# Pelvic Organ Prolapse

Pelvic organ prolapse is a medical condition that occurs when the normal support of the vagina is lost, resulting in "sagging" or dropping of the bladder, urethra, cervix and rectum. As the prolapse of the vagina and uterus progresses, women can feel bulging tissue protruding through the opening of the vagina.

**Causes and Risk Factors**

By studying large numbers of women with and without prolapse, researchers and urogynecologists have identified certain risk factors that predispose, cause, promote or worsen pelvic organ prolapse. The strength of our bones, muscles and connective tissue are influenced by our genes and our race. Some women are born with weaker tissues and are therefore at risk to develop prolapse. Caucasian women are more likely than African American women to develop pelvic organ prolapse. Loss of pelvic support can occur when any part of the pelvic floor is injured during vaginal delivery, surgery, pelvic radiation or back and pelvic fractures during falls or motor vehicle accidents. Hysterectomy and other procedures done to treat pelvic organ prolapse also are associated with future development of prolapse. Some other conditions that promote prolapse include: constipation and chronic straining, smoking, chronic coughing and heavy lifting. Obesity, like smoking, is one of the few modifiable risk factors. Women who are obese have a 40 to 75% increased risk of pelvic organ prolapse. Aging, menopause, debilitating nerve and muscle diseases contribute to the deterioration of pelvic floor strength and the development of prolapse.

**Incidence**

We do not know exactly how common pelvic organ prolapse is because research is limited to women who seek health care. It is estimated that nearly 50% of all women between the ages of 50 and 79 have some form of prolapse. The lifetime risk that a woman will have surgery for the correction of prolapse or urinary incontinence in the United States is about 11%. We also know that only one-third of these women will undergo repeat corrective surgery for these conditions. Approximately 300,000 procedures for correction of pelvic organ prolapse are performed each year in the United States. We believe that is just the tip of the iceberg as many women manage their prolapse without surgery.

**Symptoms**

Some loss of support is a very common finding upon physical exam in women, many of whom do not have bothersome symptoms. Those women who are uncomfortable often describe the very first signs as subtle—such as an inability to

keep a tampon inside the vagina, dampness in underwear or discomfort due to dryness during intercourse.

As the prolapse gets worse, some women complain of:

- A bulging, pressure or heavy sensation in the vagina that worsens by the end of the day or during bowel movements
- The feeling that they are "sitting on a ball"
- Needing to push stool out of the rectum by placing their fingers into the vagina during bowel movement
- Difficulty starting to urinate, a weak or spraying stream of urine
- Urinary frequency or the sensation that they are not emptying their bladder well
- The need to lift up the bulging vagina or uterus to start urination
- Urine leakage with intercourse

Types of Prolapse

**Anterior Vaginal Prolapse (also known as cystocele)**
This type of prolapse occurs when the wall between the vagina and the bladder stretches or detaches from its attachment on the pelvic bones. This loss of support allows the bladder to prolapse or fall down into the vagina.

Most women do not have symptoms when the anterior vaginal prolapse is mild. As it progresses outside the opening of the vagina, the prolapsed bladder may not empty well which can lead to urinary frequency, night time voiding, loss of bladder control and recurrent bladder infections. Strengthening pelvic muscles may improve the support to the bladder and neighboring organs and reduce symptoms. In addition, women can get temporary support by wearing a device called a vaginal pessary. It works much like a knee or ankle brace would support a weak joint. When these efforts are inadequate surgery is available to elevate the bladder and other internal organs to their proper position.

**Posterior Vaginal Prolapse (also known as rectocele)**
Weakening and stretching of the back wall of the vagina allows the rectum to bulge into and out of the vagina. Most often, the damage to the back wall of the vagina occurs during vaginal childbirth, although not everyone who has delivered a child vaginally will develop a rectocele. Mild rectoceles rarely cause symptoms. However, straining with constipation puts significant pressure on the weak vaginal wall and can further thin it out. Avoiding constipation may prevent progression and

also reduce symptoms from the rectocele. Some women may find benefit from pelvic floor muscle strengthening and vaginal pessaries. When these low risk interventions are insufficient to relieve symptoms, surgery is performed to reinforce the posterior vaginal wall.

**Uterine Prolapse**

When the supporting ligaments and muscles of the pelvic floor that keep the uterus in the pelvis are damaged, the cervix and uterus descend into and eventually out of the vagina. Often, uterine prolapse is associated with loss of vaginal wall support (cystocele, rectocele). When the cervix protrudes outside the vagina, it can develop ulcers from rubbing on underwear or protective pads. There is a risk that these ulcers will bleed and become infected. As with other forms of prolapse, it is not until the uterine descent is bothersome that treatment is necessary. Women who have uterine prolapse often report pelvic pressure, the need to sit or lay down to relieve the discomfort, a sensation that their insides are falling out, difficulty emptying their bladder and urine leakage. Strengthening the pelvic muscles with Kegel exercises, avoiding heavy lifting, constipation, and weight gain may reduce the risk of progression of uterine descent. Additional treatment options include pessary devices which provide support when worn or surgery.

**Vaginal Prolapse after Hysterectomy**

If a woman has already had a hysterectomy, the very top of the vagina (where the uterus used to be) can become detached from its supporting ligaments. This can results in the tube of the vagina turning inside out. This condition is also known as vaginal "vault" prolapse. Depending upon how extensively the top of the vagina is turning inside out, one or several pelvic organs (such as the bladder, small and large bowel) will prolapse into the protruding bulge. Symptoms depend on which organs prolapse. When the bladder is involved, women report difficulty in starting to urinate, and emptying their bladder well. If it is the bowel then many report the need to push up the vaginal bulge and strain to have a bowel movement. Skin sores may develop if the bulge is rubbing on pads or underwear. A pessary may provide support for the bulge otherwise surgery is recommended.

**Rectal Prolapse**

The rectum is the name given to the last 6 inches of the colon. Like the vagina and uterus, the rectum is normally securely attached to the bony pelvis by ligaments and muscles. Infrequently, the supporting structures stretch or detach from the rectal wall which results in the rectum relapsing through the anus. This looks like red, often donut shaped soft tissue coming through the anus. Early on, it is most often noticed on the toilet after a bowel movement, and can be confused with a

large hemorrhoid. Conditions associated with straining such as chronic constipation or diarrhea, nerve and muscle weakness (paralysis or multiple sclerosis) and advancing age are risk factors for rectal prolapse. Women with rectal prolapse often report the following symptoms: pain during bowel movements, mucus or blood discharge from the protruding tissue, loss of control of bowel movements, and soft, red tissue protruding from the anus. It is very important to be clear in describing where the bulging tissue is coming from (opening of the anus or the vagina) when you seek help as both conditions may be present simultaneously. Treatment for a rectocele and rectal prolapse are different.

Sources

American Urogynecologic Society
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