Female Pelvic Organ Prolapse – The new Gold Standard…

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"Up to 50% of women who have had a vaginal delivery may suffer from prolapse. A variety of urinary, bowel and sexual symptoms may also be associated." [1]

Keeping up with the latest information in each surgical discipline can be difficult for a busy general practitioner. The negative publicity surrounding pelvic surgery and trans-vaginal mesh has led to a serious decline in optimal management of patients with pelvic organ prolapse. The information included below includes alternative procedures to transvaginal mesh and seeks to clarify the surgical management of prolapse identifying the key differences between transvaginal and intra-abdominal mesh.

In 2013, the Cochrane Database of Systematic Reviews Continence Group (an International panel of urogynaecologists) concluded that:

- **"For upper vaginal prolapse (uterine or vault) abdominal sacral colpopexy was associated with a lower rate of recurrent vault prolapse… and painful intercourse than with vaginal sacrospinous colpopexy, and**
- **a higher success rate and lower reoperation rate than high vaginal uterosacral suspension and trans-vaginal polypropylene mesh"**[1]

This was after reviewing 56 randomised controlled trials involving 5,954 women with prolapse.

Suspending the vaginal apex by mesh to the presacral ligaments (sacrocolpopexy) is the most effective and long-lasting correction for utero-vaginal prolapse. In my prior role at the Sydney Women's Endosurgery Centre, we were performing laparoscopic (and now robotic) sacrocolpopexy since 2007 with thousands of women having undergone reconstructive pelvic surgery using minimally invasive techniques. The benefits of this procedure include the previously mentioned lower rate of vault prolapse along with decreased length of stay, decrease post-operative pain and blood loss and increased patient satisfaction. We have presented these findings at national conferences.

The Misconception….

Debate has arisen regarding the use of mesh as a primary procedure. Certainly, after the Royal Commission into the use of trans-vaginal mesh for pelvic organ prolapse in women, prolapse surgery should be approached with caution. Sadly, despite the highly positive surgical outcomes and the thousands of women whose lives have been transformed for the better by a sacrocolpopexy, women are still being denied access due to the misconceptions that the rates of trans-vaginal mesh erosion and associated complications are equivalent to intra-abdominal mesh.

Trans-vaginal mesh kits have been shown to be problematic and should only be used in exceptional circumstances in expert hands. The laparoscopic placement of a sacrocolpopexy (intra-abdominal mesh), is a completely different approach to the same problem with lower rates of complications. The risk of mesh erosion in these circumstances is 1% (significantly lower than trans-vaginal mesh) and there is no experience of the severe problems associated with vaginally placed mesh, such as mesh shrinking, severe pelvic pain or inability to have intercourse.

This procedure functions much like an abdominal hernia repair with mesh, but specifically addressing apical prolapse. Misinformation to the extent that women with pelvic organ prolapse should have vaginal or native tissue surgery as a primary procedure and only when that fails should they be referred for a sacrcolpopexy is not aligned with the latest and best evidence in surgical practice in gynaecology. Patients should, at the very least, be informed of all their options and the agreed upon gold standard of care for apical prolapse (level 1 support).

Please click here to find a 5-minute surgical video that demonstrates this procedure.

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1. Surgical management of pelvic organ prolapse in women (Review) Maher C, Feiner B, Baessler K, Schmid C. Cochrane Database of Systematic Reviews 2013, Issue 4, Art No.: CD 004014

Assessment

History and physical examination should be directed towards exclusion of alternate diagnoses, assessment of dehydration and weight and nutritional status.

Women with mild to moderate symptoms (PUQE <13) don't generally need investigation unless another diagnosis is suspected.

Women severe NVP (PUQE ≥13) should have:

1. Sodium, potassium, chloride, bicarbonate, magnesium, urea and creatinine
2. Bilirubin, Alanine Transaminase (ALT), Aspartate Aminotransferase (AST), Albumin
3. Obstetric ultrasound to exclude multi-fetal or gestational trophoblastic disease
4. Thyroid stimulating hormone (TSH) where indicated.

Abnormalities in the above may prompt referral for inpatient management. Women with significant comorbidities such as Type 1 Diabetes or on essential oral medications should have an early referral for specialist management.

Treatment

Treatment aims will depend on the severity of symptoms being experienced. The primary aim should be to control the symptoms adequately enough to avoid complications that would necessitate inpatient management. It is important to set realistic treatment targets as many women with the most significant symptoms will remain nauseated and continue to vomit well into their second trimester.

Diet

Women will tend to alter their diets to minimise their symptoms and they should be encouraged to eat whatever and whenever they can to maintain nutrition and hydration. Standard recommendations include eating small, more frequent meals that are low in fat.

Most women will present taking a pregnancy multivitamin and these often contain supplements that may contribute to nausea, such Iron, and up to two thirds of women report an improvement when ceasing them. They should be encouraged to continue folic acid and iodine supplement only.

Pharmacological treatments

The use of Pharmacological interventions should be based on history and women should be encouraged to time the use of medication around when symptoms are the worst.

The choice of antiemetic should be individualised, based on the woman's symptoms, previous response to treatment and potential side effects.

If an antiemetic is ineffective at maximal dose, discontinue before commencing an alternate agent. If an antiemetic is partially effective, optimise dosage and timing, and only add additional agents after maximal doses of the first agent have been trialled.

Treatment of NVP and HG may require a range of agents including:

- Antiemetics: herbal/vitamin and prescribed
- Acid suppression
- Laxatives
- Steroids
- Other-supplements.

SOMANZ (Guideline For The Management Of Nausea And Vomiting In Pregnancy And Hyperemesis Gravidarum 2019, Lowe et al) give some example regimes:

Mild-moderate NVP:

- Start with ginger ±B6
- Add oral antihistamine or dopamine antagonist if needed

Moderate-severe NVP or inadequate response to initial treatment:

- Consider IV/IM antihistamine or dopamine antagonist.
- Excessive sedation or inadequate response: add/substitute oral or IV serotonin antagonist at least during daytime
- Add acid suppression therapy

Refractory NVP or HG:

- Consider corticosteroids in addition to other antiemetics
- Intensify acid suppression
- manage/prevent constipation with laxatives.

Psychosocial assessment and support

The symptoms of NVP are very draining and not surprisingly are associated with an increased prevalence of depressive symptoms.

Women experiencing NVP report:

- Reduced quality of life
- Impaired ability to function normally on a daily basis
- Impacts upon relationships
- Financial strain if unable to work.

Women should be screened for symptoms of depression on initial presentation with standardised tools such as the Edinburgh depression scale which should be repeated, especially if symptoms are severe and protracted.

When To Refer

All of Northern Beaches Hospital's Obstetricians and Gynaecologists are happy to offer advice on NVP and assume care where necessary. We have rapid access inpatient services, imaging and other investigations as warranted.

We can admit into our specialist maternity service as required and put in place complex plans to support these women remaining at home.