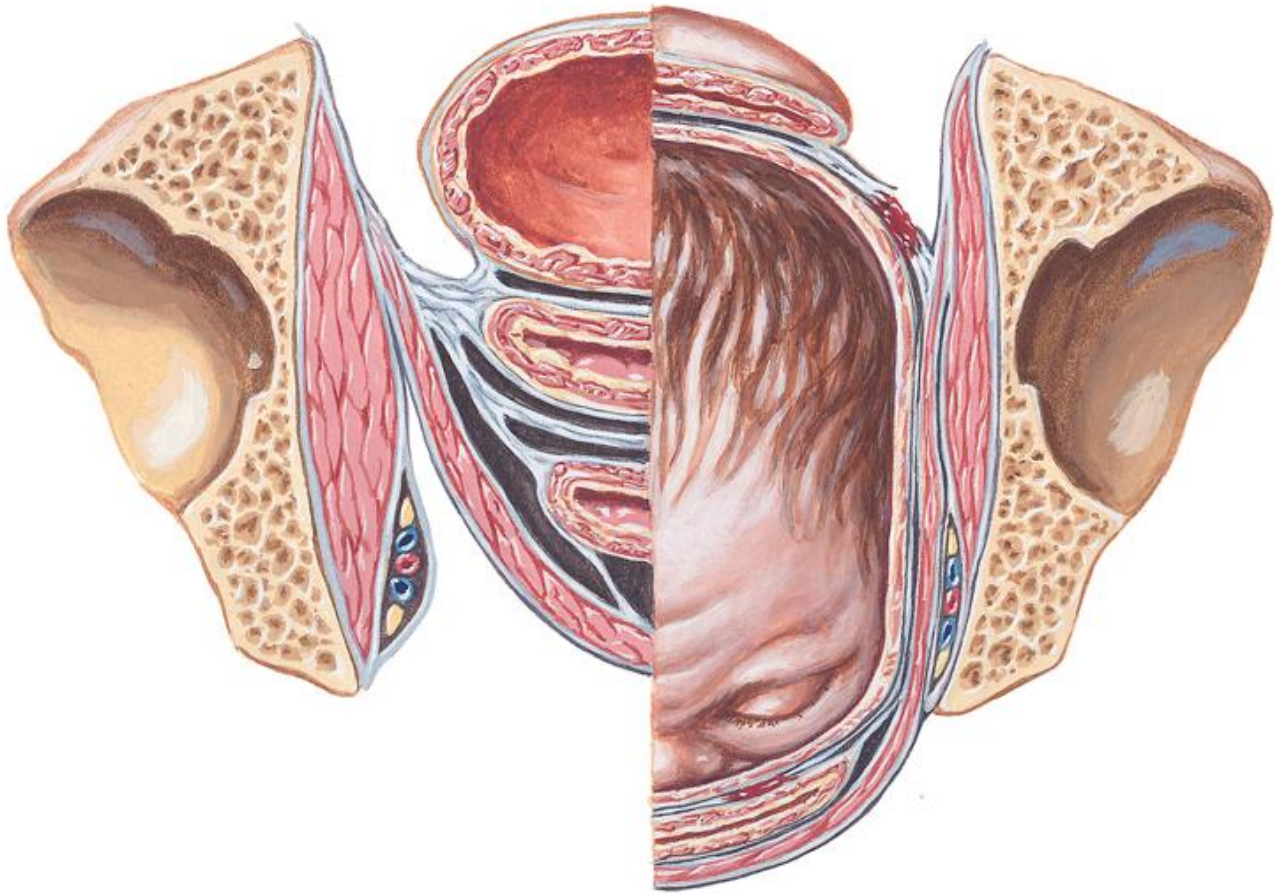
0	No Prolapse
1	Halfway to hymen
2	To hymen
3	Halfway past hymen
4	Maximum descent

Aetiology

- Genetics
- Chronic raised abdominal pressure
- Pregnancy
- Childbirth

Vaginal Childbirth and Pelvic Damage

Frontal section of pelvis



Anatomy

POP-Q Stage	Nulliparous (n=30)	CS only (n=14)	CS & SVD (n=15)	SVD (n=84)	AVD (n=51)
0	13 (43.3%)	2 (14.3%)	1 (6.7%)		
1	15 (50.0%)	9 (64.3%)	6 (40.0%)	31 (36.9%)	12 (23.5%)
2a (above the hymen)	2 (6.7%)	3 (21.4%)	6 (40.0%)	34 (40.5%)	23 (45.1%)
2b (at or below the hymen)			2 (13.3%)	19 (22.6%)	13 (25.5%)
3					3 (5.9%)

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Anatomy vs Symptoms

- Prolapse beyond the hymen
- Symptoms determine expectations
- Expectations determine satisfaction

- Satisfaction = Outcome – Expectation
- How is Outcome measured? is it a constant?
- Therefore satisfaction is directly proportional to expectation
- Patient’s default expectation is glorious rejuvenation

Symptoms

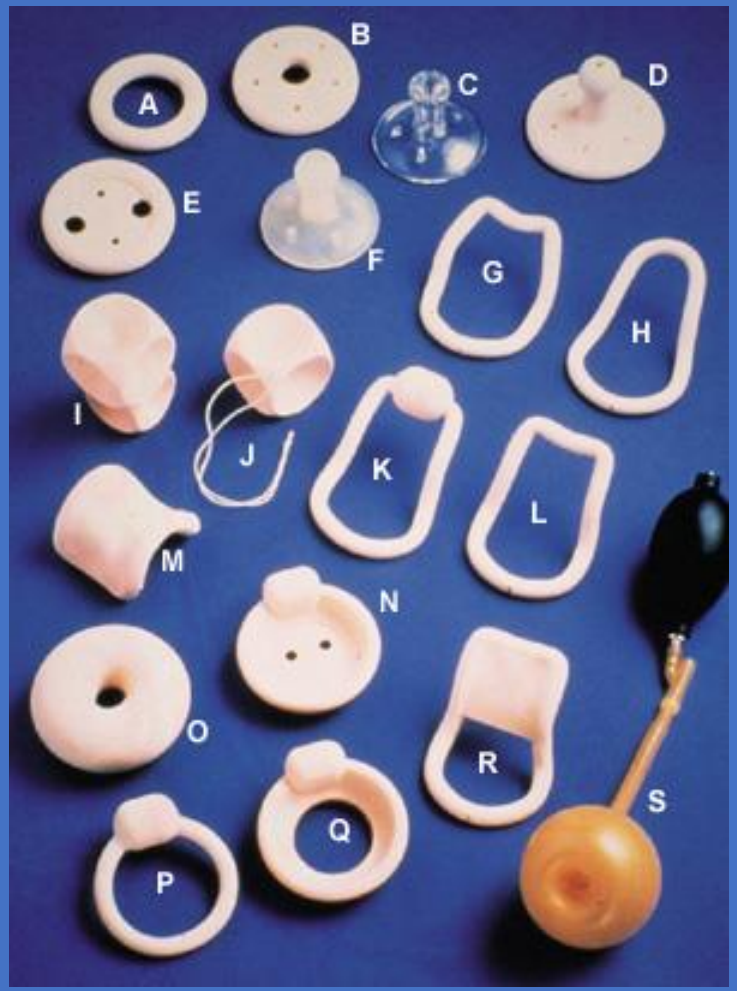
- Bulge
- Bladder
  - (urge > stress)
- Bowel
- sex

Goals of treatment

- Reduce symptoms
- Maintain function
- Restore anatomy

Conservative treatment options

- Reassurance
- Reduce abdo pressure
- Pelvic floor exercises / ‘pelvic floor safe’ activities
- Direct symptom treatment
- Physical supports

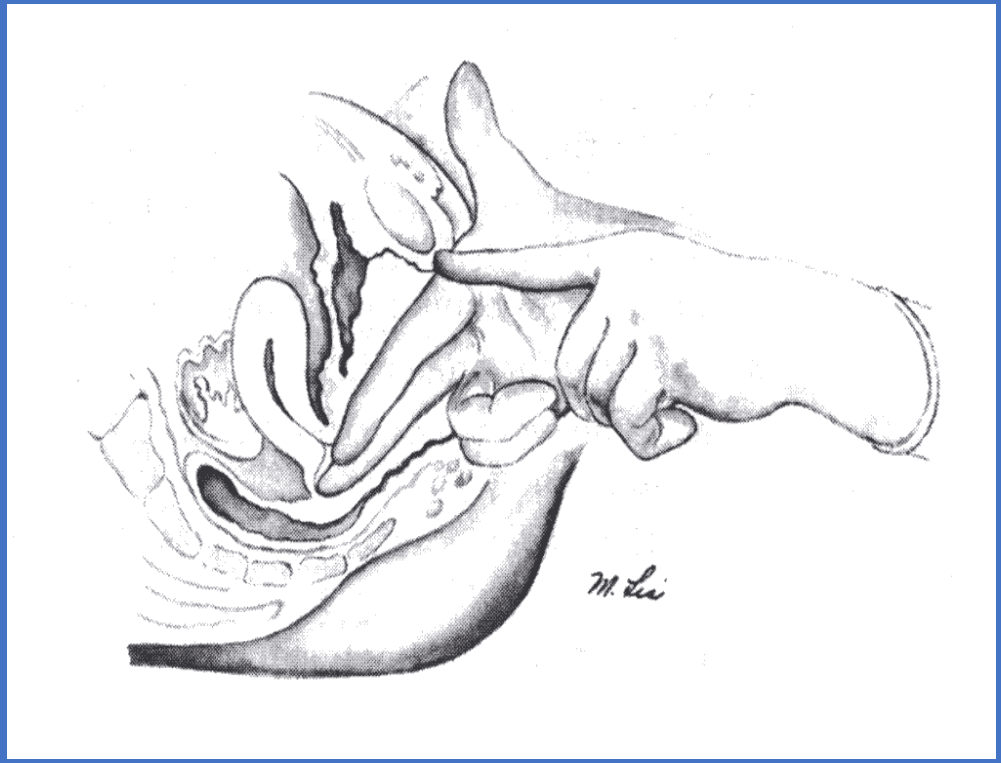

A
B
C
D
E
F
G
H
I
J
K
L
M
N
O
P
Q
R
S

MEASURING THE WIDTH

- Insert first two fingers of dominant hand deep to the posterior fornix
- Approximate size by using the fingers to determine the width
- Spread fingers wide to measure
- Remove fingers and compare to pessary sample or fitting kit

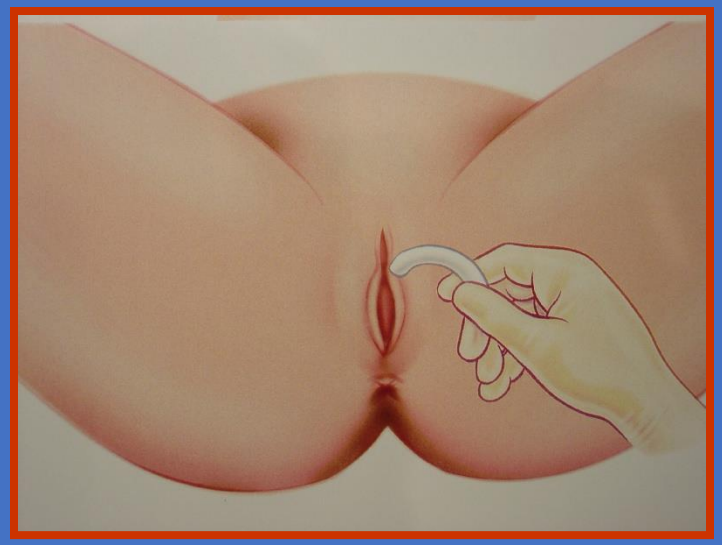
MEASURING THE LENGTH

- Reinsert fingers deep into the posterior fornix
- Make note of where the hand comes into contact with the pubic bone
- Compare to pessary.



INSERTION TECHNIQUE

- Slide it into the vagina, and curve posteriorly



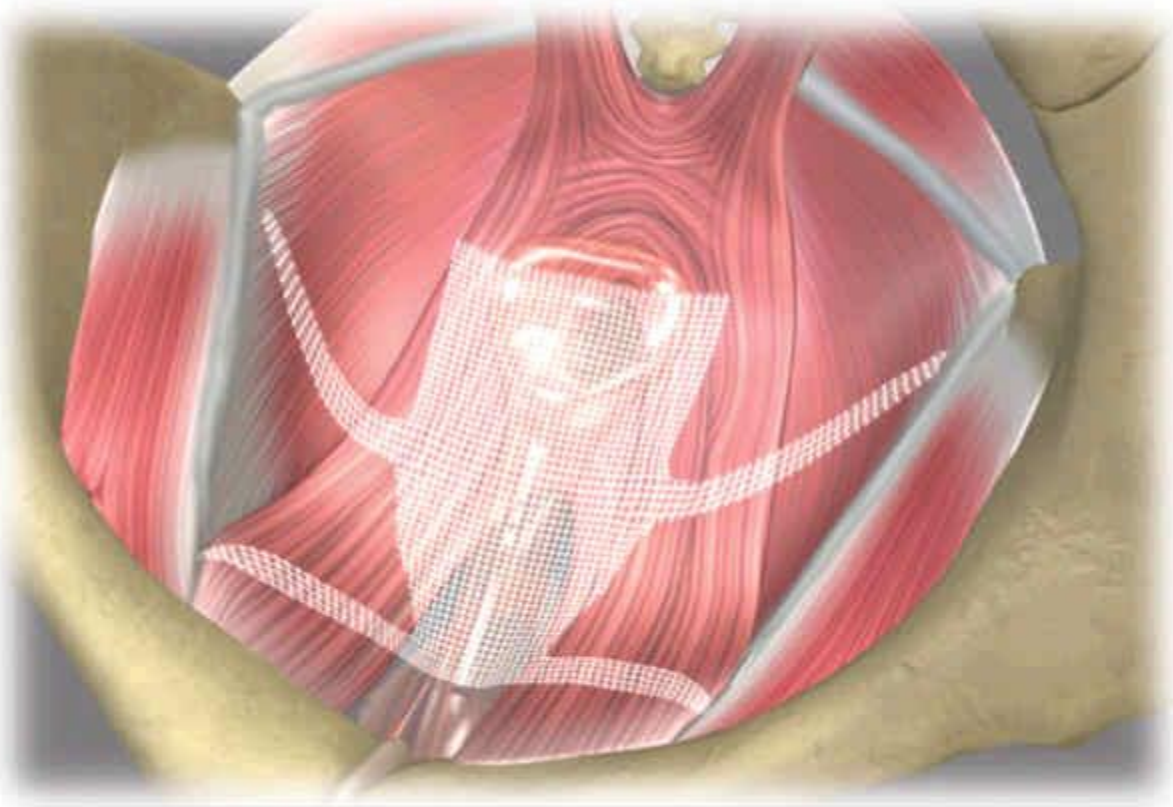
- Release and allow to spring open to its normal shape
- Push deep into the vaginal vault
- Tuck securely behind pubic bone anteriorly and under the cervix (if present) posteriorly

- 

Surgery

- ‘the only problem left unsolved by the gynaecologist of the past century is that of permanent cure of Cystocoele’

- “if only it were possible to artificially produce tissue of density and toughness of fascia and tendon, the secret of the radical cure of hernia would be discovered”



Mesh is definitely not this year’s black!

Sand et al 2001

- 5yr anatomical success- 40%
- Re-operation rate- 0%

Weber et al 2001

- anatomical success- 30%
- Re-operation rate- 0%
  (based on grade 0)
- Based on grade 2a or less 90%
- Based on symptoms 95%

operations

- Vaginal hysterectomy
- Anterior and posterior repairs

Anterior considerations

- Apical support
  - Hysterectomy (vag vs lap, +/- suspension)
  - Uterosacral suspension
  - Sacrospinous fixation
  - hysteropexy
- Vaginal length
- Specific fascial defects rare

Posterior considerations

- Defect specific repair vs levatorplasty
- Specific fascial defects very common
- Perineum
- Apical support
- ‘Enterocoele’

Level 1 procedures

- Uterus vs no uterus

uterus

- Hysterectomy vs hysteropexy
  - Fertility
  - Patient preference

- Vaginal vs laparoscopic

- Prophylactic vault suspension post hysterectomy
- Grade 3 or greater

- Sacrospinous hysteropexy
- Sacro-hysteropexy

No uterus

- Sacro-colpopexy
- Sacrospinous fixation

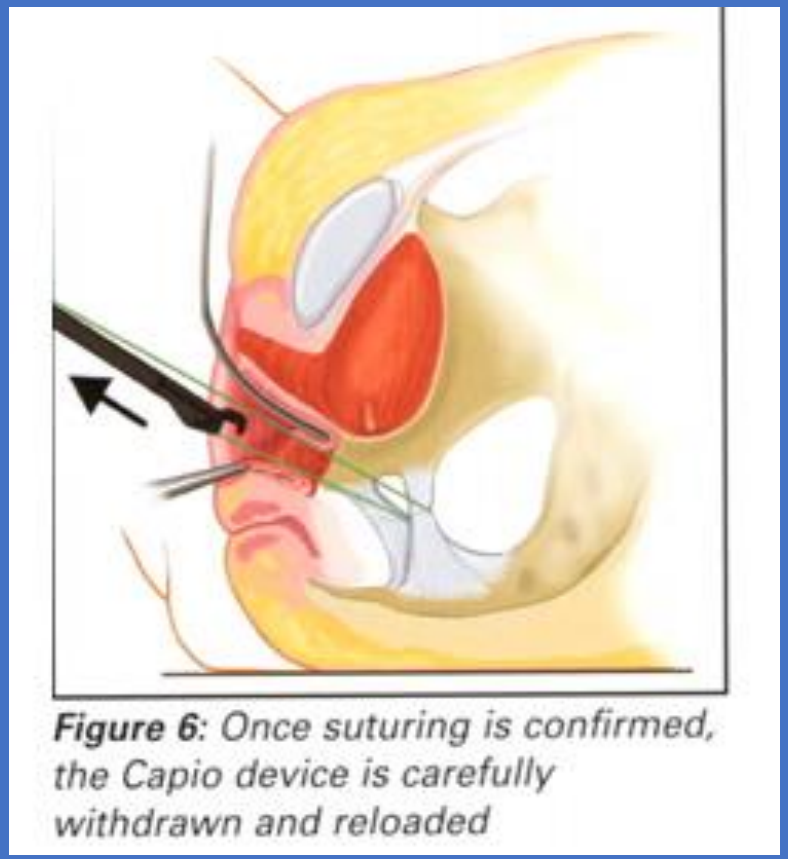


***Figure 6**: Once suturing is confirmed, the Capio device is carefully withdrawn and reloaded*

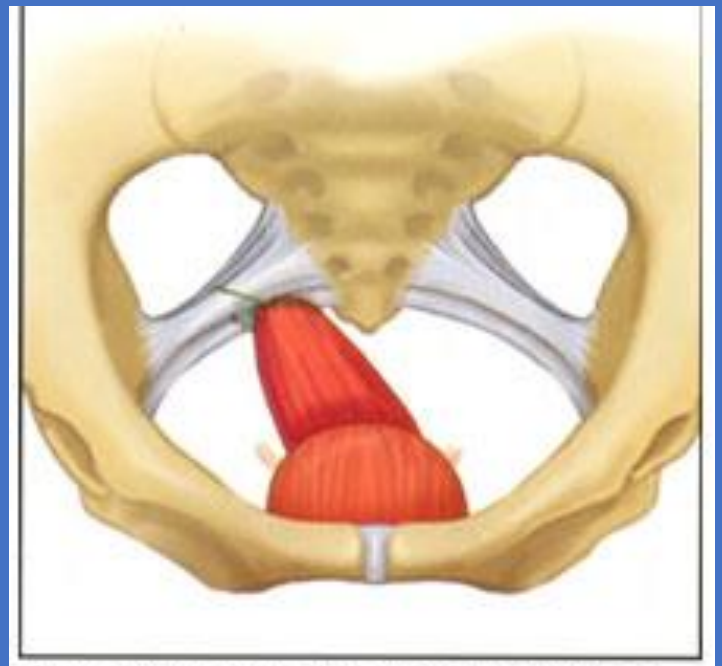
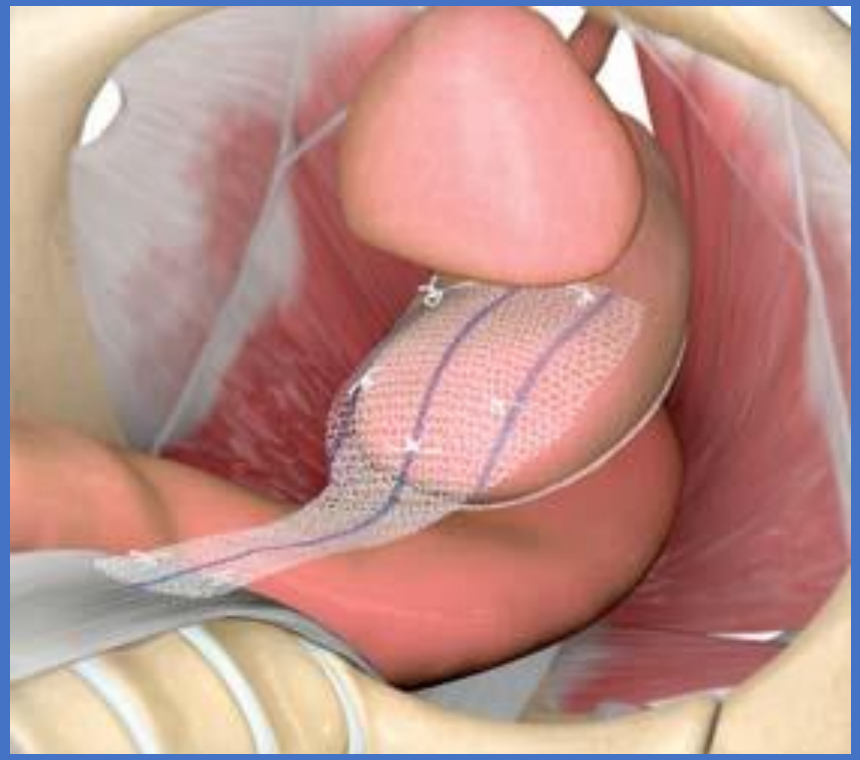


***Figure 8**: The upper vaginal vault is secured to the sacrospinous ligament, restoring vaginal wall support and correcting prolapse*

sacrocolpopexy



considerations

- Other prolapse (ant vs post)
- ‘leading’ prolapse
- Previous surgery
- Body habitus
- Co-morbidities
- Patient preference
- Age

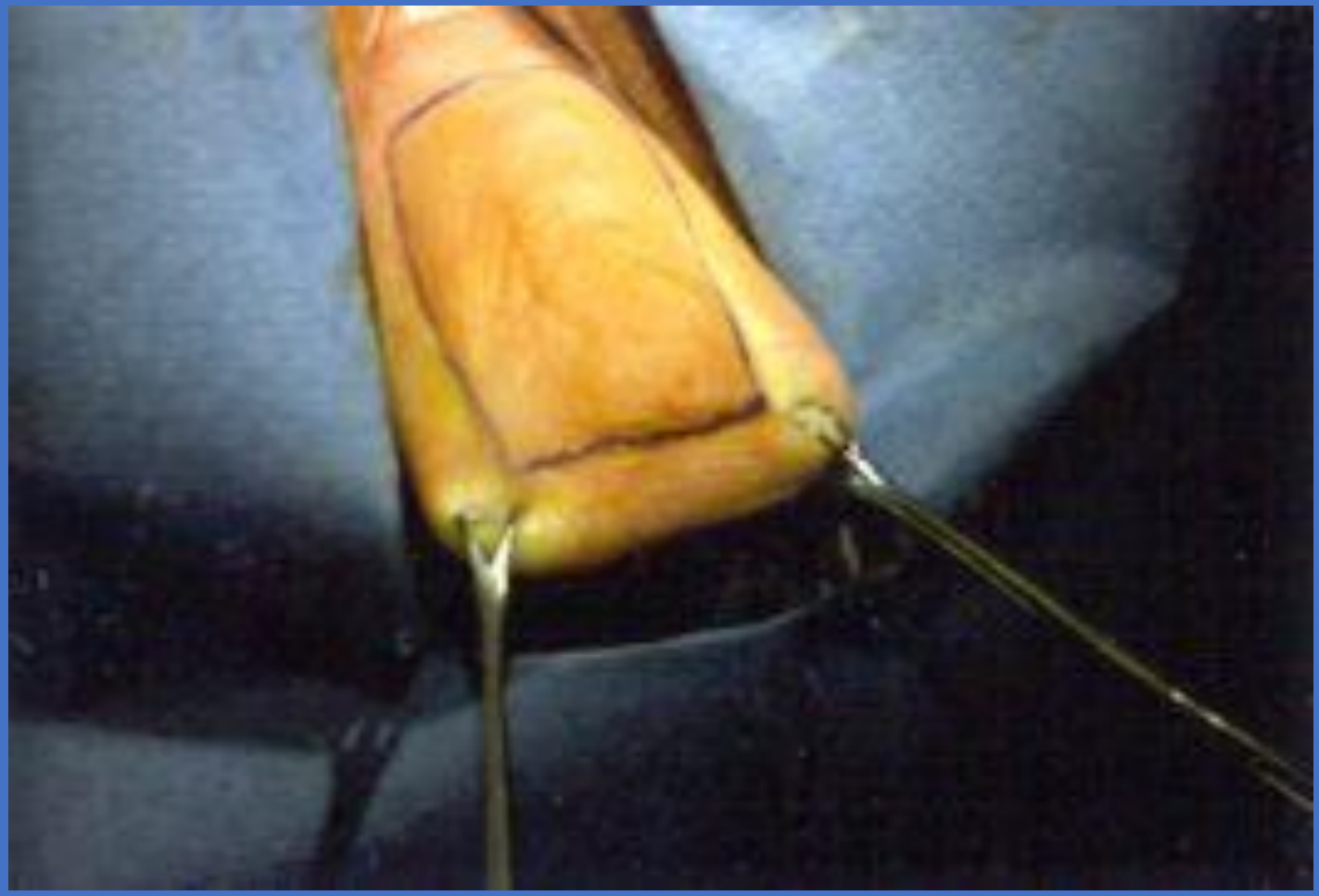
Special situations

- Long cervix
- Elderly/frail/moribund
- Recurrent prolapse

Special situations

- Cervical amputation
- Colpocliesis
- Mesh

colpocliesis



Summary

- Anatomical/functional concepts simple
- Some degree of prolapse is normal
- Deterioration is not inevitable
- Symptoms more important than signs

Summary

- Reassurance may be sufficient for some women
- Plenty of non surgical options available
  - Physio
  - Pessaries/other devices
- Surgical trends
  - Less mesh
  - Uterine preservation
  - Colpocliesis (Vaginal obliteration)

The End

- Any Questions?