Management of Urogenital Prolapse of Women in Primary Care

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www.PCWHF.org.uk
Useful websites

• RCN – genital examination in women guideline and Vaginal and pelvic examination guideline (www.rcn.org.uk)

• Primary care womens health forum
  – conservative mangement of prolapase: competency framework for primary care
  _Guidance on diagnosis and management of urogenital atrophy or GSM
    (www.pcwhf.co.uk)

• NICE guidance on menopause 2015 (www.nice.org.uk)
Genital Prolapse

• Hernia of one or more pelvic organs (uterus, vaginal apex, bladder, rectum) and its associated vaginal segment

• Affects up to 50 % of parous women
• 1 in 5 reporting symptoms
• Significant impact on quality of life
Types of prolapse

• Anterior vaginal wall prolapse
  – Urethrocele / cystocele / cystourethrocele

• Posterior vaginal wall prolapse
  – Rectocele / enterocele (small bowel prolapse)

• Apical vaginal prolapse
  – Uterovaginal (uterine descent with inversion of the vaginal apex)
  Vault (post hysterectomy inversion of the vaginal apex). Commonly known as uterine or vault prolapse
Signs of pelvic floor support defects

- Elongated vagina with widened outlet
- Posterior vaginal wall at hymenal ring
- Shortened perineal body
Cystocele
Factors contributing to prolapse

• Pregnancy and childbirth
• Vaginal delivery
• Ageing
• Menopause
• Obesity, large fibroids, pelvic tumours
• Chronic cough, straining, heavy lifting
• Genetic (eg collagen deficiencies)
• Previous pelvic surgery
• Spinal cord injuries/ neurological conditions eg MS
Symptoms

- Often none
- Heaviness/awareness of bulge/protrusion or dragging sensation
- Need to reduce the prolapse to void/defecate
- Urinary: poor stream, recurrent UTI, frequency, urgency, stress incontinence
- Bowel: obstructed defecation
- Sexual dysfunction/discomfort
- Lower back pain
- Rarely: renal impairment.
Assessment

- Symptoms: duration and severity and impact on lifestyle
- Urinary symptoms
- Bowel symptoms
- Dyspareunia
- Previous pelvic surgery/infection
- Pariety; trauma in childbirth
- Job/lifting/lifestyle
- Concurrent medical problems that may contribute
Examination

- Consent and chaparone
- Explanation
- Abdomen
- Vulva
- Obvious prolapse on cough
- Speculum exam
- Simms exam
- Weight/BMI
- Swabs
Grading of prolapse

Baden-Walker grading
0-No descent during straining
i - Does not descent below 1 cm above the hymen
ii - Extends from 1 cm above to 1 cm below hymen
iii - Extends more than 1 cm beyond the hymen
iv - Vagina completely everted

Mild/moderate/large cystocele/rectocele
Stage 1, 2, or 3 uterine prolapse

POP-Q
# Prolapse Staging

**The Baden-Walker System**

In order to select an appropriate pessary it is important to stage the descent of the prolapse. There are different systems to do this, for example, the POPQ but the below is a very simple, 5 stage system, which is widely used.

<table>
<thead>
<tr>
<th>STAGE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No descent of pelvic structures during straining</td>
</tr>
<tr>
<td>I</td>
<td>The leading edge of prolapse does not descend below 1 cm above the hymen</td>
</tr>
<tr>
<td>II</td>
<td>The leading edge of prolapse extends from 1 cm above the hymen to 1 cm below the hymen</td>
</tr>
<tr>
<td>III</td>
<td>The prolapse extends more than 1 cm beyond the hymen but there is not complete vaginal eversion</td>
</tr>
<tr>
<td>IV</td>
<td>The vagina is completely everted</td>
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</tbody>
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Nine Measurement Points for Pelvic Organ Prolapse Quantification (POP-Q)

Aa  Position of distal anterior vaginal wall, 3cm proximal to the external urethral meatus
Ba  The most distal portion of the remaining anterior vaginal wall above point Aa
Point at anterior vaginal
C   The most distal edge of the cervix or vaginal cuff
D   The position of the posterior fornix
Bp, Ap The most distal position of the posterior vagina; wall above point Ap
gh  The genital hiatus
pb  The perineal body
tvl The total vaginal length
Management

- Educate and reassure
- Ensure adequate vaginal oestrogen
- Manage constipation
- Pelvic floor exercises (women’s physio)
- Bladder training (caffeine etc.)
- Weight management and lifestyle
- Address any other medical problems
- Supportive pessaries
- Surgery
Pelvic floor exercises
Pelvic Floor

Pelvic Floor Muscles

Bottom View
Post Menopausal Vaginal Atrophy

50 – 80% of women have one or more symptoms

- Dyspareunia
- Urinary problems – frequency/urgency/recurrent UTI
- Vulval discomfort
- Vaginal discharge
Well-Estrogenized Premenopausal State  Low-Estrogen Postmenopausal State
Picture Showing Features of Atrophic Vaginitis
Hormonal creams/pessaries
Non hormonal lubricants
Lubrication websites

- Replens
  www.replens.co.uk
- Regelle
  www.korahealthcare.com
- Sylk
  www.sylk.co.uk
- Yes
  www.yesyeyesyes.org
Estriol 0.01%

- Easy to control doses
- Can be applied with or without applicator
- Applicator hold 5mls of cream containing 0.5mg estriol
- Very low dose of milder estrogen
- Not if allergy to peanuts – contains arachis oil
- Not to use with condoms
- Can be messy
- Easier to use if poor pelvic floor muscle tone
- One application each evening for 7 days followed by twice weekly – reduce as needed
- £16 per tube. 16 doses = 8 weeks +
Estradiol (Vagifem)

- Estradiol 10mg (Vagifem) stronger estrogen
- Pessaries - so less messy
- Easier with good pelvic floor
- One pessary twice a week – in the evening
- £16.72 for 24 pessaries = 12 weeks

Estradiol (estring)

Silicone pessary left in vagina and changed every 3 months
Can be removed and replace for sexual intercourse
£34 each
Easier to manage for many
Slow release
Useful websites

www.menopausematters.com
www.themenopausedoctor.co.uk
www.patient.co.uk/atrophicvaginitis

www.nice.org.uk/guidance/NG23 (menopause 2015)
www.PCWHF.co.uk (primary care womens health forum)
- Coffee
- Tea
- Green tea
- Hot chocolate
- Fizzy drink
- Diet drinks
- Energy drinks
- Fresh acidic drinks

**DRINKING FOR A HEALTHY BLADDER**

**Drinks that CAN irritate the bladder**
- Caffeinated Tea & Coffee
- Green Tea
- Hot Chocolate
- Fizzy Drinks especially Cola
- Caffeinated Energy Drinks
- Fresh acidic drinks

**Drinks that DON’T irritate the bladder**
- Decaffeinated Tea & Coffee
- Water
- All Types of Diluted Fruit Juices
- Non-acidic Fresh Drinks
- Herbal Tea
- Red Bush Tea

**Don’t cut back on your drinks**

Consume 1.5 - 2 litres (6 - 10 average mug sizes) a day.

When you’re not drinking enough, the bladder gets used to holding smaller amounts of urine and can become oversensitive. From the list above you can see that certain drinks are more likely to irritate the bladder. These include drinks that contain caffeine and fizzy drinks - especially those labelled “Lite” or “Diet” which have artificial sweeteners, such as Aspartame or Saccharin.

Alcoholic drinks, particularly spirits, can also irritate the bladder and for some, the acid in various fruit juices can make problems worse. It often feels like cutting down on fluid intake will help relieve symptoms of Overactive Bladder, but this is not the case. A reduced intake will make your urine more concentrated and is likely to make your symptoms worse.

For further information please log on to: www.bladderandbowelfoundation.org or visit our overactive bladder site at: www.bladderproblem.co.uk
Supportive Pessary

- Degree of prolapse
- Symptomatic
- Effect on urinary or bowel incontinence
- Size of introitus
- Health of vaginal tissues
- Sexual activity
- Dexterity – physical/emotional/mental
- Patient choice
- Not suitable or does not want surgery
- Waiting for surgery
- Childbearing not complete
Exclusions

- Active vaginal infection
- Pelvic inflammatory disease
- Undiagnosed vaginal bleeding
- When follow up can not be assured

- If previous prolapse surgery using mesh – should be referred to specialist
Initial fitting

- Should have slight movement.
- Comfortable
- Relief of symptoms
- Should be comfortable walking, standing, sitting, emptying bladder
- Most prolapse will be supported by ring,
- Vault prolapse and large prolapse – gellhorn – more difficult to fit and remove and more likely to cause trauma
- Supportive rings and new types of rings also useful for large prolapse
Reviewing

• Do they like it
• Any problems
• Discharge, bleeding, bowels, urine, discomfort, sexual activity
• Remove, speculum exam to exclude vaginal or cervical ulceration/erosions
• Review use of estrogen
• Review pessary – consider use of silicone pessary
• If not using estrogen or new fitting review 4 monthly
• If using estrogen and no problems review 6 monthly
• If patient removing ring herself and no problems– review yearly
erosions

- Common when not using estrogen
- Pessary rest
- Treat any infection
- Use or increase estriol if no thrush present
- If thrush use vaginal lubricants until treated.
- Consider smaller or different type of pessary
Bleeding

DO NOT assume PMB is due to ring
Vaginal discharge

- NICE guidelines – over 55 with unexplained discharge should be investigated (ultrasound)
- Pessary can cause discharge – foreign body
- Estrogen cream/ lubricants can cause discharge
- Ulceration/irritation of tissue – discharge/bleeding
- Infection – yeast/bv
- Most older women will have mixed bacterial flora which does not need treating.
- Swabs can be useful if cause of discharge not known
Stuck /Forgotton pessary

- Will probably need referral due to potential risk of trauma and fistulae
- May need to be removed under anaesthetic
- Will need to use estrogen for several weeks before procedure if not already using it
- Use of instillagel before procedure
- Use of saline to ease removal of gellhorn
VAGINAL OPERATIONS FOR PROLAPSE

• Anterior colporrhaphy
• Posterior colporrhapy - High / Low
• Enterocele repair
• Perineorrhaphy
• Amputation of cervix
• Paravaginal repair
• Hysterectomy with or without Colporrhaphy / Perineorrhaphy

• Manchester/
Fothergill’s operation
• Uterus/Cervix
suspension/fixation
• Vaginal vault
suspension/fixation
• Retro-rectal
levatorplasty and post.
anal repair for associated
rectal prolapse