CLINICAL GUIDELINE

This document is intended to guide clinical care without changing the responsibility of the health care team or the patient.
It never replaces clinical judgment and individualized care.

Developed and endorsed by SASOG as part of the BetterGYN® programme

SURGERY FOR PELVIC ORGAN PROLAPSE (POP)

Introduction:

Surgical management for pelvic organ prolapsed is offered to women in whom vaginal pessaries have failed and those who have declined the option of vaginal pessaries. Use of the NICE patient decision aid for uterine and vaginal vault surgery is recommended to promote shared decision-making.

Indication:

The aim is to improve quality of life by restoring the prolapsed pelvic organs to their normal positions. A detailed discussion of alternatives and associated surgical risks, risk of recurrence and use of mesh must precede the procedure.

Types of surgery:

Surgery for anterior compartment prolapse (i.e**. bladder prolapse**) is treated by performing an anterior repair.

Surgery for posterior compartment prolapse (i.e. **rectocoele**) is treated by performing a posterior repair. In both cases an apical suspension procedure such as a sacrospinous fixation may be performed concurrently if applicable.

Sacrocolpopexy (open, laparoscopically, or robotic) is the surgical procedure of choice for **vault prolapse** (Note: the use of mesh must be communicated). A bilateral sacrospinous fixation is also an option.

In women with **uterine prolapse** who do not require future fertility, a vaginal hysterectomy with bilateral sacrospinous fixation; sacrocervicopexy with mesh (abdominal or laparoscopically); or a Manchester repair may be considered. Otherwise, a sacrohysteropexy may be considered. An enterocoele repair is performed mostly vaginally in cases of an **enterocoele.** Obliterative vaginal procedures such as colpocleisis should also be considered.

Surgery is performed either under general anaesthesia or regional/local anaesthesia depending on the type of procedure.

Complications Include:

- Anaesthetic complications
- Injury to pelvic organs during surgery
- Bleeding

- Voiding dysfunction
- Constipation
- New onset urinary incontinence
- Urinary tract infections

What is the success rate?:

Quoted success rates for bladder repair is between 70-90% and between 80-90% for a rectocoele repair. Sacrocolpopexy has a success rate of approximately 90%.

Aftercare:

This depends on the type of surgery performed, In general:

- Avoid heavy lifting and constipation
- Expect a red-brownish discharge for a few days after the procedure. If the bleeding is heavy, call a gynaecologist
- Intercourse is advised about 6 weeks later
- Casual walks and driving may commence about 4 weeks later

Final considerations:

Review patients six months later, and annually thereafter. Ensure that a vaginal examination is performed at each visit especially in cases where mesh has been used, to check for mesh exposure.

Advise patients to consult if there is a recurrence of the prolapse.

References:

1. NICE guideline [NG123]: Urinary incontinence and pelvic organ prolapse in women: management. Published: 2 April 2019 www.nice.org.uk/guidance/ng123
2. Brubaker L, et al. Female Pelvic Medicine & Reconstructive Surgery 2010:16 (1): 9-19.

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