

PELVIC ORGAN PROLAPSE

One of the fastest growing segments in medicine is women's health. Over thirty million American women suffer from symptoms of pelvic relaxation and urinary incontinence. Prolapse of pelvic organs such as the bladder, rectum, bowel, and uterus have rapidly increased over the years as the baby boomer generation ages and the trauma of childbearing becomes apparent. Many women are either too shy or too embarrassed to even bring up the problem with their physicians.

The origins of pelvic organ prolapse can usually be traced to the weakening of tissues as a baby passes through the birth canal. This stretching and tearing of tissues gradually worsens over time as gravity and estrogen loss results in the loss of collagen in the vaginal tissues and various muscles, fascia, and ligaments. Babies born today are usually larger than ones born a few generations ago, hence, more trauma. In addition, women today are heavier and have more weight pushing their pelvic organs. It also does not help if one is a smoker due to loss of connective tissue and the chronic cough a smoker often gets. A coughing asthmatic or one with chronic bronchitis is also more prone to prolapse and incontinence. Occasionally, these problems occur in women who have never had children or have had Cesarean Sections. This is explained by one's inherited weakness of supporting structures.

The general symptoms of pelvic organ prolapse include a sensation of fullness or heaviness in the vaginal region. A woman finds a bulge starting to protrude through the vaginal opening. Sometimes the entire vagina or uterus is hanging out between a woman's legs. Others find physical activity difficult because of incontinence that often accompanies the prolapse. It takes a careful examination by the gynecologist or urogynecologist to diagnose precisely if the defect is a cystocele/urethrocele (bladder and urethral prolapse), a rectocele (rectal prolapse into the vagina), an enterocele (small bowel into the vagina), or a uterine prolapse (the uterus descending down the vaginal canal). Diagnosis of pelvic prolapse includes a complete history and physical examination. "Bladder Studies" with a computerized machine are often required to define the diagnosis.

Treatments vary. Bulges that do not cause symptoms can be left alone. Non-surgical treatments also include the use of pessaries. These are Playtex, or rubber devices that are placed inside the vagina to hold back the prolapsing structures. Some women even find the use of a tampon to function in a similar manner. Unfortunately, the well-known Kegel's Exercises have essentially no effect on pelvic organ prolapse but may be helpful for incontinence. Surgery is often needed to repair the weakened tissues that bulge into and out of the vagina. However, surgical repair of the cystocele remains one of the most difficult challenges in female pelvic floor reconstruction. Failure rates of

traditional “anterior colporrhaphy” ranges from 20-40%. New techniques that use biologic tissue or polypropylene mesh have dramatically reduced these failures to less than 10%. Unfortunately, most gynecologist, urologist, and even urogynecologist have not been trained in these newer techniques. Working in the deep pelvis is difficult and harrowing to physicians not trained in laying down tissue or mesh in the repair of these vaginal hernias. The use of tissues, such as human or pig dermis, does have its own risks such as rejection and infection. The use of polypropylene mesh also has added risks of erosion into the vagina or bladder. With improving techniques and technology these risks have been lowered and acceptance of these methods in the United States has been increasing in a dramatic fashion. The Europeans and Australians are about five years ahead of us and they deserve the credits for the changes affecting American urogynecology today.

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