W17: IUGA Workshop - How Do We Treat Pelvic Organ Prolapse in 2024?

Workshop Chair: Montserrat Espuña Pons, Spain
24 October 2024 11:30 - 13:00

Start	End	Topic	Speakers
11:30	11:40	Welcome and Introduction	Montserrat Espuña Pons
11:40	12:00	Is surgery always the best option for treatment of POP?	Cristina Ros Cerro
12:00	12:20	If we operate, should we leave the uterus in or out?	Hugo van Eijndhoven
12:20	12:40	If we save the uterus, which technique would be preferred?	Kirsten Kluivers
12:40	12:55	Discussion	Montserrat Espuña Pons Kirsten Kluivers Hugo van Eijndhoven Cristina Ros Cerro
12:55	13:00	Conclusion	Montserrat Espuña Pons

Aims of Workshop

Treatment of Pelvic Organ Prolapse (POP) has long been subject to surgeons' preference. Removal of the uterus has long been the standard surgical option for symptomatic POP. Is that the best option? Is surgery really necessary? What alternatives do we have? What evidence is available for these choices? Are patient's own perspectives taken into account in what we offer them as treatment?

Learning Objectives

1. How do patient reported improvements compare between surgery and pessary?
2. Removing or saving the uterus? Which is best from a patient's perspective?
3. What evidence do we have for the choice between uterus-sparing techniques?

Target Audience

Urogynaecology and Female & Functional Urology, Conservative Management

Advanced/Basic

Intermediate

IUGA Workshop - How Do We Treat Pelvic Organ Prolapse in 2024?

Chair: Montse ESPUÑA-PONS - Speakers: *Hugo van EIJNDJOVEN, Kristen KLUIVERS,* Cristina ROS

Times are changing and so is the treatment of pelvic organ prolapse (POP). Better understanding of women's preferences and shared-decision making have changed the attitude of (uro)gynecologists towards this subject. In this workshop we highlight and discuss the evolution of both conservative and surgical treatment over the last decade.

CONSERVATIVE TREATMENT OF PELVIC ORGAN PROLAPSE.

Cristina ROS

When faced with a woman with a POP, different therapeutic options should be offered: expectant management if the POP is asymptomatic, lifestyle interventions, pelvic floor muscle training (PFMT), pessary or surgery.

1. PELVIC FLOOR MUSCLE TRAINING

Nowadays, there is good evidence that PFMT is effective in reducing POP symptoms and improving POP stage, in women with POP stage 1, 2 and 3. However, there are no evidence of improvement after perioperative PFMT (pre- or post-surgery).

Although there is scarce data about long-term effect of PFMT on POP, it appears that there are no adverse effects or complications related to PFMT.

Nevertheless, it is essential to provide proper information to women on why and how to perform PFMT to improve pelvic floor morphology and POP. In addition, the staff should teach PFM contraction technique, assess if it is correct and offer periodic visits for at least 6 months.

A strength training regimen includes 3 sets of 8-12 close to maximum contractions at least 3-4 times/week during at least 4 months, with a PFMT maintenance including 8-12 contractions 1-2 times/week.

In conclusion, PFMT could be recommended as the first-line treatment for POP in general female population. It is effective and safe but needs instruction and supervision (Bo et al. 2022)

2. PESSARY

Among women with POP, half prefer surgery whereas one third prefer pessary. However, up to 14% of gynaecologists never inform their patients about pessaries.

The conclusion of a multicentric noninferiority randomized clinical trial (RCT) was that, among patients with symptomatic POP, an initial strategy of pessary, compared with surgery, did not show non-inferiority regarding patient-reported improvement at 24 months. Subjective improvement was reported by 76% of women in the pessary group and 81.5% in the surgery group (p=0.16). Nevertheless, cross-over from pessary to surgery occurred among 54% participants, mainly due to pessary expulsion. The most common adverse effect in the pessary group was discomfort (42.7%) (van der Vaart et al. 2022).

Women with symptomatic POP who refused to participate in the RCT due to preferences in treatment choice (surgery or pessary), were included in an observational cohort study. Both groups showed a significant reduction in bothersome POP symptoms compared with baseline. However, significantly more women in the surgery group reported a subjective improvement after 24 months (83.8% vs 74.4%). In this cohort, up to 30% of women stopped the pessary at 24 months, and 23.6% switched to surgery, due to pessary expulsion or insufficient symptom relief. Finally, comparing both population, women who chose surgery were younger, premenopausal, with higher body mass index and more severe subjective symptoms of POP. (van der Vaart et al. 2022)

In a cohort of women aged 75 or older, three quarters opted for a pessary. However, two-third of these ended up having surgery (Dykes N et al. 2023).

When the chosen treatment is a pessary, an initial visit should be performed, offering supportive or occlusive pessaries. Pessary fitting is successful if the patient feels comfortable with the pessary in situ without expulsion. In case of pessary expulsion, a trial of another type/size should be offered. If it is possible, self-management is the best option, with a personal cleaning frequency. If it is not possible, visits should be scheduled at least every 4 months.

The most common pessary complications are: vaginal discharge or bleeding, vaginal erosions, pessary expulsion, discomfort or urinary incontinence. Risk factors for pessary failure are younger age, previous hysterectomy and increasing parity.

In conclusion, pessary should be offered as a first-line option among women with symptomatic POP, with significant reduction in bothersome POP symptoms. However, the chance of significant improvement is higher following surgery. Patients needs to be advised of the possible

complications, as discomfort, vaginal discharge, erosion or expulsion, and the high chance of requiring surgery at a later stage, both in young women or over 75 years old.

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SURGICAL TREATMENT OF APICAL PELVIC ORGAN PROLAPSE.

Kristen KLUIVERS, Hugo van EIJNDJOVEN

The first choice of treatment of POP is conservative treatment, such as lifestyle interventions, pelvic floor physical therapy and pessary treatment as has been discussed in the first part of the workshop. These interventions may lead to reduction of prolapse complaints and might be satisfactory for a large population with mild prolapse complaints. For whom it is not sufficient, several surgical options are available for the treatment of POP depending on the affected site. A vaginal approach is preferred as a first surgical treatment option.

For **uterine descent**, the options can be divided in uterus preserving techniques, such as the Manchester procedure (MP) or the sacrospinous hysteropexy (SSH), or non-preserving techniques such as vaginal hysterectomy with uterosacral ligament suspension (VH). The choice for surgical technique depends on the available evidence, the general health of the women, the severity of the prolapse, the woman's preference and of the surgeon. Worldwide, VH with uterosacral ligament suspension is the most frequently executed operation for the treatment of

uterine descent (Jha et al 2018) . In recent years a upcoming trend towards uterus-preserving surgery has been noticed (Detollenaere et al 2023). Similar or even lower recurrence rates have been shown (Schulten et al 2019). Furthermore, uterus-preserving techniques are often considered to be less-invasive as they are known to have shorter operating time, less blood loss and shorter recovery time. This makes them more appealing and more in line with patient preferences. Husby et al. (2020) showed a decrease of vaginal hysterectomies and an increase of MP and SSH between 2010 and 2016 in Danmark. This is in line with findings from other countries (Madsen et al. 2017, Wu et al. 2012, Zacche et al. 2018).

Uterus removal decreases the risk of additional uterine malignancies or other uterine pathological conditions. However, the rate of these malignant conditions is low (0.8 – 1.1%) and no higher stages at discovery of malignancy have been found (Husby et al. (2022).

The technique of the Manchester procedure is discussed in most detail in the workshop, as this technique is least well known and there is most variation in the performance.

This Manchester procedure is the first reconstructive procedure preserving the uterus and was originally described by Archibald Donald of Manchester, England in 1888 when exploring different conservative prolapse operations for uterine prolapse. Initially the operation was executed by combining anterior and posterior colporrhaphy with a cervical amputation, which was often performed in two separate sittings. This technique was modified by John Fothergill, who combined the earlier two-step procedures into one single operation and included parametrial fixation. Initially the preservation of the uterus was important for potential future childbearing and religiously important, but the pregnancy rates were low and prematurity was a common complication after this procedure. The traditionally Manchester Fothergill procedure consisted of plication and fixation of the cardinal ligaments and cervical amputation. Over the years the Manchester procedure was modified to the procedure as described in the IUGA/ICS Joint report on terminology for surgical procedures to treat POP (2020): the shortening or the amputation of the cervix with preservation of the uterine body and plication of the uterosacral-cardinal ligament complex extra peritoneally caudad to this amputation.

Comparison of surgical techniques for the treatment of uterine descent

Several studies have investigated surgical outcomes after native tissue repair such as MP or SSH versus VH in the treatment of POP. A systematic review and meta-analysis by Kapoor et al. (2017) investigated SSH with VH for uterine descent. There were no statistical significant differences

between the two interventions concerning the effectivity and reoperation rate. Maher et al. conducted a Cochrane review (2016,2023) comparing SSH with VH. In the three studies included, a statistically significant higher rate of recurrence of posterior vaginal wall prolapse after VH was found compared to SSH (18% versus 7%). The SAVE-U trial is a large Dutch RCT comparing SSH with VH. This study showed that the treatment of uterine descent with SSH in comparison with VH with uterosacral ligament suspension was non-inferior after 12 months of follow-up (Detollenaere et al.2015). After 5 years of follow-up, Schulten et al. (2019) showed that SSH had less anatomical recurrences of the apical compartment with bothersome bulge symptoms or repeat surgery compared to VH with uterosacral ligament suspension. Several studies concluded that uterus-preserving surgical techniques such as the MP or SSH have comparable or even better outcomes. A Danish study found the MP to be superior to VH for the treatment of POP concerning the recurrence of POP as well as the costs perspective (Husby et al. 2017, 2018). A large randomized controlled trial comparing SSH with MP has been performed in the Netherlands. Based on the composite outcome of surgical success 2 years, the results support a finding that sacrospinous hysteropexy is inferior to the Manchester procedure (Enklaar et al 2023).

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