

How to check for a vaginal prolapse

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A new conceptual model for characterising and reporting a vaginal prolapse is simple to use and understand. This article describes how to use it.

A prolapse is the protrusion of a pelvic organ beyond its normal anatomical boundaries. It has a significant adverse effect on quality of life and often results in the need for surgery. Although the cause is not known, evidence is accumulating that connective tissue abnormalities are important.

Acquired factors leading to prolapse include:¹

- vaginal delivery
- factors associated with a rise in intra-abdominal pressure
- adverse dietary influences, such as lack of vitamin C
- obesity
- corticosteroid therapy
- previous pelvic surgery.

Clinical features

Symptoms of prolapse include a dragging discomfort, a sensation of a lump in the vagina, urinary symptoms (such as voiding difficulty) and incomplete bowel emptying. If low backache is caused by uterine prolapse, it can be relieved by lying flat or by the use of a ring pessary. Although urinary stress incontinence

may be present, prolapse is not the cause of it, and urinary stress incontinence is usually not relieved by prolapse repair.

Classification of prolapse

Terms used

A variety of terms are used to describe female genital prolapse. These terms are so fixed in the mind of practitioners that it is impossible to avoid using them.

- **Cystocele** is a downward displacement of the bladder.
- **Urethrocele** is a downward displacement of the urethra.
- **Cystourethrocele** is a cystocele that includes the urethra as part of the prolapse.
- **Uterine prolapse** is descent of the uterus and cervix down the vaginal canal toward the hymen.
- **Rectocele** is a protrusion of the rectum into the posterior vaginal wall.
- **Enterocoele** is a herniation of the small bowel into the apex of the vagina and/or the upper part of the posterior vaginal wall.

A cystocele can occur on its own; a urethrocele rarely does. Often an enterocele and rectocele coexist, and it may be difficult to detect an enterocele clinically.

Unfortunately these terms are inaccurate and misleading. They prejudge the nature of the prolapse by focusing

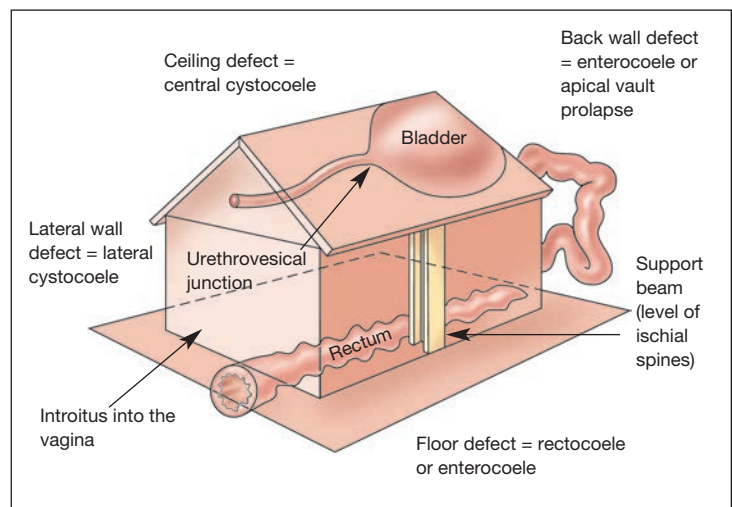


Figure 1. The conceptual model for assessing pelvic floor defects. (Diagram adapted from Scotti RJ, et al.³)

attention on the bladder, rectum or uterus rather than the specific defects that are responsible for the loss of vaginal support.

Conventional grading

Some amount of vaginal laxity is normal, and prolapse is a matter of degree rather than being absolute. There are many grading classifications, and some are very complex and impractical.

Conventionally, any descent within the vagina has been graded as first degree, descent to the hymen as second degree, and descent beyond the hymen as third degree. This is simple but lacks accuracy for scientific comparison. A more complex system has been devised by the International Continence Society,² but the average practitioner has found it confusing and somewhat difficult to learn and apply.

Conceptual model for assessing prolapse

A new conceptual approach was described recently and is simple to use and understand.³ It uses a three-dimensional rectangular model, a cubicle, with one wall missing (the introitus).

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Figure 2. Retracting the posterior vaginal wall and observing the apex and anterior and lateral vaginal walls.



Figure 3. Retracting the anterior vaginal wall and observing the posterior wall, apex and lateral walls.

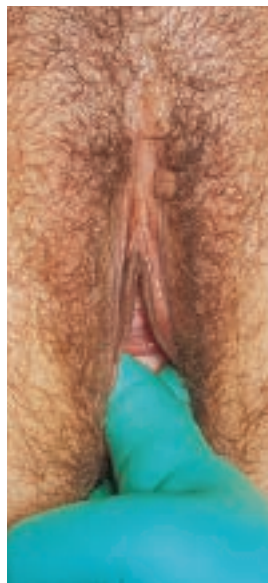


Figure 4. Evaluating the lateral walls using crossed index fingers.

The various compartments in relation to this cubicle are the floor (posterior vaginal wall), the ceiling (anterior vaginal wall), the back wall (apex) and side walls (lateral vaginal walls). In other words, the bladder is above the ceiling, the rectum is below the floor, and the remainder of the small and large bowel, along with the uterus, are bulging behind the back wall (Figure 1).

Preparation

The patient is instructed to empty her bladder – except when there are symptoms of urinary incontinence, because only with a full bladder can stress incontinence be elicited. She is asked to lie on her back on the examination couch, and is suitably draped for modesty. She should be examined initially in the dorsal position with the hips flexed and subsequently in the left lateral position. The examiner's hands should be gloved. The pelvic area is then illuminated, and the examiner faces the patient.

Instruments or equipment needed

All that is needed are gloved hands, a monovalve speculum and a disposable tape measure. If a monovalve speculum is not available, the posterior blade of a bivalve speculum is quite satisfactory.

The speculum should be warmed with tap water – not lubricated – if vaginal or cervical smears are to be obtained or if cultures are to be performed.

How to check the prolapse

Ask the patient to strain while you retract the posterior vaginal wall with the speculum and observe the apex and anterior and lateral vaginal walls (Figure 2).

Retract the anterior vaginal wall and observe the posterior wall, apex and lateral walls (Figure 3).

Insert one or two fingers in the vagina and examine both anterior and posterior walls, palpating and measuring the degree of prolapse and the length of the nonprolapsed portion of the vagina. Confirm all measurements made by

digital examination by placing the disposable tape measure along the finger.

Evaluate the lateral walls by crossing your two index fingers while the patient strains (Figure 4).

Sometimes the patient may have to stand up to demonstrate prolapse, and the examination will need to be repeated.

For each compartment, the bulges are characterised and reported as small (<3 cm), moderate (3 to 6 cm) or large (>6 cm). The level of descent is further characterised by whether it occupies the low, middle or high zone of the vagina. As the average vaginal length is 9 cm, this is easy, because each zone represents 3 cm in length – except in the few patients who have a short or very long vagina.

It is therefore possible to report the location of the prolapse by vaginal zone and its size in a reproducible and accurate system on a simple form (Figure 5).

Clinical tips

If a rectocele protrudes and obstructs an enterocele, the examining finger can reduce the rectocele, and the enterocele will be either seen at the tip of the examining finger or felt as an impulse on coughing. Further differentiation can be made by asking the patient to cough while the rectum and vagina are examined simultaneously: when the 'rectal finger' is pushed towards the vagina, the 'vaginal finger' can palpate a separate bulge above the rectal finger if an enterocele is present (Figure 6).

If the cervix protrudes outside the vagina, it may be ulcerated and enlarged, with thickening of the vaginal skin. Cervical cancer is never a sequela of prolapse, but of course it may be a coincidental finding.

A thorough abdominal and full pelvic examination should always be performed to exclude a pelvic tumour or ascites that may be precipitating the prolapse.

It may be difficult to demonstrate a rectal prolapse during a pelvic examination. If this is suspected, the patient

Location (by vaginal zone) Low = lowest third (3 cm) of vagina Mid = mid third of vagina High = upper third of vagina	Size (tick the largest diameter straining)		
	Small <3 cm	Moderate 3 to 6 cm	Large >6 cm
Anterior wall ('central cystocele')			
Low			
Mid			
High			
Left lateral wall ('lateral cystocele')			
Low			
Mid			
High			
Right lateral wall ('lateral cystocele')			
Low			
Mid			
High			
Posterior wall ('rectocele')			
Low			
Mid			
High			
Apex			
Anterior fornix			
Posterior fornix			
Cervix			

Figure 5. Sample of form for reporting the location and size of the prolapse. (Adapted from Scotti RJ, et al.³)

should be encouraged to strain and empty her bowels in the privacy of a toilet, and the rectal prolapse will materialise.

Conditions that may mimic prolapse and hence cause confusion are:

- congenital anterior vaginal wall cyst (Gartner's duct remnant)
- urethral diverticulum
- suburethral metastases from a uterine cancer
- simple inclusion cysts
- large cervical or endometrial polyps
- chronic uterine inversion.

Treatment

Asymptomatic prolapse does not need treatment. An exception is a woman with stress incontinence and prolapse who is about to undergo surgical bladder neck suspension.

Symptomatic prolapse can be treated

conservatively or surgically, depending on the individual.

Conservative management involves fitting the patient with a pessary and, for women who are postmenopausal, the use of intravaginal oestrogens. Pelvic floor exercises have no proven benefit for patients with significant prolapse.

Traditionally, prolapse has been treated by surgery, the nature of which depends on the type of prolapse. Most of the operations are performed through the vagina, while the abdominal route is reserved for recurrent or complex prolapse. The aim of surgery is restoration of the normal anatomy without compromising bladder, bowel or coital function.

Conclusion

Vaginal prolapse is very common, and it is not necessary for the woman to put



Figure 6. Examining the rectum and vagina simultaneously, to feel for an enterocele.

up with the symptoms. The right diagnosis and treatment can help restore a life free of discomfort. The conceptual approach to assessing a prolapse is simple to use.

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