# Pelvic Organ Prolapse :- Ayurvedic & Allopathy view


**Presented By**

**Dr. Umesh R. Lunawat**

**HOD & Professor, PTSR dept.**

**SVAMCH, Chandrapur**

**M.S.(Streerog-Prasutitantra), LL.B.(Sch), Ph.D.(Sch)**

# Displacement of uterus seen in :

- *Antarmukhi Yonivyapad* – Retrodisplacement
- *Mahayoni Yonivyapad* – Uterine Prolape (3rd degree /4th degree)
- *Prasramsini Yonivyapad* – 2nd degree Uterine Prolapse
- *Falini / Andini Yonivyapad* – Cystocele / Rectocele

# Causes :-

- Yonivyapad Samanya Hetu
- Yonivyapad Vishesh Hetu

# Chikitsa:-

- Samanya Chikitsa of Yonivyapad
- Vishesh Chikitsa – As per type of Y.V.
  - Aushadhi Chikitsa
  - Reposition

# Definition :

- **Prolapse:** a slipping forward or down of a part or organ of the body part from its usual position or relations.

- **POP :** Descent of pelvic organs into or through the vaginal canal.

# PELVIC ORGAN PROLAPSE

**ANTERIOR COMPARTMENT PROLAPSE**
Hernia of anterior vaginal wall often associated with descent of the bladder (**cystocele**) .

**POSTERIOR COMPARTMENT PROLAPSE**
Hernia of the posterior vaginal segment often associated with descent of the rectum (**rectocele**) .

**ENTEROCELE**
Hernia of the intestines to or through the vaginal wall

**APICAL COMPARTMENT PROLAPSE**
(uterine prolapse, vaginal vault prolapse)

**PROCIDENTIA**
Hernia of all three compartments through the vaginal introitus.

# PREVALANCE

- One of the most common gynaeological disorder
- 3rd most common cause of gynaecological surgery esp PM
- Lifetime risk for age 80yrs >10%

# SUPPORTS OF PELVIC ORGAN:

# PELVIC ORGAN SUPPORTS

- **ENDOPELVIC CONNECTIVE TISSUE is the FIRST LINE of support**

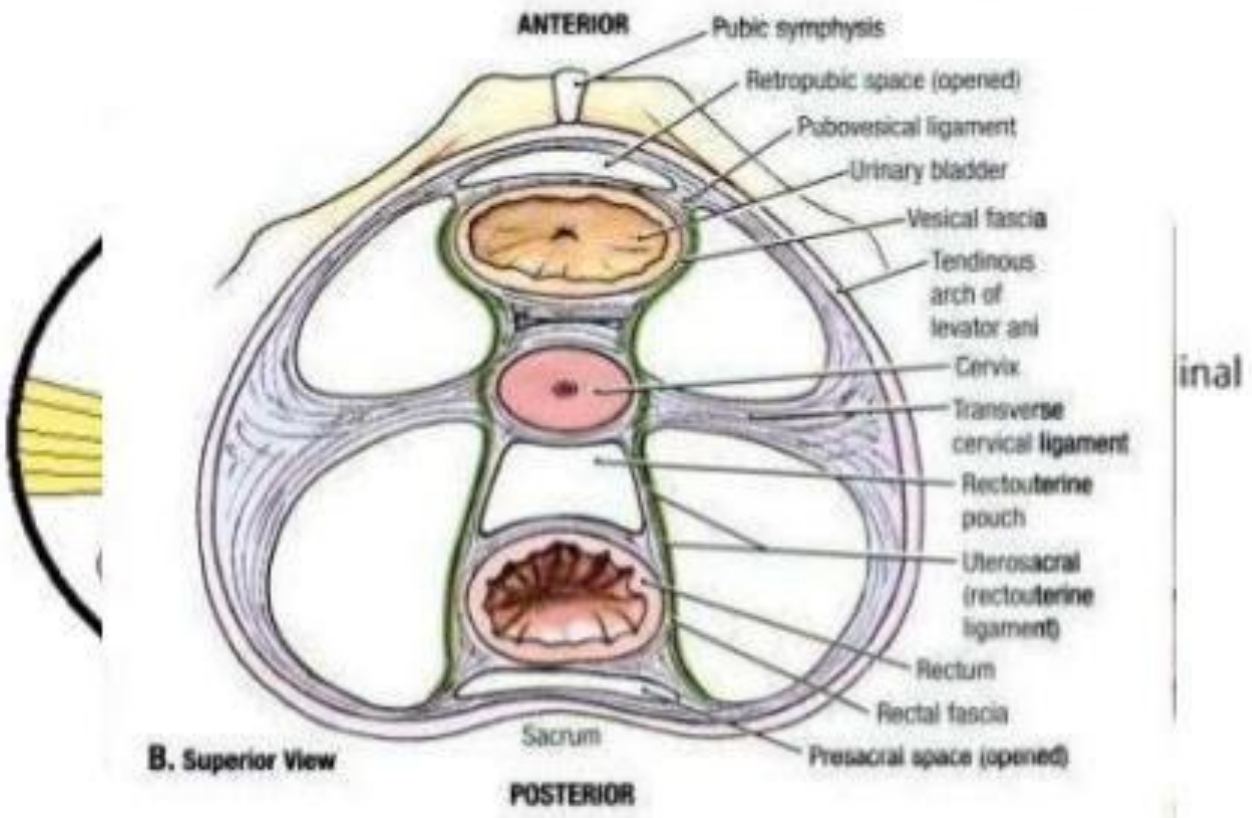
**AND**

- **BUTTRESSED INTIMATELY WITH THE PELVIC DIAPHRAGM**

# DEEP ENDOPELVIC CONNECTIVE TISSUE

- **6 pericervical ligaments**:
  - 2 uterosacral ,
  - 2 cardinal ,
  - 2 pubocervical ligaments
- **1 pericervical ring**
- **2 septa**:
  - Pubocervical septum or fascia &
  - Rectovaginal septum or fascia (fascia of Otto)

# DEEP ENDOPELVIC CONNECTIVE TISSUE



# THE PELVIC DIAPHRAGM

- The **pelvic diaphragm(pelvic floor)** is composed of:

1. **Levator ani muscle**
    i. Iliococcygeus
    ii. Pubococcygeus
2. The **coccygeus** and
3. **Pyriformis**

- This is the most important muscular support of pelvic organs.

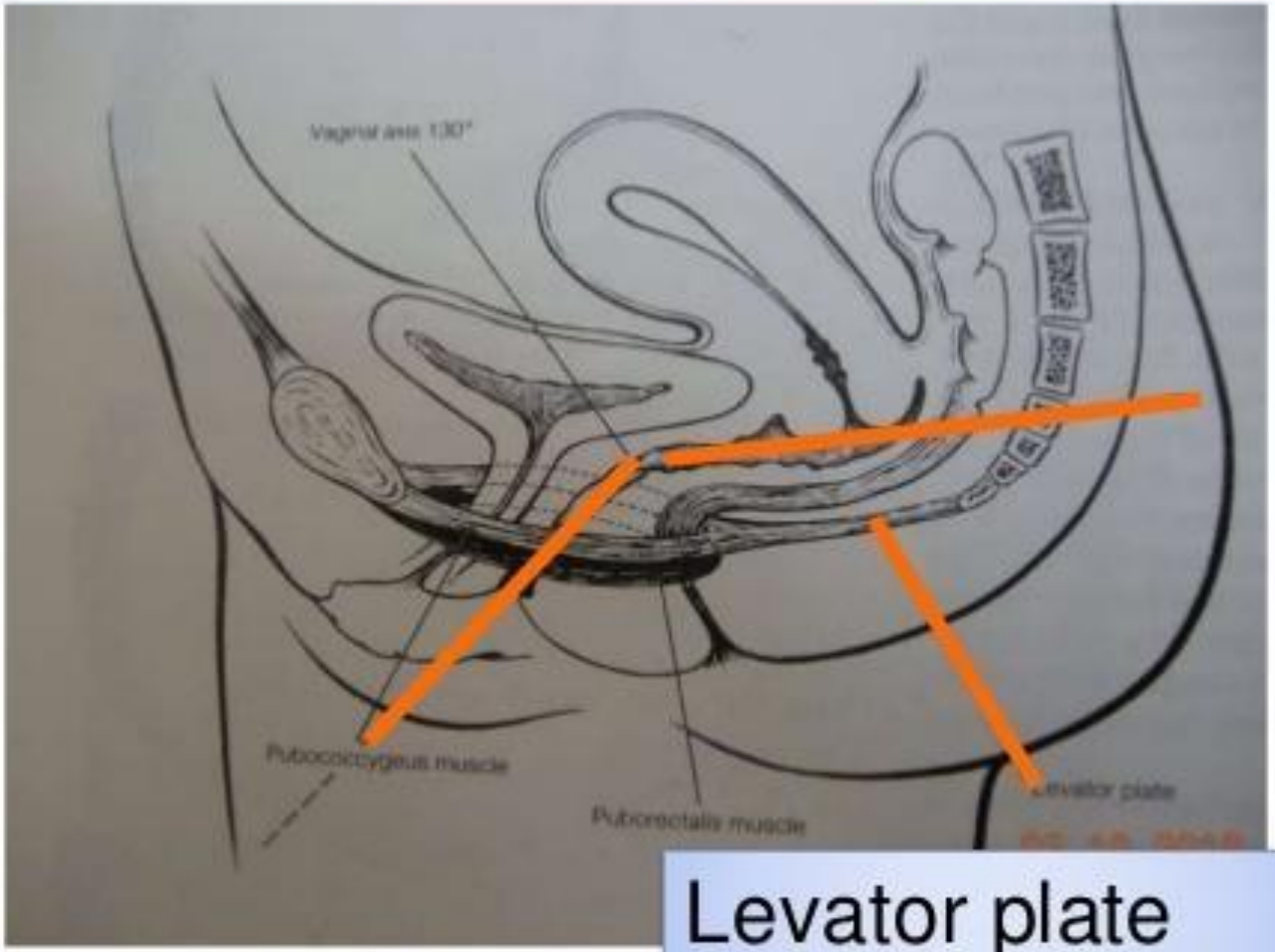
# POSITIONAL SUPPORT OF VAGINA IN NULLIPAROUS WOMAN

The lower one third of the vagina is oriented more vertically,

whereas

the upper two thirds deviate horizontally, thereby maintaining the vaginal axis in an almost horizontal position.

# Normal axis of uterus/vagina and the levator plate




Levator plate

# NEWER CONCEPT OF PELVIC ORGAN SUPPORT

- **De-Lancey's Biomechanical support**

# De-Lancey's Biomechanical support

- De-lancey's level of vaginal support
  - LEVEL I – suspends upper vagina and cervix from pelvic sidewall via the cardinal and the uterosacral ligaments
  - LEVEL II – created by vaginal attachments to arcus tendineus and fascia of levator ani
  - LEVEL III – support is created by the urethropelvic ligaments

De Lancey JOL Clin Ob Gyn 36: 897-909

# MAIN CAUSE OF POP ARE:

**Acquired**

- Levator muscle weakness
- Ligaments injury
- Nerve injury (Pudendal nerve)
- Endopelvic fascial weakness
- Perineal body weakness

**Congenital**

- Inborn weakness of support system.

# RISK FACTORS

- Genetic predisp.
- **Vaginal birth**
- Parity
- Menopause
- **Advancing age**
- Prior pelvic surgery
- Connective tissue dis.

- ↑ IA pressure
- **Obesity**
- Chronic constipation
- ↑ Straining


ACOG 2007

# 3 MOST IMPORTANT ESTABLISHED RF

1. Vaginal delivery
2. Advancing age
3. Obesity

# Staging of POP

# POP QUANTITATIVE SCORING:

| Stage | Description |
|---|---|
| 0 | No descent of Pelvic Organs |
| I | Leading edge of Prolapse remaing≥1cm above the hymenal ring |
| II | Leading edge of Prolapse extends from 1cm above or 1cm below the hymenal ring |
| III | From 1cm beyond the hymenal ring but without complete eversion of vagina |
| IV | Essentially complete eversion of vagina |

**Quantitive grading of POP**
**[ICS, AUGs, SGS 1996]**

# STAGING OF POP

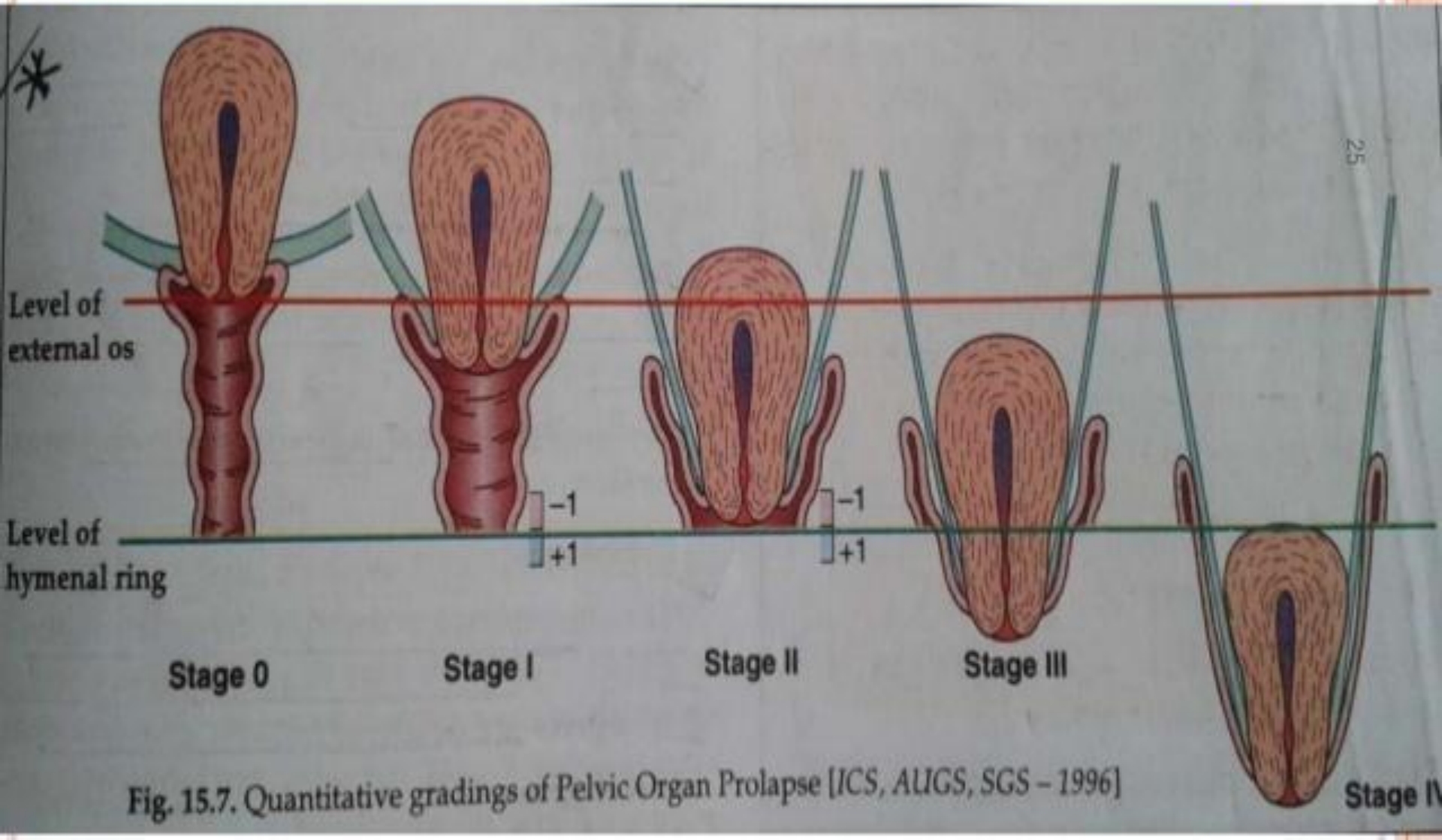



Fig. 15.7. Quantitative gradings of Pelvic Organ Prolapse [*ICS, AUGS, SGS – 1996*]

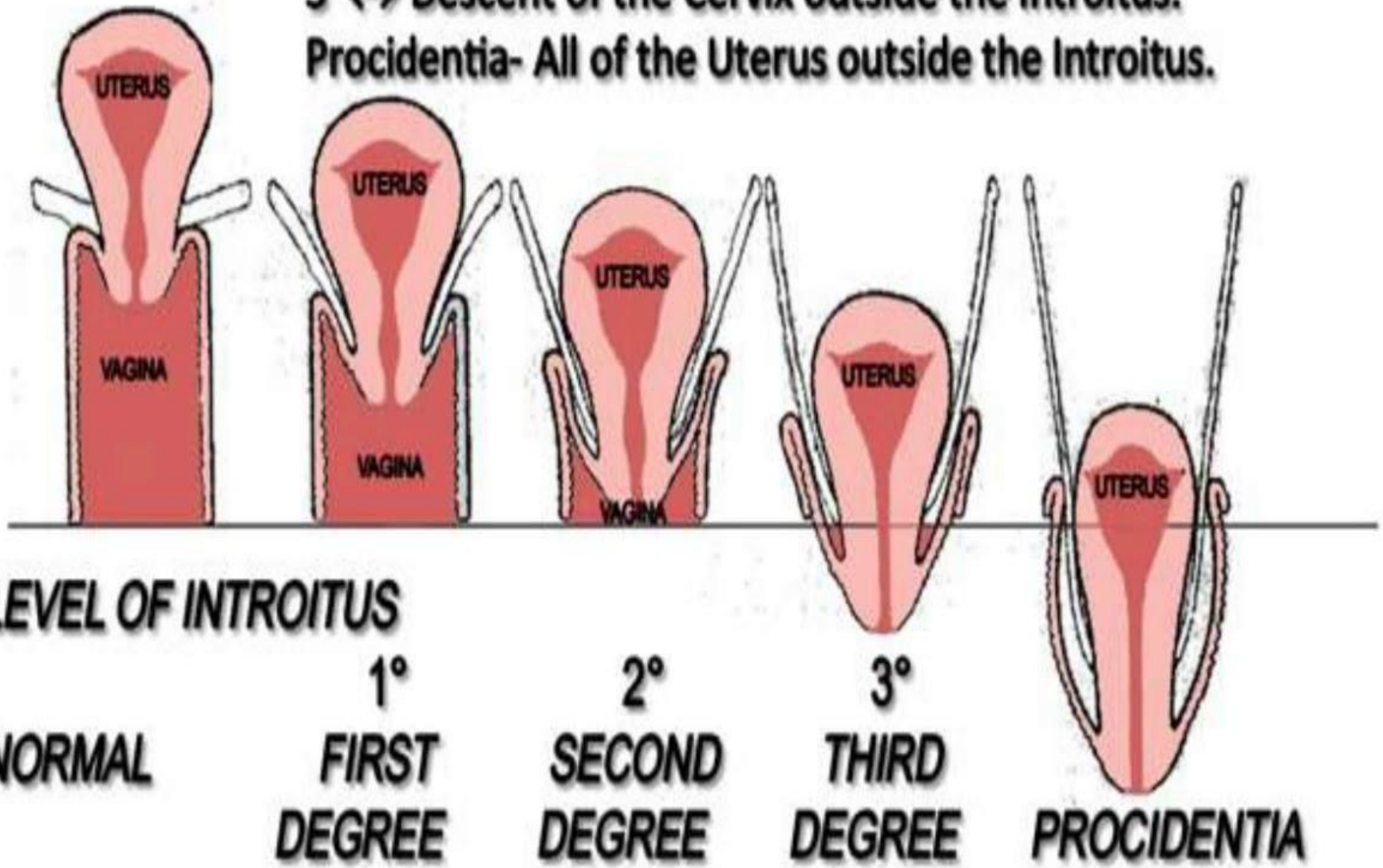
## UTERINE DESCENT:

1°↔ Descent of the Cervix in the Vagina.

2°↔ Descent of the Cervix to the Introitus.

3°↔ Descent of the Cervix outside the Introitus.

Procidentia- All of the Uterus outside the Introitus.



# Clinical Features:

# Clinical Manifestation

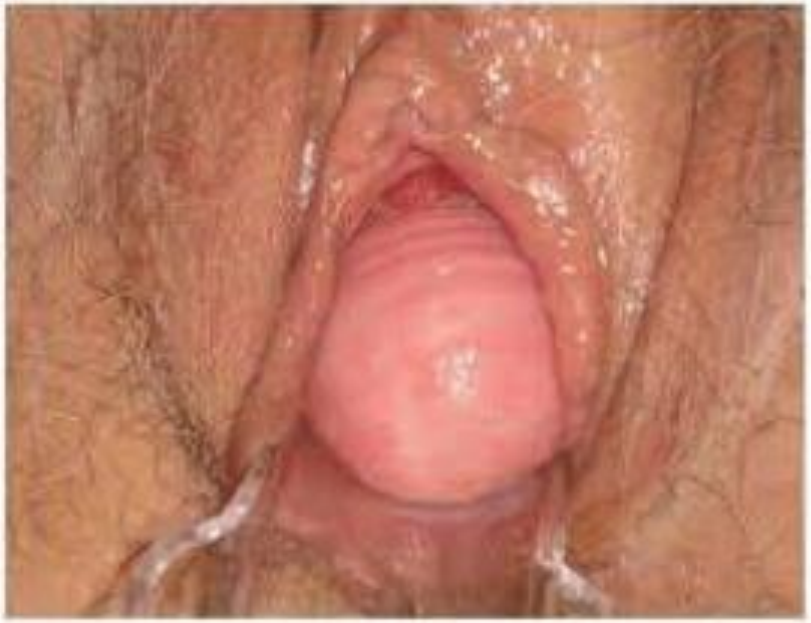
- Feeling like you are sitting on a small ball
- Difficult or painful sexual intercourse
- Frequent urination or a sudden urge to empty the bladder
- Low backache
- Uterus and cervix that stick out through the vaginal opening
- Repeated bladder infections
- Feeling of heaviness or pulling in the pelvis
- Vaginal bleeding
- Increased vaginal discharge

# D/D OF CYSTOCELE

| Gartner duct cyst | Cystocele |
| --- | --- |
| 1. Anterior or antero-lateral | 1. Midline anterior |
| 2. No rugosity | 2. Present |
| 3. Vaginal mucosa is tense & shiny | 3. No |
| 4. Well defined margins | 4. Ill defined margins |
| 5. Not reducible | 5. Reducible |
| 6. No impulse on coughing | 6. Present |
| 7. A metal catheter tip introduced through urethra **fails** to come underneath vaginal mucosa. | 7. Come underneath vaginal mucosa |

## Gartner Duct Cyst

## Cystocele



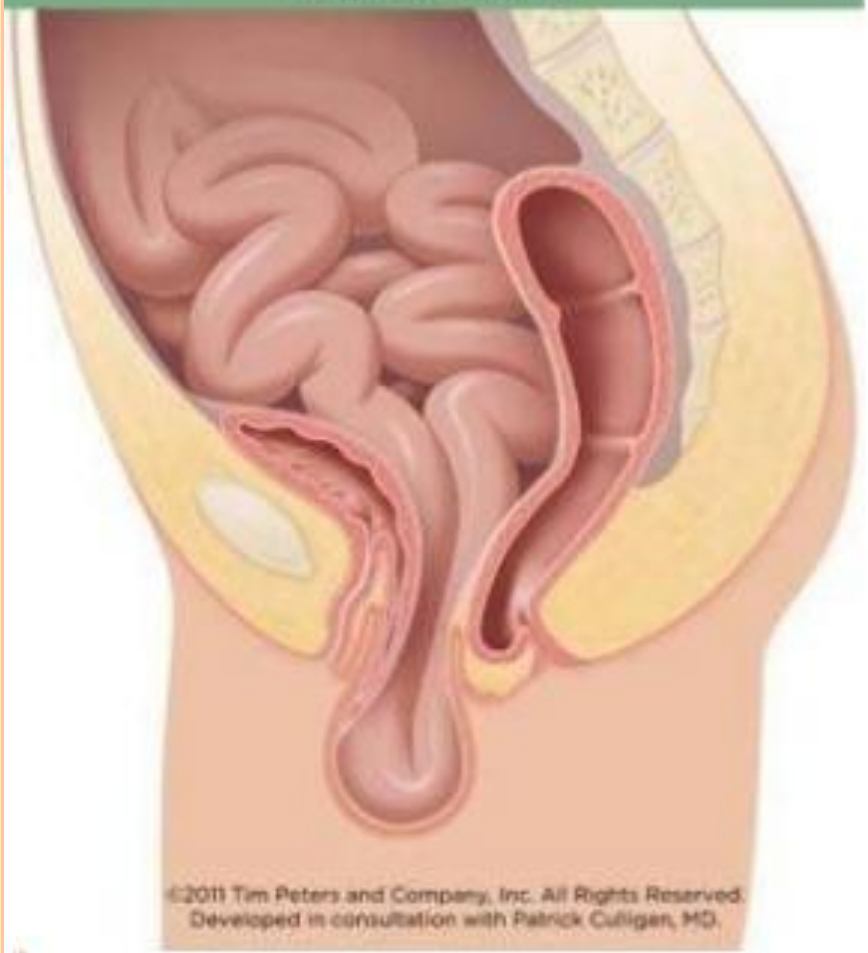
# D/D Uterine prolapse

1. Congenital elongation of cervix
2. Chronic inversion
3. Fibroid polyp

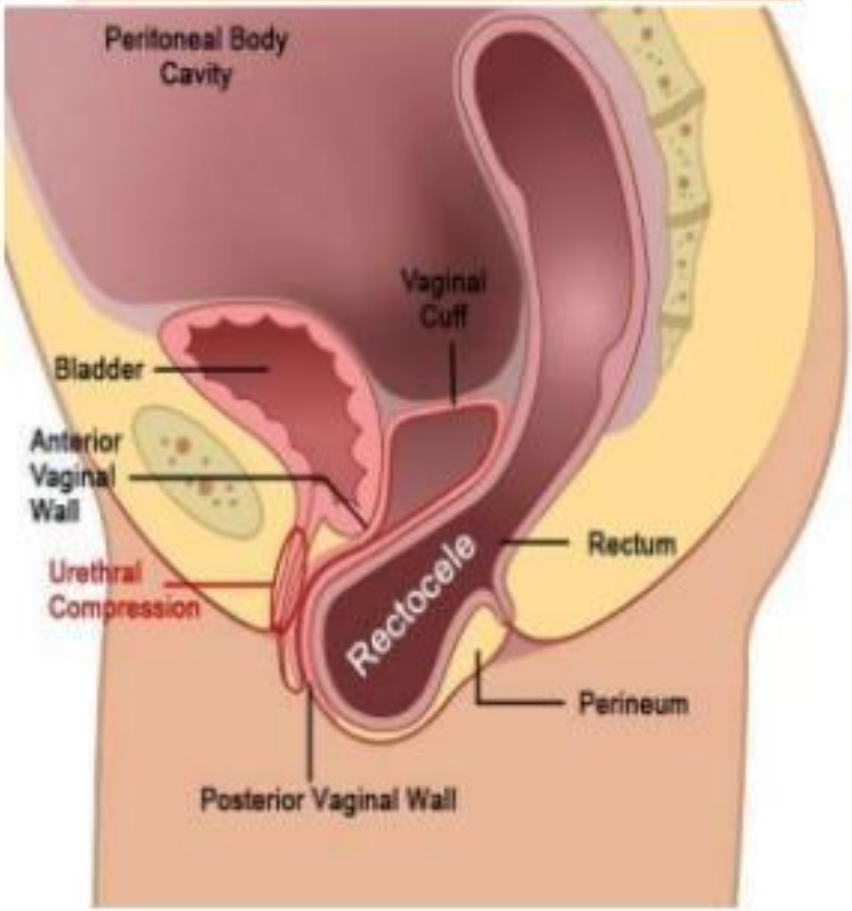
# RECTOCELE VS ENTEROCELE

| | Enterocele | Rectocele |
|---|---|---|
| Situated | High up around the posterior fornix | Low down around introitus |
| Inspection | Visible peristalsis | No |
| Sim's speculum on posterior vaginal wall | Slowly withdraw sim's speculum, enterocele will emerge from high up around the fornices | Visible after full withdrawl of speculum. |
| Per-rectal | Loops of intestine can be felt in between the examining fingers but fingers cant be apposed | Two fingers can be apposed , but no loop felt. |

## Enterocele



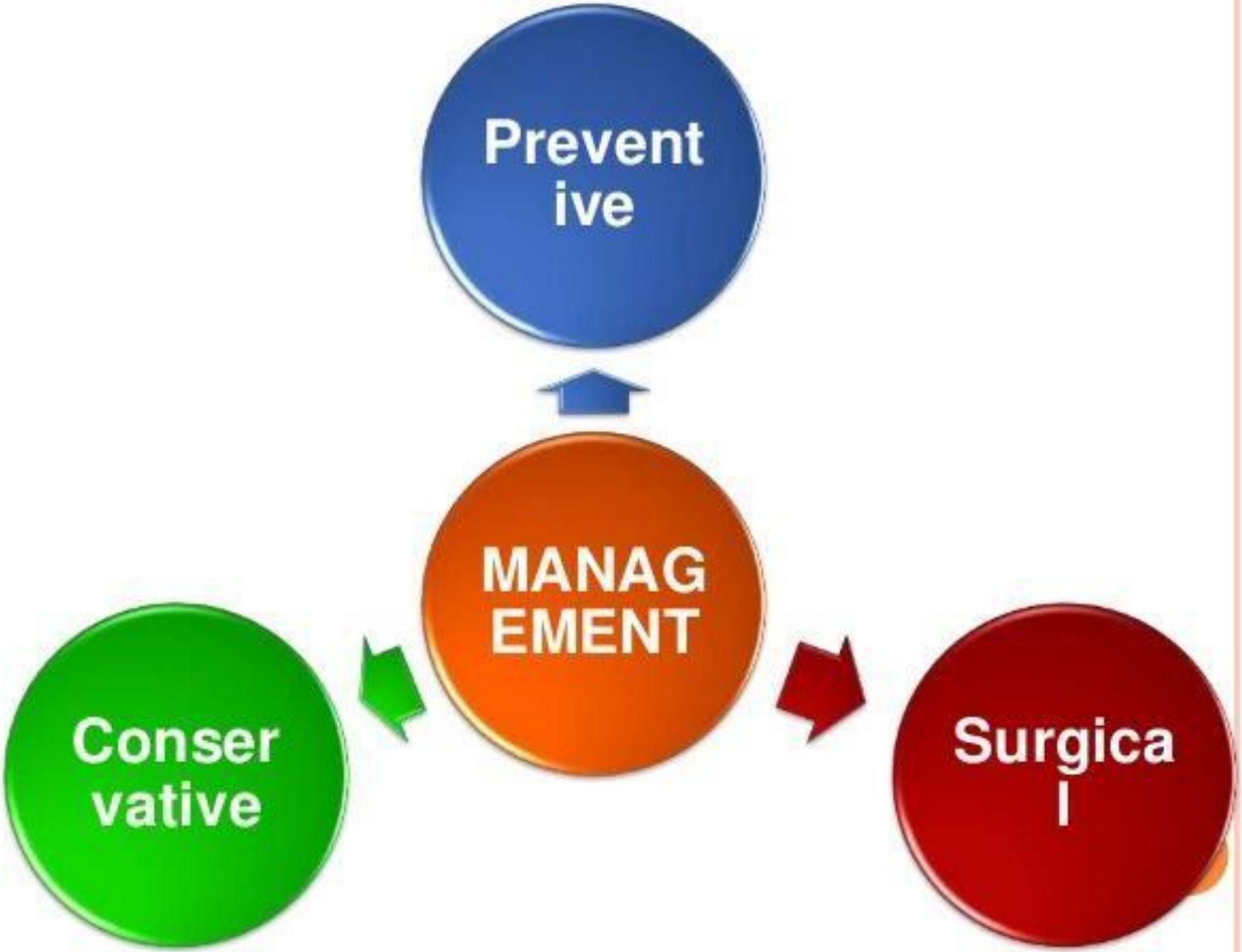

## Rectocele



# Per speculum examination

| Anterior compartment | Middle compartment | Posterior compartment |
| --- | --- | --- |
| • Sim's speculum retracting posterior vaginal wall<br>• Look for cystocele<br>• Lateral cystocele or paravaginal defect<br>• Urethrocele } stress incontinence | • Degree of descent<br>• Ulceration of cervix<br>• Vagina may show keratinisation<br>• Vaginal examination – length of cervix,position and mobility of uterus,any adnexal mass<br>• Cervical cytology | • Sim's speculum retracting anterior vaginal wall<br>• Enterocele – bulge appears from above downwards<br>• Rectal examination – impulse on<br>• tip of finger- enterocele<br>• pulp - rectocele<br>• Bimanual examination- r/o pelvic mass |

# Management:


Prevent ive
MANAG EMENT
Conser vative
Surgica l

# PREVENTIVE

1. **Adequate ANC & intra-natal care**: avoid injury to supporting structure, correct anaemia, avoid prolong labour, carefull instrumental delivery.
2. **Adequate post-natal care**: Early ambulation, Pelvic floor exercise.
3. **Contraceptives**: avoid too many & too frequent birth.
4. **General measures**: avoid strenuous exercise, chronic cough, constipation, heavy wt lifting.

# PELVIC FLOOR EXERCISE

• Squeeze the Pevic floor muscles you sense a "pulling" feeling, those are the right muscles for pelvic exercises. Lie down and spread your legs equivalent to the shoulder wide.
Relax your buttocks and lower stomach, then squeeze the pelvic floor muscles for 5 seconds.

• Lie down, bend your knees and inhale. Contract your pelvic floor muscles, while lifting buttocks. Then, release the contraction, while putting down your shoulders, back and buttocks step by step.

• Put your knees and palms on the ground. While inhaling, bend your back round and squeeze the pelvic floor muscles for 5 seconds. Then, relax while exhaling.

• Sit down and place your feet outward on the ground, then squeeze your pelvic floor muscles for 5 seconds, while rotating your feet medially.

• Sit with your legs crossed and squeeze the pelvic floor muscles slowly.

• Stand firmly and balance your body by using a chair or a table, then lift your heels.

(http://incontrolcentres.com.au/wp-content/uploads/2011/07/kegel-exercise.png)

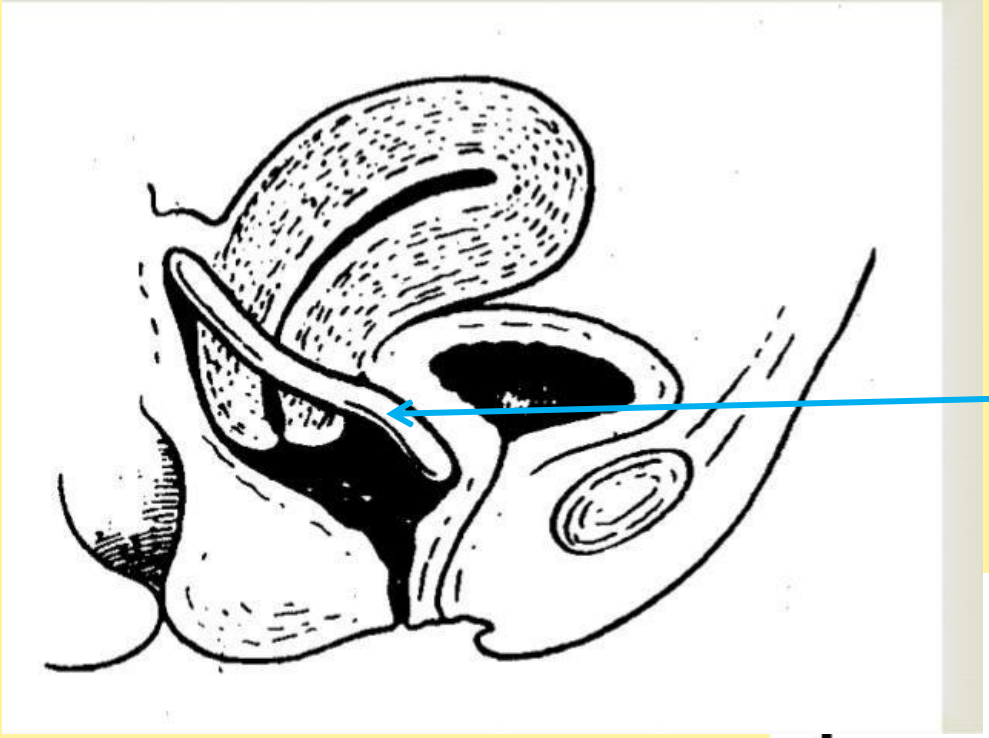
# CONSERVATIVE

**Indications:**

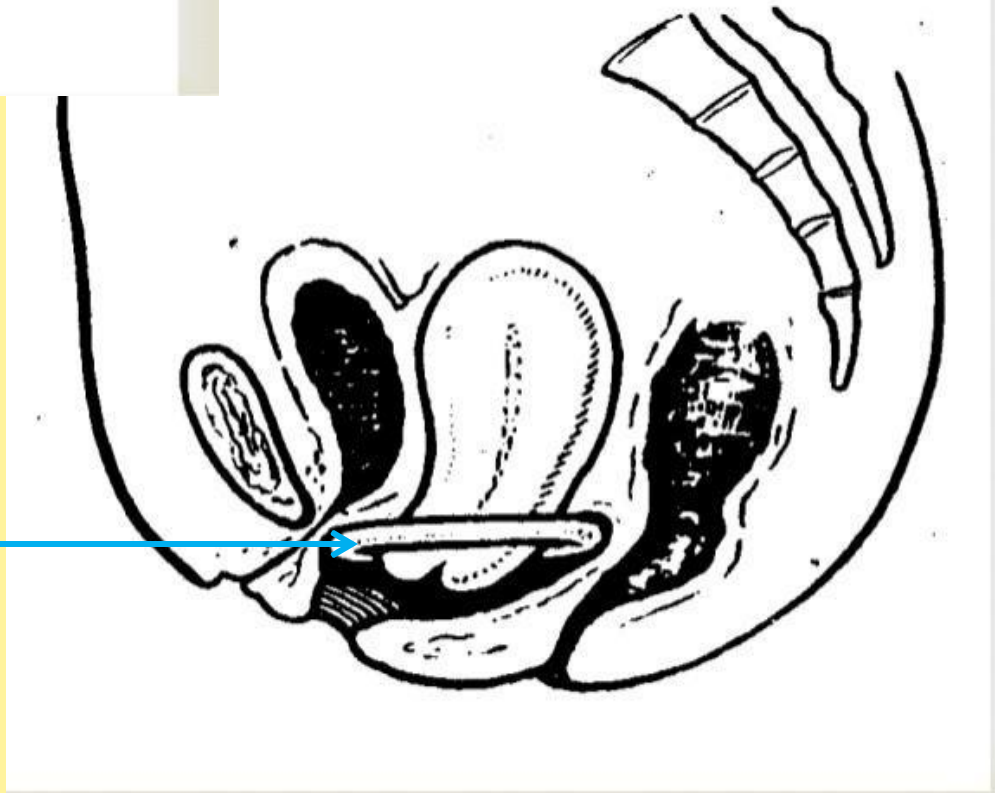
1. Asymptomatic women
2. Mild degree of prolapse
3. POP in early pregnancy

# CONSERVATIVE

1. Improvement of general health
2. **Estrogen replacement therapy** may improve minor degree prolapse in post menopausal women.
3. Pelvic floor exercise- **Kegel's** exercise.
4. **Pessary** treatment.(doughnut, gellhorn,inflatable)

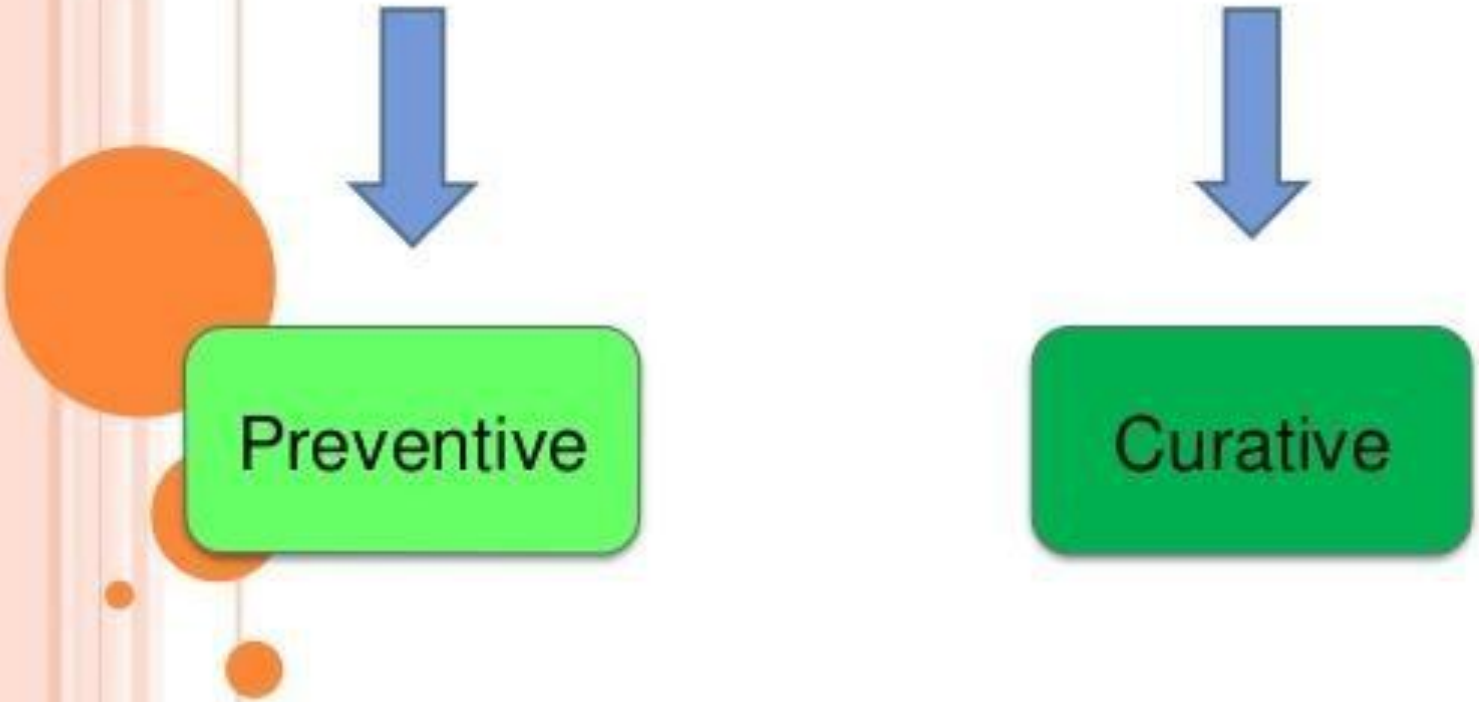


HODGE SMITH PESSARY



RING PESSARY

# SURGICAL MANAGEMENT



# PREVENTIVE SURGERIES TO PREVENT VAULT PROLAPSE AFTER HYSTERECTOMY

1. McCall Culdoplasty
2. Utero-sacral ligament fixation with the vault
3. Sacro-spinous fixation

# Vaginal wall prolapse

| | | |
|---|---|---|
| Anterior vaginal wall | Cystocele, cystourethrocele & paravaginal defect | 1. Anterior colporrhaphy<br>2. Paravaginal defect repair |
| Posterior vaginal wall (lower 2/3rd) | Rectocele | • Colpo-periniorrhaphy |
| Posterior vaginal wall (Upper 1/3rd) | Enterocele | 1. Vaginal repair of enterocele with PFR<br>2. McCall Culdoplasty<br>3. Moscowitch repair |

# UTERO-VAGINAL PROPLAPSE

| | | |
|---|---|---|
| Uterus along with vaginal wall | Utero-vaginal proplapse | 1. Vaginal hysterectomy with PFR |

# Operations for nulliparous prolapse

A) Sling Operations:

a) Abdominal

b) Laparoscopin

B) Transvaginal Sacrospinous fixation

# Aims /advantages of conservative surgery

- To Reliev the symptoms
- To Restore the anatomy to the normal
- To Restore the functions to the normal
- To Prevent recurrence in future
- To Maintain Child bearing potential
- To Maintain Menstrual function

# Conservative surgery

- The operative treatment of prolapse in young women in the childbearing age poses three important problems.
- 1) Repair of prolapse should not in any way, hamper the fertility of the patients.
- 2) The surgery must not hamper the course of normal labour and delivery.
- 3) Most importantly, the repair must not give way and cause recurrence of the prolapse after the childbirth.

# Abdominal sling operations

- Indicated when the ligaments are extremely weak.
- Preserves reproductive function.
- Principle – With a fascial strip /prosthetic material the cervix is fixed to the abdominal wall /sacrum /pelvis.
- Cystocele /Rectocele repair if needed can be done vaginally before or after.
- Enterocele repair can also be done abdominally

# Abdominal sling operations

- Types :-
  - Shirodkar's posterior sling
  - Purandare's anterior sling
  - Khanna's sling
  - Virkud's composite sling
  - Joshi's sling
  - Sacrocervicopexy

# PRINCIPLES OF DIFFERENT METHODS OF SLING OPERATIONS

# Shirodkar's Sling

- Tape is fixed to the posterior aspect of isthmus & sacral promontory.
- Anatomically corrects but Difficult to perform.

# PURANDARE'S CERVICOPEXY

Principle::

Fascial Strips are anchored to the anterior aspect of isthmus.

Advantages : - Easy to perform

- Dynamic Support
- Minimum blood loss

Disadvantages : -

- Alters pelvic anatomy by oblitering UV fold
- Vagina is being pulled forward so increased chances of enterocele formation

# Khanna's sling operation

- Tape is anchored to anterior aspect of isthmus & anterior superior iliac spine.
- Easier to perform and safer.

# Joshi's sling operation

- Anterior surface of uterus at the level of internal os is suspended to the pectineal ligament on both sides with mersilene tape.

# Virkud's composite sling operation

- Tape is anchored from the posterior aspect of isthmus to sacral promontory on the Rt. Side and anterior abdominal wall on the left side.
- Uterosacral ligament is plicated.

# Laparoscopic sling operation

- All types of sling operations can be better performed by laparoscopy.
- Associated vaginal prolapse can also be repaired laparoscopically ( Paravaginal repair)
- Vaginal Anterior /Posterior colporrhaphy can be done before /after laparoscopy

# Sacrocervicopexy

- Sacrocervicopexy is a procedure, in which a graft material is used to suspend the cervix to the anterior longitudinal ligament of the sacrum.
- Sacrocervicopexy can be performed either with uterine preservation or after supracervical hysterectomy.

- Advantages:

- Effective correction of descent
- Anteversion
- no compression on rectum or ureter

# Manchester/Fothergill's operation

- In a women who has completed her family
- With lesser degrees of uterovaginal prolapse with **supra vaginal elongation of cervix**
- but wishes to retain the uterus and opts for a vaginal procedure
- it can be combined with AC , PC or enterocele repair

# Ward mayo's operation

Vaginal Hysterectomy

+

Pelvic Floor Repair

# Le Fort's operation

- **Le Fort's operation** In very elderly women who is medically unfit for a repair procedure and not desirous of vaginal intercourse.

- Colpocleisis
- Obliterative procedure
- Total colpocleisis-total obliteration of cavity
- Partial colpocleisis-some part of vaginal epithelium is left unsutured to provide drainage tract ,useful in women with uterus to drain cervical secretions


Thank you