Solving Prolapse: It's Fallen & Can't Get Up Transcript

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Introduction to Pelvic Organ Prolapse

Hi. I'm Dr. Betsy Greenleaf. You're one of your hosts of the Solving Sexual Dysfunction Summit. And I'm going to talk about a little bit about pelvic organ prolapse.

Now, this is something that 50% of women will experience at some point in their lives, yet nobody ever talks about it. And so it can be very scary and very concerning when something like this shows up.

So I'm also going to warn you, as the first board certified female, your gynecologist in the country, this is something that I have treated for years.

And my next slide is a little graphic. So if you don't like anatomy slides, we're going to just I you can just close your eyes for a minute and I'll tell you when you can open them again, but I'll give you a little bit of history.

I was in the process of writing a chapter in a book or a textbook on pelvic organ prolapse, and I put a picture of one of my patients who had a what was called a complete prolapse.

And I had my husband, who is non-medical, proofread for me. And he came across this picture and was like, What in the world is that? Oh my God. Like, that woman has a penis and I'm and fortunately that is the result that many women think when they have what's called a complete prolapse.

A complete prolapse is where the vagina can turn completely inside out, and the uterus is now hanging between their legs. And so I'm going to flash that picture right now to get an idea of what an extreme case would look like.

So here is a complete prolapse of the vagina. And what you're looking at at the bottom is the cervix and the vagina has turned completely inside out, is now hanging between someone's legs.

What Severe Prolapse Looks Like

So for anybody who is squeamish, I now switched off that. And you can come back and watch. So half of all women 50 years and older will develop a pelvic organ prolapse, or they refer to them as a pop.

And in fact, there's about 73.6 million people right now that are walking around with this. Now, this, of course, you wake up and something like this happens and your first response is, oh, my God, what?

What is this growth? What is this? And I get people think it's a cancer. They're you know, they don't know what it is. It's very scary. It causes them to go to the emergency room.

Well, I'm here to tell you that good news is a pelvic organ Prolapse is not an emergency, though it can be a little disconcerting and can make women feel very self-conscious of their bodies.

There's really not a lot that you're going to do that's going to make things worse. Now, lifting heavy objects, especially if you don't hold your breath.

So it's the leg. This has happened because the ligaments in the pelvis that are supposed to be holding everything up have torn or they've stretched. And this can happen over a period of years, or it can happen just like that.

Like, say you lift something really heavy or bear down and have a bowel movement really hard. If you're constipated, all of a sudden you can get something that is bulging.

Now that is called a stage four prolapse. Women can get anywhere from a stage one where it's just a little bit of a

weakness all the way to stage four, which completely turned out inside out.

I know a lot of women will become self-conscious, especially if they have some of the lower stages, and they're worried that that that having sex is going to ruin this.

Typically, sex is not going to affect it. And when we're laid down, you're right, things go back up where they're supposed to. So this is one of those things where I tell people it is okay to have sex, but it's definitely something you want to get checked out either by a gynecologist or a neuro gynecologist.

Causes and Risk Factors

And another common question I get from patients is, well, I went to my gynecologist and they didn't see it. Like what was wrong with them? Like, were they not a good gynecologist?

Like, why don't they know that I have this problem? Well, once again, I say when we lay down flat, we don't have the pressure of gravity on our body. So things tend to go back up where they're supposed to be.

So a lot of times when you're at the regular gynecologists, they're not looking necessary for a prolapse. So unless you're bearing down, have a bowel movement or like, you know, kind of coughing when you're having an exam or what has your gynecologist like to do is have people stand up for their examinations so that so that we can see how far this is coming down.

But what causes the pelvic organ prolapse? Well, a lot of times it's kind of like a hammock. Like our pelvic floor is like a big giant hammock. And all our organs are just being held up by this hammock.

We don't have bones that are going across them the bottom of our pelvic floor, all we really have is muscles that are holding things in place that you get my handy dandy pelvis out.

So here's the pelvis and we take the pelvic organs out. Really like our bodies are open and our muscles are the only thing that are holding things in.

So from the inside and outside that all we have is our muscles, our skin, our nerves, our connective tissue holding things in. So that tissue can be damaged over time.

And so things like childbearing. Just being pregnant alone can. You don't even have to give birth only to have it happen in things that cause increased public pressure, such as constipation, lifting, coughing.

And some of it is just unfortunate. Things like genetics or medical conditions, smoking will weaken the tissue nutrition deficiency and sometimes just the aging process of our tissue.

So, you know, when I show people this picture in my office, they often wish they never had children. And unfortunately, it's just to show that as women, we're built with breakaway zones because nature doesn't care if your vagina is hanging out.

Nature cares that the baby gets out. So if you look on the one side of the screen, you will see on the top is a bladder. This is like if we cut the body in half and we're like from side to side and we're looking at from the front all the organs, the next layer down, you're seeing the vagina, and then the next layer down you see the rectum and then you see this kind of bluish grayish tissue.

Those are the ligaments that are holding each one of those organs in place. And you can see the bladder leans on the vagina. The rectum is on the vagina.

Everything is just kind of like in its place with these with these ligaments. And then on the other side, we have a baby's head coming through and during a vaginal birth.

And so what happens is now we're getting compression on all those organs. And often we get, you know, the body has tearaway zones. We have these ligaments will rip, rip and tear to to basically keep the baby.

We need to get the baby out. And so nature doesn't care if everything's where it's supposed to be. So this is often where it can happen. Here also is the pelvic support.

This is the looking down into a pelvis with the organs removed and this bluish gray material are all the little levels of ligaments that are often damaged during pregnancy.

Childbirth. I've seen gymnasts have problems. I've had people who've never given birth, who were in jobs where they had to lift heavy objects. Or maybe they were somebody who had chronic constipation or chronic bronchitis causing damage to this tissue.

And then once again, looking from the side. So on the one side of the screen, we have the front of the body and then we have the back of the body.

Types of Prolapse and Symptoms

And in from front to back, we have the re through the trip, through the bladder, the vagina, the cervix in the uterus and the rectum. You can see each one of those things sit so incredibly close together so that it's very, you know, ligaments in one area go, things drop.

So a lot of times people say to me, well, they come in like all my bladders dropped or my uterus is dropped unless somebody specifically told you, you don't know because that, as we call it, we may be calling it a cyst, a seal.

So here's what's a cyst to seal, which is a bladder drop. It's where the ligaments between the vagina and the bladder weaken. And the bladder? The bladder is that, first of all, bladder is not going to drop out and fall on the floor.

You're good. Nothing's going to fall on the floor. It may feel like it, but it's not. And so the bladder starts to lean on the vagina and the vagina is meant to stretch indefinitely because, I mean, look, a baby can fit through there.

So the vagina is just going to keep stretching and stretching as much as that pressure is put on it. And so that is where the bladder is dropping. Now, you could also have what's called a rectus seal where the rectum is.

The ligaments between the rectum and the vagina have been damaged and now that's pushing things out. Or you can have a uterine prolapse where and that's what we saw in that picture.

It's where the ligaments holding up the uterus, sort of the top of the vagina. Now come down and turn inside out. So what needs to be done about this?

The best thing is you don't have to do anything. Now, some people are like, what I my criteria for surgery on something like this is if it's bothering you physically or mentally enough to take the risks of surgery, that's when you do surgery.

So I'm like the anti surgeon surgeons and anti surgery surgeon. So I think that a lot of times we have to look at everybody. Individual case. I've had women that come into my practice just as bad as that one than we saw at the beginning of this lecture.

And they're like, You know what? Not bothering me. And I'm like, okay, if it's not bothering you, well then let's look at the next thing. Is it causing any medical problems?

It's not causing any medical problems. Then we just go. All right, let's just check it once a year and see what's going on or check it every six months.

So that's a possibility. Now, let's say it is bothering you, but you don't want to have surgery. There are some things you can do, things like behavior modification, trying not to get constipated and trying to keep the bowels regular so that you're not bearing down, not lifting heavy objects.

When you lift blowout as you're left, you're not increasing your pelvic pressure, putting too much pressure on the on the pelvis. Sex is not something that you need to have to worry about.

You can still have sex. You're not going to earn it. Doing legal exercise. Sometimes strengthening the pelvic floor will improve the prolapse. Now, I'm not going to take a complete prolapse and turn things back inside out before our stage one, two or three prolapse.

It can improve the appearance of the prolapse when those muscles in the pelvic floor are strengthened. I think we're doing things like external support.

So this is a external support. There's certain things like different girdles or supports that can be worn that will just push it back up in place and make it feel more comfortable.

Sometimes using a little bit of estrogen topically or DHEA, topical hormones to the vaginal tissue will help thicken the vaginal tissue and decrease the appearance of the prolapse.

Pelvic Physical Therapy. Awesome. My favorite thing in the world can help with all sorts of conditions. Usually something like a tampon out there now is on the market, something called the Impreza.

I don't recommend tampons themselves because a tampon can hold bacteria and we don't want to get an infection from of bacteria.

When Treatment Is Needed

But there are products like the Poise Impreza, which can be bought over the counter, is a tampon like device that doesn't that does not absorb bacteria that would push the prolapse up where this tampon device in that area and then it can hold things in place.

So when you're doing activities or a exercise class pester and we're going to get a little bit more into passphrase and then there's surgery. So less is more so.

So what if you do nothing? So you don't need to treat a patient or somebody who's asymptomatic, but they do have a higher risk of recurrent bladder infections because when the bladder is dropping, the urine has to travel upheld to get out.

And so sometimes we don't fully empower the bladder so they could develop. We need to make sure they're not developing something called hydrogen of process.

And this is what's seen in this picture where if the bladder is not emptying, the urine can be backing up into the kidneys. And over time can be straining and stressing the kidneys and stretching the kidney out, then that would be a reason that if we're seeing that, then doing some more intervention would be a better idea.

But urinary retention sometimes if the bladder too kinked from it dropping down, that may affect a person's ability to urinate. Not just not empty. Maybe they can't urinate at all.

That would be a time to intervene and also comfort some people. Some patients don't have any problems with it. Some people find it incredibly uncomfortable.

I also say if it mentally bothers you enough that the risks of other procedures are worth it, and that's mental anguish is another good reason to do one of the more extreme treatment.

Now, passages. Passages are kind of crazy. They are support devices that are fitted for the vagina. And nowadays we have a company that actually using three D do technology and printing will print one for your specific vagina because in the past we just had ones that were just standard, you know, came in different shots, shapes and sizes.

But this idea of a passages, it just goes in and wedges in the vagina, holds everything in place and this backs this dates back to ancient Egypt. And they used to use pomegranate potatoes, wax balls, fabric balls, wood and metal.

I do not recommend any of those. The passages that are on the market today are usually latex, free silicone. They are fitted by a health care practitioner for you and they can be either taken out every single day, washed, cleaned, put back some people, leave them.

And at night for the patients who don't have Dexter ready enough to take them in and out on their own, we typically leave them, can leave them in for about three months.

Pessaries and Conservative Management

But on an individual basis, I don't like leaving them past six months. Even then, there's no hard data saying how long to leave them. I have seen people who've left them in accidentally for years and you know, came to me.

They were first time patient and had gotten one from another place and didn't realize it was in there. And the longer you leave it in there and the higher risk of having a discharge, but you can also get the tissue can actually start to grow around it.

I have seen that happen. So these do have to be taken out and cleaned from time to time. You can have sex with some of them in place. So that is another option.

Some of them can actually be left in place during sexual activity. So once again, they can be they basically are designed to wedge in place and hold things up some.

They should never be painful and you should never know that they're there. So once they're in place, you shouldn't like just be like, okay, this is normal.

But if you're having pressures or unmasks incontinence, you didn't know you're having this and they need to be adjusted. Same thing if you're getting constipated with them.

So some of the risks in pessaries can be urinary retention, fecal retention, ulceration, and if they're often too long, if they grow around or they can also rate through the tissue and perforate the vagina if left in too long and not managed properly.

And once there is no evidence of how long they can be in place. So some patients will take them out and clean them every day, week, month on average. We will take them in and out every about every three months, 3 to 4 months.

Now there is a whole host of surgeries and the what and they are called so many different things. There is a perfect couple cases compacted, complexly called the plastic pair of adrenal repair, a whole mouthful of things.

The key is with surgery is that surgeries do not necessarily fix this a lifetime. No, I trained in a day and age when we were using a lot of agile mesh and they were like, oh, this is the new thing.

It's going to be great and everyone's going to be fixed and they're never going to have a problem again. We've already shown that people who have a prolapse, number one, have a propensity for their tissue to rip and tear.

So they're much higher or much higher risk of having it happen again. So even though it's been surgically fixed, we love it when patients get a lifetime out of it. We're ecstatic.

We're happy if people get five years out of a out of a repair. So just you know, I've had some women, we repair them. Things have been perfect. And then they decided to go lift up a big turkey for turkey dinner and Pap hadn't had another had it come back out.

So this is something you need to really consider. There's there's risks with surgery, there's risks of bleeding, there's risks of infection, there's risks of pain.

If you're having pain to begin with, don't do surgery. If you're having a pelvic pain condition, you want that looked into way before you do any kind of surgery because surgery can worsen it.

Surgical Options and Recurrence Risk

So the key is have a really long discussion with your your surgeon and ask them like, what are the expectations if somebody is going to tell you or fix it and it's going to be good for life, don't believe them.

Go find the next one, because we really there's no way to predict how the tissue is going to respond to this. So this is something that we do these surgeons do all the time.

There's different ways to do it from in through the vagina or coming in from the top. But statistically and the research doesn't show that one is necessarily better than the other.

And that brings up that tissues can be. We do see that some people this have a genetic predisposition and this is why some people's ligaments are much, much thinner than other people's ligaments.

And so just having one surgery predisposes you to having more surgery because your ligaments have already shown they have a propensity to rip and tear.

So that's and then just to consider about before having surgery. So this has been our little intro on Prolapse and some of the options that are out there.

You want to if you're looking for a neuro gynecologist that does this type of surgery, I would recommend you go to voices for pelvic floor.org (voicesforpfd.org) So it's voicesforpfd.org That is the website for the American Neuro Gynecology Association.

Finding a Specialist and Closing Remarks

There's also if you're live in another country, there is the International Neuro Gynecology Association. You can look them up online and, you know, we will be talking more about this and upcoming masterclasses and lectures.

So follow me for more information and stick around because we have more great sessions coming up.