



Transcript of Video with Dr. Lucente Discussing Pelvic Organ Prolapse

Experts in minimally invasive gynecological surgery talk with NWHRC Executive Director Elizabeth Battaglino Cahill, RN at AAGL's recent Global Congress of Minimally Invasive Gynecology. Read the transcripts [here](#).

What is pelvic organ prolapse?

Pelvic organ prolapse is a term we use to describe a condition in which the organs of the female pelvis have become displaced. They're out of their normal position. Normally there's connective tissue, sort of like ligaments that you have in your elbows and knees that hold the pelvic organs, mostly the vagina primarily in a normal place. And do to a combination of factors, a lot of being it aging and childbearing, these supportive structures are disrupted, torn and disrupted. Now what was holding the vagina in place is again no longer continuous and the vagina begins to move, sag, protrude and whatever word you want to use, they're mechanically displaced. And because the opening of the vagina is sort of the weakest area then everything begins to bulge towards that opening. But interestingly a lot of women are confused when they hear I have a dropped bladder. Because it really isn't the bladder that has dropped. What has dropped is the vagina. The vagina supplies support to both the bladder above it and the rectum below. And when women begin to have prolapse they start to have sensations of pressure, fullness, something bulging down there in the vagina and that is what we refer to, sort of globally, as a pelvic organ prolapse condition.

How common is pelvic organ prolapse?

We look at how many women prevalence and how common it is, it's sort of a difficult thing to determine because it's hard to draw a line where exactly does the beginning of the condition start. Because if it's not really symptomatic and it's a little bit of mild changes and support like we see in our bodies as we look in the mirror as the years click by when does that become truly abnormal. So because of that definition it sort of moves around. I think probably the best way to get a handle on it is look at well how many women actually wind up being treated for the condition. Because the time when a woman decides well I'm going to have treatment for it and that treatment lifetime risk is around 11 to 12% when some of the studies have looked at surgical risk for the treatment of pelvic organ prolapse. It's a number we don't really know. We do know we're only seeing the tip of the iceberg. A lot of the conditions are misdiagnosed or under diagnosed.

What are the risk factors for pelvic organ prolapse?

That's a great question. When we look at risk factors like a lot of things it's multifactorial. A lot of it goes into it. There's been great work that's been done very recently by Dr. Norton and her group looking at genetics and really identifying chromosome #9 genetic factors. Some great work has been done by Peter Sand and his group looking at twins. Taking women that are genetically matched and look at these twin sisters and see who gets prolapse and who

doesn't. And in those twin studies showing that the obstetrical factors very much come into play and in genetically matched women. So it's multi-factorial but I would say the big two in that equation is it can be environmental, chronic lifting, heavy straining but the big two are going to be genetics and then obstetrical experience and then finally the thing that tends to level the playing field and that's the aging phenomena.

Can pelvic organ prolapse happen to a woman at any age?

We look at age in terms of onset. Again, that's a difficult thing to pin down. It tends to happen with older women but, yes, I've seen women very young develop pelvic organ prolapse. Usually, most commonly after a fairly traumatic vaginal delivery. It's even been reported in young women in the Air Force who don't open their chute correctly and have a very traumatic vertical deceleration as they hit the ground, mechanically overcoming their support of the prolapse. So it really can happen at any age depending on the situation but it most commonly tends to be in older women say average range being in their sixties.

Is it easy for a doctor to miss prolapse during a routine office visit?

It's very easy to miss. I think the most common reason that it is missed is the most common positioning during a pelvic exam is for the woman to lay flat in a supine position. And really that's really suboptimum. The really magnified the force is to the pelvis a woman should be upright, preferably even standing. But at least upright sitting position and bearing down creating some force to sort of demonstrate how the prolapse exists as their up during the day and walking about and having a vigorous day. In fact commonly if a woman describes a situation that I really don't see on exam, even on examining them in an upright bearing down position and it's an early morning exam I'll say you know what you need to come back on another day at the end of the office hours, late in the day when they've been up all day long. Unless you're, again, going to sort of replicate those situations you're going to miss it more often than not.

When should a woman tell her doctor if she suspects pelvic organ prolapse?

I think as soon as possible. I think the sooner a woman shares with a physician that she's having some changes in her sensations in her pelvis, like something doesn't feel right, something feels like it's out of position or I've got pressure more towards the end of the day a fullness, a bulging, any kind of symptomatology even if it's soft it ought to be brought to the physician's attention because that's going to begin at least having some dialogue and education about what can we do now at the very early signs to hopefully prevent progression. Are there changes in lifestyle activities that you should avoid? Should we do something about your pelvic floor muscles because like the rest of our body, the muscles are more important in support than the connective tissue. Our collagen, elastin and fibrin, the things that come together that make ligament like support structures are stabilizing support structures. But the thing that gives you the moment to moment dynamic support responding to what we're doing are the muscles. And there's a big group of muscles in the bottom of a female pelvis and a lot of women are familiar with the term of a Kegel exercise trying to actively squeeze those muscles. And I think earlier on when women begin to discuss symptoms with their physician they can begin to make some positive changes that hopefully stop the progression of it and hopefully even avoid a surgical intervention.

How can a woman avoid pelvic organ prolapse?

I don't know if you can truly avoid it. I think if it's sort of genetically there and you live long enough it may be in the cards. But I definitely think that you can do things to minimize the

risk. One of those is to be very open and candid with your obstetrician about labor and delivery. Everything from their viewpoints on episiotomy with a lot of literature now supporting that an episiotomy is more harmful than it is beneficial in the majority of cases and how the episiotomy is performed. How vigorous should we pursue this Holy Grail of a vaginal delivery. Because if we start really looking at caring for a woman over her entire lifetime, versus the episodic care of being 29 and pregnant and should be via C-section or vaginal delivery, that maybe the morbidity associated with a C-section is actually less than the morbidity of reconstructive pelvic surgery when you're 60. Until physicians start thinking about that, women actually need to help catalyze that conversation as well and saying I'm concerned about my pelvic health. My mother had prolapse or incontinence and my sister did. I want to talk about, especially going into a pregnancy, as well as after the first delivery and talk about well was there damage during that delivery and how do we consider that going forward. So I think there are definite things you can do to minimize it. One of which is going to be really carefully considering your obstetrical experience in terms of managing the labor with your physician.

So it's also important to examine your family history too?

Well absolutely and especially, just like a lot of things, first-degree relatives are going to be the most predictive. And then other, again, factors. Smoking is a big factor. Obesity is a big factor. Chronic, heavy straining and lift so environmental, whether it's an occupation or even another medical condition like allergies with vigorous, violent coughing or sneezing repetitively. So there are a lot of things that you can definitely begin to do to manage your lifestyle, manage your co-morbidities such obesity, which is a tremendous problem in our population. But a lot of things that women can do to minimize, can they truly avoid it by paying attention to all those, that's an interesting question but I think it's hard to predict.

What types of treatments are there for pelvic organ prolapse?

If you look at treatments, and again I don't consider observation only a treatment and some people early on opt for that. It really using a supportive device into the vagina that is placed, it's called a pessary. Kind of a strange name. But it can be placed and removed and sort of worn like you would wear a knee brace. Put it on and take it off. And we encourage women who may want to use that as a first start or as a temporary device until they want to have more definitive surgery to buy themselves some time, whether it be on their work life schedule or just watching the surgical technology evolve. And you know surgery keeps getting better and the techniques and some of the implants we're using keep getting better than maybe it's best to hold off for a couple of years using a conservative modality like a pessary. It's a great option. And then honestly the other option is a surgical treatment to correct the defects in pelvic support and re-establish the normal anatomy of the pelvis.

How successful are repairs for the pelvic organ prolapse?

In terms of success, it really depends what type of repair has been done. I guess it's probably easiest to group them into traditional endogenous tissue suture repair, which means the doctor uses your own body's tissues and a series of stitches or sutures to reattach the vagina to the pelvis and actually what we call plicate and it actually means just taking muscle and bringing it together and sort of plicating it over. Sort of a tucking of tissue and oversewing a bit. And that, unfortunately, and evidence shows that it's really not that successful, especially over time. So if you follow those patients over time, approximately 30 to 40% of them will fail over time. So it's not very good numbers when tissue, endogenous tissue, your own tissue and suture only. And that what has really driven and inspired a lot of physicians to start looking

elsewhere for another way to improve the durability of the surgery. And that has led to the concept of augmenting that repair with an implant. And that implant can either be a biologic implant or it can be a synthetic implant. And as we look at the evidence on how those surgeries are doing, it's starting to look fairly clearly, although the data is not robust, and it's not long-term, but there's some great comparative trials, meaning looking at one group of women versus another. And the ones that are using a synthetic, permanent synthetic material, especially kind of designed for this use, we learned a lot from the hernia world but the material has to be designed for this use and be very safely implemented and is really starting to show some promising results. How long? Yet to be determined but if you look over a period of a year or two, relatively short, the permanent materials are outperforming the traditional surgery without an implant by a significant margin.

What are the complications associated with the surgery?

The complications associated with the surgery are the traditional ones that you have any time that you go and to have a surgical intervention. First of all there can be an infection at the operative site because the surgical incision disrupts your normal host protection for bacteria and they can invade the surgical wounds. So there's always infection with any surgery. And of course there can be bleeding that's not desired and creating even maybe a transfusion situation if there is excessive bleeding. Then there's also the risk of injury to surrounding, adjacent organs. So when someone is operating on your vagina, the bladder next to it or the rectum could be injured during that. So there's always a risk of infection, bleeding, and injury. But when it comes to restorative surgery, which is different than taking out your appendix. When you take out your appendix, it's not coming back. But if I restore torn tissue in your body, whether it the rotator cuff in your shoulder or the torn ligaments in your pelvis, you can tear them again. So there's the risk of recurrence. So those risks are out there regardless if you have an implant or not. Once you start using an implant then the actual implant and the graph brings a new set of risks to the patient. And those have gotten a lot of attention. The FDA just recently this month in October of 2008, the FDA issued a notification of safety to physicians, making them more aware of the reports they've been receiving about probably the biggest area is erosion. That means that material has moved through the vaginal lining is now exposed. Or the other one is that the material is creating pain in the pelvis that is fairly refractory to treatment. So it's pain and obviously it's going to be most commonly with intercourse because that's when the vagina has the most mechanical strain put to it during intercourse. So pain with intercourse and erosion are the ones that are really being highlighted as having a slightly higher incident with using implants. And there lies the challenge of new surgeries, new innovations and surgical expertise in putting them in properly and safely.

If necessary, can the mesh ever be removed?

It can. It's difficult. I have taken mesh out that other physicians have placed in that was bothering the patient. That's very tedious. When I lecture I always say it takes 40 minutes to put one in and four hours to take one out. It's a very, very tedious procedure to remove the mesh. And we really can't get it out in its entirety. Some of the arms sort of are used to support the mesh, these arms wrap over and around the bones of the pelvis and through the muscles and they provide a holding force early on into the tissue grows into the mesh. So we can't get those arms out but they also tend not to be the troubled part of the mesh. It's the center body of the mesh that really is juxtaposed to the vaginal walls. We can remove it but it's tedious and it takes some skill.

How important is the skill of the surgeon in pelvic organ prolapse repair?

I would say it's critically important. And that's a big challenge, I think for the medical community. Because as innovation comes around and engineers are thinking about how to help with surgical approaches to things like wear and tear on our bodies. We're literally outliving our bodies. We're outliving our knees. We're outliving our joints. Women are outliving the supportive elements of their pelvis. So, yes, if you tear your ligament really bad when you're 18 or your knee, the doctors are going to repair that. If you do the same injury if your 80 and you have a bad knee, their most likely going to replace the knee. And so this replacement is a phenomena of aging and as engineers start to help surgeons with that there's definitely the technical aspects of how to properly place it. And how do you learn that if you're no longer a resident in a hospital setting with this controlled environment in that sort of apprentice style learning. So it is difficult and unfortunately physicians very often in kind of a desperation to try to help the patients and try to learn these new things, we really haven't gotten the experience broadly to do that. I think it's critical that patients find out what is the surgeon's experience and skill set with doing these new surgeries. Quite simply you just can ask. How many have you done? How many years have you been performing it? And ask them what are their results. I was lecturing just the other day and saying when you speak to your patients, and it's actually spelled out in the FDA, that you should discuss with patients the risks and quantify them for the patient. So you should be quoting the patient, what is your infection rate? Not what is reported in the literature by other physicians but you should be following your patients and you should know what your infection rate, you should know what your erosion rate and be able to share them with a patient and then patients will basically write them down and then call another physician immediately and look around a little bit. It's always amazing that people will comparatively shop for their automobiles or appliances and maybe which hotel they're staying in but they don't really do any comparative shopping for which physician will be doing the surgery, which is disappointing.

And what answers should she be looking for in pelvic organ prolapse repair surgery?

Well like I said, the first is how many of these surgeries have you done and how long have you been performing them. And, again, the longer they've been doing it and the more surgeries they've done, again from a probability stand more likely their experience has gotten them further long in their learning curve. And once you get a sense of okay so the doctor's been doing it for a couple of years and has done, hopefully, several, someplace in the range of 50 and greater. I think my teachings on this when surgeons ask well how long is it going to take me. So you really don't become, I don't think, truly an expert at it until you've done around 50. You're kind of beyond your learning curve. So I look for 50 or beyond in the number of cases. I would like to have the physician doing it for greater than a year. A year is sort of the minimum in terms of what your long-term sort of followup with your patients. And then they ask questions like infection rate, transfusion rate, complication rate and start from there. But it's easier than you think to really get this information, either candid questioning with the physician as well as doing a little shopping on-line and looking to see has the physician done any research on this particular area. Do they lecture and teach? Do they publish and write books? Because those will tend to be the leading experts in the field and you can quickly find that, like all things today, over the Internet. And I would also caution as any time a physician has difficulty answering these questions and doesn't really quite give you a clear answer, it's time to be a little bit concerned.

Thank you very much.