

EDITORIALS

Managing mild, symptomatic pelvic organ prolapse

The best course of action may be to delay any treatment for prolapse until symptoms become bothersome

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In a linked paper (doi:10.1136/bmj.g7378), Wiegersma and colleagues report a well designed randomized trial evaluating pelvic floor muscle training for women with mild symptomatic pelvic organ prolapse.¹ Fifty seven per cent of women in the intervention group reported an overall improvement in prolapse related symptoms over three months, compared with 13% of controls managed with watchful waiting ($P<0.001$).

Women given pelvic floor muscle training also improved by on average 9.1 (95% confidence interval 2.8 to 15.4) points more on a validated symptom scale (the Pelvic Floor Distress Inventory-20, range 0-300) than did controls. However, this difference, although statistically significant, was too small to be noticeable clinically. The minimum clinically relevant difference on this scale is 15 points. As the authors mention, the three month treatment duration may not have been long enough to make any appreciable difference to symptoms. Pelvic floor muscle training works by strengthening the muscles of the pelvic floor and providing women with valuable biofeedback as to how to control their pelvic floor. This process takes time and requires good adherence to training, exercises at home, and lifestyle advice.

Another recent randomized trial by Bø and colleagues evaluated pelvic floor muscle training to both treat and prevent the signs and symptoms of pelvic organ prolapse.² In a group of 175 primiparous postpartum women without symptoms and with no prolapse, the training had no effect on the development of stage 2 prolapse over a four month period starting six to eight weeks after delivery. However, the short study period may not have allowed enough time for the development of pelvic organ prolapse in either group.

In the Pelvic Organ Prolapse Physiotherapy (POPPY) trial, Hagen and colleagues compared four months of individual face to face pelvic floor muscle training with no intervention in women with symptomatic stages 1, 2, and 3 pelvic organ prolapse.³ Participants were followed up for one year. Women who received active training reported significantly fewer

symptoms than controls at six months (52% v 17%) and 12 months (57% v 45%). Of particular interest, a significantly smaller percentage of women in the intervention group sought additional treatments such as surgery, pessary, drugs, or additional physiotherapy (24% v 50%; $P<0.001$). These findings suggest that longer treatment may be beneficial and that higher stage, symptomatic prolapse may be more responsive to pelvic floor muscle training than the lower stage prolapse treated in Wiegersma and colleagues' study.

Surgery remains an effective treatment for pelvic organ prolapse when more conservative measures fail,⁴⁻⁵ despite recent controversies about the safety and effectiveness of vaginally placed mesh.⁶ Overall, we are now more aware of the need to support the apex of the vagina to prevent recurrent prolapse. In addition to apical suspension procedures approached through the vagina, sacrocolpopexy can now be performed laparoscopically and robotically, allowing for smaller incisions and a shorter recovery time.⁷ For anterior and posterior compartment prolapse without a significant apical component, colporrhaphy continues to be effective with a low complication rate.⁸ Colpocleisis is a safe surgical option for older women who are no longer interested in sexual activity, with minimal risk of recurrence of prolapse.⁹ With careful selection of patients, surgical options for the management of pelvic organ prolapse are safe and effective.

The fact that 57% of women in Wiegersma and colleagues' trial reported overall improvement in symptoms after pelvic floor muscle training is an interesting finding: more than half of women who performed this training for symptomatic mild prolapse felt better. Regardless of the placebo effect (a potentially large contributor), this improvement might be reason enough to offer pelvic floor muscle training to women with mild prolapse.

However, viewing the findings of the trial objectively, the symptomatic response to pelvic floor muscle training looks inadequate, so we could also argue that prolapse is best managed

with pessaries or with surgery once symptoms reach a certain level of bother. Wiegersma and colleagues are evaluating this very question now in their study “Pelvic floor muscle training versus watchful waiting or pessary treatment for pelvic organ prolapse (POPSS).”¹⁰

In a multicenter observational study of 1004 women aged between 18 and 83 years who were assessed during a routine gynecological visit, Swift and colleagues found the prevalences of pelvic organ prolapse stages 0, 1, 2, and 3 to be 24%, 38%, 35%, and 2%, respectively.¹¹ Asymptomatic prolapse of varying stages could be considered a variant of normal. On the basis of Swift’s findings, as well as results of the study by Wiegersma and colleagues,¹ the best course of action may be to delay any treatment for prolapse until symptoms become bothersome. At that point, both pessary management and surgery should be discussed.

It would be valuable if the authors of this latest study followed up their participants for at least 12 months after randomization, and ideally for longer, to determine whether pelvic floor muscle training helps to reduce symptoms, prevents worsening of prolapse, and perhaps helps women to avoid surgical interventions in the future. Definitive clinical trial evidence that prompts intervention with pelvic floor muscle training could prevent progression of early stage prolapse and its associated symptoms would revolutionize the way we manage this condition.

Competing interests: We have read and understood the BMJ policy on declaration of interests and declare the following interests: JTA is an

investigator for American Medical Systems sling safety studies and co-investigator for Boston Scientific sling safety studies.

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- 1 Wiegersma M, Panman CM, Kollen BJ, Berger MY, Lisman-Van Leeuwen Y, Dekker JH. Effect of pelvic floor muscle training compared with watchful waiting in older women with symptomatic mild pelvic organ prolapse: randomised controlled trial in primary care. *BMJ* 2014;349:g7378.
- 2 Bø K, Hilde G, Stær-Jensen J, Siafarikas F, Tennfjord MK, Engh ME. Postpartum pelvic floor muscle training and pelvic organ prolapse—a randomized trial of primiparous women. *Am J Obstet Gynecol* 2014; published online 28 Jun.
- 3 Hagen S, Stark D, Glazener C, Dickson S, Barry S, Elders A, et al. Individualised pelvic floor muscle training in women with pelvic organ prolapse (POPPY): a multicentre randomized controlled trial. *Lancet* 2013;383:796-806.
- 4 Hudson CO, Northington GM, Lyles RH, Karp DR. Outcomes of robotic sacrocolpopexy: a systematic review and meta-analysis. *Female Pelvic Med Reconstr Surg* 2014;20:252-60.
- 5 Barber MD, Brubaker L, Burgio KL, Richter HE, Nygaard I, Weidner AC, et al. Comparison of 2 transvaginal surgical approaches and perioperative behavioral therapy for apical vaginal prolapse: the OPTIMAL randomized trial. *JAMA* 2014;331:1023-34.
- 6 Wood LN, Anger JT. Urinary incontinence in women. *BMJ* 2014;349:g4531.
- 7 Lee RK, Mottrie A, Payne CK, Waltregny D. A review of the current status of laparoscopic and robot-assisted sacrocolpopexy for pelvic organ prolapse. *Eur Urol* 2014;65:1128-37.
- 8 Nunes Tamanini JT, de Oliveira Souza Castro RC, Tamanini JM, Castro RA, Ferreira Sartori MG, Batista Castello Girão MJ. A prospective, randomized and controlled trial for the treatment of anterior vaginal wall prolapse: medium-term follow-up. *J Urol* 2014; published online 8 Oct.
- 9 Koski ME, Chow D, Bedestani A, Togami JM, Chesson RR, Winters JC. Colpocleisis for advanced pelvic organ prolapse. *Urology* 2012;80:542-6.
- 10 Wiegersma M, Panman CM, Kollen BJ, Vermeulen KM, Schram AJ, Messelink EJ, et al. Pelvic floor muscle training versus watchful waiting or pessary treatment for pelvic organ prolapse (POPSS): design and participant baseline characteristics of two parallel pragmatic randomized controlled trials in primary care. *Maturitas* 2014;77:168-73.
- 11 Swift S, Woodman P, O’Boyle A, Kahn M, Valley M, Bland D, et al. Pelvic Organ Support Study (POSS): the distribution, clinical definition, and epidemiologic condition of pelvic organ support defects. *Am J Obstet Gynecol* 2005;192:795-806.

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