Genitourinary Prolapse (1 of 6)

This information is for you if you have been told that you have or if you think you may have a prolapse into the vagina. It explains what can cause prolapse and the treatment options. There are various treatments possible for a genitourinary prolapse and the prognosis (outlook) is generally good.

What is a genitourinary prolapse?

A genitourinary (GU) prolapse occurs when the normal support structures are weakened and are no longer effective. The result is that one or more of the pelvic organs (uterus, bladder or rectum) drop down (prolapse). The ‘free space’ available for them to drop down into is the vagina. Sometimes, the prolapse can be so bad that the organ, or organs, can protrude completely outside the vagina.

How common is a GU prolapse?

It is difficult to estimate how many women are affected by GU prolapse because many of them do not visit their doctor for help. Many women with a mild prolapse will not experience any symptoms and treatment is not necessary. However, it does seem that prolapses are very common.

What causes a GU prolapse?

- The most common cause of a GU prolapse is pregnancy and childbirth. During childbirth, there is excessive stretching of the ligaments, nerves and muscles around the birth canal, or vagina. This stretching can damage them and make them weaker and less supportive. It is more likely if you have a particularly large baby, prolonged labour or after an assisted delivery (ventouse or forceps).
- A prolapse is more common as you get older, particularly after the menopause. This is due to a decrease in hormones, which can make the ligaments and muscles less springy and supportive.
- Being overweight can weaken the pelvic floor.
- Constipation, persistent coughing or prolonged heavy lifting can cause a strain to the pelvic floor and can cause a pelvic organ prolapse.
- Smoking can contribute to prolapse due to a persistent cough and damage to the connective tissues.
- It is possible to have a natural tendency to develop prolapses.

Often it is a combination of these factors that results in you having a prolapse.
What are the different types of GU prolapse?

Different types of GU prolapse can occur depending on which pelvic organ, or organs, are bulging into the vagina.

The common types of prolapse are:

- **Anterior wall prolapse (cystocele)** – when the bladder bulges into the front wall of the vagina. This is the most common type of prolapse.

- **Posterior wall prolapse (rectocele)** – when the rectum bulges into the back wall of the vagina.
• Uterine prolapse – when the uterus hangs down into the vagina. Sometimes the uterus may protrude outside the body. This is called a procidentia or third-degree prolapse.

Vault prolapse - after a hysterectomy, the top (or vault) of the vagina may bulge down. This is called a vault prolapse. This happens to 1 in 10 women who have had a hysterectomy to treat their original prolapse.

What are the symptoms of a GU prolapse?

You can have a prolapse and not have any symptoms from it. A doctor may just notice it when you are examined for another reason.

• You may feel a lump in the vagina or a feeling of something dragging or coming down. Symptoms are usually worse after long periods of standing and improve after lying down.
• You may also notice a discharge from the vagina that may be blood stained or smelly.
• Sex may be uncomfortable or painful.
• If your bladder has prolapsed into the vagina, you may:
  * experience the need to pass urine more frequently
  * have difficulty in passing urine or a sensation that your bladder is not emptying fully
  * leak urine when coughing, sneezing, laughing or lifting heavy objects
  * have frequent urinary tract infections (cystitis)
  * have the need to change position on the toilet to enable urine to pass.

If your bowel is affected, you may:

• have difficulty passing stools
• have a feeling your bowels have not emptied fully. You may need to push back the prolapse to allow stools to pass
• have a sudden urge to pass stools
• experience low back pain.
How is a GU prolapse diagnosed?

A prolapse is usually diagnosed by performing a simple vaginal examination. Your doctor will usually insert a speculum (a plastic or metal instrument used to separate the walls of the vagina to show or reach the cervix) into the vagina to see exactly which organ(s) are prolapsing. These examinations are not usually painful.

Will I need any investigations?

You may have had a urine test to check for infection. If you have bladder symptoms, you may be referred for special bladder tests known as urodynamic studies. These tests check on your urine flow and are usually done in a hospital.

What are the treatment options for a GU prolapse?

Firstly, you do not have to have any treatment at all. This is particularly true if you only have a mild prolapse or are not experiencing many symptoms. Your doctor will talk through which options may be suitable for you.

Conservative measures:

- **Lifestyle changes:**
  * losing weight if you are overweight
  * managing a chronic cough if you have one; stopping smoking will help
  * avoiding constipation
  * avoiding heavy lifting.
- Pelvic floor exercises may help to strengthen your pelvic floor muscles. You may be referred to a physiotherapist for a course of treatment.
- Vaginal hormone treatment (oestrogen) – your doctor may recommend vaginal tablets or cream.

Pessary

- A pessary is a good way of supporting a prolapse. You may choose this option if you do not wish to have surgery, are thinking about having children in the future or have a medical condition that makes surgery more risky.
- The pessary is a plastic or silicone device that fits into the vagina to help support the pelvic organs.
- Fitting the correct size of pessary is important and may take more than one attempt.
- Pessaries should be changed or removed, cleaned and reinserted every 6 to 12 months.
- It is possible to have sex with a ring pessary, although you and your partner may occasionally be aware of it.
Surgery
The aim with surgery is to provide a definitive (curative) treatment for GU prolapse. You may want to consider surgery if other options have not adequately helped or if your symptoms are severe. If you plan to have children, you may be recommended to delay surgery until your family is complete.

There are various operations that can be done depending on the type of prolapse that you have. Your gynaecologist can advise you on which operation my suit you best.

The anterior (front) and posterior (rear) walls of the vagina can be reinforced using, either the existing tissues around the vagina. A synthetic mesh or special tape may be used in exceptional circumstances where other methods are likely to fail. Any lax, or stretched, tissue is removed during the surgery. The prolapsed organs can also be stitched or attached to stronger ligaments within the pelvis. A hysterectomy (removal of the uterus) is also a common treatment for uterine prolapse.

How successful is surgery for GU prolapse?
No operation can be guaranteed to cure your prolapse, but most offer a good chance of improving your symptoms.

About 25–30 out of 100 women having surgery for a prolapse will develop another prolapse in the future. There is a higher chance of the prolapse returning if you are overweight, constipated, have a chronic cough or do heavy physical activities.

What are the possible complications of prolapse surgery?
As with all surgery there are possible side effects and risks associated with surgery for GU prolapse.

General risks of all operations:
• With a general anaesthetic, small areas of the lung may collapse, increasing the risk of a chest infection.
• There is a risk of clots in the legs (venous thromboembolism or VTE) with pain and swelling. Rarely, part of this clot may break off and go to the lung, which can be fatal.
• There is a risk of a heart attack because of strain on the heart, or a stroke.

Risks of the GU surgery
• There is a risk of bleeding during the operation, which may result in a blood transfusion being recommended (1.5% or 1-2 patients in every 100 operations). Less than 1 in 100 women (0.8%) need a further operation to stop the bleeding.
• There is a risk of infection (0.5% or 1 in every 200 operations), which may delay wound healing.
• There is a risk of damage to the bowel or bladder which may require another operation to repair it.
Recovery from surgery

Your length of stay in hospital depends on the type of operation you have, though you may need to stay in hospital for a few days.
You should avoid heavy lifting and sexual intercourse for 6 weeks. You should expect full recovery after about 3 months.
You should be able to return to a light job after about 6 weeks. Leave a very heavy or busy job until 12 weeks.
You can drive as soon as you can make an emergency stop without discomfort, generally after 3 weeks, but you must check this with your insurance company, as some of them insist that you should wait for 6 weeks.

Further help

The Continence Foundation
307 Hatton Square, 16 Baldwins Gardens, London ECIN 7RJ
Helpline: 0845 345 0165 (Monday to Friday, 9.30am - 1.00pm)
Web: www.continence-foundation.org.uk
Helps people who have any problem with their bladder or their bowels.

Recovering after your operation

RCOG patient information on Return to Fitness: Recovering Well:
www.rcog.org.uk/recovering-well