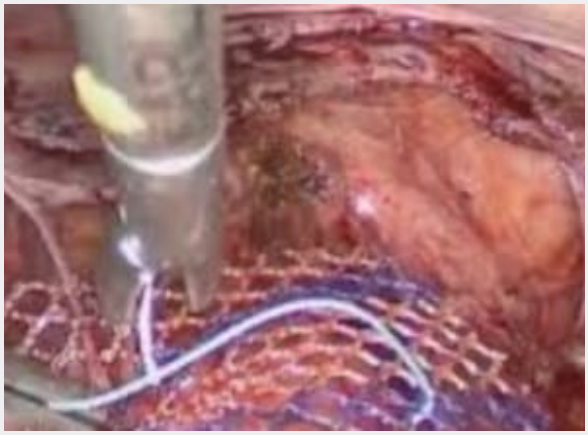
Chennai Menopause Society

"Changes not Challenges"

POP in Midlife



Healthy Aging - Series 7

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PRESIDENT'S NOTE

Dear CME Friends,

Let me first wish you all a happy, healthy, prosperous New Year 2022. I am pleased to present the first newsletter of 2022. There was a trace of light at the end of the Covid 19 tunnel due to vaccination, but the appearance of a new variant Omicron prevented us to have the conference and meeting face to face. We have continued to have our programs virtually.

On world sexual health day CMS along with World Association for Sexual Health (WAS) and Indian Association for Sexology organized a webinar on Sexual health in Midlife and beyond on 4th September on the theme "Sexual health in the digital world"

We were honored to have Dr. Pedro Nobre President of WAS as chief guest. Speakers highlighted many aspects of the theme.

Webinar on 11th October on "Fit at Forty "was organized by CMS along with Tiruvannamalai Obstetrics & Gynaecology Society. We were honored to have Prof Ambuja Choranur President IMS as chief guest and speakers discussed on various problems at midlife namely Psychological Problems, Financial stability, and lifestyle modification.

On World Menopause Day on 18th October, Chennai Menopause Society & Directorate of Public & Preventive Health & Tamil Nadu National Health Mission organized Webinar on "Healthy Aging of Postmenopausal women" for 1000 Nursing staff.

On 20th Oct World Osteoporosis day, CME was organized on "Postmenopausal Osteoporosis" along with Tamil Nadu Orthopaedic Association.

International webinar on Healthy Aging on Oct 22nd and 23rd with Pre-congress live workshop on office hysteroscopy and COSMESIS workshop were well attended and appreciated and the International webinar was a phenomenal success.

It was encouraging to see our undergraduates and postgraduates participating in quiz and Poster Presentation in great numbers and in appreciation they were awarded Prizes

I am pleased to say that the webinar on Fertility at forty was informative

We were thankful to have Dr. Hrishikesh Pai President FOGSI as chief guest and Dr. Madhuri Patel Secretary-General FOGSI and DR Shobhana Mohandas President-Elect as guests of honor.

Chennai Menopause Society conducted Guru Kul programme among medical students at Chettinad Medical College, Muthukumaran Medical College, SRM Trichy and Tagore Medical College.

To promote healthy aging among midlife women, Chennai Menopause Society conducted NCD health camp

Our membership is on the increasing trend and 29 new members have joined the society.

We will continue our mission by conducting an awareness Programme about menopause and its consequences amongst doctors, paramedical, students, and public.

I wish you all the best for the year 2022.

Dr. N. Hephzibah Kirubamani
President Chennai Menopause Society

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CURRENT CONCEPTS IN PELVIC ANATOMY

Dr A Tamilselvi FRCOG (UK)

Madras Medical Mission Hospital- IRM& WH

Chennai

Female pelvic anatomy can be a conceptual challenge. Understanding the anatomy helps in the identification, assessment, and management of pelvic floor pathology. To those dealing with disorders of the pelvic organs and to the reconstructive pelvic surgeon, knowledge of the functional anatomy is crucial.

The viscera in the female pelvis, have integrated anatomical support with each other due to their orientation within the pelvis and at the same time function as individual units. The pelvic floor musculature and the connective tissue (fascia) supports of the pelvic organs are reinforced by their attachments to the bony pelvis. In general, the supports of the female pelvic viscera help in the reproductive, storage, and elimination function of the pelvic organs.

The female bony pelvis not only provides the framework for muscular and fascial supports, but it has also gained importance in reconstructive pelvic surgery with certain bony landmarks guiding the planning of reconstructive surgery. The pelvic outlet is diamond-shaped with the apices defined by bony landmarks – symphysis pubis anteriorly, ischial tuberosities laterally, and the tip of the posterior anal

triangle. The lateral edges of the anterior triangle are the ischio-pubic rami – which are of significant land mark in identification of obturator foramen.

Ischial spine on the lateral wall of pelvis is an excellent surgical reference point. The Sacrospinous ligament travel medially and posteriorly from the ischial spine to the anterior and lateral aspects of lower portion of sacrum and coccyx. Along with the sacro-tuberous ligament SSL divides the greater sciatic foramen into greater and lesser sciatic foramen. Pudendal nerve and vessel exit the pelvis through the greater sciatic foramen, course beneath the ischial spine and sacrospinous ligament before reentering the lesser sciatic foramen

The Arcus tendinous fascia pelvis, the line of attachment of the pubocervical and rectovaginal fascia runs along the lateral wall of the pelvis from pubic bone and ends at the spine

The curvilinear thickening of the parietal fascia overlying the obturator internus is known as ATLA – arcus tendinous levator ani. The iliococcygeus portion of the levator ani originates from this fascial thickening extending from the posterior pubic symphysis and the ischial spine.

The pelvic floor musculature maintains the pelvic organs in position and in proper alignment with each other. Levator ani (LA) muscle constitutes the primary muscular support to the pelvic organs.

Approaching the anatomy from the perineal end - The external genitalia anatomy gives a clue to the underlying structural pathology either in the form of widened urogenital hiatus, short perineum, fecal or urinary soiling. Beneath the skin and superficial fatty layer, is the Superficial perineal fascia. The membranous fascia is attached posteriorly to the posterior end of perineal membrane and the perineal body. On each side it is attached to the margins of pubic arch and to

the deep fascia. The superficial perineal muscles which converge to form the perineal body, lie between the superficial perineal fascia and the deep perineal membrane. The deep perineal membrane encloses the deep transverse perineal muscles. Cranial to these structures lies the pelvic floor – the levator ani muscle complex. The whole expansion of the levator ani along with the coccygeus muscle, perineal membrane and perineal body is the pelvic diaphragm.

The normal resting levators maintain a constant state of contraction and relaxation occurs only during the elimination process (micturation, defecation and parturition. Neuromuscular injury to the levators such as during childbirth can lead to widening of the urogenital hiatus and lead to vertical inclination of levator plate leading to dysfunction or prolapse of pelvic organs.

The pelvic visceral connective tissue is referred to as the endopelvic fascia and its dense condensations at different sites are referred to as ligaments. The endopelvic fascia is a continuous structure extending from the sacrum as uterosacral ligaments proximally to the pubic bone and perineum. The lateral attachments of the fascia are to the pelvic side wall along the ATFP with its medial attachments to the lateral wall of the uterus and vagina. This attachment stretches the vagina transversely between the bladder and rectum and divides the pelvis into an anterior and posterior compartment. This fascial layer itself is called the pubocervical or vesicovaginal fascia anteriorly and rectovaginal fascia posteriorly.

The 3 integrated levels of support projected by DeLancey to explain the pelvic organ prolapse is defined by the endopelvic connective tissue. The cervix and upper vagina are suspended by the endopelvic fascia (parametria, paracolpium) and condensations of the connective tissue, the uterosacral and cardinal ligaments. Uterosacral ligaments pass posteriorly from the cervix and upper vagina, attaching to the front surface of sacrum, while the Cardinal ligaments attach to the postero-lateral pelvic walls from the cervix and lateral vaginal fornix. These attachments are referred to as the Level I or suspensory support. Failure of the Level I support leads to uterine or vaginal vault prolapse (Apical prolapse).

The fascial attachment in the mid-vagina from lateral vaginal walls to the ATFP and medial surface of levator ani prevents the descent of anterior and posterior vaginal walls with increase in abdominal pressure. This is referred as the Level II support or attachment axis. The endopelvic connective tissue extends as pubourethral ligaments, from the urethra to the posterior surface of the pubic bone, providing urethral support and maintenance of bladder neck closure during valsalva maneuvers. The lateral detachment of the fascia from the ATFP causes paravaginal defect and anterior wall prolapse referred to as displacement "cystocele". The anterior wall prolapse resulting from weakening or disruption of

fascia in midline is referred to as distension "cystocele." The bladder neck through its relation to the anterior vaginal wall is indirectly supported by the attachment axis. Hence failure of level II support leads not only to anterior and posterior vaginal wall prolapse but also to Stress urinary incontinence.

The lower one-third of the vagina is fused with the surrounding structures, through the endopelvic fascia - anteriorly to the urethra, posteriorly to the perineal body and laterally to the pubovaginalis muscle and perineal membrane. This is referred to as the Level III support or the fusion axis. Level III disruption anteriorly can result in stress urinary incontinence from urethral hypermobility and posterior disruption can result in distal rectocele or perineal descent.

The dynamic interaction between the muscular and connective tissue support is critical for the pelvic organ support. The pelvic organs are suspended over the levator plate by the fascial support. When the pelvic floor muscle weakens, the urogenital hiatus opens and the orientation of the levator plate becomes vertical. The fascia becomes the primary support mechanism in this scenario and overtime can weaken or break leading to prolapse or other pelvic dysfunction.

The interaction between the muscular and connective tissue support has been explained using the analogy of ship floating in the water attached by ropes on either side to a dock. The ropes srepresenting the endopelvic fascia and the water to the pelvic floor muscle and the ship to the pelvic organs. When the pelvic floor muscles are intact structurally and neurologically the endopelvic fascia is under less tension (akin to the ropes when water level is maintained), When the pelvic floor muscle is damaged, the tension on the endopelvic fascia is increased and tends to break, resulting in descent of pelvic organs, like the ropes put under tension when water level is reduced.

Our understanding of anatomy is evolving with use of imaging techniques and use of biomechanics evaluating the anatomy and its related function. With better understanding of pelvic anatomy, pelvic surgeons can achieve optimal outcomes through their surgical interventions.

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Prevention of Pelvic Organ Prolapse

DR. SHEELA RAMACHANDRAN, M.P.T., (Ph.D.,)
(Specialized in Musculoskeletal, Sports & Urogynaecological Physiotherapy)

Founder & Director (*Sheela Physiocare*, *Kamath Institute of Physiotherapy Education & Research,* and *Vituka (An institutional based natural birth center))*

Pelvic organ prolapsed (POP) is considered as one of the most common and hidden causes of women's reproductive health morbidity and quality of life. Reports suggest that 1 out of 3 women in India are affected by POP. However, postmenopausal women who had one or more vaginal deliveries tend to have uterine prolapse. Such conditions need to be prevented and treated with importance and facilitate women to lead a healthy life.

Why is Prevention Important?

The research shows that Asians are more prone to Pelvic organ prolapse, however, the exact cause is unknown (Catherine et al.). Women don't seek timely medical help due to lack of awareness, feeling shy and economical constraints. Moreover, due to prolonged duration of rehabilitation, patients often drop out of treatment regimen thereby leading to inferior outcomes. Hence, prevention will be of immense importance for this condition, which will be cost

effective too. Further, education and awareness program for Public and Health professionals on prevention measures are of utmost importance to avoid POP. There are a number of methods to prevent this issue, which will differ according to the age, because the causative factors are different in each age group.

Kegels Exercise is not a magic wand!!!!!

Nowadays, "Kegels Exercise " is being extensively used for the treatment, prevention of POP, and for any women's reproductive health issues. However, Kegels cannot serve as the modality of choice for all POP issues. Importantly, this exercise is a contraindication for many of women's reproductive health issues. Such generalized treatments will not only lead to failure but also aggravate the condition. Hence, finding the cause and treating the condition is of utmost importance.

Prevention methods according to the age category

The causes and the symptoms vary in different age categories, so the treatment and preventive methods also varies to achieve expected outcomes.

Under 25 yrs

The main causes for the POP in this category are poor posture, prolonged seating work and being overweight. Usually in this category, it will be an asymptomatic type of POP with clinical features of low back ache, painful intercourse, constipation and urinary incontinence. Recent years, majority of women perform prolonged seating work at their workplace. Hence, the prevalence of POP is predicted to increase in the near future. In such a scenario, education & awareness regarding the prevention of POP is of immense importance. In addition, **treating constipation, customized core stabilization**

exercises with proper breathing techniques improving pelvic floor muscle flexibility should be promoted along with general fitness. Since this category is asymptomatic, and they are more prone to POP in the near future, care should be taken to avoid missing on diagnosis & treatment.

Between 25 yrs - 50 yrs

Though pregnancy, labour and childbirth are the major causes in this age group, there are other aggravating causes like constipation, obesity, and respiratory problems like chronic, prolonged cough, which often requires treatment to achieve good prognosis in POP.

The antenatal and postnatal exercises are mainly focused on normal delivery and for tummy reduction respectively. However, postnatal pelvic floor rehabilitation is completely neglected which is the main cause of POP. Hence, to prevent POP implementation of a **"structured and customized Pelvic floor rehabilitation protocol"**, is highly essential within 6 months of postnatal period. The awareness, scheduling and briefing to patients regarding such postnatal rehabilitation should be done in the antenatal period itself, in order to achieve the desired outcomes.

After 50 yrs

The major causes for POP in this age category are Hysterectomy, constipation and obesity. Herein, the patient will have a symptomatic type of POP. Lack of awareness regarding the importance of "customized post surgical (hysterectomy) rehabilitation" amongst the health professionals and public are the major cause for POP in this age group. So in order to prevent the POP, **education & awareness should be created amongst the health professionals**

and implementing "customized post surgical (hysterectomy) rehabilitation protocol" should be made mandatory after surgery.

After 70 yrs

In this age group, Pelvic floor muscle weakness is common, hence, prevention is difficult in this age group, but aggravating symptoms can be avoided by early diagnosis and intervention, in addition to lifestyle modification and diet.

Constipation Vs POP

In all age groups Constipation is the main cause for the POP, hence, treating constipation plays a vital role in the prevention of POP. Usually the treatment of the constipation includes Diet, Hydration and stool softener - laxative. However, pelvic floor muscles can also lead to constipation which when missed leads to poor prognosis and lifelong treatment. So in order to get the complete resolution from constipation, treatment protocol should include the measures to improve the flexibility of pelvic floor muscles.

To conclude, POP is the major cause for Women's reproductive health morbidity caused due to lack of awareness and is the condition "Roar Behind the silence". Due to lifestyle modification, prolonged seating work, it is predicted that the prevalence will increase in the near future which will impact society and family. Since the prognosis is poor and requires long term treatment, ' 'Prevention '' plays an important role in the POP management, which will be cost effective and leads to a healthy society. Hence, proper measures such as awareness & education on prevention of POP should be implemented in order to improve the quality of life, physical and psychological health of women.

"Prevention is better than Cure"

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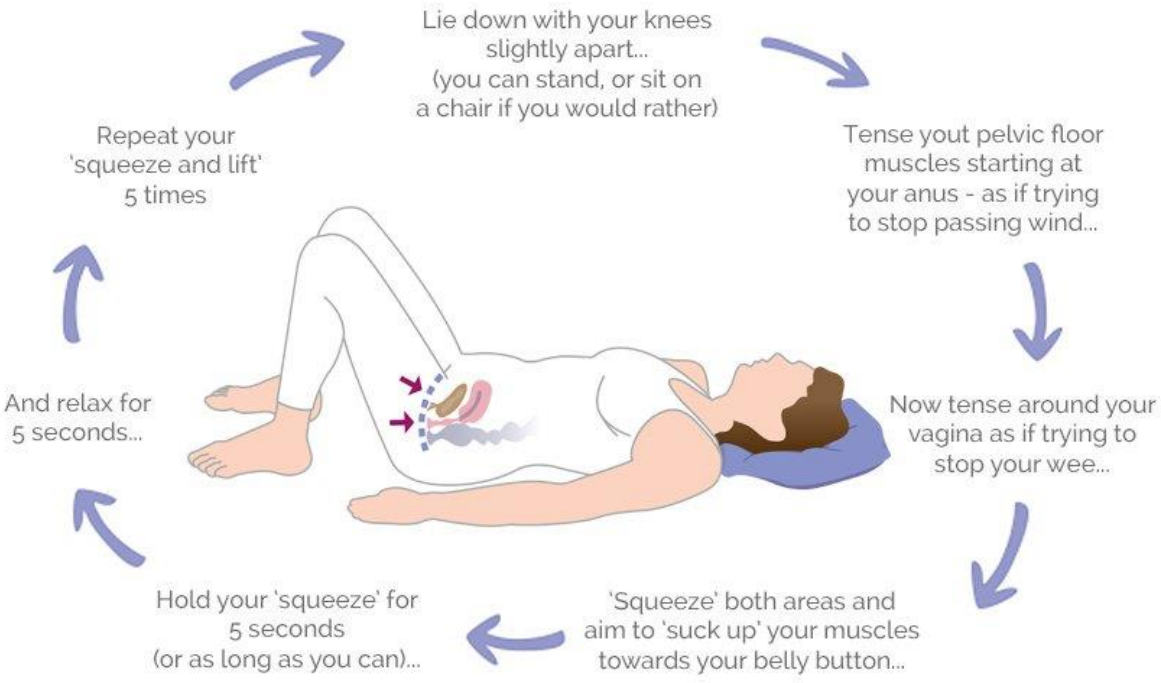
Kegel's Exercise

Kegel's exercises were developed by Dr Arnold H Kegel, an American Gynaecologist in 1940's as a non-surgical way to prevent uterine prolapse in women and urinary incontinence in men and women. Although it is a simple exercise, you will not reap the benefit unless you use the right set of muscles. One third of women use the abdominal, buttock or inner thigh muscles instead of the pelvic floor muscles. The best way to understand this is to try to stop the stream of urine while passing urine and became aware of what muscles to contract. To start with, practise in the position of lying down. Make sure the abdomen, buttocks and thighs are relaxed. Do not lift the pelvis. Hold the squeeze to a count of 3-5 and then relax. Repeat it ten times. Repeat the set of 10 for 3-5 times in a day so that you do 30-50 times in a day. Once you have mastered it, you can do it while sitting and standing too. Do it consistent daily.

It works for men with urinary incontinence too!!



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Non-Surgical Management of Prolapse

Mr Jagdish Gandhi
Consultant Uro -Gynaecologist,
Lead Urogynaecologist,
Hull University Teaching Hospitals UK

The prolapse refers to the bulging or herniation of one or more pelvic organs into or out of the vagina. Pelvic organ prolapse (POP) occurs when the muscles, ligaments and fascia that hold these organs in their correct positions become weakened.

There are number of causes for POP including childbirth, aging and menopause and the conditions that cause excessive pressure on the pelvic floor such as obesity, chronic cough, chronic constipation, heavy lifting and straining.

The non-surgical management options for POP include Do nothing, lifestyle changes such as losing weight, managing cough, stop smoking, pelvic floor exercises, biofeedback, electrical stimulation, vaginal cones and Pessary treatment

Pelvic floor exercise (PFE)

PFE increases muscles volume and closes the levator hiatus so that it helps to elevate resting position of bladder and rectum. The "knack" – pfm contractions during effort (cough) has been shown to reduce urinary incontinence. The pelvic floor exercises can avoid or delay the surgery. The regime includes slow pull ups in which pelvic floor is tighten up, held and released. This builds endurance. The fast pull ups help to react when cough, lift etc. These should be performed 10 contractions – 3 times a day. Usually, improvement is noticeable in 3-6 months.

What if Pelvic floor muscles training fails?

Biofeedback and Electrical stimulation have a place in the management of POP. Types of biofeedback include electrical muscles stimulation, perineometer and vaginal cones. Biofeedback can improve the efficacy of pelvic floor muscle (PFM) exercises. It has been recognized that the pelvic floor muscle training performed together with biofeedback is greater beneficial than the pelvic floor exercises performed alone.

What is Biofeedback?

Biofeedback is the gaining awareness of physiological functions by using instruments. This includes stimulating the pelvic floor muscles through electrical impulses via vaginal electrode. It helps women identify & contract pelvic floor muscles using signals from their own body. This is particularly helpful to the women who are unable to activate PFM or unsure of correct muscle use. Daily use may show a benefit in 3 months.

Perineometer

The perineometer is inserted into the vagina to monitor PFM contraction and can be used to enhance the effectiveness of Kegel exercises.

Vaginal cones

Biofeedback with vaginal cones is as effective as electrical stimulation. Vaginal cones are used for 15 minutes twice a day

Pessaries

Pessaries are Non-toxic, medical-grade silicone and are biologically inert - does not absorb vaginal odor. They are pliable and can be autoclaved or soaked in cidex. They are available in a variety of sizes and shapes. The outside diameter is measured in inches with a range of one to four inches.

Why consider the pessary?

Pessaries offer an effective conservative management for women with pelvic organ prolapse and urinary incontinence (UI). They also offer a viable alternative for women who do not wish to undergo or are unfit for surgery. They are suitable for women who suffer with pelvic organ prolapse during pregnancy.
Pessary use offers a very effective treatment option which carries a very low risk of complications. The satisfaction rate is high as 72-92% for symptom relief.

Benefits of pessaries

- Relieves the discomfort of a pelvic organ prolapse.
- May improve a prolapse or prevent one from worsening.
- May uncover the presence of any hidden incontinence related to a marked cystocele.
- Provides a diagnostic means of predicting which patients would be helped with surgical correction

Types of Pessaries

RING - with and without support

These are Commonly used and are simple to fit, insert and remove as they are round flexible ring. They help support the urethra and bladder neck. The membrane provides additional support for a cystocele. They are useful for a first or mild second-degree uterine prolapse associated with a mild cystocele.

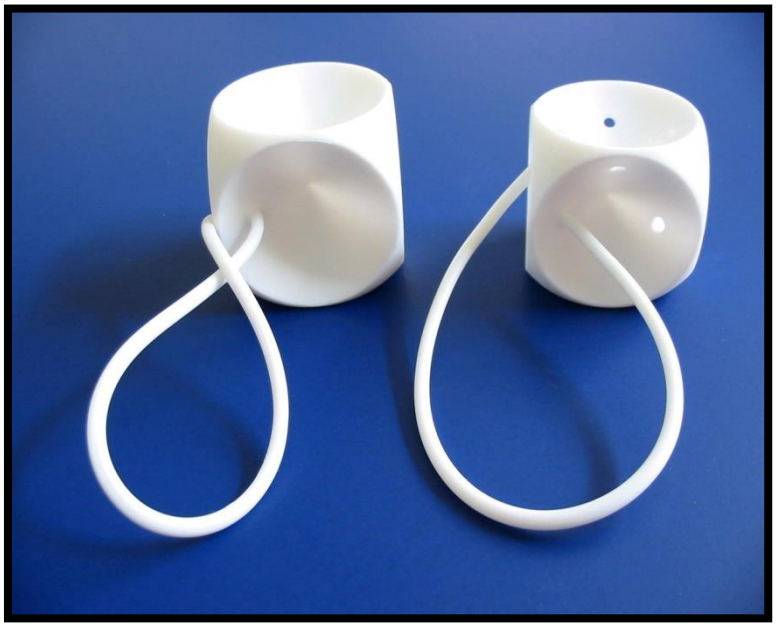
GELLHORN Pessary

Most commonly used pessary for uterine prolapse. They provide support for third-degree uterine prolapse and procidentia. However they provide less support for a rectocele.

DONUT Pessary

They are made of soft silicone, donut shaped. They occlude upper vagina and support a uterine prolapse and are useful for cystocele or rectocele. Good for prolapse of the vagina after a hysterectomy.

CUBE Pessary



They are useful in a third-degree prolapse, cystocele or rectocele, with or without good vaginal tone. They stop the vaginal wall from collapsing from its six pressure points.

Precautions / Contraindications

Pessary use is considered carefully in women with severe vaginal atrophy. Vaginal estrogen can help reverse these atrophic changes. Vaginal estrogen should be used for 4 to 6 weeks prior to insertion of the pessary.
Vaginal bleeding of unknown causes is a contraindication as it could be from endometrial hyperplasia or cancer.

Pessaries & Sexual Activity

Some pessaries are similar in size to the contraceptive diaphragm and intercourse is certainly possible with the pessary in place.

Intercourse is not possible with a vaginally occlusive pessary such as the Gellhorn, Donut, or Cube.

Predictors of Failure

In some women there is higher likelihood of pessary failure such as Short vaginal length, wide introitus, posterior wall defects, previous hysterectomy/ prolapse surgery.

Pessary Fitting

The bladder and bowel should be as empty prior to the fitting. It is possible for the pessary to descend after a bowel movement or long periods of standing. Should the pessary slip downward toward the introitus, the woman should lie flat, raise one leg, and reach in her vagina until she feels the pessary and push it back in a deep as possible.

Measuring The Width

- Insert first two fingers of dominant hand deep to the posterior fornix
- Approximate size by using the fingers to determine the width
- Spread fingers wide to measure
- Remove fingers and compare to pessary sample or fitting kit

Insertion Technique

- Slide it into the vagina, and curve posteriorly
- Release and allow to spring open to its normal shape
- Push deep into the vaginal vault
- Tuck securely behind pubic bone anteriorly and under the cervix (if present) posteriorly

Post-Fitting & Follow Up

The vaginal introitus is observed for the presence of the prolapse slipping around the pessary, or protrusion of the pessary itself.

Ask about any discomfort. The presence of the pessary should not be apparent to the user. Inform the woman that it usually takes the body a few days to "settle-in" around the pessary.

Follow up at 4-6 months - Observe for a vaginal tissue reaction such as discharge, irritation, odor, or ulceration and determine if there has been any improvement in symptoms.

Reasons For Discontinuing

- Inconvenient to use
- Inadequate relief of symptoms
- Uncomfortable
- Elected for surgery
- Unable to remain in place
- Difficulty urinating or having a bowel movement
- Incontinence increased

Complications

- Increase in vaginal discharge
- Odor
- Ulcerations
- Pelvic discomfort
- Incarceration
- Scar/granulation tissue may form around pessary

Conclusion

Non-Surgical Management options for the pelvic organ prolapse include do nothing, lifestyle changes, pelvic floor exercises, Biofeedback, Electrical stimulation, use of Vaginal cones and Pessary treatment. There are various types and sizes of pessary. Case selection and trial may be necessary before a suitable pessary is identified for a woman. They offer a real alternate to a surgical treatment. However, a careful evaluation, fitting and follow up is necessary.

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Laparoscopic Pectopexy

Dr. Mala Raj

MBBS, DGO, FICOG, Dip.In Adv Lap Surg (Germany)

Dip.In Reprod Med (Germany), Fellowship in Aesthetic Gynaecology(USA)

Endoscopic Surgeon and Fertility Specialist Aesthetic Gynaecologist

Managing Director, Firm Hospitals

Laparoscopic Pectopexy is a novel procedure first described by Noe in 2007 for repair of apical prolapse. This method uses Iliopectineal ligament on both sides for mesh fixation, so that there is no restriction caused by the mesh, as it follows the natural structures like the round ligament and broad ligament, without crossing ureter or bowel and the mesh is well away from the hypogastric nerve. It has been demonstrated by Cosson and associates that the iliopectineal ligament is significantly stronger than the Sacrospinous ligament and the Arcus tendineus pelvic fascia [1]. The mesh is fixed to the lateral part of Iliopectineal ligament and the height of the lateral fixation corresponds to S2 level. During Sacrocolpopexy, the anterior longitudinal ligament is used for the fixation of the mesh. To achieve a physiologic axis of the vagina, the cranial anchor point should be at the S2 level. Although sacrocolpopexy has been the most effective option overtime, the procedure is still associated with problems like defecation disorders and SUI [2].

It is also found that gastrointestinal complications like small bowel obstruction, ileus or defecation disorders occur in 0.1 - 5% of sacrocolpopexy procedures. The mesh placed between the sacrum and the vagina (cervix) always narrows the pelvis and cause defecation disorder due to reduced space in the pelvis (outlet obstruction), adhesions or trauma of the hypogastric nerves. Another major problem is pre-sacral hemorrhage which is a dangerous complication of sacrocolpopexy [3].

Operative Techniques of Laparoscopic Pectopexy:

The peritoneum along the round ligament towards the pelvic side wall is opened. An incision in the medial and the caudal direction is made with harmonic scalpel and the right external iliac vein is identified. The soft tissue in that area is dissected and 4-5cm of the Iliopectineal ligament (Cooper's ligament) adjacent to the insertion of psoas muscle is identified. The same is repeated on the opposite side. The peritoneal layers on both sides are opened towards the vaginal apex and prepared for mesh fixation. If the uterus is present, the anterior peritoneum of the uterus is opened and the lower anterior segment of the uterus was prepared for mesh fixation. Now the polypropylene mesh of 15cm x 3cm is introduced into the abdominal cavity and fixed to Iliopectineal ligament on both sides and the uterus or vaginal apex in the centre to provide a hammock like effect. Finally the peritoneum over the mesh is closed.

Conclusion:

Laparoscopic Pectopexy is an alternative to sacrocolpopexy and is found to be feasible safe, comfortable procedure in the apical prolapse surgery and is an alternative to sacrocolpopexy.

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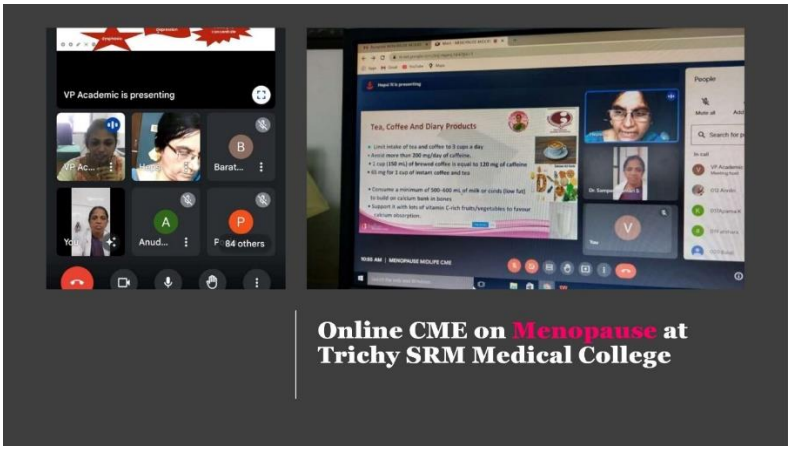

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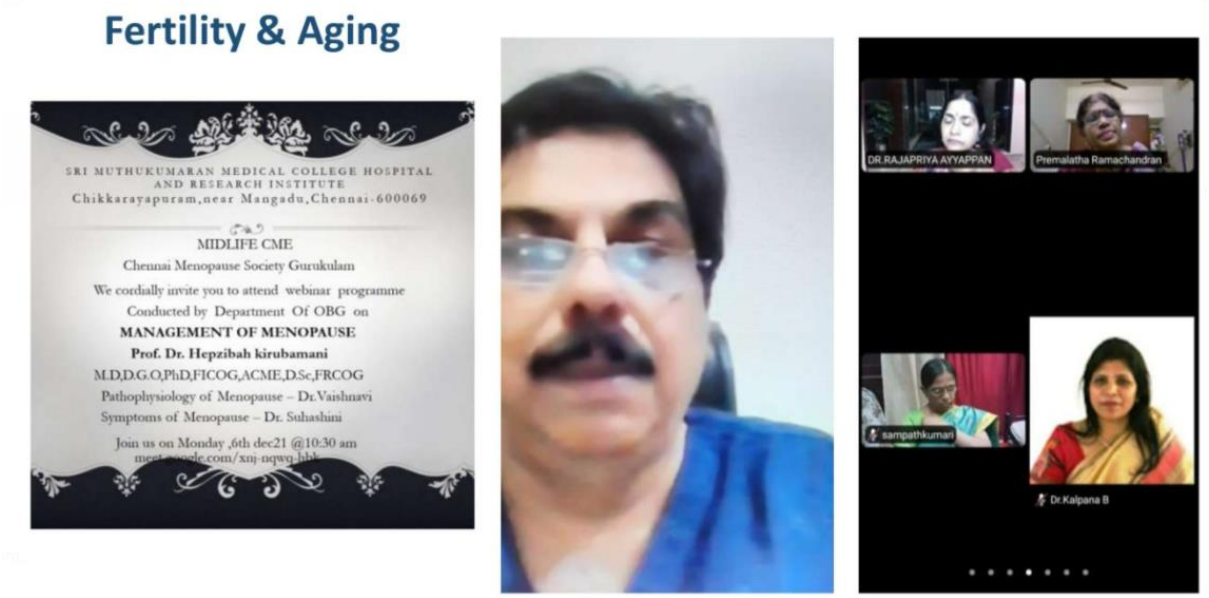

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OLD IS WHEN
YOU GIVE UP

UNTIL THEN
YOU ARE
SPECTACULAR