Genital prolapse occurs when pelvic organs (uterus, bladder, rectum) slip down from their normal anatomical position and either protrude into the vagina or press against the wall of the vagina. The pelvic organs are usually supported by ligaments and the muscles, connective tissue and fascia which are collectively known as the pelvic floor. Weakening of or damage to these support structures allows the pelvic organs to slip down.

The condition is most common in postmenopausal women who have had children, but can also occur in younger women and women who have not had children. It is estimated that at least half the women who have had more than one child have some degree of genital prolapse (although only 10-20% complain of symptoms).

Types of prolapse

There are a number of different types of prolapse. The prolapse of a pelvic organ may occur independently or along with other pelvic organ prolapses. Prolapses are graded according to their severity; first, second or third degree prolapse.

Uterine prolapse: involves the descent of the uterus and cervix down the vaginal canal due to weak or damaged pelvic support structures.

Cystocele: where the tissues supporting the wall between the bladder and vagina weaken, allowing a portion of the bladder to descend and press into the wall of the vagina.

Urethrocele: where the urethra (tube leading from the bladder to the outside of the body) descends and presses into the wall of the vagina. A urethrocele rarely occurs alone, instead usually accompanying a cystocele. The term cystourethrocele is used to refer to the prolapse of both part of the bladder and the urethra.

Rectocele: where the tissues supporting the wall between the vagina and rectum weaken allowing the rectum to descend and press into the wall of the vagina.

Enterocoele: is similar to a rectocele, but instead involves the Pouch of Douglas (area between the uterus and the rectum) descending and pressing into the wall of the vagina.

Vaginal vault prolapse: where the top of the vagina descends in women who have had a hysterectomy.
Symptoms

Symptoms of prolapse differ according to the organs involved and the severity of the prolapse. For example, a woman with a minor prolapse may not have any significant symptoms. Symptoms which are commonly reported include:

- A dragging sensation or feeling that something is falling down - these feelings are especially noticeable when sneezing or coughing, with physical exertion, after long periods of standing or at the end of the day.
- Lump or bulge in the vagina or vaginal entrance.
- Aching discomfort in the pelvic region.
- Urinary problems - the change in position of the bladder that can occur with prolapse may lead to stress incontinence (leaking of urine when coughing, sneezing, laughing), frequent urination, incomplete emptying of the bladder and urinary infections.
- Bowel problems - a rectocele can result in constipation or difficulty in emptying the bowel.
- Dull backache.
- Sexual problems - prolapsed pelvic organs can limit the depth of penetration or make penetration difficult or painful. The loss of pelvic tone can result in decreased sensation and women who have a cystocele/urethrocele may experience a loss of urine during intercourse.
- Psychological - prolapse can result in a loss of self-esteem and a negative self image.

Causes

Prolapse occurs due to a weakness or damage that has occurred to the structures which hold the pelvic organs in place. There are a number of contributing factors including:

Pregnancy and childbirth - The most significant causal factor for prolapse is having children. During pregnancy, hormonal changes and the extra weight and pressure of the baby can contribute to the weakening of the pelvic floor. In addition, a vaginal delivery can result in the supporting pelvic structures being stretched or torn. Damage to the pelvic floor occurs particularly in long second stages of labour, instrumental deliveries (the use of forceps or vacuum extraction) and in the delivery of large infants. Often damage that occurs during pregnancy and childbirth goes unnoticed at the time, with symptoms only developing later in life, following menopause.

Menopause/ageing - The female hormone oestrogen plays an important role in maintaining the strength of the pelvic floor. At menopause, a woman's oestrogen levels decrease and, as a result, the pelvic floor becomes weaker. The lack of oestrogen at this time often exacerbates existing damage that may have occurred as a result of childbirth or other factors. The pelvic support structures also relax due to the natural ageing process.

Pressure in the abdomen - Factors such as obesity, chronic coughing (e.g., coughing associated with smoking or conditions like bronchitis or asthma), the lifting of heavy objects, straining during a bowel movement and the presence of pelvic masses (i.e., fibroid) all place pressure on the pelvic floor. If these pressures are sustained over a long period of time they can weaken the pelvic floor.

Genetic - Some women are born with a weakness in their pelvic floor muscles and so are at a higher risk of prolapse. Congenital weakness explains why some young women and women who have never had children develop a prolapse.

Pelvic surgery - Women who have previously had pelvic organ prolapse surgery may be at increased risk of developing other prolapses.

Diagnosis

If a woman experiences symptoms associated with prolapse she should consult her doctor. The doctor will take her medical history and then perform a vaginal examination. A rectal examination may also be performed if a rectocele or enterocele is suspected. The woman may be asked to cough or push down during the examination as this raises the pressure in the abdomen and pushes any prolapse downwards, making it easier to see or feel. Coughing or pushing down can also help identify any associated stress incontinence. These examinations may also be conducted while the woman is in a standing position. The doctor will also carry out a thorough abdominal examination to ensure there are no other pelvic problems.

Treatment

There are a range of treatment options available for prolapse. The most appropriate treatment will depend upon the type of prolapse or prolapses, their severity, the age of the woman, her state of health and her plans regarding children. Treatments can be divided into three types, conservative, mechanical and surgical. Conservative and mechanical treatments are generally considered for those with a mild prolapse, women whose childbearing is not complete and for those who do not wish to have surgery or who are unsuitable candidates for surgery (e.g., elderly women).

CONSERVATIVE

Lifestyle changes – Simple measures such as losing weight (if overweight), avoid lifting heavy objects and treating conditions like chronic coughing and constipation may alleviate some symptoms. All of these factors place pressure on the pelvic floor so making changes to relieve pressure may be beneficial.

Pelvic floor exercises – These exercises are designed to strengthen the pelvic floor muscles through actively tightening and lifting them at intervals. The exercises can be performed sitting, standing or lying down. As with any exercise program, women should start gradually, building up the number of contractions and perform the exercises regularly. As some women have difficulty locating the appropriate muscles and performing the exercises correctly, seeking assistance from a physiotherapist specialised in pelvic floor to learn the correct techniques is often recommended. Biofeedback, where a sensor is used to measure the pelvic floor muscle contractions can also be used to assist women to perform the exercises. If a woman’s pelvic floor muscles are very weak, electrical stimulation via small electrodes can be performed.

While conservative measures have proven to be effective in the treatment of conditions such as urinary incontinence, there are few quality studies into their use for genital prolapse. More studies are required to determine how beneficial lifestyle changes and pelvic floor exercises are in treating genital prolapse.
MECHANICAL (PESSARIES)
A pessary is a device which is inserted into the upper part of the vagina to provide support to the pelvic structures. The majority of pessaries are made of silicone and come in a number of shapes and sizes. A pessary needs to be inserted by a medical professional and can be kept in place for 3-4 months, after which it will require changing. When inserted properly, a woman should not be able to feel a pessary. Pessaries provide a temporary solution to prolapse symptoms for pregnant women, women who have recently given birth or for women who are awaiting surgery. Pessaries can also be used permanently by women who do not wish to have surgery or who are unsuitable candidates.

SURGICAL
If non-surgical treatment options do not provide sufficient relief from symptoms, surgical repair of the prolapse is recommended. Generally the aim of surgery is to repair and reconstruct the pelvic support structures so that the pelvic organs are restored to their normal positions. Restoring and maintaining bladder, bowel and sexual function are also key factors.

There are a number of different surgical procedures and approaches to treat prolapse. The most appropriate procedure will depend on which organ or organs have descended, the woman’s age, history of previous pelvic surgery and whether she wishes to retain her uterus. In many cases more than one pelvic organ has prolapsed and so a combination of procedures is required. Women are often advised to delay surgery until after their childbearing is complete as future pregnancies can increase the risk of recurrence.

Vaginal repair – involves a repair to the tissues supporting the vaginal wall. There are a few different types of vaginal repair depending on where the weakness is located (centre or sides of the front vaginal wall, back vaginal wall). A vaginal repair is generally performed through the vagina but now are also sometimes performed laparoscopically. A laparoscopic approach involves carrying out the procedure through 2-3 tiny incisions in the abdomen with the assistance of a laparoscope (a telescope like instrument).

Vaginal vault repair – There are two main procedures performed to treat vaginal vault prolapse. The first attaches a piece of synthetic mesh or fascia to the top of the vagina and then anchors it to the sacrum (bone near the spine). It is performed abdominally and laparoscopically. The second procedure involves securing the top of the vagina to a pelvic ligament and is performed through the vagina.

Hysterectomy – This procedure involves the removal of the uterus for the treatment of uterine prolapse. A hysterectomy is often performed in conjunction with other procedures (ie., vaginal repair). A hysterectomy for prolapse is usually done through the vagina but an abdominal approach may be required if the uterus is large. For further information see our hysterectomy factsheet.

Uterine preservation surgery – For women with uterine prolapse who wish to preserve their uterus there are a number of procedures available. Women can ask their doctor about what uterine preservation procedures are currently available.

SURGERY RISKS AND RECOVERY
As with any surgical procedure, the surgical treatment of genital prolapse carries the risks associated with the use of anaesthetics and the possibility of bleeding and infection. Other side effects of prolapse surgery may include injuries to adjacent organs, urinary problems (retention of urine, stress incontinence, urinary infection, urinary urgency), pain during sex (dyspareunia) and the formation of blood clots.

The length of hospital stay and recovery time will depend on the type of procedure performed and whether it was carried out vaginally, abdominally or laparoscopically (3-6 days in hospital if abdominal or vaginal and 2-3 days in hospital if laparoscopic).

After leaving hospital, care should be taken not to place any strain on the repaired area (eg., lifting heavy objects, straining with bowel motion and coughing). A woman will generally be able to return to work in approximately 4-6 weeks. She should wait six weeks before having sexual intercourse.
The recurrence of prolapse following surgery is not uncommon. However, this is often due to the presence of other weaknesses in the pelvic support structures not being evident or not being recognised at the time of surgery. If these weaknesses go unrepaired they can progress, leading to either the recurrence of the original prolapse or the prolapse of other pelvic organs. Further surgical procedures would then be required. It is, therefore, very important that every effort is made to identify and correct all pelvic floor weaknesses during the initial surgery.

Prevention

While women have little control over some contributing factors to prolapse (e.g., having a long labour or giving birth to a large infant), there are a number of other steps they can take to reduce their risk.

- Perform pelvic floor exercises regularly, particularly during pregnancy, after childbirth and into menopause.
- Avoid constipation and straining during a bladder and bowel movement. A physiotherapist or continence nurse can provide information on toileting positions to minimise risk to the pelvic floor and assist in the complete emptying of the bladder and bowel.
- Treat the cause of any chronic cough (if it is smoking-related seek assistance in quitting).
- Maintain a healthy weight.
- Avoid lifting heavy objects frequently. If lifting heavy objects, make sure to bend at the knees and keep the back straight.

For help understanding this fact sheet or further information on genital prolapse call the Health Information Line on 3839 9988 (within Brisbane) or 1800 017 676 (toll free outside Brisbane).

A full list of references is available from Women’s Health or on the website.