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Jerry G. Blaivas, MD
Clinical Professor of Urology, Weill Medical College of Cornell University, and Attending Surgeon, New York Presbyterian Hospital, Lenox Hill Hospital, New York, NY

Mickey M. Karram, MD
Director of Urogynecology, Good Samaritan Hospital, and Professor of Obstetrics and Gynecology, University of Cincinnati School of Medicine, Cincinnati, Ohio

*Drs. Blaivas and Karram co-chair the 6th Annual International Symposium on Female Urology & Urogynecology, to be held April 26–28, 2007, in Las Vegas (**www.urogyn-cme.org**).*

Pelvic surgery controversies

Treating the range of lower-tract symptoms in prolapse

Does prolapse correlate with lower urinary-tract symptoms? What are the testing and treatment options for those symptoms?

Lower urinary tract symptoms are common in women who have pelvic organ prolapse (POP). For some, these symptoms resolve or improve after surgery for prolapse; for others, symptoms remain unchanged or become worse. These clinical pearls can help you decide how to counsel, evaluate, and treat patients who have POP and coexisting lower-tract symptoms.

FAST TRACK

If voiding improves when prolapse is reduced, the prolapse is probably causing urethral obstruction

How are POP and lower-tract symptoms related?

Lower-tract symptoms that result from, or coexist with, POP include urinary incontinence (stress, urge, mixed), irritative symptoms (frequency, urgency, nocturia), and difficulty voiding (hesitancy, weak or intermittent stream). Prolapse can produce lower-tract symptoms by:

- causing urethral obstruction
- dissipating the effects of abdominal pressure during Valsalva voiding, which makes voiding more difficult
- masking sphincteric incontinence.

Paradoxically, many women who have urethral obstruction caused by POP complain of symptoms of an overactive bladder (OAB). Ultimately, however, correlation between POP and lower-tract symptoms is unpredictable and poorly understood. Mild or moderate prolapse may be associated with significant lower-tract symptoms, whereas a very large prolapse may not be associated with any lower-tract symptoms at all.

Is prolapse causing symptoms or masking stress incontinence?

Some clues to answering this question can be obtained from the history:

- If the patient says that she voids better when the prolapse is reduced, prolapse is probably causing urethral obstruction
- If the patient says that she experienced stress incontinence previously but that it has subsided and she now only has difficulty voiding, she probably has occult stress incontinence and, possibly, urethral obstruction.

Occult stress incontinence can be diagnosed during the physical exam by examining the patient with a full bladder and manually reducing prolapse while she coughs or strains. The goal of any reduction maneuver is to simulate the effect of surgical correction of prolapse. You can gain more information by treating her with a well-fitting pessary and then documenting her symptoms (using a pad

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test and bladder diary). A more scientific means of assessment is to perform a urodynamic study while prolapse is reduced by a pessary or vaginal pack.

How is treatment established for lower-tract symptoms?

Prolapse is graded by any of several classifications that are based on the severity and extent of the condition.

Mild degrees of prolapse rarely, if ever, cause urethral obstruction or mask stress incontinence; you can manage lower-tract symptoms in these patients as if they did not have prolapse. Stress incontinence, which is common among these women, can be corrected either in isolation or in conjunction with repair of the prolapse, if such repair is indicated.

More advanced degrees of prolapse, defined as prolapse that extends to or beyond the hymen, are commonly associated with urethral obstruction or occult sphincteric incontinence, or both. This makes it important to diagnose these conditions (by means described earlier) before you intervene surgically to repair the prolapse.

Can surgery for POP affect lower-tract symptoms?

Paradoxically, surgical treatment of prolapse can treat lower-tract symptoms successfully in some patients but cause them in others. How can this be?

- **Surgery works** when prolapse has caused obstruction and the obstruction is relieved when you resupport the pelvic floor
- **Surgery can cause symptoms** when occult stress incontinence goes unrecognized and is unmasked after repair of prolapse without concomitant anti-incontinence surgery
- **De novo irritative symptoms and OAB** can arise secondary to placement of a sling.

Treat all prolapse surgery patients with prophylactic anti-incontinence surgery?

Some experts recommend that practice. But anti-incontinence surgery carries its own risk of complications, so we believe that the need for anti-incontinence surgery should be individualized—based on symptoms, anatomy, the results of diagnostic testing, and the patient's quality-of-life priorities. Of course, when there is pre-existing or occult stress incontinence, you should routinely consider concomitant anti-incontinence surgery.

When is POP surgery effective for OAB symptoms?

The literature is scant on this question. We believe that, in patients who have an advanced degree of prolapse (especially when urethral obstruction has been documented), symptoms of OAB subside most of the time after effective prolapse surgery.

We do not recommend surgery for mild degrees of prolapse or when there is no pre-existing obstruction. ■

***FAST** TRACK*

Before repairing an advanced degree of prolapse, identify any urethral obstruction or occult sphincteric incontinence