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Genitourinary prolapse

Pathophysiology^[1] ^[2]

The pelvic organs are mainly supported by the levator ani muscles and the endopelvic fascia (a connective tissue network connecting the organs to the pelvic muscles and bones).

Genitourinary prolapse occurs when there is descent of one or more of the pelvic organs including the uterus, bladder, rectum, small or large bowel, or vaginal vault. The anterior and/or posterior vaginal walls, the uterus and the vaginal vault can all be affected by this descent. There is resulting protrusion of the vaginal walls and/or the uterus. It is usually accompanied by urinary, bowel, sexual, or local pelvic symptoms.

Studies of risk factors have often been contradictory in their results and much is yet unclear. A multifactorial cause is likely. Weakening of the support structure through direct muscle trauma, neuropathic injury, disruption or stretching is often involved. The orientation and shape of the bones of the pelvis have also been implicated in the pathogenesis of genitourinary prolapse.

Risk factors^[3]

Modifiable

- A body mass index (BMI) over 25 kg/m².
- Smoking.
- Lack of exercise.
- Constipation.
- Diabetes.

Non-modifiable

- Increasing age.
- Family history of urinary incontinence, overactive bladder or faecal incontinence.
- Gynaecological cancer and associated treatments.
- Gynaecological surgery (eg, hysterectomy).
- Fibromyalgia.
- Chronic respiratory disease and cough (chronic cough may increase the risk of faecal incontinence and flatus incontinence).

Related to pregnancy:

- Age over 30 years when having a baby.
- Previous pregnancy.

Related to labour:

- Assisted vaginal birth (forceps or vacuum).
- Occipito-posterior vaginal birth.
- Active second stage of labour taking more than one hour.
- Injury to the anal sphincter during birth.

Genitourinary prolapse epidemiology

- Pelvic organ prolapse is common, occurring in 40-60% of parous women^[4]. The exact incidence of genital prolapse may be difficult to determine, as many women do not seek medical advice.
- A woman's lifetime risk of surgery for pelvic organ prolapse is 12-19%^[5].
- 1 in 12 women in the community in the UK report symptoms of pelvic organ prolapse^[6].
- In the UK, pelvic organ prolapse accounts for 20% of women waiting for major gynaecological surgery and is a leading indication for hysterectomy in postmenopausal women^[7].

- Prolapse of the anterior vaginal wall is the most common type.

Types of genitourinary prolapse

Prolapse can occur in the anterior, middle, or posterior compartment of the pelvis.

Anterior compartment prolapse

- **Urethrocele:** prolapse of the urethra into the vagina. Frequently associated with urinary stress incontinence; other symptoms are infrequent.
- **Cystocele:** prolapse of the bladder into the vagina. An isolated cystocele rarely causes incontinence and usually leads to few or no symptoms. However, a large cystocele may cause increased urinary frequency, frequent urinary infections and a pressure sensation or mass at the introitus.
- **Cystourethrocele:** prolapse of both urethra and bladder.

Middle compartment prolapse

- **Uterine prolapse:** descent of the uterus into the vagina.
- **Vaginal vault prolapse:** descent of the vaginal vault post-hysterectomy. Often associated with cystocele, rectocele and enterocele. With complete inversion, the urethra, bladder, and distal ureters may be included, resulting in varying degrees of retention and distal ureteric obstruction.
- **Enterocele:** herniation of the pouch of Douglas (including small intestine/omentum) into the vagina. Small enteroceles are usually asymptomatic. Can occur following pelvic surgery. The neck of the hernial sac is usually sufficiently wide to make strangulation very rare. Can be difficult to differentiate clinically from rectocele but a cough impulse can be felt in enterocele on combined rectal and vaginal examination.

Posterior compartment prolapse

- **Rectocele:** prolapse of the rectum into the vagina.

Cystourethrocele is the most common type of prolapse, followed by uterine prolapse and then rectocele.

Classification of genitourinary prolapse^[8]

There are several classifications or grading systems in use.

The Pelvic Organ Prolapse Quantification (POP-Q) system was devised by the International Continence Society. It is based on the position of the most distal portion of the prolapse during straining:

- Stage 0: no prolapse.
- Stage 1: more than 1 cm above the hymen.
- Stage 2: within 1 cm proximal or distal to the plane of the hymen.
- Stage 3: more than 1 cm below the plane of the hymen but protrudes no further than 2 cm less than the total length of the vagina.
- Stage 4: there is complete eversion of the vagina.

The degree of uterine descent can also be graded by the Baden-Walker or Beecham uterine prolapse classification system:

- 1st degree: cervix visible when the perineum is depressed – prolapse is contained within the vagina.
- 2nd degree: cervix prolapsed through the introitus with the fundus remaining in the pelvis.
- 3rd degree: procidentia (complete prolapse) – entire uterus is outside the introitus.

Symptoms of genitourinary prolapse

- Mild genital prolapse may be asymptomatic and an incidental finding. However, in other women, symptoms can severely affect their quality of life.
- Symptoms are related to the site and type of prolapse.
- Vaginal/general symptoms can be common to all types of prolapse.

Vaginal/general symptoms

- Sensation of pressure, fullness or heaviness.
- Sensation of a bulge/protrusion or 'something coming down'.
- Seeing or feeling a bulge/protrusion.
- Difficulty retaining tampons.
- Spotting (in the presence of ulceration of the prolapse).

Urinary symptoms

- Incontinence.
- Frequency.
- Urgency.
- Feeling of incomplete bladder emptying.
- Weak or prolonged urinary stream.
- The need to reduce the prolapse manually before voiding.
- The need to change position to start or complete voiding.

Coital difficulty

- Dyspareunia.
- Loss of vaginal sensation.
- Vaginal flatus.
- Loss of arousal.
- Change in body image.

Bowel symptoms

- Constipation/straining.
- Urgency of stool.
- Incontinence of flatus or stool.

- Incomplete evacuation.
- The need to apply digital pressure to the perineum or posterior vaginal wall to enable defecation (splinting).
- Digital evacuation necessary in order to pass a stool.

Examination^[3]

- Thorough history taking is needed to determine the patient's main symptoms and the effect of these on their daily life. In addition to presenting symptoms, ask about coital difficulty, and if the woman has recently given birth, enquire about any symptoms of pelvic floor dysfunction during routine postnatal care, in hospital or in the community.
- For women who are taking multiple medications, conduct a medication review.
- Assessment in primary care may require involvement of physiotherapists, bladder and bowel team members, and continence advisors.
- A focused examination may be required to exclude other causes of the symptoms - eg:
 - Pelvic masses.
 - Neurological disease.
 - Urinary tract infection.
 - Adverse effects of medication.
 - Diabetes.
 - Cancer.
 - Fistula.
 - Inflammatory bowel or bladder conditions.
 - Endometriosis.
 - Mobility and cognitive impairment.

- Examine the patient with them in both a standing and a left lateral position if possible.
- Ask the woman to strain, and observe both whilst standing and supine.
- Use a Sims' speculum inserted along the posterior vaginal wall to assess the anterior wall and vaginal vault and vice versa. Ask the patient to strain.
- A bivalve speculum can also be used to identify the cervix or vaginal vault. Ask the patient to strain, and slowly remove the speculum. Look for the degree of descent of the vaginal apex.
- Determine the parts of the vagina (anterior, posterior or apical) that the prolapse affects. Determine the degree of prolapse.
- Ulceration and hypertrophy of the cervix or vaginal mucosa with concomitant bleeding may be seen in women with prolapse that protrudes beyond the hymen.
- A rectal examination can be helpful if there are bowel symptoms.

Investigations^[5]

- Diagnosis is usually clinical and based on history and examination.
- If there are urinary symptoms consider the following:
 - Urinalysis ± a midstream specimen of urine (MSU).
 - Post-void residual urine volume testing using a catheter or bladder ultrasound scan.
 - Urodynamic investigations.
 - Urea and creatinine.
 - Renal ultrasound scan.

- If there are bowel symptoms consider the following:
 - Anal manometry.
 - Defecography.
 - Endo-anal ultrasound scan (to look for an anal sphincter defect if faecal incontinence is present).
- Occasionally ultrasound or MRI scans may be helpful.

Genitourinary prolapse treatment and management^[9]

Treatment is not necessary if the genitourinary prolapse is mild and/or asymptomatic.

The current management options for women with symptomatic genitourinary prolapse are:

- Conservative. These measures are particularly helpful for women who:
 - Have mild prolapse.
 - Want to have further pregnancies.
 - Are frail or elderly.
 - Have a high anaesthetic risk.
 - Do not wish to have surgery.
- Vaginal pessary insertion.
- Surgery. (However, the risks of surgery for some, even for advanced prolapse, may not be warranted.)

Conservative^[3]

A community-based multi-disciplinary team is best placed to manage women who present with pelvic floor dysfunction. Such a team should have expertise in assessment, identifying risk factors and assisting women in managing their condition and understanding the options available.

Options available include:

- **Lifestyle modification:** consider giving advice on lifestyle modifications such as weight loss (if the BMI is greater than 30), minimising heavy lifting and preventing or treating constipation if relevant. Motivation and encouragement should be provided and referral to a weight loss support service should be considered. Do not wait for the woman to lose weight, however, before discussing other pelvic floor dysfunction options.
- **Diet:** for all women with pelvic floor dysfunction:
 - Explain how a balanced diet and appropriate fluid intake can improve stool consistency, which can help with their symptoms.
 - Advise them to follow guidance from the National Institute for Health and Care Excellence (NICE) on maintaining healthy bowel habits (including for women aged under 18 or with symptoms other than faecal incontinence) ^[10] .
- **Caffeine and fluids:** advise women with overactive bladder or urinary incontinence associated with pelvic floor dysfunction to:
 - Reduce their caffeine intake.
 - Modify their fluid intake (increasing if it is too low, decreasing if it is too high).
- **Physical activity:** women doing supervised pelvic floor muscle training who want to be physically active should be advised that supervised exercise (for example, yoga) may help with their symptoms. Women with pelvic floor dysfunction should however be advised that there is no evidence that unsupervised physical activity (such as walking or swimming) will improve or worsen their symptoms.

- **Pelvic floor muscle exercises:**
 - Pelvic organ prolapse – for women with symptomatic pelvic organ prolapse that does not extend greater than 1 cm beyond the hymen upon straining, consider a programme of supervised pelvic floor muscle training for at least four months.
 - Stress urinary incontinence or mixed urinary incontinence – offer a programme of supervised pelvic floor muscle training for at least three months with stress urinary incontinence or mixed urinary incontinence (including pregnant women).
 - Faecal incontinence with coexisting pelvic organ prolapse – consider a programme of supervised pelvic floor muscle training for at least four months for women with faecal incontinence and coexisting pelvic organ prolapse.
 - Supplemental training – consider supplementing pelvic floor muscle training with biofeedback techniques, electrical stimulation or vaginal cones.

Vaginal pessaries

- **Intravaginal devices:** consider a trial of intravaginal devices for women with urinary incontinence, only if other non-surgical options have been unsuccessful.
- **Vaginal oestrogen creams:** consider vaginal oestrogen for women who have signs of [vaginal atrophy](#).
- **An oestrogen-releasing ring:** this may be considered for women who have physical or cognitive problems, making use of vaginal oestrogen pessaries or creams difficult.

Consider pessaries for women who have symptomatic pelvic organ prolapse. Before starting treatment with a pessary, discuss with the woman the pros and cons (eg, that it may not improve urinary and bowel symptoms) and that the prolapse will return when the pessary is removed. Also advise that reducing the prolapse with the pessary may cause new stress urinary incontinence.

Vaginal pessary insertion

- May provide a good alternative to surgery alone or in combination with pelvic muscle exercises.
- Inserted into the vagina to reduce the prolapse, provide support and relieve pressure on the bladder and bowel.
- Made of silicone or plastic. A ring pessary is usually the first choice.
- Pessaries are effective:
 - For short-term relief of prolapse prior to surgery.
 - In the long term if surgery is not wanted or is contra-indicated.
- Consider referring the patient to a specialist urogynaecology service if expertise is not available within primary care.
- A Cochrane review was not very convincing. The authors concluded that pessaries in addition to pelvic floor training probably improve women's pelvic organ prolapse symptoms and prolapse-specific quality of life. However, there may be an increased risk of adverse events with pessaries compared to pelvic floor training, and more research was needed ^[11].
- Consider treating vaginal atrophy before fitting a pessary.
- Make the patient aware that:
 - More than one pessary fitting may be necessary.
 - The pessary may have an effect on sexual intercourse. If one type does not suit, another may be tried. Another option is to remove the pessary before intercourse and replace it afterwards.
 - Complications may include bleeding, discharge, difficulty removing the pessary and expulsion.
 - The pessary should be removed every six months to avoid complications.

- Fitting a pessary:
 - Ensure the patient's bladder and bowel are empty.
 - Perform a bimanual examination and estimate the size of the vagina.
 - Getting the size right may involve a degree of trial and error, but one option is to start with a size just below the distance in cm between the urethral meatus and anus measured on Valsalva ^[1].
 - The aim is to fit the largest pessary that does not cause discomfort.
 - The pessary fits well if a finger can be swept between the pessary and the walls of the vagina.
 - Ask the patient to walk around, bend and micturate to ensure that the pessary is retained.
- Offer six-monthly follow-up appointments to women with physical or cognitive difficulties which make pessary removal difficult.
- Complications: vaginal discharge and odour, vesicovaginal and rectovaginal fistulas, faecal impaction, hydronephrosis, urosepsis. These tend to occur in women who are not regularly followed up.

Surgery^[9]

Indications for referral^[1] :

- Failure of conservative treatment.
- Presence of voiding problems or obstructed defecation.
- Recurrence of prolapse after surgery.
- Ulceration.
- Irreducible prolapse.
- The woman prefers surgical treatment.

Goals of surgery are to restore anatomy, improve symptoms and return bowel, bladder and sexual function to normal. Surgery can be very effective but a combination of procedures may be required and the requirement for re-operation is common (29% in all, 13% within five years). The choice of procedure will depend on whether the woman is sexually active, whether her family is complete, her general fitness, whether she has had a hysterectomy in the past and the nature of the prolapse. Surgery may be by the abdominal route, or vaginal. 80-90% of procedures are done by the vaginal route.

Prior to referral, a discussion with the woman should take place so that she is able to make an informed choice. A patient decision aid is available within online NICE guidance to facilitate joint decision making^[9]. If the woman's choice is not available from the consulting surgeon, refer to an alternative surgeon.

The discussion should cover:

- The different options for treatment, including no treatment or continuance of non-surgical treatment.
- Complications of the various types of surgery (eg, changes in urine, bowel or sexual function).
- Uncertainty about long-term effects.
- Differences in anaesthesia, lengths of stay, incision sites and expected recovery.
- The role of intraoperative assessments in deciding the most appropriate procedure.
- The risk of postoperative urinary incontinence (which may require further treatment) in women undergoing surgery for apical or anterior prolapse.

Women who do not have urinary incontinence but may be at risk should not be referred for prolapse repair simply as a preventative measure.

Mesh repair

Surgery may use a mesh or not. Use of mesh is currently the topic of much controversy, study and potentially litigation. There are many types of mesh used, including biological grafts, absorbable synthetic mesh and non-absorbable synthetic mesh.

There are concerns about the complications and long-term potential problems with mesh repairs. Vaginal mesh extrusion and erosion are the most common complications, presenting with vaginal bleeding, pelvic pain, dyspareunia, or bowel or bladder dysfunction.

Important information

NICE states that current evidence on the safety of transvaginal mesh repair of anterior or posterior vaginal wall prolapse shows there are serious but well-recognised safety concerns. Evidence of long-term efficacy is inadequate in quality and quantity. Therefore, this procedure should only be used in the context of research ^[12] .

Current NICE guidance states that if other types of mesh surgery is to take place:

- The woman should be informed of the type of mesh that is to be used and whether or not it is permanent.
- Written information should be given to the woman about the implant, including its name, manufacturer, date of insertion, and the implanting surgeon's name and contact details.
- The details of the procedure and its subsequent short- and long-term outcomes should be recorded in a national register (details of how to do this are available within the guidance).

Surgery for bladder/urethral prolapse

- **Anterior colporrhaphy:** involves central plication of the fibromuscular layer of the anterior vaginal wall. Mesh should not be used. It is performed transvaginally. Intraoperative complications are uncommon but haemorrhage, haematoma and cystotomy may occur.

- **Colposuspension:** performed for urethral sphincter incontinence associated with a cystourethrocele (open or laparoscopic). The paravaginal fascia on either side of the bladder neck and the base of the bladder are approximated to the pelvic side wall by sutures placed through the ipsilateral iliopectineal ligament.

Surgery for uterine prolapse

- **Hysterectomy:** a vaginal hysterectomy has the advantage that no abdominal incision is needed, thereby reducing pain and hospital stay. This can be combined with anterior or posterior colporrhaphy.
- **Open abdominal or laparoscopic sacrohysteropexy:** this can be performed if the woman wishes to retain her uterus. The uterus is attached to the anterior longitudinal ligament over the sacrum. Mesh is used to hold the uterus in place subject to the latest NICE guidance on mesh surgery (see above).
- **Sacrospinous fixation:** unilateral or bilateral fixation of the uterus to the sacrospinous ligament. Performed via vaginal route. This has a lower success rate than sacrohysteropexy. There is risk of injury to the pudendal nerve and vessels and the sciatic nerve.

Surgery for vault prolapse^[13]

- **Sacrospinous fixation:** unilateral or bilateral fixation of the vault to the sacrospinous ligament. Performed via vaginal route. There is risk of injury to the pudendal nerve and vessels and the sciatic nerve. This has a higher failure rate but a lower peri-operative and postoperative morbidity/mortality than sacrocolpopexy, and is associated with faster recovery and higher patient satisfaction.
- **Laparoscopic or open abdominal sacrocolpopexy:** this has been found to be the most effective procedure in terms of low recurrence rate. A mesh may be attached at one end to the longitudinal ligament of the sacrum and at the other to the top of the vagina and for a variable distance down the posterior and/or anterior vaginal walls.
- **Robotic sacrocolpopexy:** also used in some areas. One systematic review reported that whilst similar results to non-robotic surgery were achieved, the robotic technique was actually less cost-efficient^[14].

Surgery for rectocele/enterocele

- **Posterior colporrhaphy:** involves levator ani muscle plication or by repair of discrete fascial defects. Mesh should not be used. Levator plication may lead to dyspareunia.
- Evidence confirms a transvaginal approach is more effective than transanal repairs^[15].

Obliterative surgery (colpocleisis)^[13]

- Corrects prolapse by moving the pelvic viscera back into the pelvis and closing off the vaginal canal.
- Vaginal intercourse is no longer possible.
- Advantages are that it is almost 100% effective in treating prolapse and has a reduced peri-operative morbidity.
- Safe and effective for those who are frail or do not wish to retain sexual function.
- Pre-operative counselling is essential.

Complications

- Ulceration and infection of organs prolapsed outside the vaginal introitus may occur.
- Urinary tract complications include stress incontinence, chronic retention and overflow incontinence, and recurrent urinary tract infections.
- Bowel dysfunction may occur with a rectocele.
- There are many potential complications from surgery, some of which are discussed above.

Prognosis

- It has been traditionally assumed that left untreated, uterine prolapse will gradually worsen. There is evidence, however, that this may not be the case and that spontaneous remission may happen^[16]. Obesity is a risk factor for progression.

- Good prognosis is associated with young age, good physical health and a BMI within normal limits.
- Poorer prognosis is associated with older age, poor physical health, respiratory problems (eg, asthma or chronic obstructive pulmonary disease) and obesity.
- Recurrence after pelvic organ repair requiring further surgery is around 29%^[5].

Genitourinary prolapse prevention^[3] ^[17]

Possible preventative measures are listed below, although the evidence base for some is more supportive than for others:

- The lifestyle advice for women with pelvic organ prolapse outlined above (eg, a balanced diet, physical exercise) also applies to those who wish to reduce their risk of developing this condition.
- Vaginal delivery is a recognised cause. However, there is insufficient evidence to recommend caesarean section as a routine preventative measure, although it may be worth considering in at-risk patients.
- Women of all ages should be encouraged to do pelvic floor exercises, including women who are pregnant and those who have just given birth.
- Instrumental trauma should be avoided. Prolonged labour in second stage is a recognised risk factor for levator ani dysfunction^[18].
- Topical hormone replacement may have more of a preventative effect than oral, but further research on the effectiveness of both treatments is required.
- Smoking cessation will reduce chronic cough (and therefore intra-abdominal pressure).
- Weight loss if overweight or obese (although studies suggest subjective benefits are not borne out by objective examination).
- Treatment of constipation throughout life (though evidence from systematic evidence is lacking).

Royal College of Obstetricians and Gynaecologists (RCOG) guidelines advise that the following at the time of hysterectomy may help to prevent subsequent post-hysterectomy vault prolapse (PHVP) ^[13] :

- McCall culdoplasty at the time of vaginal hysterectomy.
- Suturing the cardinal and uterosacral ligaments to the vaginal cuff at the time of hysterectomy is effective in preventing PHVP following both abdominal and vaginal hysterectomies.
- Sacrospinous fixation at the time of vaginal hysterectomy should be considered when the vault descends to the introitus during closure.

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Authored by:	Peer Reviewed by: Dr Colin Tidy, MRCGP	
Originally Published: 20/11/2023	Next review date: 19/01/2022	Document ID: doc_2189

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