Dr Eva Fong

Urologist

Auckland

Pelvic Organ Prolapse - Concurrent Workshop

Saturday, 22 June 2013 Start 4:30pm Duration: 360mins Opus

Pelvic Organ Prolapse
GPCME 2013

Eva Fong
Urologist

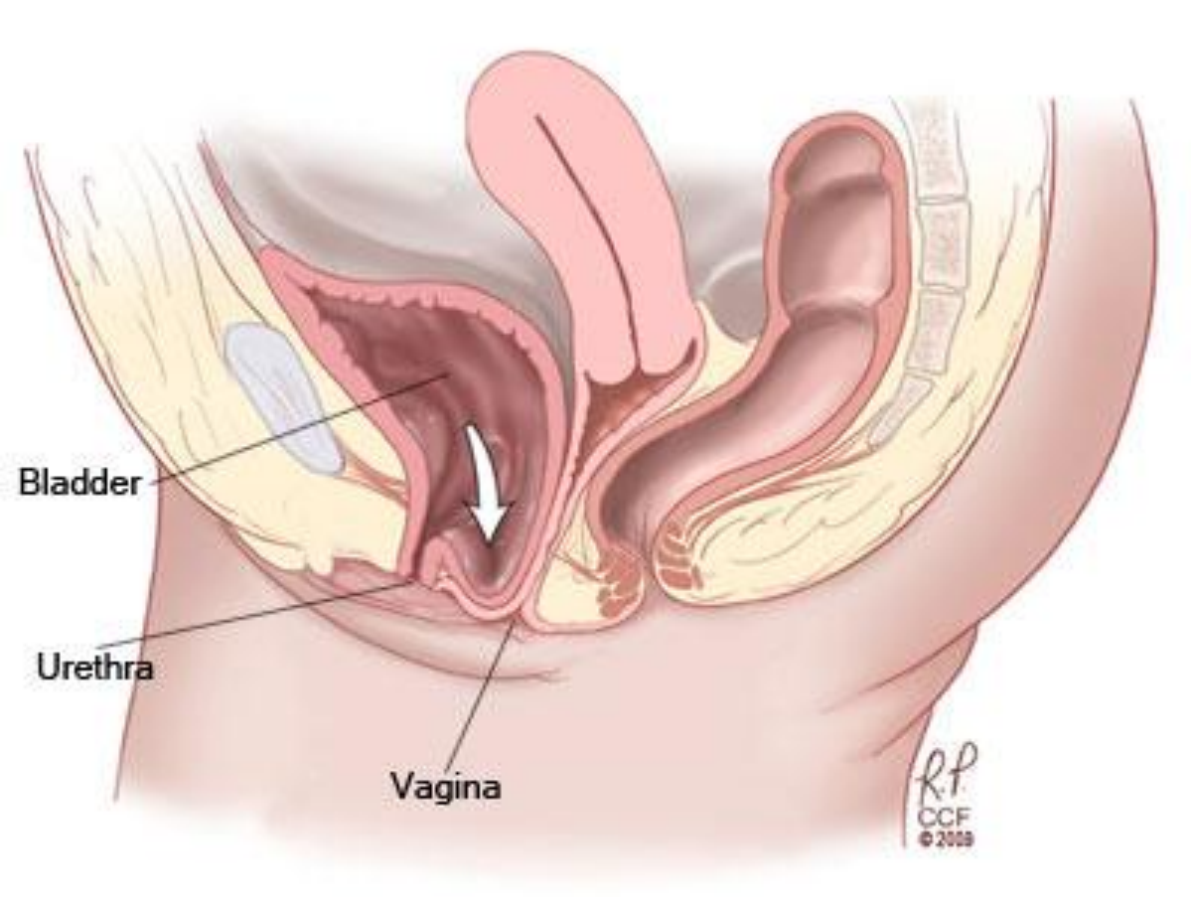
Learning objectives

- Recognising symptoms of prolapse
- 5 minute examination technique
- How to treat in primary care
- Specialist treatment options
- About the mesh controversy
- Case studies

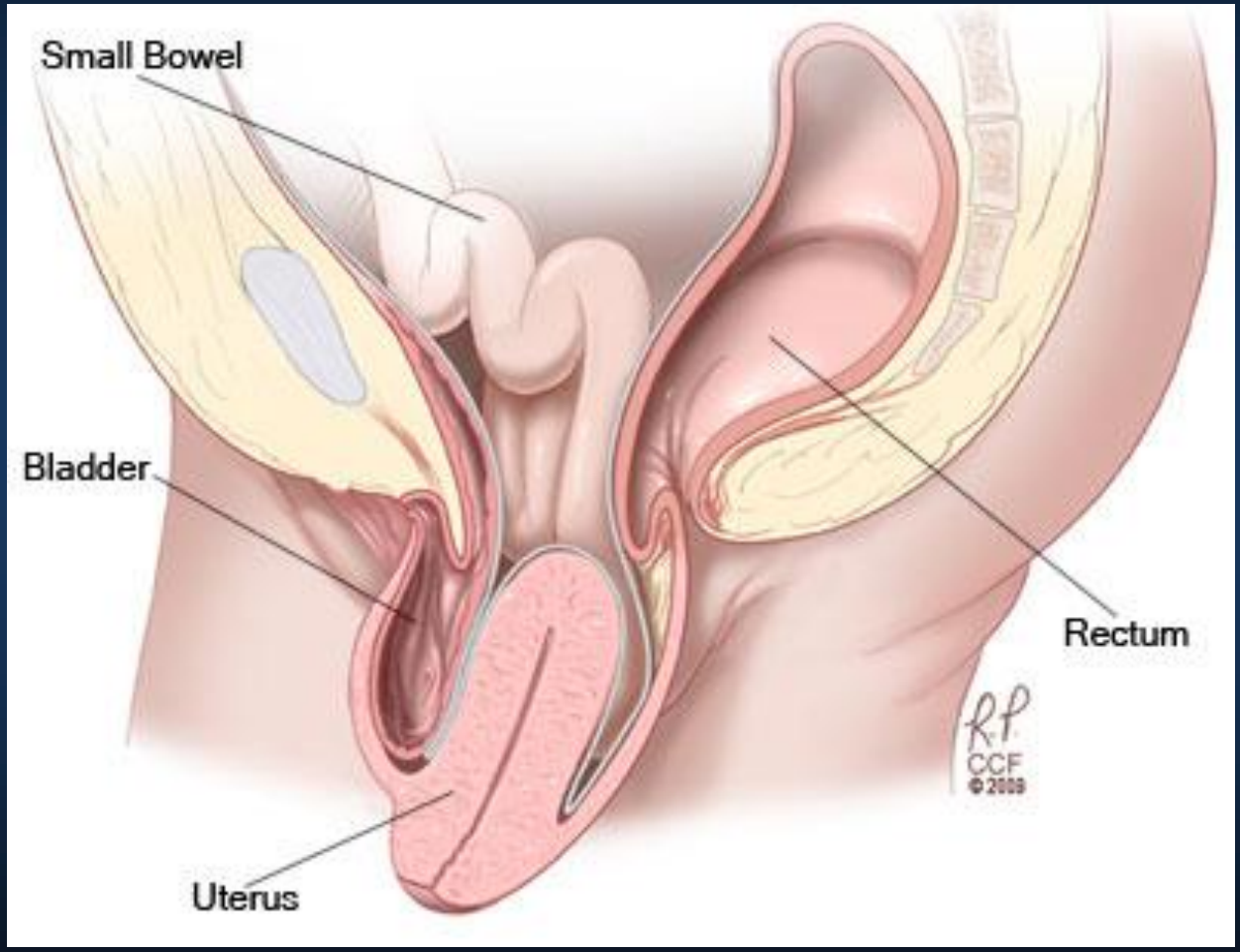
Types of prolapse

- Anterior wall: cystocoele
- Apical: uterine/ vaginal vault
- Posterior wall: rectocoele (enterocoele)

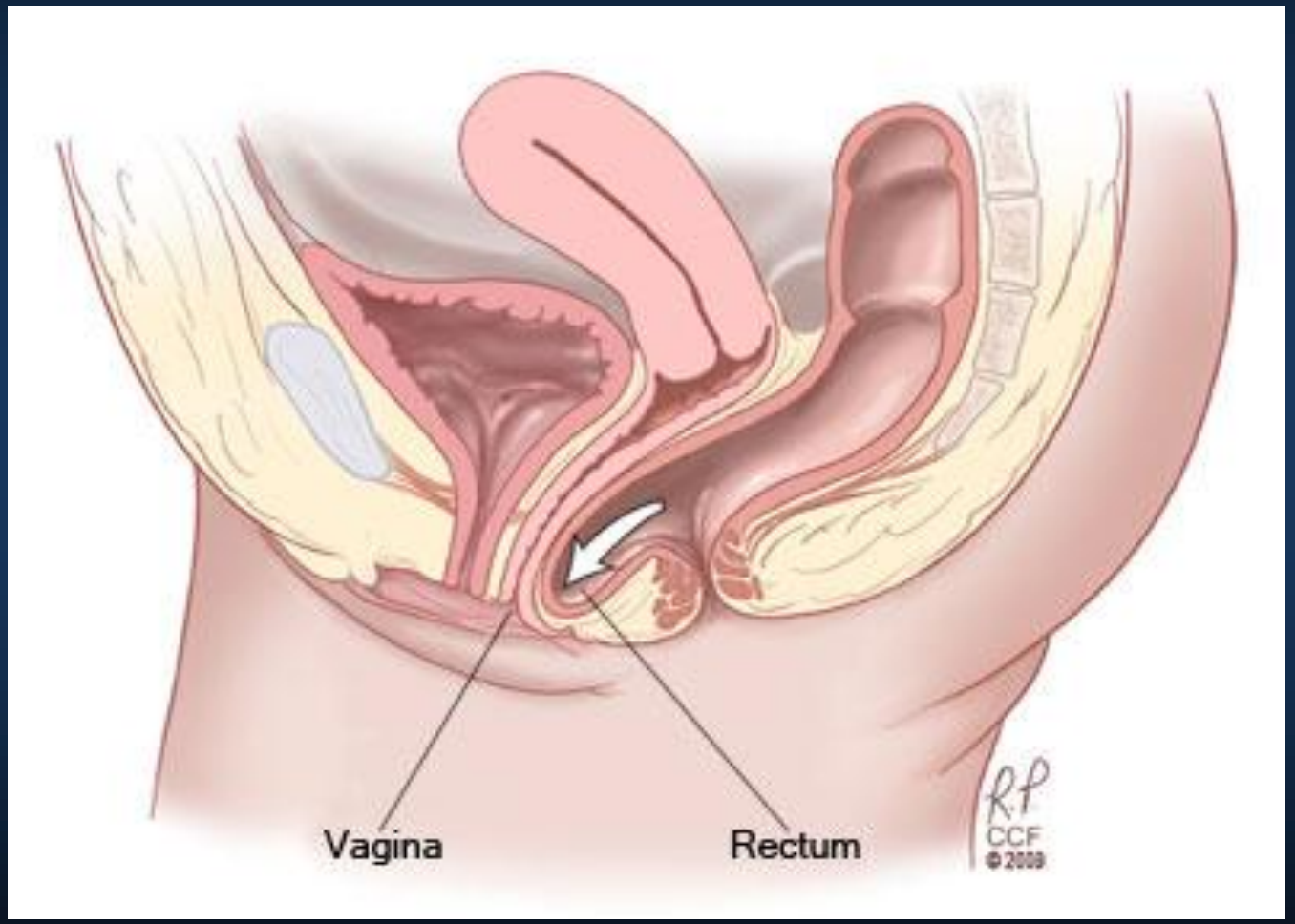
POP: Cystocoele



POP: Apical prolapse



POP: Rectocoele



Bladder symptoms

- *Likely to be due to prolapse*
  - Frequency, dysuria, urgency, urge incontinence
  - Difficulty emptying the bladder, slow flow
- *Possibly due to prolapse*
  - Urinary tract infection
- *Unlikely to be due to prolapse*
  - Stress incontinence
  - Haematuria

Bowel symptoms

- *Likely to be due to prolapse*
  - Rectal pressure, a feeling of incomplete emptying after bowel motion, having to digitate into vagina to evaculate rectum
- *Possibly due to prolapse*
  - Constipation
- *Unlikely to be due to prolapse*
  - Faecal incontinence

Pelvic/vaginal symptoms

- *Likely to be due to prolapse*
  - Feeling a bulge down below
  - Feeling like something is falling out
  - Dragging/ heavy sensation
    - Worse at end of the day (after standing)
  - Feeling like they are “sitting on a ball”
- *Possibly due to prolapse*
  - Dyspareunia
- *Unlikely to be due to prolapse*
  - Vaginal bleeding

Asymptomatic

- Incidental finding during cervical smear/ pelvic exam

What to ask

- How long have you had these symptoms?
- Do these symptoms bother you?
- Do these symptoms stop you from doing things?

What else to ask

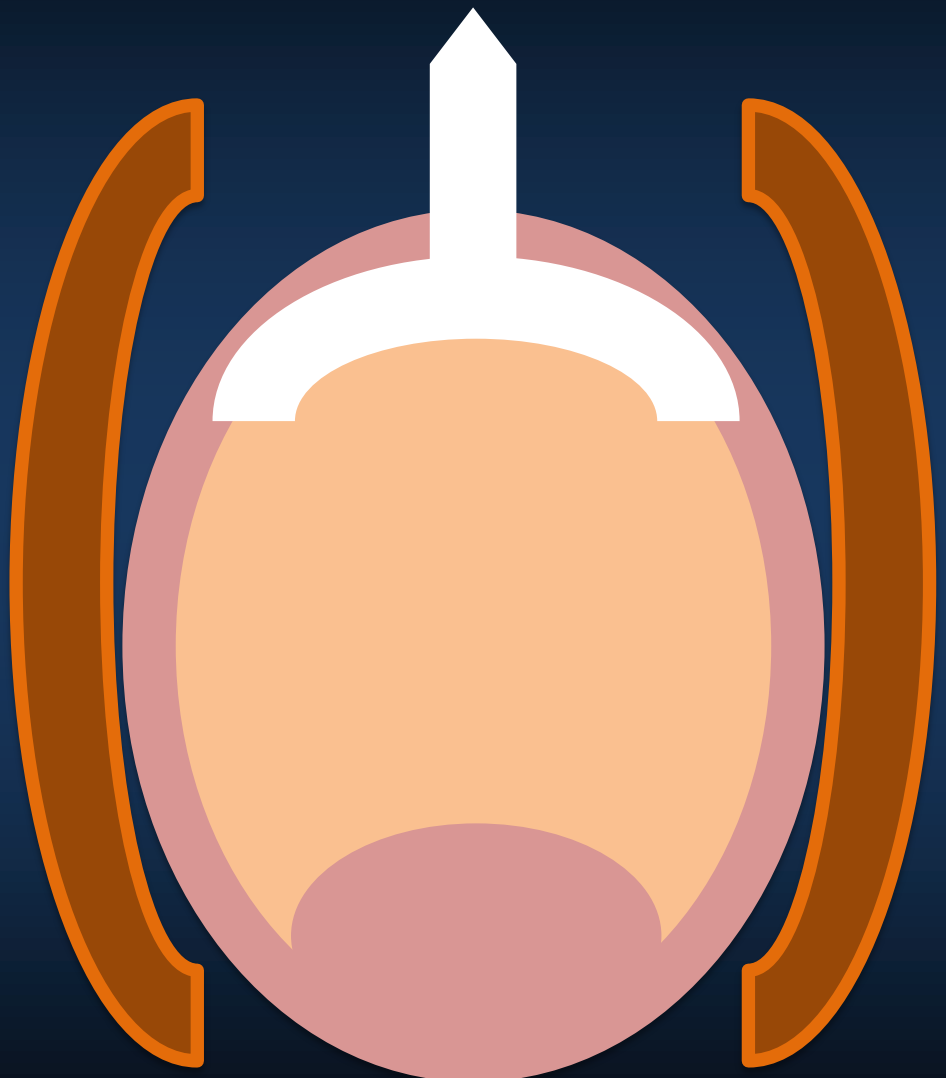
- Brief gynecologic history
  - Note if patient is currently sexually active
    - If so any dryness/ dyspareunia
  - Pre or post menopausal
  - Parity
  - Previous treatments/ procedures
  - Up to date with cervical smears?

Examination technique

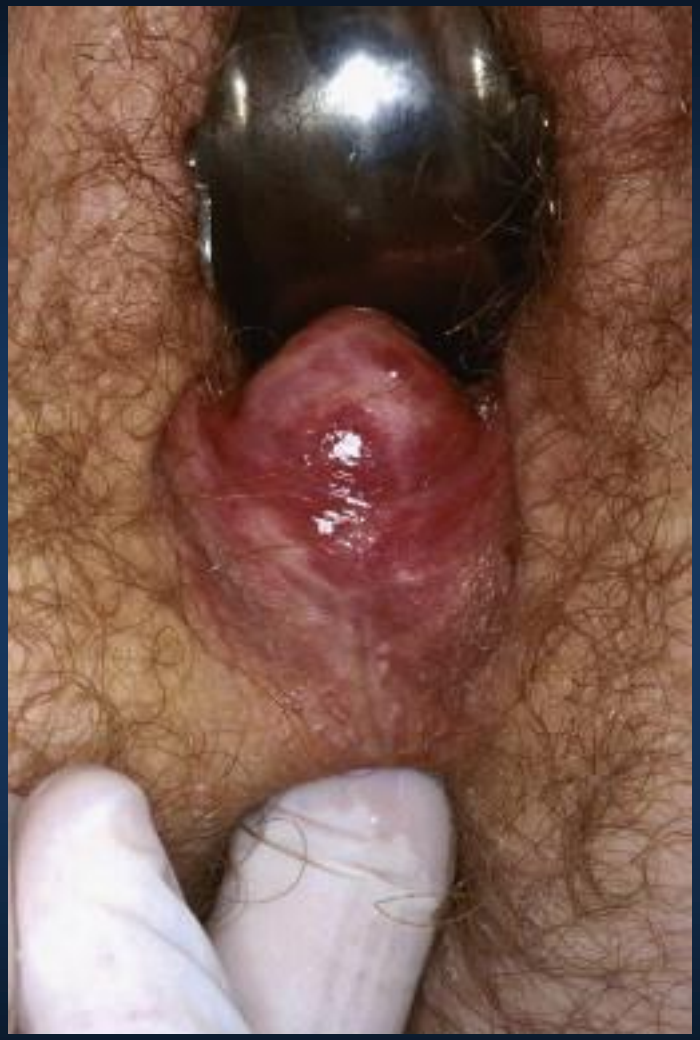
- Position supine with frogleg
- Look
  - vulva for skin changes (pale & loss of rugae ?atrophic vaginitis), scars, obvious prolapse at rest
- Bimanual exam
- Split speculum exam using posterior blade
  - Ask patient to valsalva to see maximal extent
  - Identify where prolapse is coming from
- Pelvic floor contraction
- Rectal exam (confirm rectocoele)

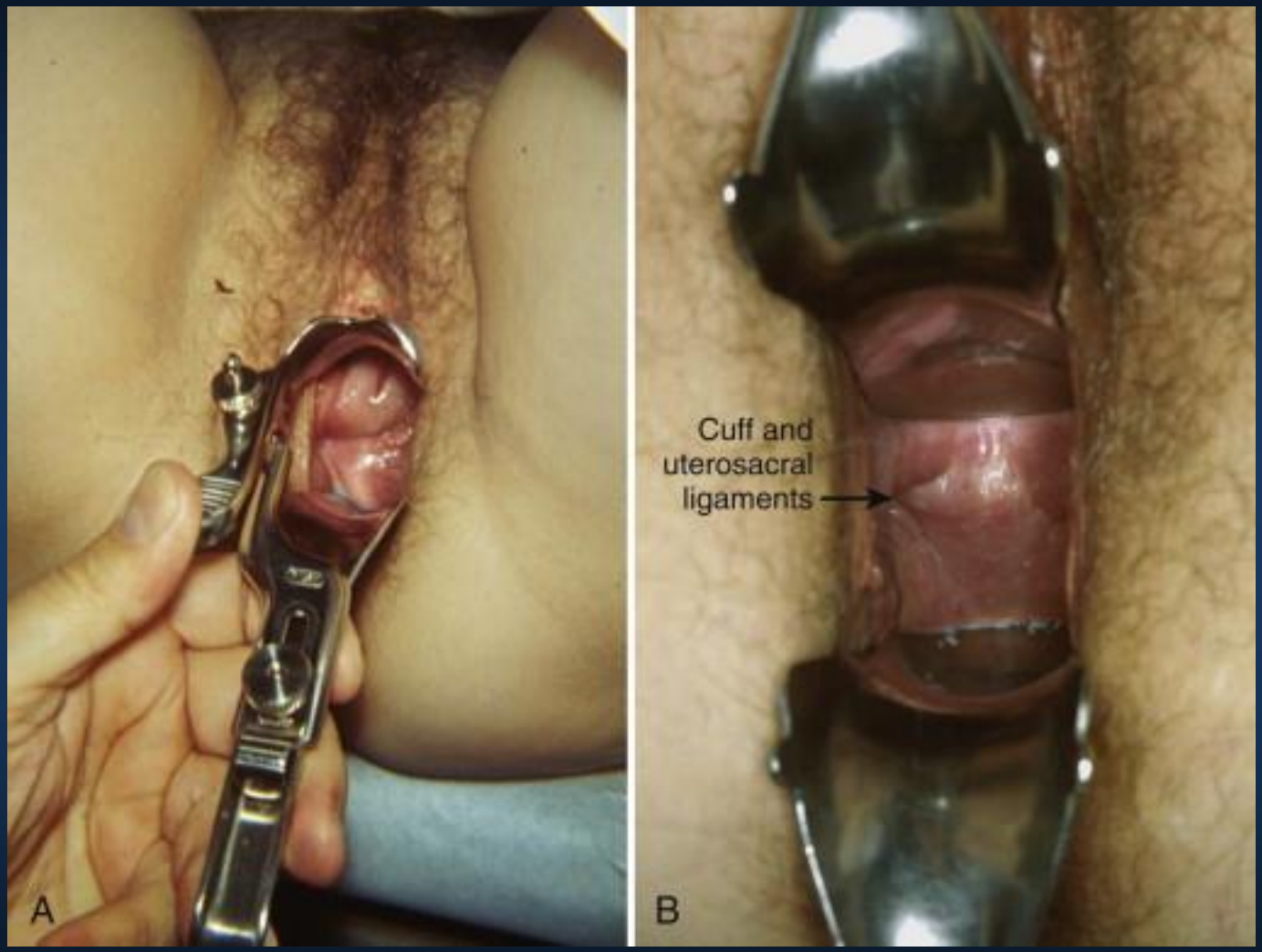
Cystocoele

Rectocoele



Apical prolapse




A
Cuff and
uterosacral
ligaments
B

Treatment in primary care

- No symptoms
  - Maximizing pelvic floor function
    - Pelvic floor exercises
    - Specialist pelvic floor physio
  - Improving estrogen levels in vagina
    - Ovestin cream
  - Preventing progression

Preventing progression

- Managing constipation
  - Kiwicrush, metamucil, fluid, exercise
- Avoiding heavy lifting
- Avoiding chronic cough
  - Managing asthma
  - Quitting smoking
- Losing weight

Young women and prolapse

- May not have completed family
- Contributing factors
  - Early post partum recovery
  - Relatively hypoestrogenic state due to breast feeding or mini-pill

Young women and prolapse

- Prevention
  - Pelvic floor exercises
  - Can try vaginal oestrogen during breast feeding
  - Managing constipation
  - Future childbearing/ delivery
    - Avoiding excessive pregnancy weight gain/ losing baby weight
- Treatment
  - Repairs should be durable and maintain good sexual function

When to refer

"Symptomatic prolapse affecting quality of life"

Treatment in secondary care

- What specialist will do
- Treatment options

Treatment in secondary care

- Repeat history and exam
- Investigations
  - MSU
  - Post void residual
  - Urodynamics
  - Pelvic ultrasound +/- cervical smear

What is urodynamics?

- A functional test of how your bladder works
- Takes 20-30 minutes
- Some patients find embarrassing but not painful

What is urodynamics?

- Small urethral catheter (6Fr)
- Small rectal balloon
- Fill with saline
  - Cough, strain
  - Ask them to void

Why we do it?

- To understand how bladder symptoms relate to prolapse
  - So we know what will and won't be fixed by treating prolapse
- To look for "occult" stress incontinence
  - New incontinence after prolapse repair

Treatment options

- No symptoms
  - Preventative treatments

Treatment options

- Symptoms
  - Non-surgical: Ring pessary
  - Pros
    - Easy on the patient
    - Completely reversible
  - Cons
    - Some patients find uncomfortable
    - Vaginal discharge/ bleeding
    - Sexually active women - inconvenient

Factors for success

- Pelvic
  - 80% of prolapses within the introitus can be treated with a pessary
  - More successful if uterus present
- Patient
  - Compliant with followup 3-6 monthly
    - Or can self-clean
  - Post menopausal
    - Need to use oestrogen cream

Fitting a pessary

- Estimating size of ring:
  - Place middle finger in posterior fornix
  - Place index finger behind pubic notch
- Distance between fingers is diameter of ring

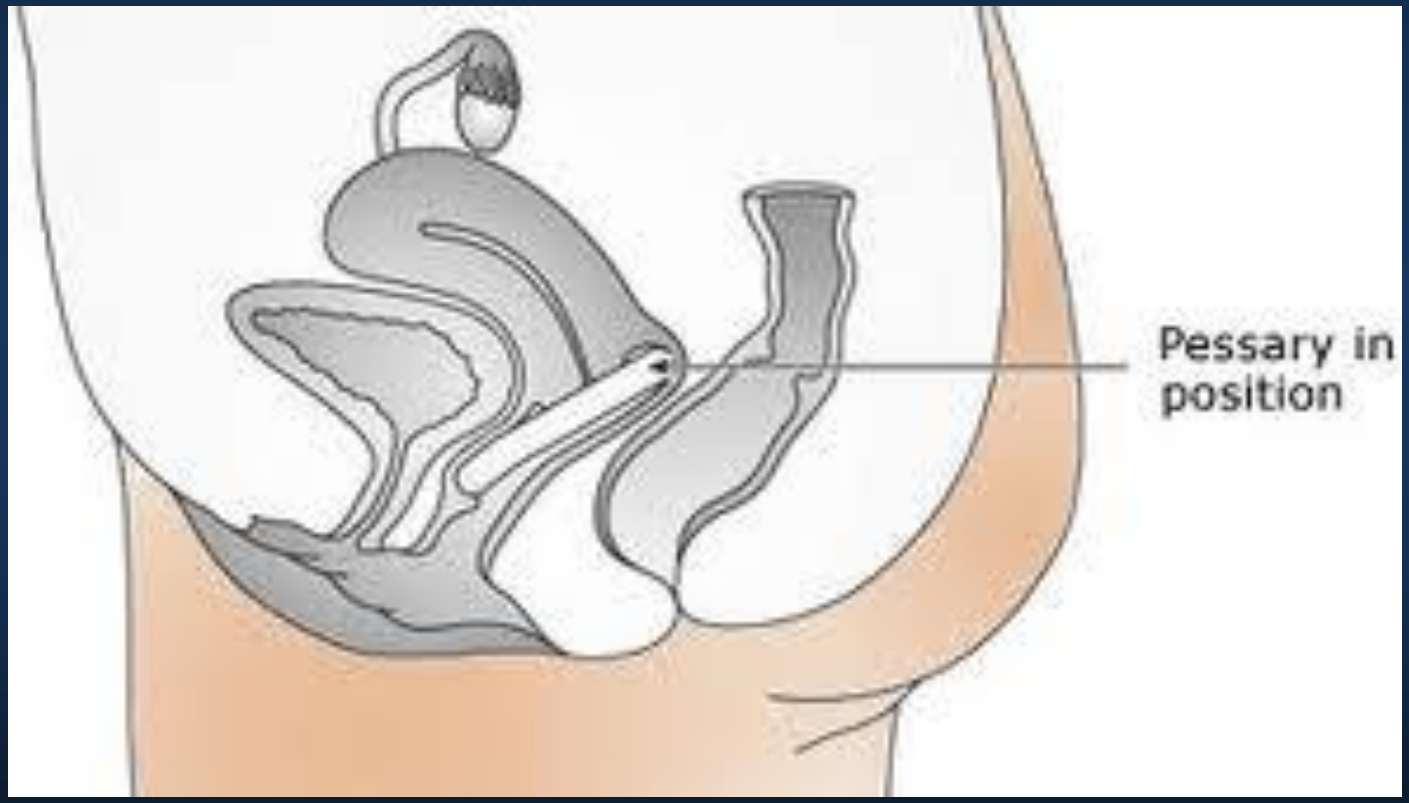
Fitting a pessary

- Fold ring in half, insert by folding (only folds one way) with lubrication
- Ring sits behind cervix and towards pubic notch
- Rotate two small holes so lie front and back
- Rotate back 90 degrees, to fold and remove

Pessary care

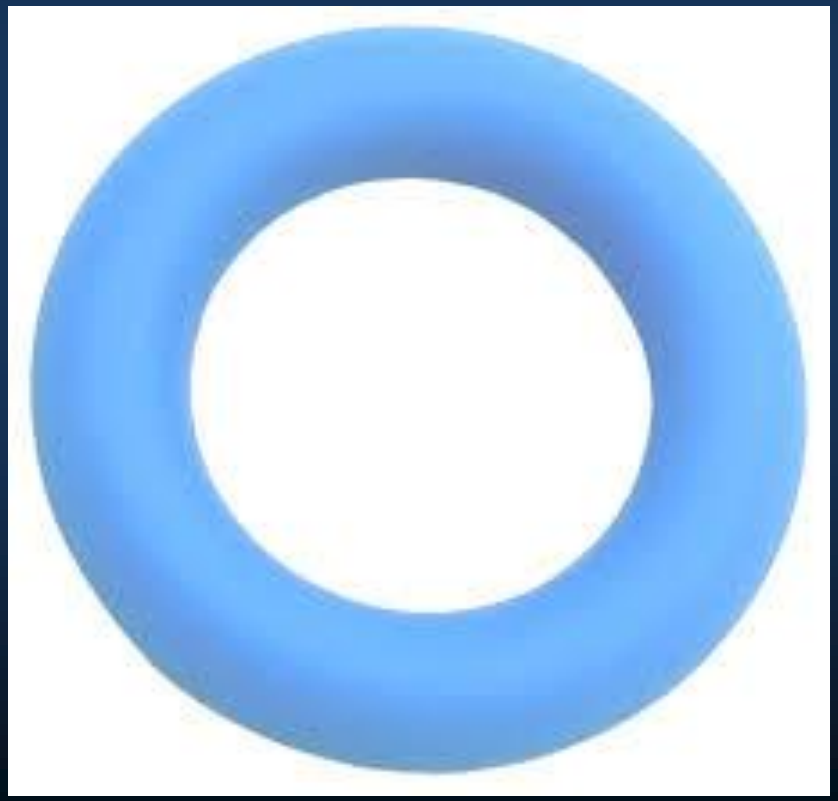
- Teach patient to remove and clean
  - Can remove or leave in for sex
  - Each pessary lasts 5 years
- Use with vaginal estrogen
- Medical check every 3-6 months for vaginal ulcers/erosion

Position of pessary



Ring without support

- Uterine prolapse



Ring with support

- Cystocoele

Ring with knob

- Prolapse and stress incontinence

Surgical treatments

- Vaginal
  - Native tissue
  - Mesh
- Abdominal

- More importantly
  - Traditionally: emphasis on anatomic results
  - Modern: functional results

What does the patient want?

- Feel better (prolapse reduced)
- Bladder and bowels to work well
- Good sexual function
- Avoid complications
- Minimise recurrence

Comparing treatments

- Vaginal approach +/- mesh
  - Pros:
    - Minimal recovery time and postoperative pain
  - Cons
    - High recurrence rate – 30%
    - Vaginal shortening/ dyspareunia
  - Mesh – controversial

Comparing treatments

- Abdominal
  - Pros:
    - More durable, recurrence rate <10%
    - Good vaginal length and normal axis
  - Cons
    - Longer recovery (Pfannenstiel)
  - Not as widely available

Problems and complications: what's ok and what's not

- Expected early post-op symptoms:
  - Vaginal bleeding/ vaginal itch
  - Urinary frequency/ urgency
  - Lower pelvic discomfort responding to simple analgesics
  - Constipation

Problems and complications: what's ok and what's not

- Warning signs
  - Feeling of difficulty emptying the bladder
  - Leg/ buttock pain
  - Smelly vaginal discharge
  - Heavy ongoing smelly vaginal bleeding/discharge
  - Pain during sex

What about mesh?

The New Zealand Herald

Surgical mesh costs millions

By Chloe Johnson
6:30 AM Sunday Sep 30, 2012

A surgical mesh that is the subject of international lawsuits and health warnings is still being implanted in hundreds of New Zealanders.

Heather Anderson has been in severe pain for years after surgical mesh was implanted in her abdomen. Photo / Kellie Blizard

The mesh is often used for hernia repairs and prolapsed pelvic organs and muscles, despite ACC paying $3.1 million in treatment and compensation to people with post-surgical complications.

Heather Anderson has been in pain for eight years since the mesh was implanted in her lower abdomen.

She said it was like a cheese grater cutting through her internal organs.

In the US thousands of women complained of severe pain, infections, excessive bleeding and organ

Why use mesh

- Widely used in hernia surgery to improve results
- Native tissue vaginal repairs – 30% recurrence rate
- Natural progression
  - High risk or recurrent prolapse cases

It’s complicated

Complications from mesh

- Most common
  - Vaginal erosion (3-14%)
  - Dyspareunia
- Less common but serious
  - Bladder/ bowel erosion or perforation
  - Severe bleeding
  - Pain: buttock/leg/ vaginal/ pelvic
  - Vaginal shortening

Safe use of mesh

- High level training in pelvic surgery
- Informed consent of risk and alternatives
- Experience recognising what's normal and what's not after surgery (promptly)
- Ability to remove mesh if problems occur

Mrs S

- Pelvic floor repair and “never felt right” afterwards, went home with left incision site infection
- “After 4 weeks at my 1st check- up I complained about unusual pain – abdominal, radiating, and also down my legs, plus bowel pain.”
- “Initially my slight pre surgery bladder leakage had settled, but as I became more active post op, those symptoms got worse than before surgery

- After 6 months
  - Referred to a urologist who asked “is sex important to you”
- Gynaecologist – MRI – couldn’t see a problem
- ↑ Pain and ↑ urinary incontinence
- Saw another urologist, suggested sling for incontinence
- Saw another gynecologist who diagnosed mesh erosion
- Had partial mesh removal

Lessons learned

- Poor informed consent
- Lack of recognition at 4 week post-op of mesh complications
  - Not normal to have high levels of pain after mesh
- Mesh should have been removed at that stage
- Instead, delayed management caused chronic pain, symptoms and distress
  - Ongoing after partial mesh removal

What to look for

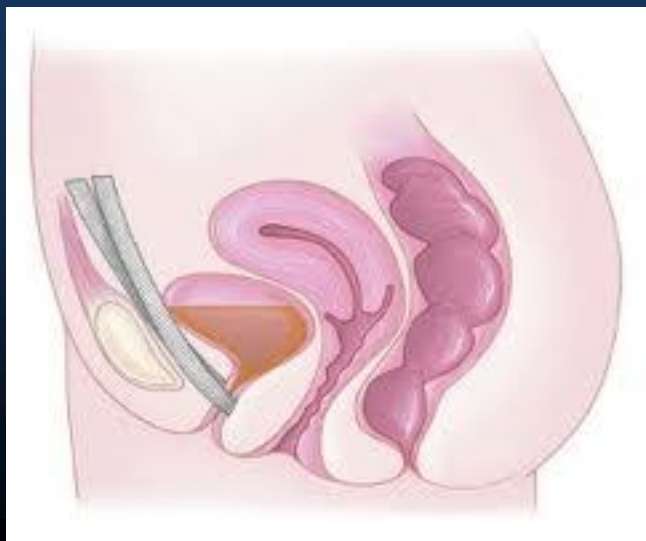
- Vaginal symptoms
  - Bleeding, pain during sex (woman or her partner), foul smelling discharge
- Pain
  - Buttock/ leg/ deep pelvic pain
- Bladder or bowel symptoms
  - Bleeding, urinary tract infections, dysuria

Refer

- To someone with experience in mesh complications
  - Many require mesh removal which is difficult

Other pelvic mesh use

- FDA warning is for transvaginal mesh only
- Specifically excludes mesh used for:
  - Mid-urethral slings
  - Abdominal repair
    - Safety and efficacy have been proven over 15-30 years
- Eg Mid urethral slings
    - Millions have been placed
    - Erosion rate into urethra <0.01%



Case study: Mrs S

- Mrs S
  - 6 weeks post implantation of vaginal mesh for prolapse
  - Persistent right leg pain and parasthesia
  - Worse with standing
- History
  - No pain prior to operation
  - No other new bladder/ bowel problems
- O/e:
  - No mesh erosion into vagina. Tender over right arm of mesh
  - Numbness over right thigh

Case study: Mrs S

- Referred for second opinion
- Advised removal of right mesh arm
- Right mesh arm removed several days later
  - Difficult procedure due to scarring

- Post operative: Immediate resolution of pain and improvement of parasthesia

Conclusion

- Prolapse is quality of life problem
  - Patient knows best the effect (if any) on QOL and need for treatment
- Focus on prevention of progression for asymptomatic
- Successful treatment outcome dependent on thorough work-up and understanding patient's lifestyle and expectations