Care Pathway for the Management of Pelvic Organ Prolapse (POP)

SPECIALIST MANAGEMENT

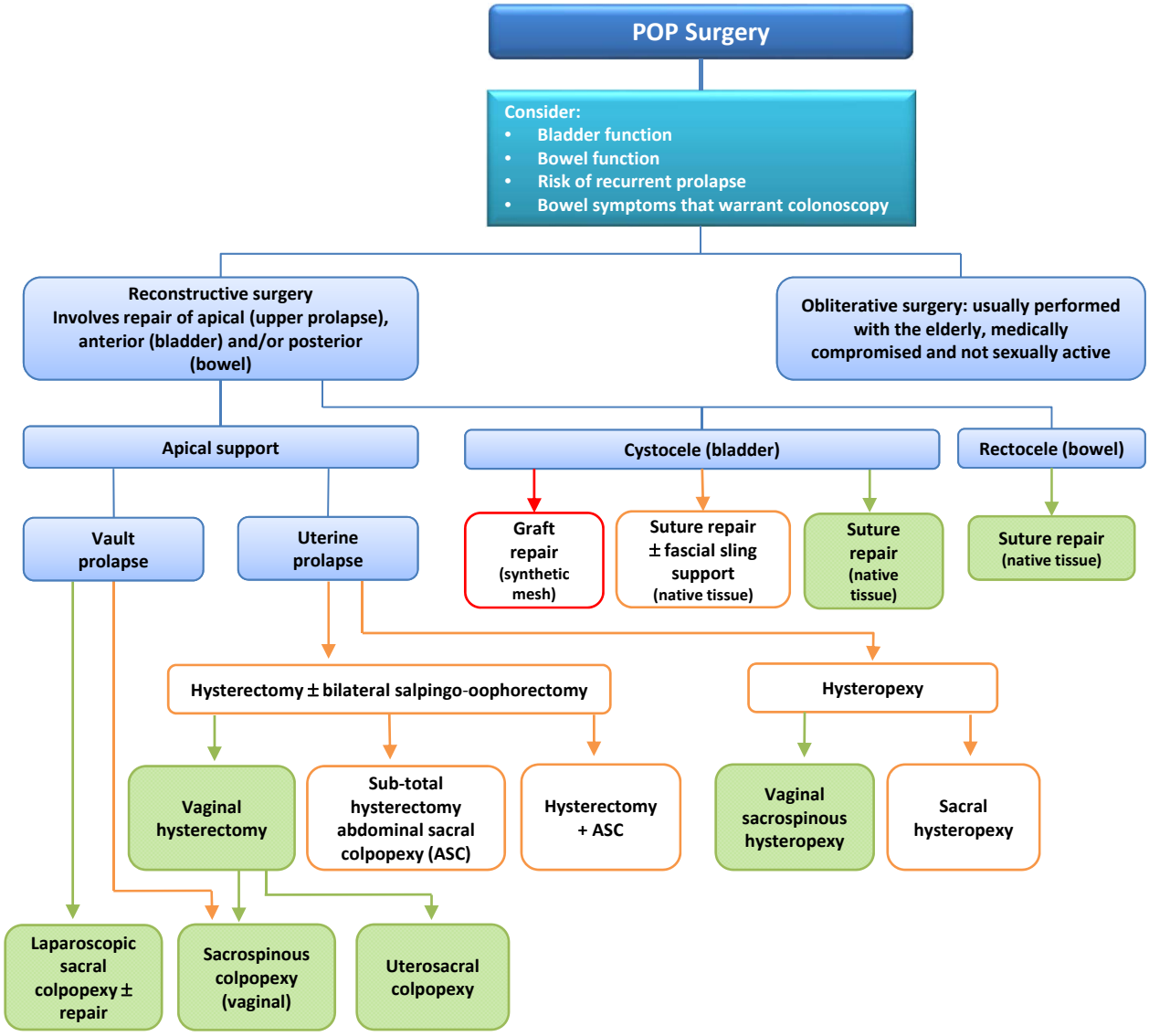
This may include care by gynaecologists, urogynaecologists, urologists and colorectal surgeons with a special interest in pelvic floor

No treatment

Non-surgical treatments

Patient assessed as requiring operative management

POP Surgical Pathway



Patients should be offered the opportunity for a minimum period of six months follow-up after surgery.

→ Preferred options for treatment – use of mesh for these procedures is supported by evidence.

→ Possible pathway – these procedures are supported by evidence, but more data is needed

→ Not recommended

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Pelvic Organ Prolapse (POP) Surgical Pathway

Risk factors for recurrent prolapse	GoR*
• Perioperative physiotherapy did not reduce the rate of recurrent prolapse	A
• Stage 3 or Stage 4 prolapse	B
• Low volume surgeons have ↑ rate of complications compared to high volume surgeons	B
• Patient age < 60 years	C
• Less experienced surgeons have higher rates of recurrent prolapse after transvaginal surgery	C
• Preoperative widened genital hiatus or levator defects on urinary signs and symptoms: data are inconclusive	D

Reconstructive Surgery	GoR*
Isolated cystocele:	
• Anterior Colporrhaphy (AC) is generally recommended however permanent synthetic mesh could be considered for recurrent prolapse if women understand the risk/benefit profile	A
• Non-autologous grafts offer no significant advantage over AC	B
• Native tissue repair is recommended, but carries a higher risk of prolapse recurrence	B
• Mesh repairs are associated with higher risk of adverse events	B
• Mesh repair may be considered for recurrent prolapse after patient informed and accepts the risk/benefit	B
• Adjunctive fascial slings may be used to prevent recurrent prolapse in high grade cystoceles	C
Isolated rectocele:	
• Posterior Colporrhaphy (PC) is the procedure of choice	B
• Levatorplasty associated with high rate of dyspareunia	B
• PC reduced prolapse with equal functional outcome compared to transanal approach	B
• Fascial plication is superior to site specific posterior vaginal repair	C
• No evidence demonstrating benefit for synthetic or biological graft	C
• Those with combined vaginal prolapse and bowel symptoms benefit from colorectal and gynaecologist collaboration	C
• Ventral rectopexy and vaginal graft is unnecessary for isolated rectocele	D
Apical Support	
• Apical suspension at AC or PC significantly reduces the need for subsequent prolapse surgery	B
Vault prolapse (post hysterectomy)	
• Sacral colpopexy (SC) has significant anatomical and functional advantages when compared with a broad group of vaginal surgery (±mesh)	A
• Transvaginal apical mesh confers no advantage when compared to native tissue repairs	A
• Uterosacral and sacrospinous colpopexy have similar efficacy for apical prolapse	B
• Laparoscopic SC has advantages over both robotic and open approach however the learning curve with the laparoscopic approach is significant	B
• Sacrospinous ligament fixation and abdominal sacrocolpopexy have equivalent success rates	B
• Vaginal apical suspensions appropriate in those not suitable for SC (Delphi)	C
Uterine prolapse	
• Vaginal hysteropexy is equally effective as vaginal hysterectomy with apical suspension and is associated with reduced blood loss and operating time	B
• Vaginal hysterectomy with apical suspension has a lower reoperation rate for prolapse than abdominal sacro-hysteropexy	B
• Salpingectomy ↓risk of ovarian cancer in women retaining ovaries at the time of hysterectomy	B
• Bilateral salpingo-oophorectomy (BSO) at hysterectomy in post-menopausal women ↓rate of ovarian cancer without ↑ morbidity	B
• SC with hysterectomy is not recommended due to high rate of mesh exposure	B
• Supracervical hysterectomy has a lower rate of mesh exposure than hysterectomy and SC	B
• Sacro-hysteropexy has a ↑ reoperation rate for prolapse than SC with hysterectomy	C
• Supracervical hysterectomy has ↑ rate of recurrent POP compared to SC and hysterectomy	C
• Although data is not complete, vaginal based apical suspensions should generally be considered for uterine prolapse reserving SC for recurrent or post hysterectomy prolapse	C

* Grades of Recommendation

Adapted from International Consultation on Incontinence (ICI). 2017 ICI Surgical Pathway for Pelvic Organ Prolapse. (urogynaecology.com.au)

The Grade of Recommendation has been derived from the ICI (see Int Urogynecol J. 2013 Nov;24(11):1781 *https://link.springer.com/article/10.1007/s00192-013-2168-x*) and expert opinion during the Commission's development of the guidance.

Pelvic Organ Prolapse (POP) Surgical Pathway (continued)

Reconstructive Surgery (continued)	GoR*
Prolapse surgery and lower urinary tract functions	
Women with POP + SUI	
• Surgery for POP + SUI shows a higher rate of cure of urinary incontinence in the short term	A
• Combined POP + SUI surgery carries a higher risk of adverse events	A
Women with POP + occult SUI	
• POP + occult SUI equals POP and continence surgery (consider staged procedure)	B
• Women with POP + occult SUI are at risk of development of incontinence post POP repair alone, with some proceeding to additional SUI surgery at a later date	A
• Combined POP + SUI surgery reduces the risk of post operative incontinence	A
• Combined POP + SUI surgery increases the risk of adverse events	A
Continent women with POP	
• POP without occult SUI does not require concomitant continence surgery	B
Women with POP and Overactive Bladder (OAB)	
• There is low level (inconsistent) evidence to suggest that operative repair can improve OAB symptoms	C

Obliterative Surgery	GoR*
• Effective low morbidity surgery for women not wishing to retain coital activity	C

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