female pelvic organ prolapse

Adelaide gynaecologist and pelvic reconstructive surgeon **Dr Oseka Onuma** explains some of the types and symptoms of pelvic organ prolapse.

Thirty percent of women over the age of 30, the majority of whom will have had one or more children, will suffer from one or more symptoms of pelvic organ prolapse (POP). Many will never have these problems addressed because they are under the impression that their symptoms are 'normal' and all 'part of being a woman'. Some will be too embarrassed to seek help until their symptoms are debilitating and others will be told to persist with pelvic floor exercises in the hope of cure.

The key to providing women who suffer from symptoms of POP with choice is to be able to identify their symptoms and then correlate them with clinical findings. Beyond this, the importance of reassuring the woman that she is not unique and that there are options for improving her quality of life cannot be over-emphasised.

Every organ within the female pelvic floor is subject to stresses – from gravity to the delivery of a baby. Muscle, connective tissue and epithelium can break, tear, stretch and lose their elasticity with functional consequences as a result.

The organs within the female pelvic floor which can be subject to prolapse include the urethra, bladder, uterus, vaginal walls, perineum and labia minora. All can present as a lump or mass that was not previously visible or noted by the woman.

Urethral Prolapse

The urethra can be prolapsed from within or as a result of failure of the extrinsic supports. Both intrinsic and extrinsic support failure can result in urinary stress incontinence. Intrinsic support failure can also produce urinary urgency, the sensation of incomplete voiding with the need to return repeatedly to the toilet, dysuria and postcoital urinary tract infections. Both intrinsic and extrinsic urethral support failure can cause post-micturition dribbling.

Bladder Neck Prolapse

The most common symptom of bladder neck prolapse is stress incontinence.

Bladder Base/Anterior Vaginal Wall Prolapse

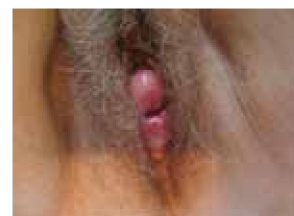
It is practical and convenient to consider bladder base and anterior vaginal wall prolapse together. Essentially most of the bladder base sits on top of the anterior vaginal wall, hence prolapse of one results in prolapse of the other. Bladder base prolapse is in fact a consequence of failure of anterior vaginal wall supports and does not occur in isolation. The bladder can contain diverticulae but these are not prolapses. Consequences of prolapse include stress incontinence, voiding dysfunction, interrupted flow, slow flow, needing to strain in order to empty the bladder, recurrent urinary tract infections, urinary urgency during intercourse and deep dyspareunia.

Anterior vaginal wall prolapse, especially where associated with anterior vaginal wall relaxation (stretching of the vaginal epithelium), can lead to reduced sensation during intercourse and vaginal wind.

Uterine Prolapse

Third to fourth degree uterine prolapse, where the uterus is at the vaginal introitus or external to the body can result in urinary retention. Lesser degrees of prolapse may lead to voiding dysfunction. The prolapse may present as a mass and it is usually the cervix which is palpated by the woman or her partner as a mass within the vagina.

Uterine prolapse may also result in deep dyspareunia, the sensation of 'hitting something' during intercourse. As the uterus descends, the upper part of the bladder base/ anterior vaginal wall may also descend leading to urinary urgency on movement (such as getting up from a sitting position). One of the most common consequences of uterine prolapse is the description of a dragging sensation within the pelvis or a lower backache which is worse when standing or lifting heavy objects.



Uterus presenting at vaginal entrace; Uterine prolapse

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