PIPADOR REVISION

MRCOG Part 1 Revision Notes

Pelvic Organ Prolapse

CLINICAL MANAGEMENT • LECTURE 498

VISUAL EXAMINATION REVISION NOTES

2026 Edition

498

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Pelvic Organ Prolapse

Definitions, staging, assessment and conservative and surgical management of POP (NICE NG123)

POP-Q	PFMT	Pessary	≈ 30%
Staging system	≥ 16 weeks	Effective alternative	Recurrence after surgery

■ KEY FACTS: Learning objectives

- Define pelvic organ prolapse and its compartments, and describe POP-Q staging.
- Describe assessment and conservative management, including pessaries (NICE NG123).
- Describe surgical options for anterior, posterior, uterine and vault prolapse and the restrictions on mesh.

498.1 Key definitions

Term	Definition
Pelvic organ prolapse (POP)	Descent of one or more of the anterior vaginal wall, posterior vaginal wall, uterus (cervix) or vaginal vault
Cystocele / urethrocele	Anterior wall prolapse (bladder/urethra)
Rectocele / enterocele	Posterior wall prolapse (rectum) / small bowel herniation (pouch of Douglas)
Uterine / vault prolapse	Apical descent of the uterus or post-hysterectomy vault
Procidentia	Complete eversion of the uterus/vagina (stage IV)
POP-Q	Pelvic Organ Prolapse Quantification system — standardised measurements relative to the hymen

■ IN PLAIN ENGLISH: Prolapse

Prolapse happens when the pelvic floor and its ligaments can no longer support the pelvic organs — usually after childbirth and with ageing. **Only symptomatic prolapse needs treatment**: pelvic floor exercises, a pessary or surgery.

498.2 Assessment

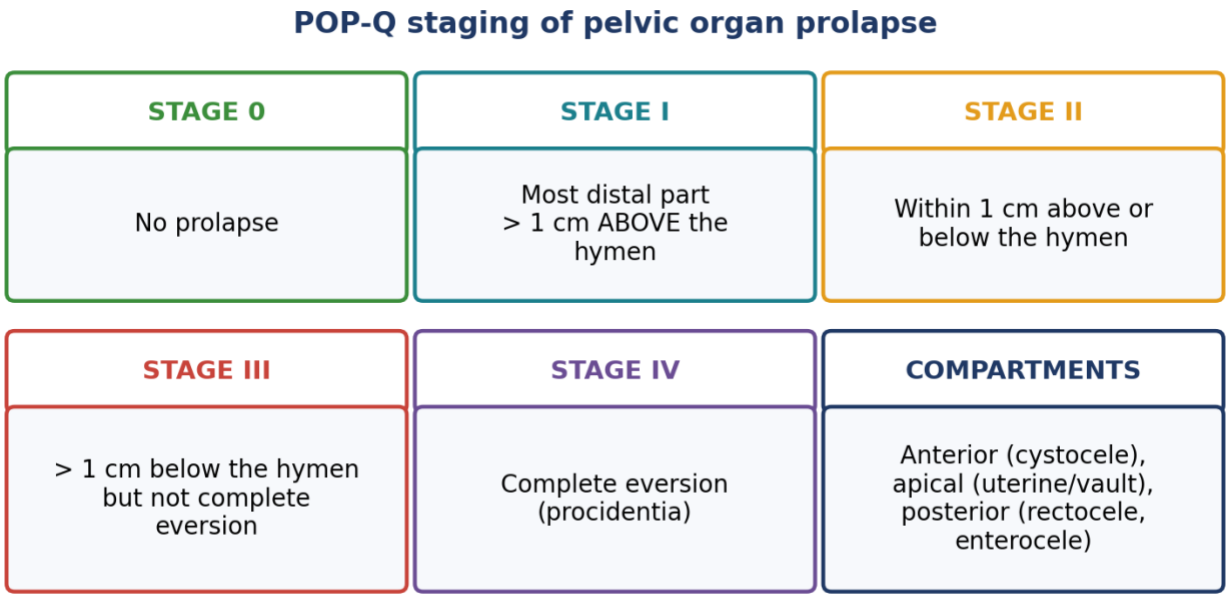


Figure 498.1 — POP-Q staging

- Symptoms: vaginal bulge/dragging
  - Need to digitate to empty bowel/bladder
  - Urinary (frequency, incomplete emptying, occult SUI)
  - Bowel and sexual symptoms
  - Impact on quality of life.
- Examination: Sims' speculum in left lateral and standing/straining positions
  - POP-Q staging
  - Check for atrophy, ulceration
  - Pelvic floor strength
  - Post-void residual.
- Risk factors: vaginal birth (instrumental, large babies), age, menopause, obesity
  - Chronic cough/constipation
  - Connective tissue disorders
  - Previous pelvic surgery.

498.3 Management

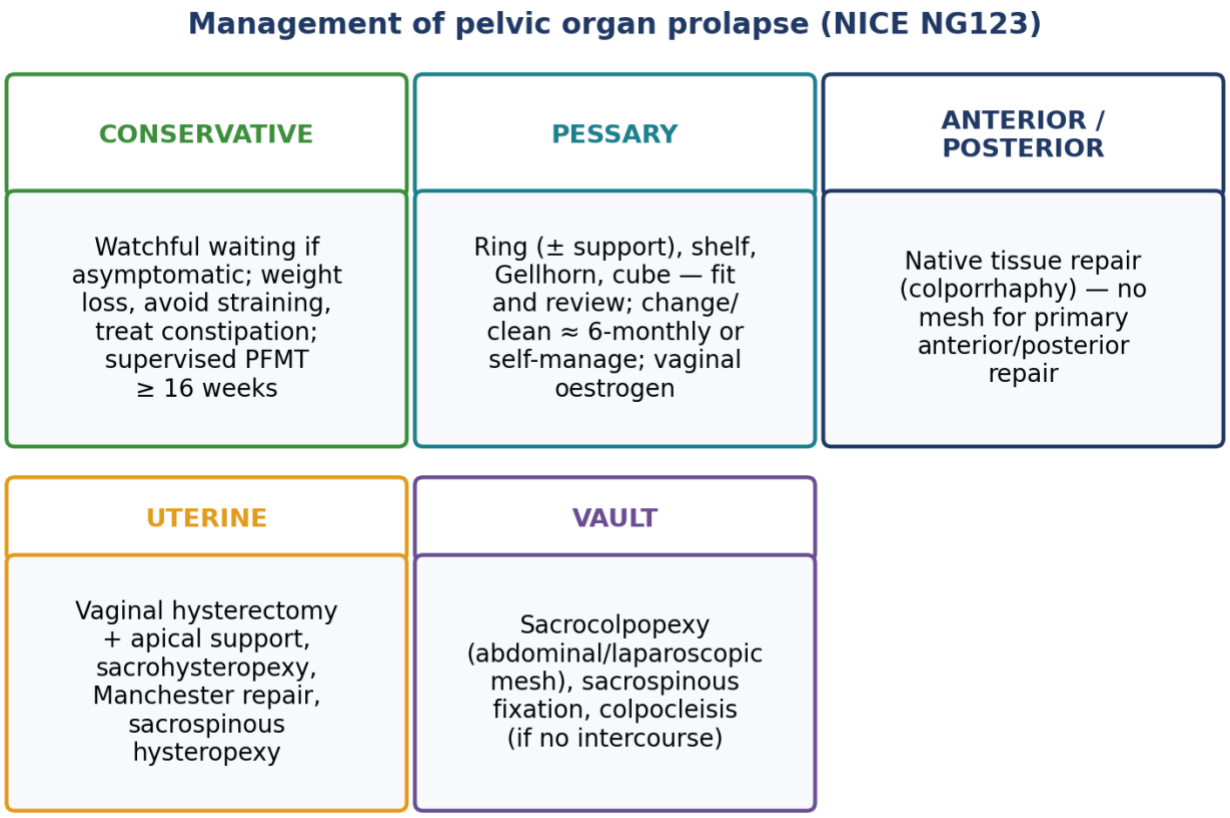


Figure 498.2 — Management of POP (NICE NG123)

Topic	Details
Conservative	• Watchful waiting if asymptomatic • Lifestyle (weight loss, avoid heavy lifting/straining) • Supervised PFMT for at least 16 weeks
Vaginal pessary	• Ring, ring with support, Shelf, Gellhorn, cube — fit, review • Regular change/clean (≈ 6-monthly) or self-management • Vaginal oestrogen to reduce erosion • Complications: discharge, bleeding, erosion, rarely fistula/impaction
Anterior/posterior repair	• Native tissue repair (anterior/posterior colporrhaphy) • Do NOT use mesh for primary anterior/posterior repair
Uterine prolapse	• Vaginal hysterectomy with apical support (McCall culdoplasty/sacrospinous fixation) • Uterus-preserving: sacrospinous hysteropexy, sacrohysteropexy (mesh), Manchester repair
Vault prolapse	• Sacrocolpopexy (abdominal/laparoscopic, mesh — counsel) • Sacrospinous fixation • Colpocleisis (if not sexually active — high success, low morbidity)
Considerations	• Occult SUI after repair • MDT for recurrent/complex/mesh cases • Consent using NICE decision aids • National mesh registry

■ COMMON PITFALLS

Operating on asymptomatic prolapse.

Not offering a pessary as an alternative to surgery.

Using mesh for primary anterior/posterior repair.

498.4 Must-know summary

■ EXAM TIP

- POP = descent of anterior, posterior or apical compartment; POP-Q stages 0–IV (relative to hymen).
- Conservative: lifestyle, PFMT ≥ 16 weeks, pessary (+ vaginal oestrogen).
- Surgery: native tissue repair for anterior/posterior; uterine — VH + apical support, hysteropexy, Manchester; vault — sacrocolpopexy, sacrospinous fixation, colpocleisis.
- Mesh restricted; recurrence ≈ 30%; consider occult SUI.

■ MNEMONIC / MEMORY AID

Prolapse options — 'Wait, Work (PFMT), Wear (pessary), Repair'.