Information for women

Prolapse
– uterine and vaginal

There are many types of prolapse, which differ according to which organ is affected. When the walls of the vagina become lax, the organs that they should be supporting bulge into the vagina, creating the sensation of a lump hanging down. The uterus is supported at the top of the vagina, and when the ligaments in this wall loosen, the uterus bulges downward. This condition is called uterine prolapse. Other types of prolapse include prolapse of the bladder into the front wall of the vagina (cystocele), that of the rectum into the back wall (rectocele), and that of the small intestine into the top of the vagina (enterocele). A combination of the last two is known as a recto-enterocele.

Causes of Prolapse

The common causes of prolapse are childbirth, loss of hormones at menopause, being overweight and chronic illnesses which create a lot of pressure inside the abdomen (such as chronic lung disease, which causes considerable congestion and coughing). It is less common in women who have not had babies, and most common in those who have had difficult vaginal deliveries, but there is evidence to indicate that women who have had caesarean sections may also develop vaginal wall weakness. This is thought to be due to pregnancy hormones, which allow the tissues to stretch beyond their rebound limits, and also the weight of an ever-growing womb containing the baby. Prolapse can also be worsened by the loss of muscle tone commonly associated with aging.

Symptoms

Uterine prolapse

Those who suffer from uterine prolapse often report a sensation of dragging, heaviness or pulling in the pelvis, with a feeling of "sitting on a small ball". It can also be accompanied by low backache and, in moderate to severe cases, protrusion from the vaginal opening. Uterine prolapse may also cause difficult or painful sexual intercourse.

Cystocoele

Lax bladder support leads to a "reservoir effect" where the bladder is not completely emptied when the urine is passed. The remaining urine then irritates the bladder, leading to bladder over-activity, which causes urgency and is sometimes severe enough to produce an involuntary leakage (incontinence). The lowering of the neck of the bladder with prolapse can result in stress incontinence, which involves the leakage of urine from the urethra in response to any sudden pressure such as occurs when coughing, sneezing or exercise. This is sometimes followed by a contraction of the bladder causing even more leakage. A lax and over active bladder may also leak during intercourse, due to the pressure exerted upon it.

Rectocoele

Those who suffer from rectal prolapse complain of a sensation of bulging in the vagina when they strain to open their bowels. There is in effect an "S-bend" effect in the vagina, where faeces move into the reservoir created by the prolapse. Despite the urgency to open the bowels, very little bowel motion is likely to occur, as the reflexes tend to be lost due to this pouch effect. Constipation and irritable bowel syndrome may result from this. When the small intestine is also prolapsed (enterocoele), patients complain of a bulge and a dragging or "balloon like" sensation in the upper vaginal wall. This may also make intercourse painful.

This fact sheet has been prepared by Women's Health Concern and reviewed by the medical advisory council of the British Menopause Society. It is for your information and advice and should be used in consultation with your own medical practitioner.

Diagnosis

Prolapse is usually diagnosed by a pelvic examination.

Treatment

Physiotherapy sessions can be very successful in helping to reduce symptoms. When the prolapse is troublesome, soft ring pessaries are available. The effect of these is to hold the walls of the vagina away from the centre and hence tighten the "hammock" of tissues that hold the organs. These rings should be changed regularly, and are often used along with topical estrogen creams. When the prolapse involves the womb or the top of the vagina, or when there is no womb from a previous hysterectomy, another device called a Gellhorn Pessary can be inserted, which effectively provides an additional shelf-like support for the prolapse. Again, the use of hormone creams help keep tissues healthy and allows the use of these devices on a long-term basis.

If pessaries are not effective, uncomfortable or undesirable, surgery is often the next step. Repair of prolapse with vaginal or abdominal surgery can be performed where the prolapse is reduced and supporting sutures inserted. Patients should discuss possible treatment options with their doctor.

Useful contacts

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(formerly the Bladder & Bowel Foundation)
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