

Nonsurgical Management of Pelvic Organ Prolapse and Bowel Dysfunction

Part 2 of a 2-part series

Janelle Evans, MD; Mickey Karram, MD

There are a number of office-based evaluations and treatments for all categories of pelvic floor disorders, including pelvic organ prolapse and bowel dysfunction. Treating patients with nonsurgical procedures may be the first step prior to surgery.

Conservative therapies for patients who are not appropriate surgical candidates or those who do not desire corrective surgery are available,¹ even though the majority of treatment options for severe pelvic organ prolapse (stages III and IV) are surgical. The ACOG practice bulletin recommends pessary trial use prior to surgical management in patients.²

Pelvic Organ Prolapse

Initial Management and Troubleshooting

Pessaries may be used both for long-term support and for initial management and symptom troubleshooting. If a patient does not appear to have significant prolapse on exam, placement of a ring pessary to elevate the vaginal tissue can be used in a trial fashion to investigate if that relieves the symptoms of pressure or bulge. In addition, placement of a pessary may also elicit occult stress incontinence after reduction of the prolapse, indicating the need for an anti-incontinence procedure at the time of future surgery.

Pessaries come in a variety of shapes, sizes, and functional modifications (Fig-

ure). Many patients find pessary use nonintrusive and simple to maintain. Some types of pessary, such as the ring or ring-with-support, can be independently managed if the patient possesses ad-

equate daily functionality. Other types, such as the cube, doughnut, or inflatable pessaries, are more difficult to manage and may require frequent office visits to prevent vaginal ulceration and infection.

Importance of Proper Fitting

Proper fitting is often a trial-and-error process, with the goal of sizing to be large

Janelle Evans, MD, is Urogynecology Fellow, The Christ Hospital, Cincinnati, OH; and **Mickey Karram, MD**, is Director of Urogynecology, The Christ Hospital, Cincinnati, OH.

FOCUSPOINT

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FIGURE: Various shapes and sizes of available pessaries. Used with permission. © Clara Angela Foundation, clara-angela@t-online.de

Bowel Dysfunction

Bowel complaints in routine gynecologic practice span from constipation to chronic diarrhea to fecal incontinence. In the average urogynecology clinic, there is a significant amount of overlap in pelvic floor derangements and bowel dysfunction. Miedel et al reported on a cohort of 206 women who were evaluated to assess associations between

enough to remain in the vagina during daily activities, including straining and lifting, yet not so big as to be bothersome to the patient. Most patients can be managed successfully with a ring pessary with support, especially with early-stage prolapse. For stage III and IV prolapse, the ring is still a possibility, but a space-occupying pessary such as a Gellhorn may be more efficacious. Other types of pessaries such as a Gehrung can be helpful with predominant cystocele or rectocele support.³

Recommendations vary for pessary maintenance follow-up. However, follow-up generally ranges from 2 to 6 months for many pessary types after patient satisfaction is established. In our office, we prefer ring pessaries for most patients, secondary to ease of insertion, removal, and low erosion of the vaginal epithelium.

It is important to recognize that about 20% of women will have occult stress incontinence after proper placement of a pessary, due to restoration of a more normal vaginal axis, and may be better served with a pessary that has an incontinence knob. If patients continue to have significant incontinence, an injection with a bulking agent or midurethral sling can be considered.¹

Other Therapeutic Options

In mild cases of prolapse, estrogen cream or the estrogen vaginal ring, with or without physical therapy, are options. Estrogen cream is also an adjunctive therapy to pessary use to prevent vaginal thinning and ulceration from the foreign body.

compartmental prolapse and pelvic floor symptoms.⁴ Compartmental defects in the anterior, posterior, and apical support were quantified in conjunction with complaints of bowel, urinary, or mechanical symptoms (bulge/pressure).

Not surprisingly, there was a wide overlap in reports of bowel and urinary symptoms, with 63% of women reporting either urge or stress incontinence and 73% of women complaining of at least one bowel symptom (hard stool, difficult evacuation, pain). Incontinence of flatus was reported in 40%. Incontinence of both stool and urine can coexist in up to 60% of women complaining of either symptom.⁴

Bowel Regimens

Bowel regimens to improve problems with transit time or consistency are often first steps. Fiber intake of more than 25 g/day is recommended, as well as adequate fluid consumption. Some medications, such as antimuscarinics and tricyclic antidepressants, can cause slow gastrointestinal motility and should be minimized in cases of severe constipation. For chronic diarrhea leading to bowel dysfunction, bulking agents and loperamide are often required to achieve appropriate stool consistency. It is essential to rule out more dangerous causes of bowel complaints, eg, malignancy or inflammatory bowel disease, prior to initiation of conservative therapies.

Management of Constipation

Constipation is a common complaint in the United States. From a therapeutic standpoint, its treatment is aimed

at addressing the etiology, whether it is anatomic or functional in origin. Constipation due to hard stools is treated with increased fluid intake and fiber, as well as with stool softeners and mild laxatives as needed. It is important to avoid straining with bowel movements, and proper stool consistency is often maintained with minor dietary modifications. Long-standing constipation due to lifestyle factors can lead to diverticulosis, hemorrhoids, pelvic organ prolapse, and anal fissures.⁵

Constipation due to defecatory dysfunction can be due to anatomic or motility disorders. Anatomically, outlet obstruction due to pelvic organ prolapse or nonrelaxing puborectalis muscles can cause chronic entrapment of stool. Motility disorders such as Hirschsprung disease or neurologic disorders can also cause difficult evacuation or unacceptably slow transit.

Anatomic obstruction due to pelvic organ prolapse may be appropriately treated with a pessary or splinting on the vagina against a protruding rectocele. Obstruction due to nonrelaxing puborectalis may be treated with pelvic floor physical therapy for muscle retraining. Hirschsprung disease and other neurologic disorders are often treated with chronic laxative and enema use to encourage motility and prevent obstruction.⁶

Fecal Incontinence

Unintentional loss of flatus and stool is a physically and socially impairing disorder affecting an estimated 2% to 3% of noninstitutionalized adults. Fecal incontinence is often due to anal sphincter injury during childbirth or other pelvic floor trauma, but it can also be caused by many other factors, eg, neurologic dysfunction, anatomic derangements such as rectal prolapse, or motility disorders. Use of endoanal ultrasound and defecography can aid in the diagnosis prior to initiation of therapy.

The mainstay of treatment for fecal incontinence is dietary modification (eg, increased fiber intake and avoidance of foods that may cause the person to devel-

op loose or watery stools), stool bulking agents containing fibers, and pelvic floor physical therapy with or without electrical stimulation (e-stim). In addition, antitility agents such as loperamide may be used to slow gut transit. Combinations of these therapies are often used to maximize therapeutic effect.⁷

Summary

As illustrated, there are a number of conservative, office-based evaluations and treatments for all categories of pelvic floor disorders. Being well-versed in both the surgical and nonsurgical aspects of treatment of patient complaints is essential for a well-rounded practice that offers patients all of the appropriate options.

Part 1 of this 2-part series focuses on Lower Urinary Tract symptoms (*The Female Patient*.2011;36[8]:14-20).

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