ATELIER Jean COHEN
Samedi 07 Novembre 2015

PROLAPSUS GENITAL DE LA FEMME
QUOI DE NEUF ?

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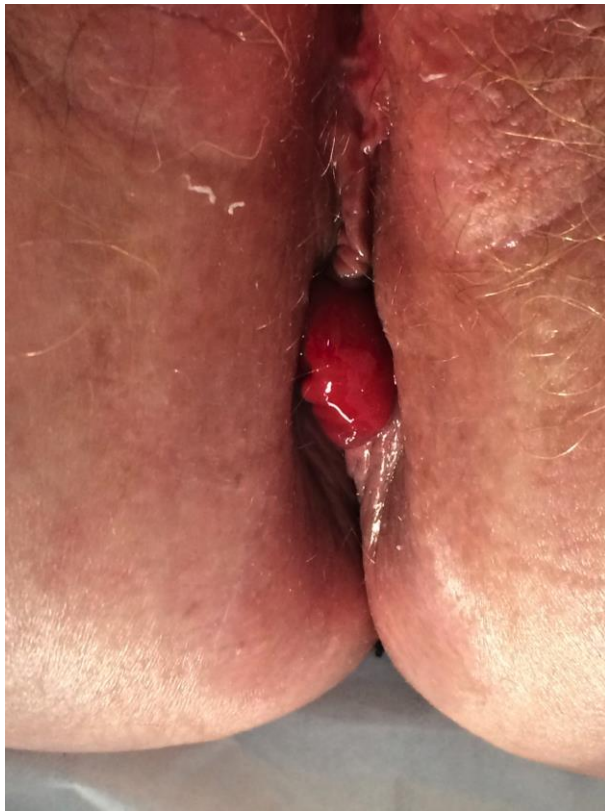
L’EXTERIORISATION PERINEALE N ‘EST PAS FORCEMENT UN PROLAPSUS GENITAL



Le prolapsus Génital (POP) de la femme est défini par :

A. Une mobilité d'un des segments du vagin dans l'introitus.
B. Un des organes pelviens en deçà de l'introitus.
C. Un des organes pelviens à l'introitus
D. Un élément pelvien en deçà de l'introitus associé à une Incontinence urinaire

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DEFINITION (S)

- ACOG: « Protrusion of the pelvic organs into or out of the vaginal canal »

- Cerbonet - 1970 « Toute saillie permanente ou à l'effort, dans la lumière vaginale ou à l'orifice vulvaire ou hors de celui-ci, de tout ou partie des parois vaginales plus ou moins doublées de la vessie, du rectum et des culs de sac péritonéaux adjacents, ainsi que du fond vaginal solidaire du col utérin »

- NIH (National Institue of Health) a définit plus récemment le prolapsus génital par la descente d'un des éléments pelviens à au moins 1 cm des reliquats hyménéaux (*AM Webern Int urogynecol pelvic floor dysfunction 2001*), soit un stade 2 de la classification internationale

- L'analyse récente du croisement des symptômes et de l'examen clinique, a permis de redéfinir par Swift S. et al (*Am J obstet Gynecol Aout 2003*) le prolapsus génital par l'extension des éléments pelviens **AUX RELIQUATS HYMÉNÉAUX OU POINT 0 DU POP Q.**

Dans la *population générale* la **fréquence** d'un <u>trouble de la statique pelvienne</u> :

A. 1 Femme sur 2
B. 1 Femme sur 3
C. 1 Femme sur 4
D. 1 Femme sur 5
E. 1 Femme sur 6

Dans la *population générale* la **fréquence** d'un trouble de la statique pelvienne :

A. 1 Femme sur 2
B. 1 Femme sur 3
C. 1 Femme sur 4
D. **<u>1 Femme sur 5</u>**
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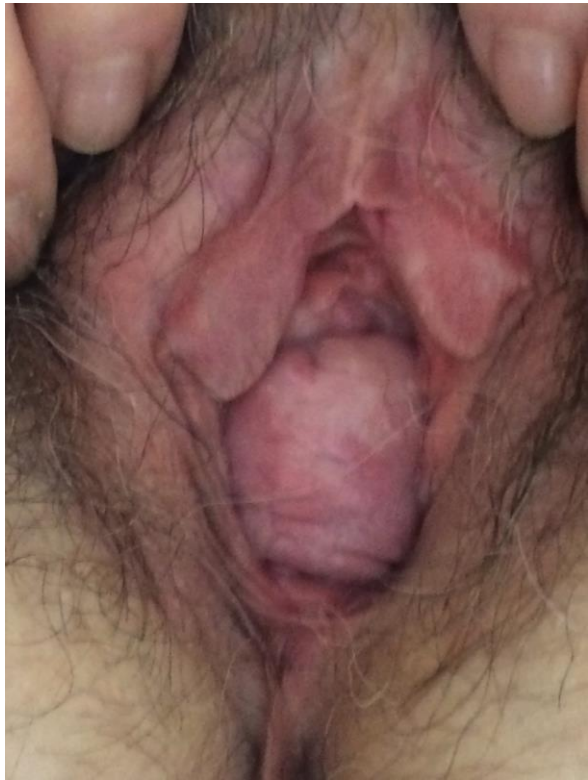

JAMA®

Online article and related content current as of March 15, 2009.

Prevalence of Symptomatic Pelvic Floor Disorders in US Women

Ingrid Nygaard; Matthew D. Barber; Kathryn L. Burgio; et al.

JAMA. 2008;300(11):1311-1316 (doi:10.1001/jama.300.11.1311)

Design, Setting, and Participants A cross-sectional analysis of 1961 nonpregnant women (≥20 years) who participated in the 2005-2006 National Health and Nutrition Examination Survey, a nationally representative survey of the US noninstitutionalized population. Women were interviewed in their homes and then underwent standardized physical examinations in a mobile examination center. Urinary incontinence (score of ≥3 on a validated incontinence severity index, constituting moderate to severe leakage), fecal incontinence (at least monthly leakage of solid, liquid, or mucous stool), and pelvic organ prolapse (seeing/feeling a bulge in or outside the vagina) symptoms were assessed.

Main Outcome Measures Weighted prevalence estimates of urinary incontinence, fecal incontinence, and pelvic organ prolapse symptoms.

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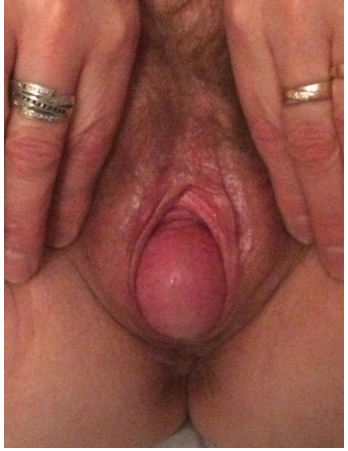
- The weighted prevalence of at least 1 pelvic floor disorder was:
  - **23.7%** ,
    - 15.7% of women experiencing urinary incontinence,
    - 9.0% of women experiencing fecal incontinence,
    - **2.9% of women experiencing pelvic organ prolapse.**
- The proportion of women reporting at least 1 disorder increased incrementally with age, parity, overweight.
  - 9.7% in women between ages 20 and 39 years **49.7% in those aged 80 years or older** (P < .001),
  - 12.8% , 18.4% , 24.6% , and **32.4%** for 0, 1, 2, and 3 or **more deliveries**, respectively; P < .001).
  - Overweight and obese women were more likely to report at least 1 pelvic floor disorder than normal weight women (**26.3%, 30.4%** and 15.1% , respectively; P < .001).
  - We detected no differences in prevalence by **racial/ethnic group**

Parmi ces facteurs de risques l'un n'est **pas retrouvé** dans la survenue d'un POP de la femme ? :

1. Le facteur âge
2. Le facteur obstétrical
3. Le facteur racial
4. La facteur familial
5. Le facteur poids



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3. **<u>Le facteur racial</u>**
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5. Le facteur poids

Prolapsus génital

The Racial Distribution of Female Pelvic Floor Disorders in an Equal Access Health Care System

J Urol 2009

Christine L. Gray Sears,* Johnnie Wright, Jennie O'Brien, James R. Jezior, Sandra L. Hernandez, Todd S. Albright, Sohail Siddique and John R. Fischer

Table 2. *Patients by ethnic group*

	No. Racial Group (%)					
	Asian	Black	Hispanic	White	Not Identified/Other	Totals
POP	4 (26.7)	42 (31.3)	8 (42.1)	167 (33.7)	25 (43.9)	246 (34.2)
SUI	2 (13.3)	21 (15.7)	5 (26.3)	102 (20.6)	12 (21.1)	142 (19.7)
UUI	1 (6.7)	22 (16.4)	1 (5.3)	52 (10.5)	2 (3.5)	78 (10.8)
Other UI	2 (13.3)	6 (4.5)	0	25 (5.1)	2 (3.5)	35 (4.9)
OAB-dry*	0	6 (4.5)	1 (5.3)	13 (2.6)	1 (1.8)	21 (2.9)
Pelvic pain	1 (6.7)	11 (8.2)	3 (15.8)	47 (9.5)	5 (8.8)	67 (9.3)
Fecal incontinence	0	5 (3.7)	0	10 (2)	3 (5.3)	18 (2.5)
Urinary retention	1 (6.7)	0	0	11 (2.2)	1 (1.8)	13 (1.8)
Urinary tract infection	1 (6.7)	0	0	5 (1)	1 (1.8)	7 (1)
Other	3 (20.0)	21 (15.7)	1 (5.3)	63 (12.7)	5 (8.8)	93 (12.9)
Totals	15 (2.1)	134 (18.6)	19 (2.6)	495 (68.8)	57 (7.9)	720 (100)

* Urinary urgency without incontinence.

Pas de différence entre les différentes ethnies concernant la prévalence du prolapsus génital anatomique (tous stades confondus, pas de seuil)

JAMA®

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Prevalence of Symptomatic Pelvic Floor Disorders in US Women

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Prolapsus génital

Influence de l'âge
Risque d'être opérée

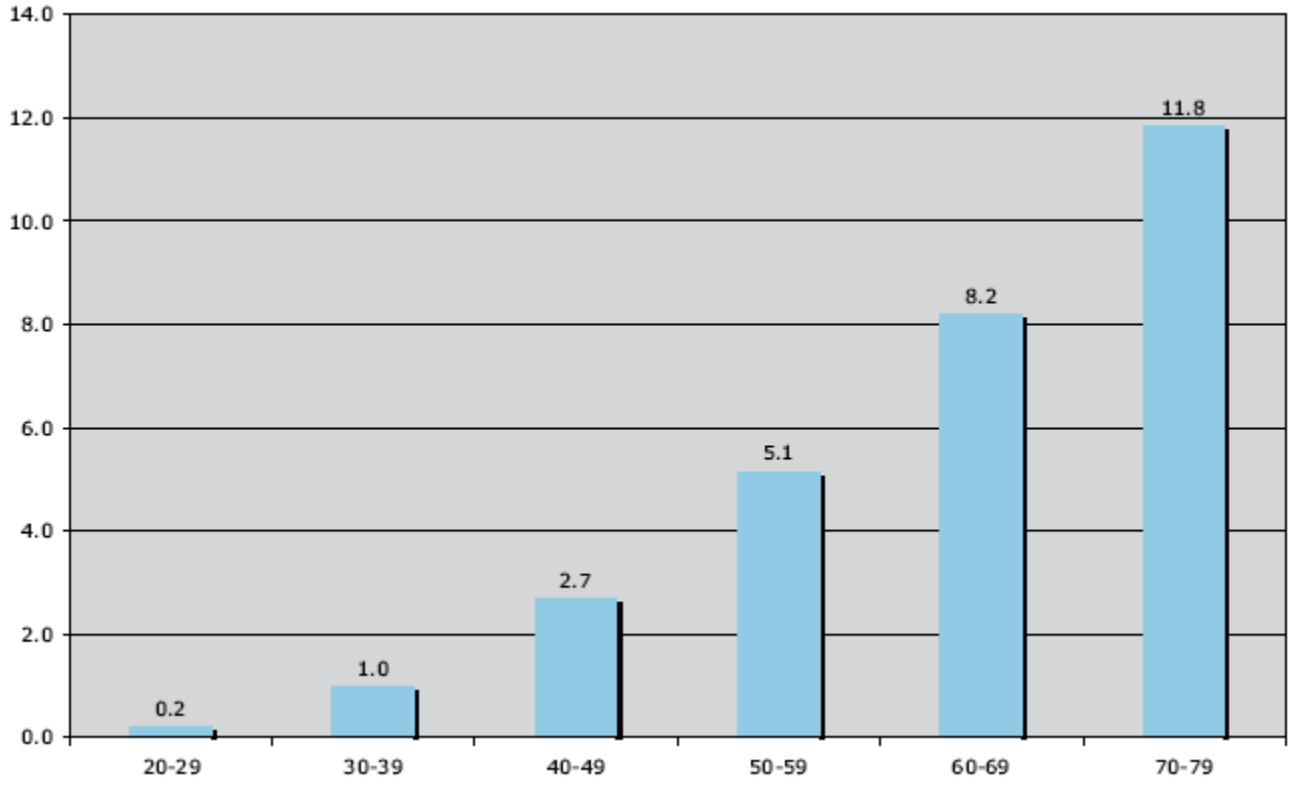
Int Urogynecol J (2008) 19:437–440
DOI 10.1007/s00192-007-0459-9

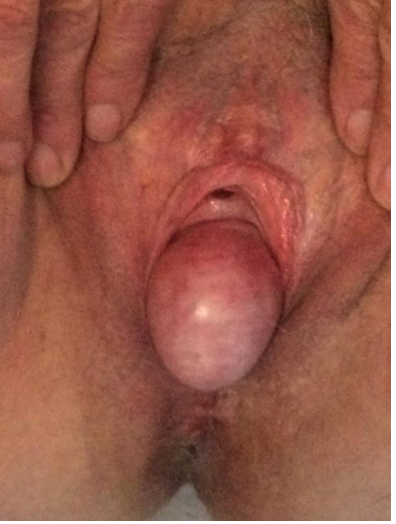
ORIGINAL ARTICLE

Lifetime risk of surgical management for pelvic organ prolapse or urinary incontinence

M. F. Fialkow · K. M. Newton · G. M. Lentz · N. S. Weiss

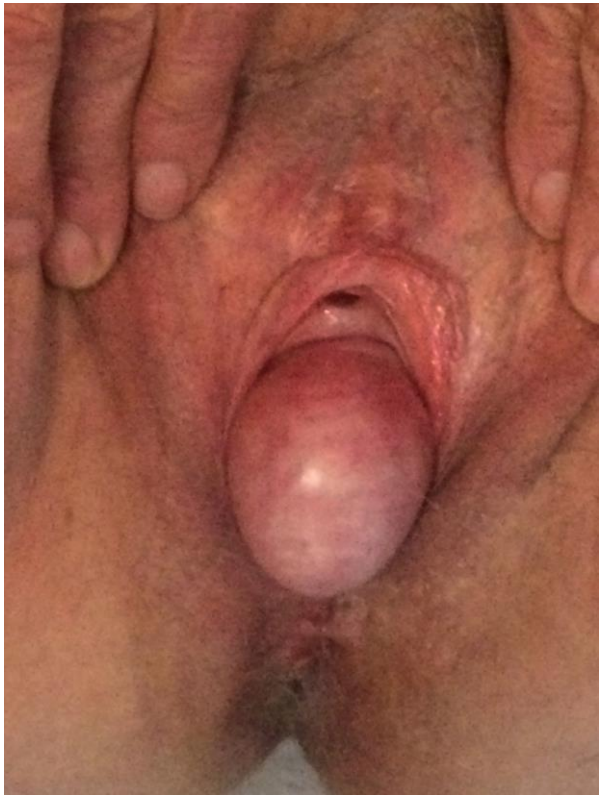
Fig. 2 Cumulative incidence of primary surgery for POP or UI by age group in years





L'élément pelvien le plus souvent prolabé dans le POP de la femme est :

A. L'utérus
B. La vessie
C. Le fond vaginal
D. Le cul de sac de douglas
E. Le rectum



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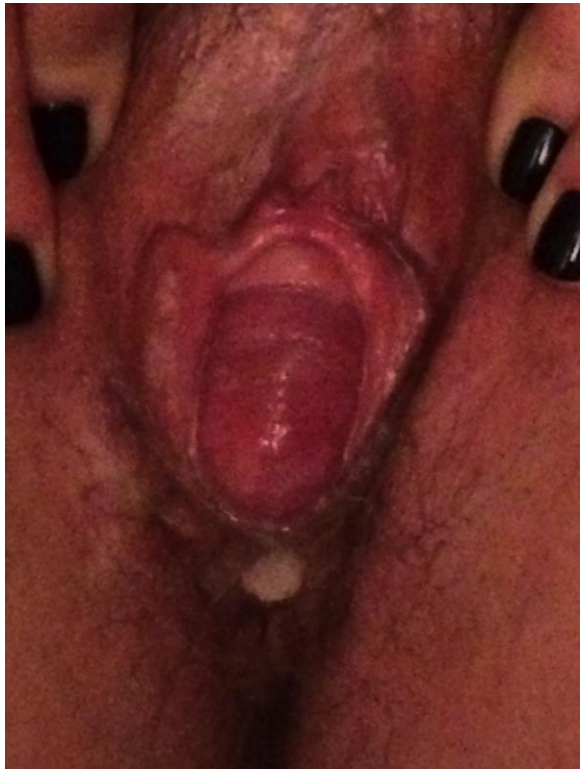

Registre du WHI (Women ‘s Health Initiative) , *Hendrix Am j obstet gynecol June 2002*

N = *27. 342*

Pelvic organ prolapse in the Women's Health Initiative: Gravity and gravidity

Susan L. Hendrix, DO,[a] Amanda Clark, MD,[b] Ingrid Nygaard, MD,[c] Aaron Aragaki, MS,[d] Vanessa Barnabei, MD,[e] and Anne McTiernan, MD, PhD[f]

Detroit, Mich, Portland, Ore, Iowa City, Iowa, Seattle, Wash, and Milwaukee, Wis

OBJECTIVE: The purpose of this study was to describe the prevalence of and correlates for pelvic organ prolapse.

STUDY DESIGN: This was a cross-sectional analysis of women who enrolled in the Women's Health Initiative Hormone Replacement Therapy Clinical Trial (n = 27,342 women). Baseline questionnaires ascertained demographics and personal habits. A baseline pelvic examination assessed uterine prolapse, cystocele, and rectocele. Descriptive statistics and logistic regression models were used to investigate factors that were associated with pelvic organ prolapse.

RESULTS: In the 16,616 women with a uterus, the rate of uterine prolapse was 14.2%; the rate of cystocele was 34.3%; and the rate of rectocele was 18.6%. For the 10,727 women who had undergone hysterectomy, the prevalence of cystocele was 32.9% and of rectocele was 18.3%. After controlling for age, body mass index, and other health/physical variables, African American women demonstrated the lowest risk for prolapse. Hispanic women had the highest risk for uterine prolapse. Parity and obesity were strongly associated with increased risk for uterine prolapse, cystocele, and rectocele.

CONCLUSION: Pelvic organ prolapse is a common condition in older women. The risk for prolapse differs between ethnic groups, which suggests that the approaches to risk-factor modification and prevention may also differ. These data will help address the gynecologic needs of diverse populations.

(Am J Obstet Gynecol 2002;186:1160-6.)

Key words: Pelvic organ prolapse, cystocele, rectocele, uterine prolapse, risk factors, ethnicity

Uterine prolapse, cystocele, and rectocele are among the most common indications for benign gynecologic surgery. Except for urinary incontinence, little is known about the incidence or prevalence of these disorders of pelvic support. The National Center for Health Statistics lists genital prolapse as one of the 5 most common reasons for hysterectomy in women.[1] More than 338,000 procedures for prolapse are performed annually in the United States.[2] The estimated lifetime risk by age 80 years to undergo surgery for urinary incontinence or pelvic organ prolapse was 11.1% in a large managed care population in Oregon.[3] The Oxford Family Planning Association study followed up 17,032 women who attended family planning clinics between 1968 and 1974 who were aged between 25 and 39 years at study entry.[4] The incidence of a hospital admission for the diagnosis of prolapse was 2.04 per 1000 person-years of risk. The incidence of prolapse that required surgical correction after hysterectomy was 3.6 per 1000 person-years of risk. The number of women with pelvic organ prolapse who were treated without hospitalization or surgery or women who did not seek medical care is not known. Incidence and prevalence estimates that are based on hospital admissions or surgical procedure codes undoubtedly underestimate the enormity of the problem.

The functional consequences of pelvic organ prolapse include, but are not limited to, urinary incontinence, voiding dysfunction, symptomatic pyelectasia, posthysterectomy vaginal prolapse, fecal incontinence, sexual dysfunction, and difficulty with defecation. Although some women treat their symptoms conservatively with pessaries, medications, physiotherapy, or behavioral therapy, others resort to protective undergarments and vagi-

From the Wayne State University School of Medicine,[a] Oregon Health Sciences University,[b] the University of Iowa College of Medicine,[c] the Women's Health Initiative Clinical Coordinating Center, Fred Hutchinson Cancer Research Center,[d] the Medical College of Wisconsin,[e] and the Cancer Prevention Research Program, Fred Hutchinson Cancer Research Center,[f]

Supported by National Institutes of Health contracts No. N01-WH-3-2126, N01-WH-3-2100, N01-WH-3-2101, N01-WH-3-2102, N01-WH-3-2103, N01-WH-3-2104, N01-WH-3-2105, N01-WH-3-2106, N01-WH-3-2107, N01-WH-3-2108, N01-WH-3-2109, N01-WH-3-2110, N01-WH-3-2111, N01-WH-3-2112, N01-WH-3-2113, N01-WH-3-2115, N01-WH-3-2116, N01-WH-3-2117, N01-WH-3-2118, N01-WH-3-2119, N01-WH-3-2120, N01-WH-3-2121, N01-WH-3-2122, N01-WH-4-2007, N01-WH-4-2108, N01-WH-4-2109, N01-WH-4-2110, N01-WH-4-2111, N01-WH-4-2112, N01-WH-4-2113, N01-WH-4-2114, N01-WH-4-2115, N01-WH-4-2116, N01-WH-4-2117, N01-WH-4-2118, N01-WH-4-2119, N01-WH-4-2120, N01-WH-4-2121, N01-WH-4-2122, N01-WH-4-2123, N01-WH-4-2124, N01-WH-4-2125, N01-WH-4-2126, N01-WH-4-2128, N01-WH-4-2130, N01-WH-4-2131.

To be presented at the 2002 Annual Meeting of the Central Association of Obstetricians and Gynecologists.

Reprint requests: Susan L. Hendrix, DO, Department of Obstetrics and Gynecology, Detroit Medical Center, Hutzel Hospital, 4707 St Antoine, Detroit, MI 48201. E-mail: shendrix@med.wayne.edu.

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0002-9378/2002/$35.00 + 0 6/6/123819

doi:10.1067/mob.2002.123819

16. 616 utérus en place

- Cystocèle / 34.3%
- Rectocèle /18,6%
- Prolapsus utérin / 14, 2%.

10. 727 femmes hystérectomisées

- Cystocèle / 32,9%
- Rectocèle / 18,3%
- Prolapsus du dôme / ns

La fréquence des troubles de la statique pelvienne vont en diminuant jusqu'à s’éteindre en 2050.

A. Vrai
B. Faux

La fréquence des troubles de la statique pelvienne vont en diminuant jusqu'à s'éteindre en 2050

A. Vrai

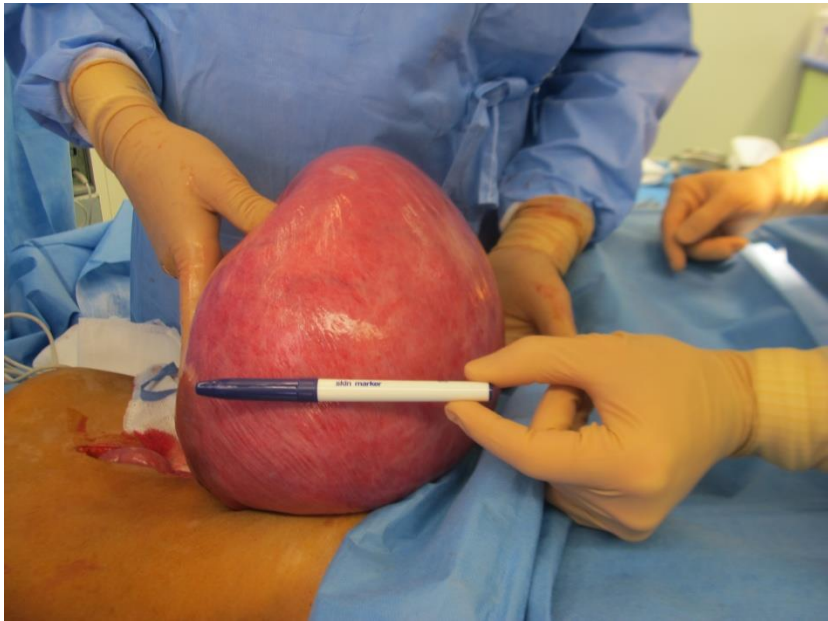
B. <u>Faux</u>

Forecasting the prevalence of pelvic floor disorders in U.S. Women: 2010 to 2050.
Wu JM, Hundley AF, Fulton RG, Myers ER.
Obstet Gynecol 2009

- The number of American women with at least one pelvic floor disorder will increase from **28.1 million in 2010 to 43.8 million in 2050.**
- During this time period, the number of women with **UI** will increase 55% from **18.3 million to 28.4 million.**
- For **fecal incontinence**, the number of affected women will increase 59% **from 10.6 to 16.8 million,**
- The number of women with **POP** will increase 46% from **3.3 to 4.9 million**.

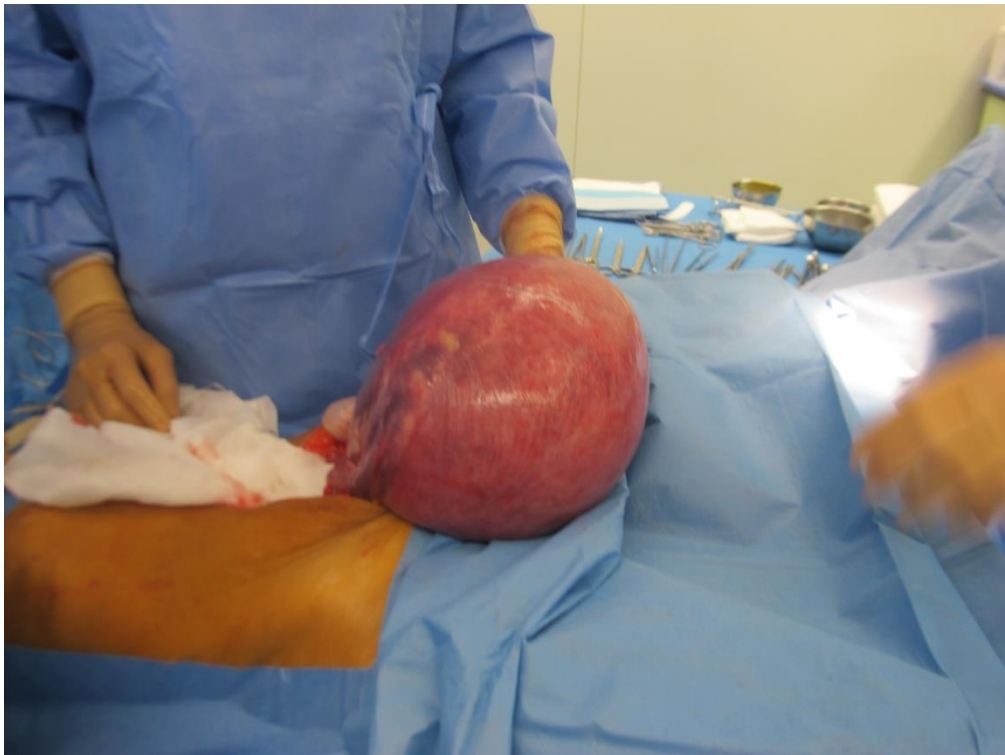
L’ Hystérectomie est un FDR de survenue de POP de la femme.

A. Vrai
B. Faux



L’ Hystérectomie est un FDR de survenue de POP de la femme.

A. Vrai
B. **<u>Faux</u>**



HYSTÉRECTOMIE ET PROLAPSUS GÉNITAL DE LA FEMME

- Dans l'étude épidémiologique de Mant et al, l'incidence du POP dans la population est de 16 pour 1000, l'incidence du prolapsus après hystérectomie est de 29 pour 1000, le **risque cumulé est de 1% à 3 ans et de 5% à 15 ans.**
- Le risque étant plus important pour des patientes ayant eu une hystérectomie pour prolapsus génital (158 pour 1000).(1)
- Dans une étude rétrospective ayant inclus 149 554 femmes, âgées de 20 ans et plus, l'intervalle entre l'hystérectomie et la survenue d'un trouble de la statique est de **19,3 ans.(2)**
- Intervalle de temps retrouvé dans l'étude de Blandon RE et al (3), intervalle de **13 ans**

- (1) Mant et al BJOG 1997
- (2) Clark AL, Am J Obstet Gynecol 2003
- (3) Blandon et al; Obstet Gynecol 2009

COLPOCÈLE ANTÉRIEURE

PROLAPSUS APICAL

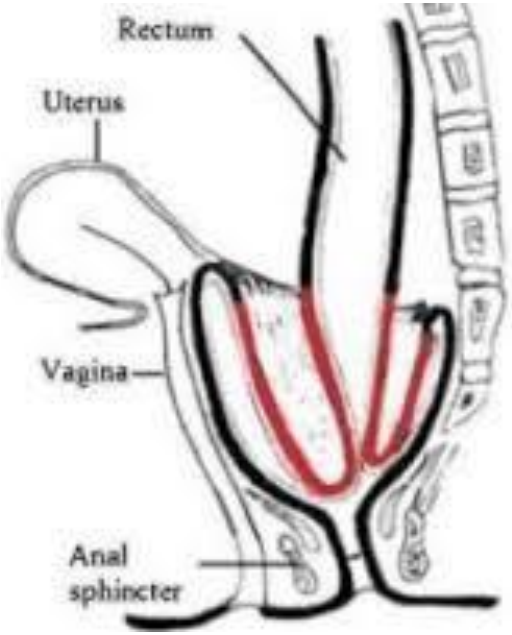
PROLAPSUS APICAL

COLPOCÈLE POSTERIEURE

FORMES BI-SEGMENTAIRES OU TRI SEGMENTAIRES

PROLAPSUS MIXTE

GENITAL + RECTAL



Low grade internal prolapse
Rectum
High Grade Internal Prolapse
Anal Canal

Que comprend l'examen clinique?

- Interrogatoire
  - Antécédents
  - Symptômes
- Examen physique
  - Inspection
  - Valves
  - Touchers pelviens

Corrélation anatomo-clinique

L'interrogatoire

Qu'est ce qui vous amène en consultation ?

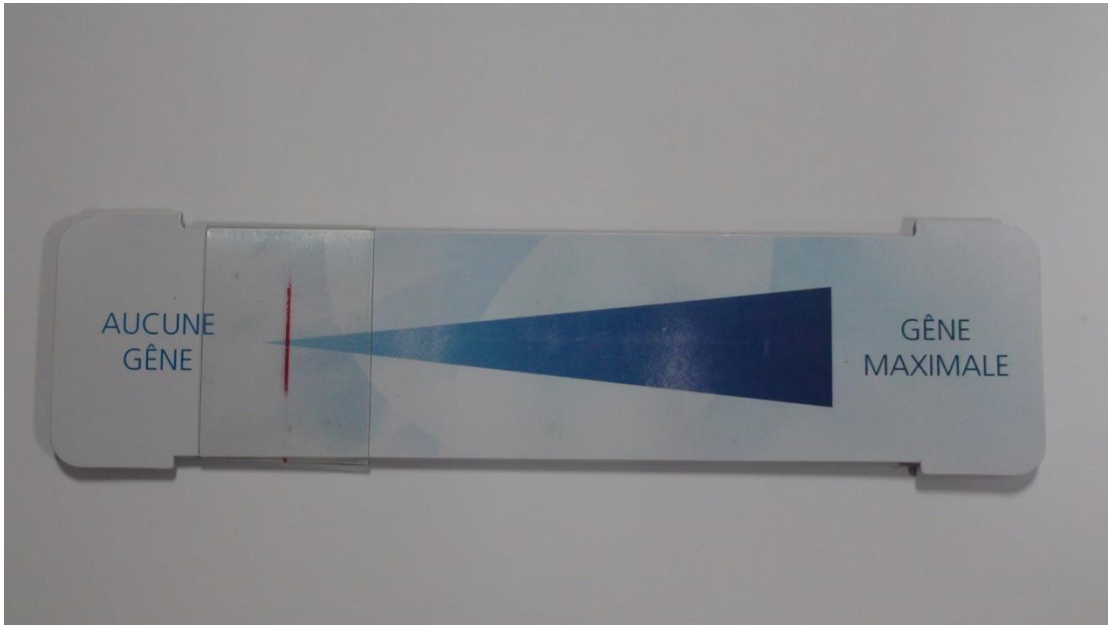
Problèmes vaginaux ?	Problèmes urinaires ?	Problèmes selles ?	Problèmes rapports ?
Boule ? Frottement ? Pesanteur ? Corps étranger ? Gaz vaginaux ? Tampons ?	Vidange vésicale ? IUE ? IUU ? Infections ? Douleurs ?	Rythme selles ? Consistance ? Vidange rectale ? Manœuvres ? Incontinence ? IA passive ou active ? Fréquence IA ?	Activité sexuelle ? Douleurs ? Orgasmes ? Si non, pourquoi ? Pb estime de soi ? Pb douleurs ? Pb masculin ? Pb incontinence ? Pb couple ?

2 motifs « cachés »

- Altération de l'estime de soi
  - Fréquent chez patientes « jeunes »
  - Dissimulé derrière symptômes pas évidents

- Crainte d'une pathologie ou de complications graves
  - Cancer

Echelle Visuelle Analogique



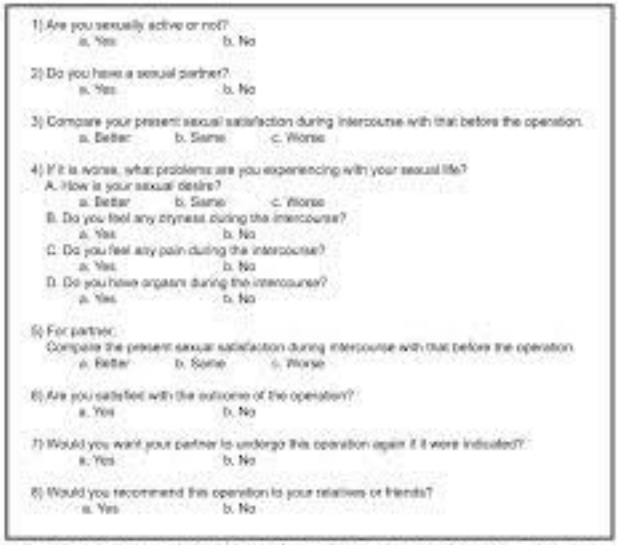
AUTO-QUESTIONNAIRES

PFDI

PFIQ

PSQ

Wexner



1) Are you sexually active or not?
a. Yes b. No

2) Do you have a sexual partner?
a. Yes b. No

3) Compare your present sexual satisfaction during intercourse with that before the operation.
a. Better b. Same c. Worse

4) If it is worse, what problems are you experiencing with your sexual life?
A. How is your sexual desire?
a. Better b. Same c. Worse
B. Do you feel any dryness during the intercourse?
a. Yes b. No
C. Do you feel any pain during the intercourse?
a. Yes b. No
D. Do you have orgasm during the intercourse?
a. Yes b. No

5) For partner:
Compare the present sexual satisfaction during intercourse with that before the operation.
a. Better b. Same c. Worse

6) Are you satisfied with the outcome of the operation?
a. Yes b. No

7) Would you want your partner to undergo this operation again if it were indicated?
a. Yes b. No

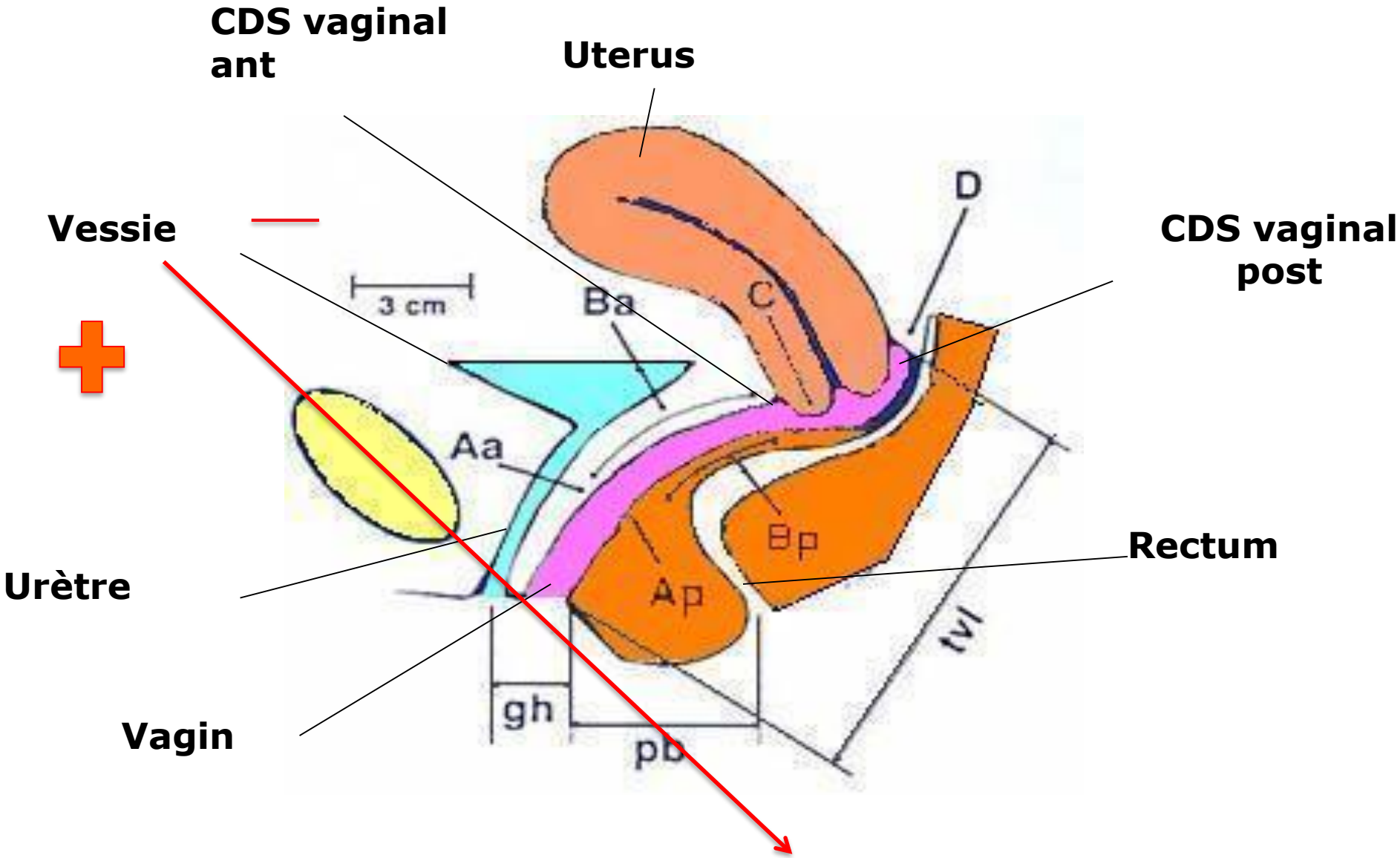
8) Would you recommend this operation to your relatives or friends?
a. Yes b. No

Figure 1 – Questionnaire that was designed for the evaluation of the sexual function after anti-incontinence surgery.

Tableau 2 Score de sévérité de l'IAR selon Wexner[2]
Jamais : 0 ; rarement : < 1 x/mois ; parfois : < 1 x/semaine, ≥ 1 x/mois ; régulièrement : < 1 x/jour, ≥ 1 x/semaine ; toujours : ≥ 1 x/jour.
0 = continence parfaite ; 20 = incontinence complète.

Type d'incontinence	Fréquence				
	Jamais	Rarement	Parfois	Régulièrement	Toujours
Solides	0	1	2	3	4
Liquides	0	1	2	3	4
Gaz	0	1	2	3	4
Port de protections	0	1	2	3	4
Altération de la qualité de vie	0	1	2	3	4

POP-Q Classification



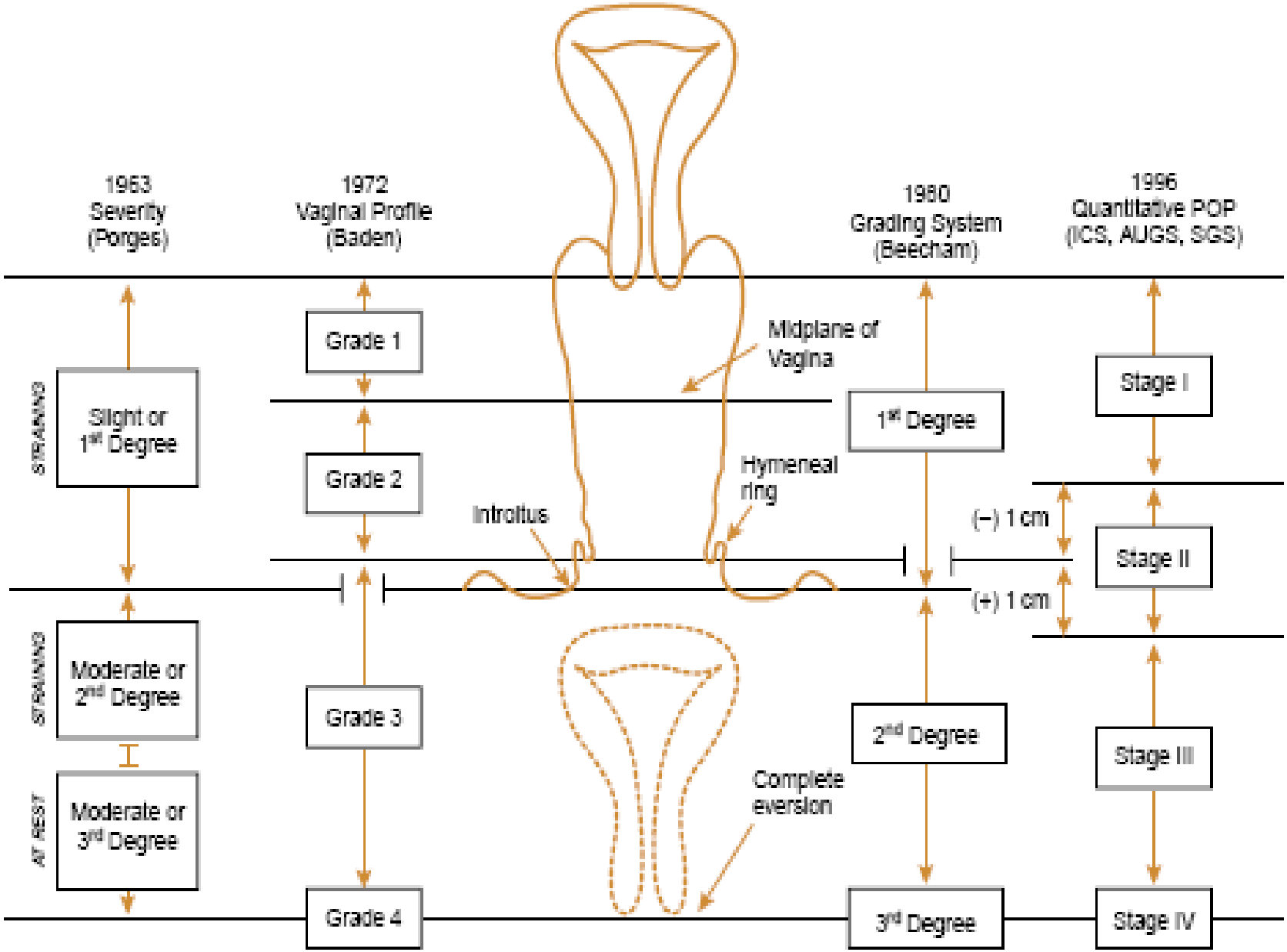


Figure 4. Comparison of commonly used grading systems.

ALTERNATIVE A LA CHIRURGIE
REEDUCATION, PESSAIRE

Bruno DEVAL, Renaud de TAYRAC, Bary BERGHMANS, Siegfried HELAGE,

PARIS – MAASTRICH- NIMES

Madame Linda M., âgée de 69 ans, Récidive de POP.

Rappel :

Antcd Obst.	G4 P 4, 4 AVN, < 4000 g, TO -
Antcd Chir.	Chirurgie de POP (OSC 2000), Hystérectomie (2004)
Antcd Fam.	Mère (POP), Sœur (POP)
Antcd Med.	1m 70, 75 kg.
DDR	Pré-ménopause, THS 0, Dernier Mammographie en attente

Anamnèse

Depuis 1 an, sensation de boule, EVA 9/10,
Incontinence urinaire Effort 0, Urgenturie +, IUM 0, fq mictionnelle N : 1, Diurne < 8, Miction normale, UTI 0, Incontinence anale aux gaz 0, Constipation 0, pesanteur rectale 0.
RS 0.

Examen clinique

En position semi-assise et poussée maximale :Ba + 4 (Prolapsus Antérieur: dôme vaginal)

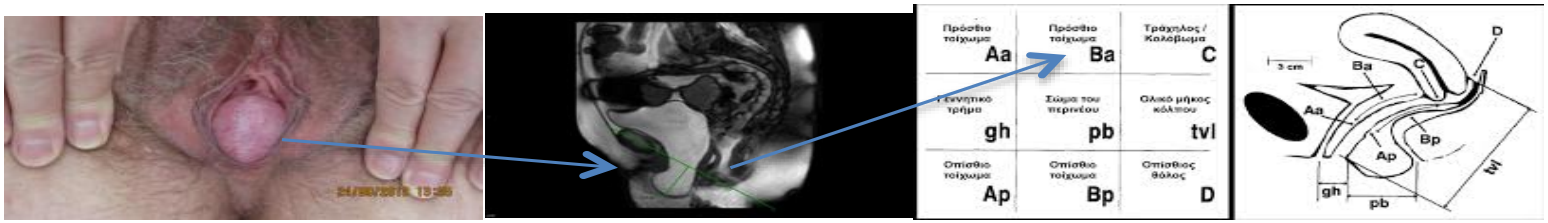
***Soeur Elisabeth F.*, âgée de 66 ans,** pour récidive de **prolapsus génital,**.

Antcd Obst / G0P0,
Antcd Chir / Hystérectomie Sub -Totale interannexielle par voie abdominale – Prolapsus voie Basse (Trachélectomie, Myorraphie vraie de releveurs – sacrospinofixation de RICHTER)
Antcd Fam / POP (mère)
Antcd Med / 1m 63, 74 kg, HTA, ESIDREX®, ATENOLOL®, SIMVASTATINE®
Antcd Gyn. / Ménopausée depuis 16 ans, dernière Mammographie RAS

Symptômes

Sensation de Boule, EVA 8 /10.
Incontinence urinaire à l'effort +, dysurie +, manœuvres digitales +, fq mictionnelle N 0, D < 8, urgenturie 0.
Incontinence anale 0, constipation 0.

Examen clinique



Madame Marie – Hélène A. , âgée de 55 ans, pris en charge pour **Récidive de POP.**

Rappel :

Antcd Obst.	G2P2, 2 AVN, < 4000g, 199§, F0, E+, EA 0, RP +
Antcd Chir.	Colposuspension de Burch, Myorraphie Vraie des releveurs (1997)
Antcd Fam.	Mère (IUE)
Antcd Med.	1m 76, 79 kg.

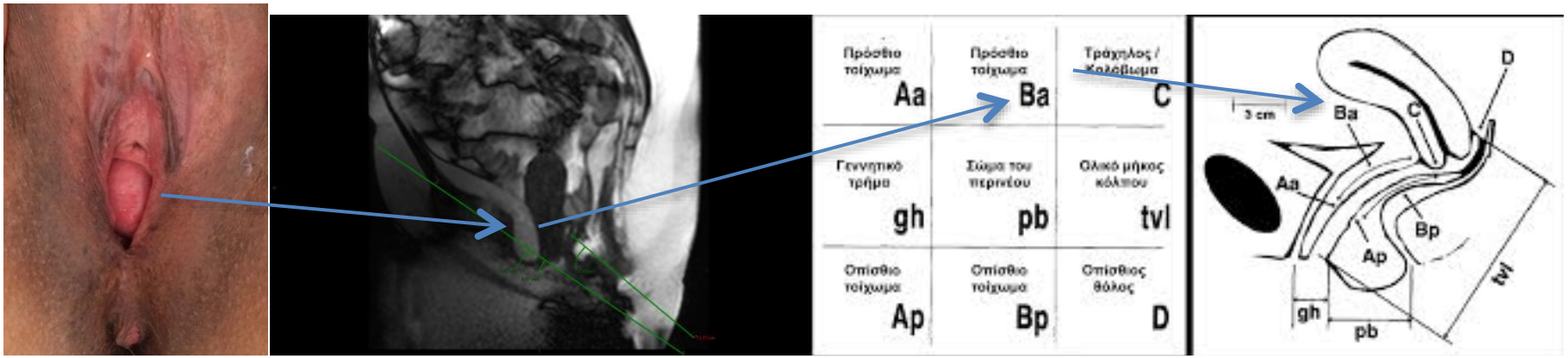
Anamnèse

Récidive après Colposuspension de Burch (1997)
RP ++ (100 séances de rééducation périnéale), Depuis 30 ans
PADS 1 / jour, Actuellement, UTI 0 , fq mictionnelle N 1 à 2, D < 8, urgenturie 0, IUE grade III, Mictions en 2 temps, EVA 8/10

Pesanteur vaginale +
Incontinence anale +, Urgenturie défécatoire 0, constipation EVA : 6/10

Examen clinique :

En position semi-assise et poussée maximale, U2C3H1E+R2



Madame Josette G., âgée de 66 ans, **pour récidive de POP + Erosion vaginale + Rétraction douloureuse après Interposition Prothétique.**

Rappel :	
Antcd Obst.	G2P2, 2 AVN, < 4000g, 199§, F0, E+, EA 0, RP +
Antcd Chir.	PROLIFT (2013)
Antcd Fam.	Mère (POP)
Antcd Med.	1m 76, 79 kg.

Anamnèse

Récidive quasi immédiate
Pesanteur vaginale +
Saignements, Rétraction Douloureuse

Examen clinique :

En position semi-assise et poussée maximale, Rétraction douloureuse, Erosion au tiers proximal du vagin.

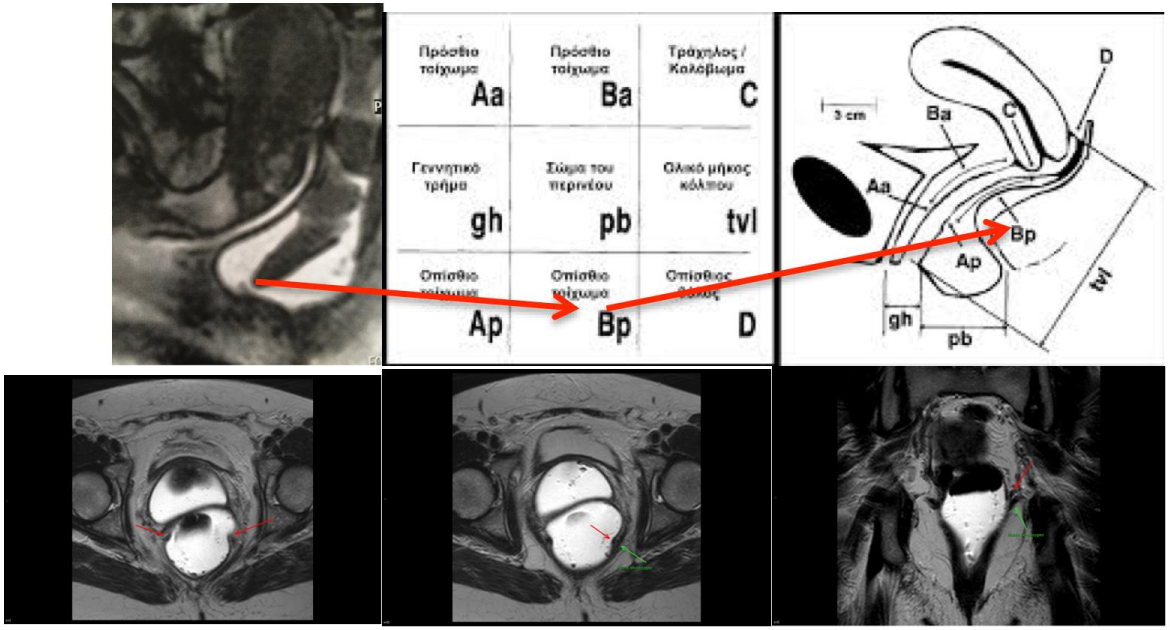
Madame Valérie M., âgée de 48 ans, pour Récidive de POP + ***Dyspareunie profonde + Dyschésie rectale, + incontinence urinaire à l'Effort Invalidante.***

Pour rappel /	
Antcd Obst /	G3P3, 3AVN, 1983, 1987,1990, > 4000g, F 0, E +, D 0, RP + (20 séances)
Antcd Chir./	Promonto Coelio (2 mai 2013)
Antcd Med /	1M62, 83 kg
Antcd Fam /	RAS
Antcd Gyn /	Menstruations normales, Dernier FCV Nal, Dernière Mammographie nale,

Anamnèse

IUE, **EVA 7/10.** RP 0, depuis les accouchements, Depuis 24 ans, Grade 1. UTI 0, pollakiurie, urgenturie 0,
Mictions en 1 temps,
Fuites aux RS 0, Pesanteur vaginale 0
Incontinence anale + aux gaz, Urgenturie défécatoire +, constipation O
Sensation de Boule, EVA 7/10 , Exonération douloureuse +, Manœuvre périnéale (pression au noyau fibreux central du périnée) pour éxonérer
Gene aux RS.

Examen clinique
Points douloureux à l'insertion des releveurs, Erosion au cul de sac latéral gauche , Bp 0



Management of Pelvic Organ Prolapse
(including urogenital prolapse and rectal prolapse)

ICI 2013

HISTORY

Bothersome pelvic organ prolapse

Complex or recurrent prolapse

CLINICAL ASSESSMENT

Symptoms Screening: assess bothersomeness, frequency and severity of urinary, ano-rectal, genital and sexual symptoms

- **Urinary:** PVR, cough stress test, urinalysis.
- **Physical Examination:** Sufficient to determine the site and severity of prolapse and detect other significant findings
  - Selective use of urodynamics when results would alter planned treatment
  - Selective use of upper tract imaging when observation is planned
- **Ano-Rectal:** Endoscopy, lower GI tract imaging

Investigation by specialist

DIAGNOSIS

UROGENITAL PROLAPSE WITH OR WITHOUT OTHER PELVIC SYMPTOMS

RECTAL PROLAPSE WITH OR WITHOUT OTHER PELVIC SYMPTOMS

MANAGEMENT *

- Observation
- Lifestyle interventions
- Pelvic floor muscle training
- Pessary
- Reconstructive surgery
- Obliterative surgery

- Observation
- Lifestyle interventions
- Transperineal surgery
- Transabdominal surgery

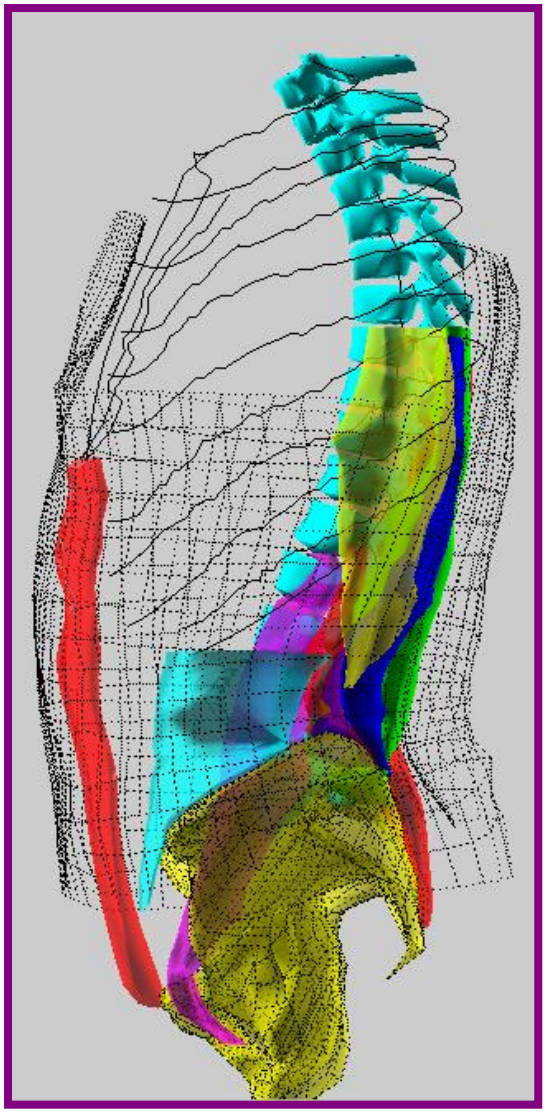
Specialist management

* At any stage of the patient's care pathway, management may need to include continence products

RECIDIVE DE PROLAPSUS GENITAL
ALTERNATIVE A LA CHIRURGIE

PLACE DE LA RÉÉDUCATION

Valancogne G, Acta Endoscopica 2004



- ✓ **Fermeture du hiatus urogénital** dans la prévention de l'aggravation des prolapsus

- ✓ **Déclenchement automatique des contractions du plancher pelvien** lors de l'augmentation des pressions intra-abdominales

- ✓ Travail de la correction des **troubles de la statique lombo-pelvienne** associés

Morphological changes after pelvic floor muscle training measured by 3-dimensional ultrasonography: a randomized controlled trial.

Braekken et al.,

Obstet Gynecol. 2010 Feb

- ✓ 109 femmes avec prolapsus de grade ≥ 1
- ✓ Randomisation en 2 groupes : rééducation (59) vs contrôle (n=50)
- ✓ Résultats :
  - ✓ Adhésion à la rééducation 80 %
  - ✓ **<u>Après rééducation</u>**

✓ ↑ de l'épaisseur musculaire	1,9 mm (1,1-2,7)	p<0,001
✓ ↓ du hiatus vaginal	1,8 cm (0,4-3,1)	p=0,026
✓ ↓ de la longueur musculaire	6,1 mm (1,5-10,7)	p=0,007
✓ Élévation de la position de la vessie	4,3 mm (2,1-6,5)	p<0,001
✓ Élévation de la position du rectum	6,7 mm (2,2-11,8)	p=0,007

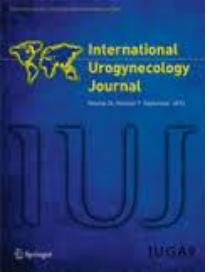
Morphological changes after pelvic floor muscle training.

Balmforth et al., 2006

Brækken et al., 2010

- ***Increased muscle thickness.***
  - 8% hypertrophy shown for women with SUI
    - *Balmforth et al 2006 .*
  - 17% increase in muscle thickness for women with POP
    - *Brækken et al 2010*
- ***Narrowing the levator hiatus***

  7% reduced hiatal area, with a differences of 1.8 cm2
    - *Brækken et al 2010*

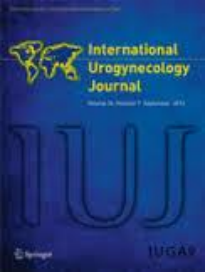


Pelvic floor muscle training for treatment of pelvic organ prolapse: an assessor-blinded randomized controlled trial

Stuup et al

Int Urogynecol J. 2011 Oct

- **N = 37 women**
- Stage II prolapse,
- RCT : PFMT (n = 21) vs control group (n = 16).
- <u>14 weeks PFMT</u>
- The intervention group showed significantly greater anatomic **improvements** in the anterior and posterior vaginal wall prolapses than did the control group (P<0.001 and 0.025, respectively) and a **decrease** of symptoms.



A randomized controlled trial of pelvic floor muscle training for stages I and II pelvic organ prolapse.

Hagen S et al.,

Int Urogynecol J Pelvic Floor Dysfunct. 2009 Jan

- **N = 47 women**
- RCT (5 séances en 16 semaines avec exercices quotidiens à domicile) vs abstention
- N =23 vs N = 24, 16 semaines
- Amélioration significative des **symptômes** liés au prolapsus dans le groupe rééducation de 3,5 points vs 0,1 (p=0,021)
- **Satisfaction** des patientes : 63 vs 24%, (p=0,012)
- Réduction significative du **stade** du prolapsus (45 vs 0%, p=0,038)
- **Force** des muscles du plancher pelvien significativement augmentée de 0,5 sur l'échelle modifiée d'Oxford (IC95% : 0,2-0,8 ; p=0,008).

THE COCHRANE COLLABORATION®

Conservative prevention and management of pelvic organ prolapse in women

Cochrane Database Syst Rev. 2011 Dec

Hagen S et al,

- 6 essais randomisés dont 2 avec effectifs faibles (moins de 25 patientes par groupe) et 2 avec biais importants.

- 4 comparaisons renforcement musculaire vs contrôle (n=857)
  - La rééducation améliore la force musculaire
  - La rééducation améliore les troubles urinaires et digestifs associés
  - La rééducation réduit le stade du prolapsus dans 17% des cas

- 2 comparaisons rééducation + chirurgie vs chirurgie seule (n=118)
  - La rééducation améliore la force musculaire dans 1/2 essai
  - La rééducation améliore les troubles urinaires associés dans 1/2 essai

THE COCHRANE COLLABORATION®

Conservative prevention and management of pelvic organ prolapse in women

Cochrane Database Syst Rev. 2011 Dec

There is now some evidence available indicating a **positive effect** of PFMT for prolapse symptoms and severity.

The largest most rigorous trial to date suggests that **six months** of supervised PFMT has benefits in terms of anatomical and symptom improvement

A large trial of PFMT supplementing surgery is needed to give clear evidence about the usefulness of combining these treatments.

Individualised pelvic floor muscle training in women with pelvic organ prolapse (POPPY): a multicentre randomised controlled trial.

Hagen S & POPPY Trial Collaborators,

Lancet. 2014 Mar

- Etude multicentrique randomisée dans 23 centres
  - (UK, New Zealand, Australia) entre 2007 et 2010
- **N = 447 patientes** stade I, II, III
- Programme individualisé de renforcement musculaire (n=225) vs conseils seuls (n=222)
- 295 (66%) suivies à 12 mois
- **Amélioration significative des symptômes de prolapsus dans le groupe rééduqué**
  - **réduction moyenne du POP-SS score de 1,52 (p=0,0053)**

Peri-operative physiotherapy improves outcomes for women undergoing incontinence and or prolapse surgery: results of a randomised controlled trial.

Jarvis SK et al.,
Aust N Z J Obstet Gynaecol. 2005 Aug

- RCT
- N = 30 vs N = 30
- Amélioration significative de la qualité de vie et des symptômes urinaires en faveur de la rééducation
- Amélioration de la pression de clôture urétrale dans le groupe rééduqué (+ 2,7 vs -1,8 cmH2O (p=0,022)).

Peri-operative physiotherapy to prevent recurrent symptoms and treatment following prolapse surgery: supported by evidence or not?

Int Urogynecol J. 2013 Mar

PubMed database from 1966 to May 2012, for all types of studies reporting on the effects of peri-operative PFMT on recurrent treatment and/or pelvic floor symptoms after POP surgery.

The first RCT concluded that peri-operative PFMT reduced the risk of pelvic floor symptoms 12 weeks after surgery and improved the quality of life.

The second trial concluded that there is no significant beneficial effect 12 months after surgery.

Author's personal copy

anatomical outcomes and prolapse symptoms. Costs are not considered in this study.

Clinical practice in the Netherlands

To evaluate current clinical practice in the Netherlands a mailed questionnaire was sent to 26 gynaecologists with a special interest in urogynaecology. The questionnaire was intended to evaluate current clinical practice with respect to peri-operative pelvic physiotherapy. All of the gynaecologists approached responded, 5 of them were working in a university hospital, 16 in non-university teaching hospitals and 5 in non-teaching hospitals.

It appeared that there is a huge variation among gynaecologists regarding the frequency of referral as primary treatment. One out of three gynaecologists referred less than 10% of the patients with POP as primary treatment to a pelvic physiotherapist, whereas one out of three did this in between 10 and 30% of the patients and one out of three in more than 30%. This low referral rate to a pelvic physiotherapist as primary treatment is not surprising as in the Dutch health care system most women first visit their home physician who more commonly refers them to a pelvic physiotherapist. When visiting the gynaecologists most women have already received PFMT or have complaints that are considered too severe for treatment with PFMT.

More consensus existed about postoperative pelvic physiotherapy. Only 15% of the gynaecologists referred more than half of their patients after POP surgery to a pelvic physiotherapist, whereas nearly 70% of the gynaecologists referred less than 10% of their patients after surgery. The two main reasons given to refer a patient to a pelvic physiotherapist before and/or after POP surgery were first, that pelvic physiotherapy is effective in the treatment of pelvic floor symptoms, and second, that pelvic physiotherapy teaches patients to optimally use their pelvic floor muscles. Furthermore, many gynaecologists reported that they referred to a pelvic physiotherapist those patients with POP in whom they considered the anatomical abnormalities not severe enough to justify surgical intervention.

Among the reasons to not refer a patient to a pelvic physiotherapist before and/or after POP surgery was that gynaecologists were not convinced that such practice is supported by scientific evidence and therefore will not result in a positive effect on prolapse. Considering the limited evidence we found for the recommendation of peri-operative PFMT, these results are not surprising.

Conclusion

We found early signs of a possible role of peri-operative PFMT in the treatment of female pelvic floor symptoms. Two small studies showed promising results regarding post-operative micturition symptoms, quality of life and pelvic floor muscle strength when peri-operative PFMT was added to POP surgery. However, there is no evidence that these improvements reduce the need for recurrent treatment.

This lack of evidence of the effect of peri-operative PFMT on recurrent treatment after POP surgery may partly explain the current clinical practice amongst urogynaecologists, who seldom offer peri-operative PFMT to their patients.

We think that there is an urgent need for robust, well-designed trials to evaluate the effectiveness, efficacy and cost-effectiveness of peri-operative PFMT in reducing recurrent treatment after POP surgery.

Conflicts of interest J.P.W.R. Roovers: investigator initiated studies with AMS and Pohl Boskamp.

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11. Diez-Itza I, Aizpitarte I, Becerro A (2007) Risk factors for the recurrence of pelvic organ prolapse after vaginal surgery: a review

Conclusion 1

Effective PFMT due to morphological changes: PFM strength, volume,

shortened PFM length, reduction in size urogenital hiatus
Frawley 2012

Intensive physiotherapy-supervised PFMT reverses and prevents further development POP

Braekken 2012

Recent RCTs confirm effectiveness PFMT for POP, long-term results needed

ICI 2012

Conclusion *2*

PFMT may help prevent deterioration of anterior prolapse, and may help improve prolapse symptoms and severity more generally

.Grade B *ICI* *2009*

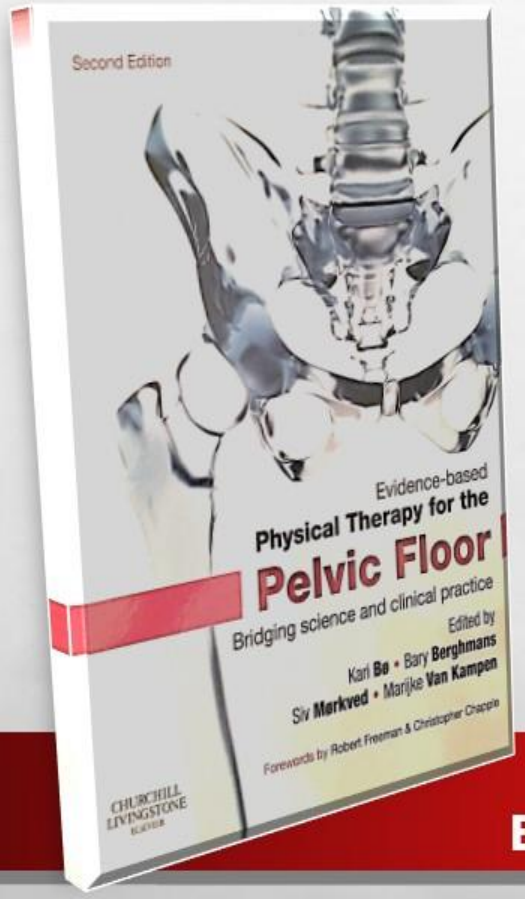
Preoperative PFMT may help improve quality of life and urinary symptoms in women undergoing surgery for POP.

Grade B *ICI* *2009*

Currently no rigorous evidence from RCTs regarding the use of conservative interventions for POP.

Hagen 2004, Cochrane Collaboration review

EVIDENCE-BASED PHYSICAL THERAPY FOR THE PELVIC FLOOR 2ª EDITION



Edited by:
Kari BO
Bary Berghmans
Siv Morkved
Marijke Van Kampen

Elsevier

PROLAPSUS GENITAL
ALTERNATIVE A LA CHIRURGIE :

PLACE du PESSAIRE

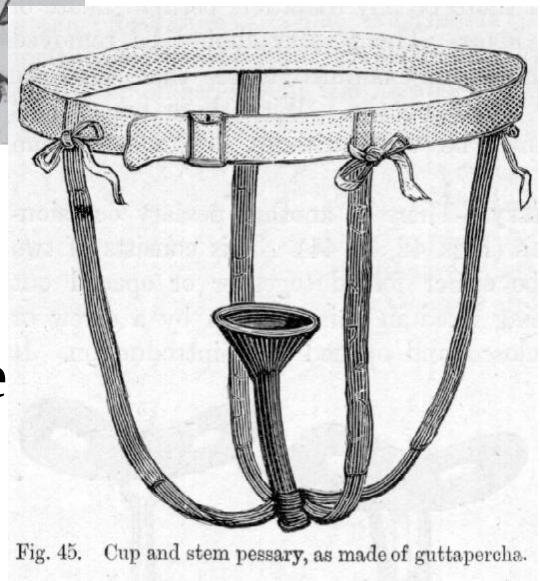
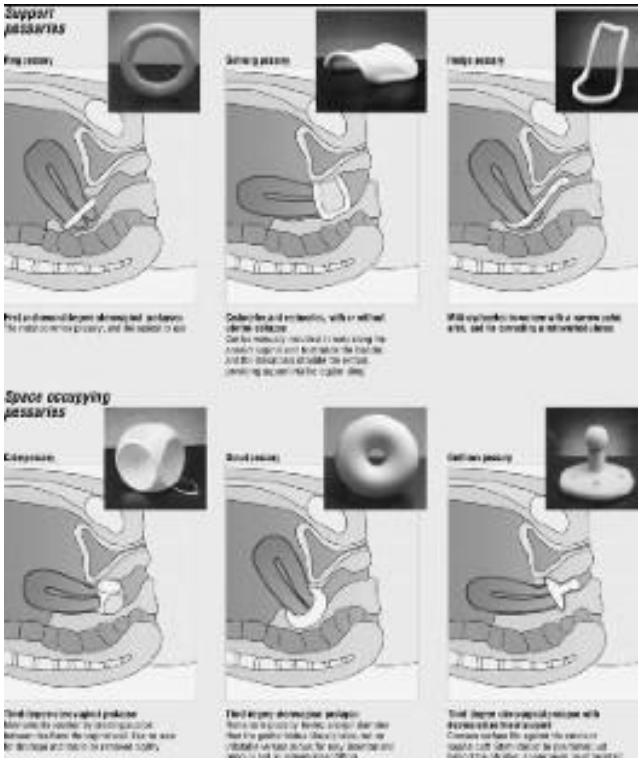
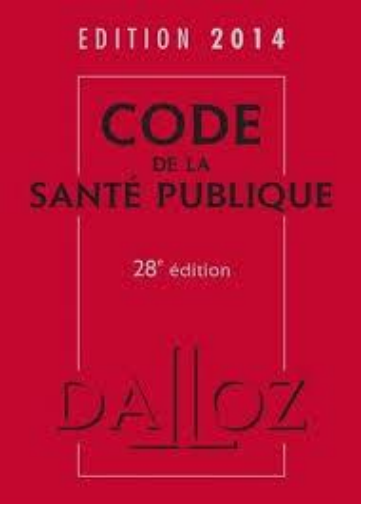


Fig. 45. Cup and stem pessary, as made of guttapercha.

du
16ème siècle
…



… à nos jours



CODE DE SANTÉ PUBLIQUE ARTICLES DE LOI

Article 35 (article R.4127-35 du code de la santé publique)

Le médecin doit à la personne qu'il examine, qu'il soigne ou qu'il conseille une **information loyale, claire et appropriée** sur son état, les investigations et les soins qu'il lui propose (….)

Art. L. 1111-2. -

Toute personne a le **droit d'être informée** sur son état de santé. Cette information porte sur les différentes investigations, traitements ou actions de prévention qui sont proposés (….). Cette information incombe à tout professionnel de santé dans le cadre de ses compétences et dans le respect des règles professionnelles qui lui sont applicables. Seules l'urgence ou l'impossibilité d'informer peuvent l'en dispenser.

Art. L. 1111-4. -

Toute personne prend, avec le professionnel de santé et compte tenu des informations et des préconisations qu'il lui fournit, les décisions concernant sa santé (…) Le médecin doit **respecter la volonté de la personne après l'avoir informée des conséquences de ses choix.**

The use of pessaries in vaginal prolapse,

Vierhout ME,

Eur J Obstet Gynecol Reprod Biol. 2004

- Support
- Remplit l'espace

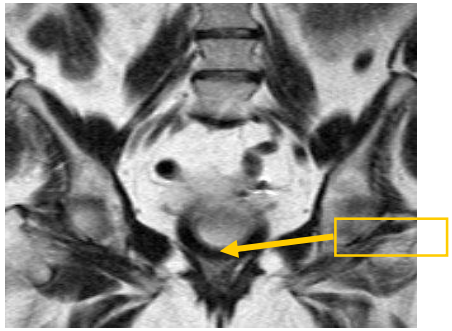
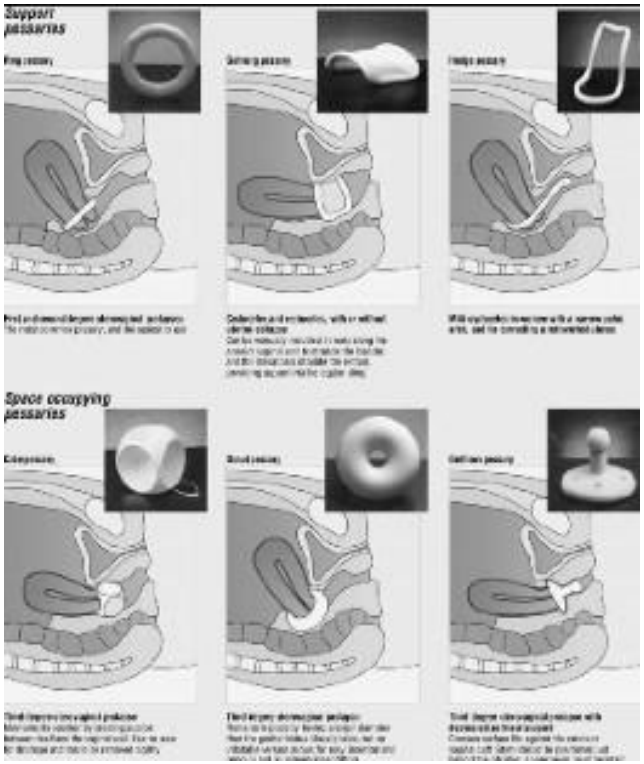


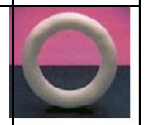
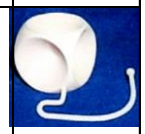
Table 1

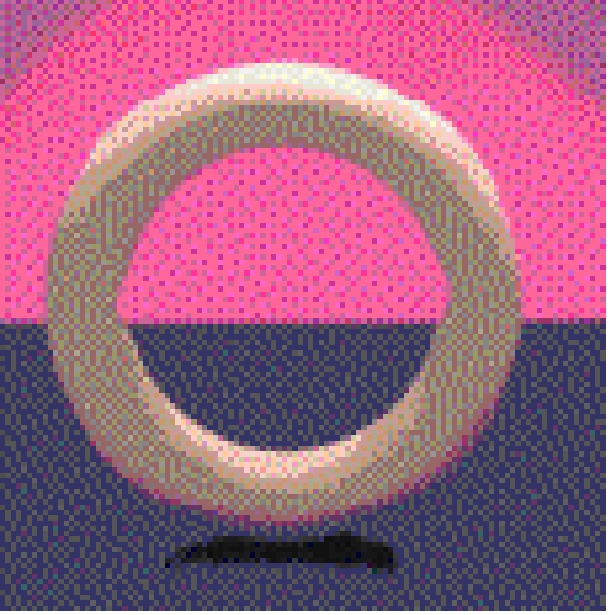
Overview of the various types of pessaries, their working mechanism, their names and indications

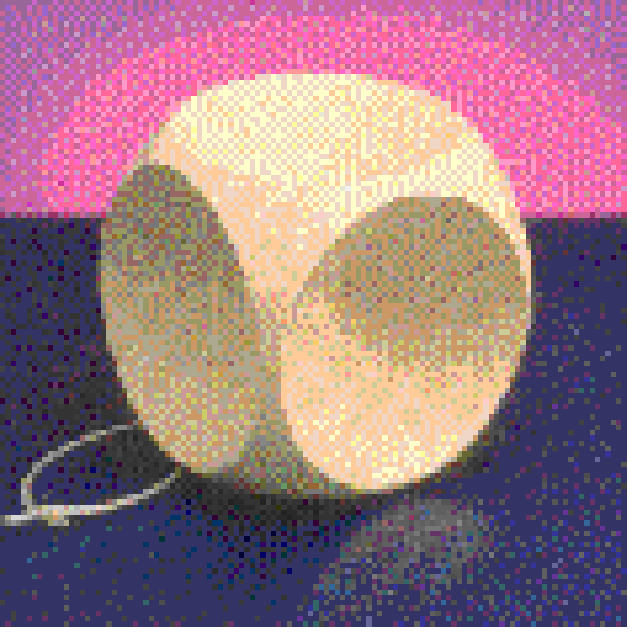
Type of pessary	Working mechanism	Name	Indication	Remarks
Ring	Supportive	–	Cystocele, mild uterine descensus	Various sizes thickness and rigidity
Donut	Supportive/spacefilling	Donut	All prolapse except major posterior defects	
Lever	Supportive	Hodge, Smith–Hodge, Riss	Cystocele mild uterine descensus	Supposed to follow the vaginal curve
Dish	Supportive	Falk, Shaatz	Best suitable for severe procidentia	
Stem	Supportive	Gellhorn	Cystocele, mild procidentia	
Cube	Spacefilling, self adhesive	Arabin	All prolapse	Daily removal necessary
Inflatable	Spacefilling	Inflatoball	All prolapse	Daily removal necessary

Différents types de pessaires



Type de pessaire	Mécanisme d'action	Nom	Indication	
Anneau	Soutènement		Cystocèle	
Donut	Soutènement Remplissage	Donut	Tous prolapsus excepté defects postérieurs	
Lever	Soutènement	Hodge, Smith-Hodge,	Cystocèle	
Dish	Soutènement	Falk, Shaatz		
Stem	Soutènement	Gellhorn	Cystocèle	
Cube	Remplissage auto adhérant	Arabin	Tous prolapsus	

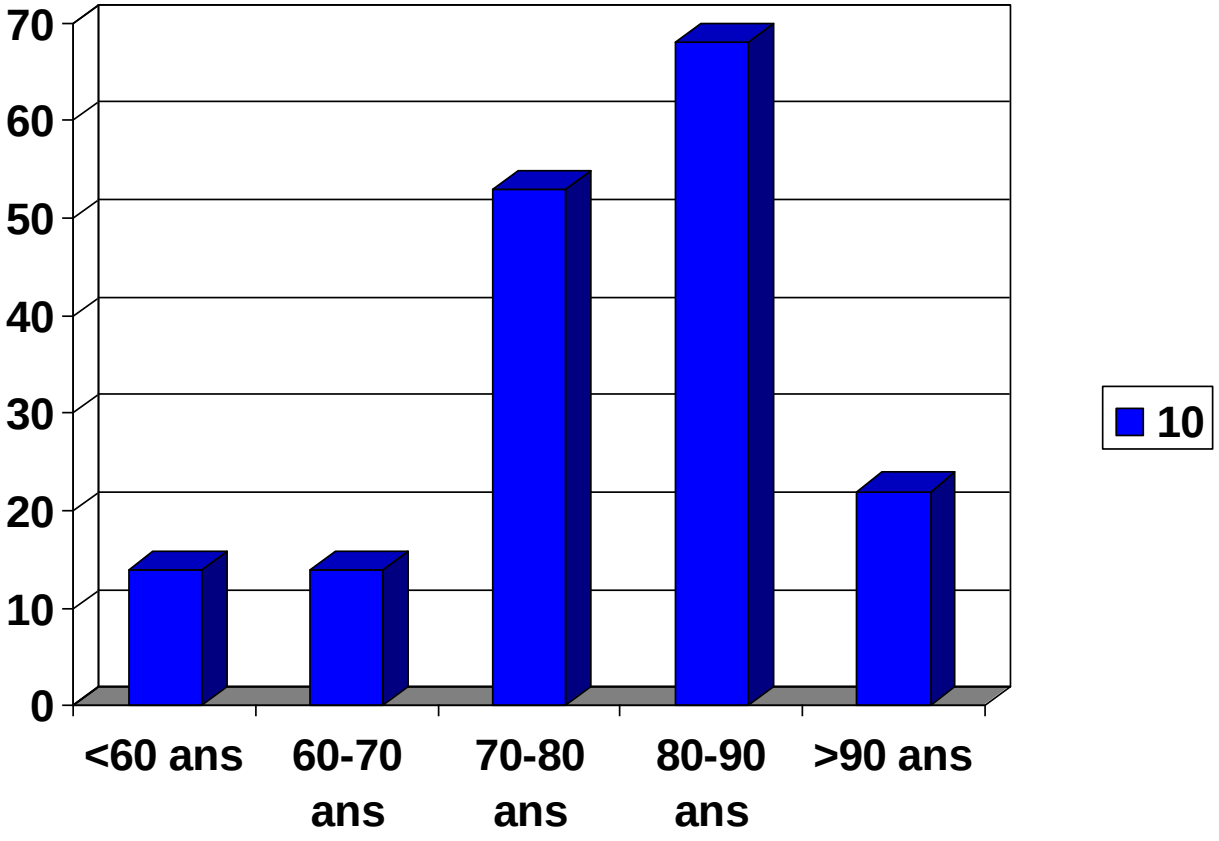




Pessaire en Cube

Pessaire et âge

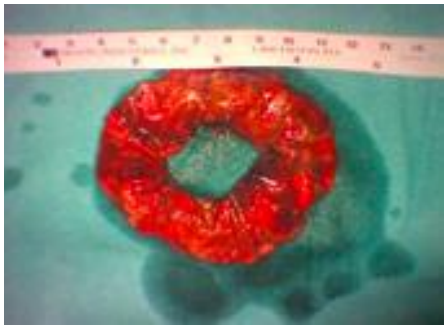
- N=183 (36-101 ans)
  - <60 ans = 10
  - 60-70 ans = 14
  - 70-80 ans = 53
  - 80-90 ans = 68
  - >90 ans = 22



Avec la courtoisie d'Odile Cotelle

Complications des pessaires: rares….

- Suppuration
- Incarcération
- Fistules
- Cancers



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ATELIER Jean COHEN
Samedi 07 Novembre 2015

Comment prescrire les pessaires ?

1° consultation: Traitement hormonal local 1mois +++
Choix de la taille et prescription du pessaire (jeu de pessaires +++)
Information +++ sur le choix pessaire (Fiche)
Bilan: ECBU, Echo pelvienne et rénale pré et post mictionnelle

2° consultation J7: Apprentissage pose et retrait
Information entretien, incidents, expulsion, « rétention » …
N° de tel si problème
Prescription TT local à renouveler

3° consultation à 3 mois

Puis 1 Cs / 6 mois ou 1 an

ATELIER Jean COHEN
Samedi 07 Novembre 2015

PORTEUR D'UN DISPOSITIF MEDICAL

-Un pessaire est un dispositif médical intra-vaginal destiné à contenir un prolapsus vaginal. Il nécessite surveillance.

- La muqueuse du vagin doit être de bonne qualité (pas de sécheresse), un traitement oestrogénique local est quasi-systématique.

-En cas d'accident, de maladie aigüe, infectieuse ou non, ou d'hospitalisation, prévenir le médecin de la présence de ce dispositif, afin qu'il soit éventuellement retiré si besoin.

-Le retrait est en général un geste facile : il suffit de l'attraper entre deux doigts et de tirer vers l'extérieur (un lubrifiant est utile)

-Le pessaire est destiné à améliorer la qualité de vie, mais peut être responsable d'une infection vaginale, d'une infection urinaire (cystite), de douleurs, de saignements, il faut dans ces circonstances consulter votre médecin.

-DATE dernier contrôle : /_____/_____/_____/

En pratique
mode de prescription

- Nom prénom
  - Date
  - Pessaire x mm
  - Colpotrophine®
- Carte Dispositif Médical
- Surveillance

Coût de la technique à long terme

- Sur 20 ans : 2 consultations/an
  Traitement local
  Pessaires 34 € (latex) (Burnet – Clément)

- TIPS rubrique P tarif 103P04 arrété du 18/05/98

- En pratique :
  Remboursement de 10 Euros (sécu)
  Complément mutuelle

Patient satisfaction and changes in prolapse and urinary symptoms in women who were fitted successfully with a pessary for pelvic organ prolapse.

Clemons and al.
AJOG Apr. 2004.

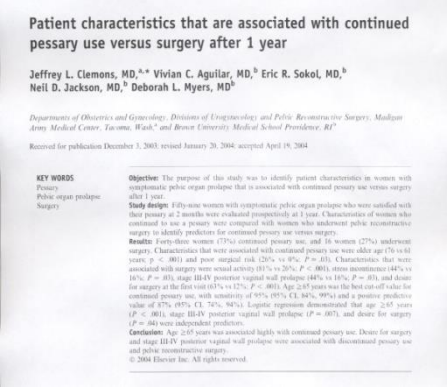
- Régression des symptômes après 2 mois :
  - Sensation de prolapsus : 90 à 3 % (p<0.001)
  - Pesanteur : 49 à 3 % (p<0.001)
  - Pertes : 12 à 0 % (p=0.003)
  - Manœuvres d'évacuation urinaire et fécale : 14 à 0 % (p=0.001)
  - Incontinence urinaire d'effort : améliorée dans 45 %
  - Impériosités urinaires : améliorées dans 46 %
  - Difficultés mictionnelles : améliorées dans 53 %

– **Mais : chez patientes sans symptôme urinaire,**
  - 21 % incontinence urinaire d'effort de novo
  - 6 % impériosités urinaires de novo
  - 4 % de difficultés mictionnelles de novo

Clemons JL Ajog April 2004.

N=73 / QOL J0.J60

- Résultats Globaux
  - **92 % satisfaites à 2 mois**
  - 8 % ablation pessaire, essentiellement lié à apparition d'incontinence urinaire d'effort occulte.



Patient characteristics that are associated with continued pessary use versus surgery after 1 year

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KEY WORDS
Pessary
Pelvic organ prolapse
Surgery

Objective: The purpose of this study was to identify patient characteristics in women with symptomatic pelvic organ prolapse that is associated with continued pessary use versus surgery after 1 year.

Study design: Fifty-nine women with symptomatic pelvic organ prolapse who were satisfied with their pessary at 2 months were evaluated prospectively at 1 year. Characteristics of women who continued to use a pessary were compared with women who underwent pelvic reconstructive surgery to identify predictors for continued pessary use versus surgery.

Results: Forty-three women (73%) continued pessary use, and 16 women (27%) underwent surgery. Characteristics that were associated with continued pessary use were older age (76 vs 61 years; $p < .001$) and poor surgical risk (26% vs 0%; $P = .03$). Characteristics that were associated with surgery were sexual activity (81% vs 26%; $P < .001$), stress incontinence (44% vs 16%; $P = .03$), stage III-IV posterior vaginal wall prolapse (44% vs 16%; $P = .03$), and desire for surgery at the first visit (63% vs 12%; $P < .001$). Age ≥65 years was the best cut-off value for continued pessary use, with sensitivity of 95% (95% CI, 84%, 99%) and a positive predictive value of 87% (95% CI, 76%, 94%). Logistic regression demonstrated that age ≥65 years ($P < .001$), stage III-IV posterior vaginal wall prolapse ($P = .007$), and desire for surgery ($P = .04$) were independent predictors.

Conclusion: Age ≥65 years was associated highly with continued pessary use. Desire for surgery and stage III-IV posterior vaginal wall prolapse were associated with discontinued pessary use and pelvic reconstructive surgery.

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Patient characteristics that are associated with continued pessary use versus surgery after 1 year.

Clemons and al.

AJOG jul 2004.

- N = 59 femmes ayant conservé le pessaire à 2 mois, réévaluation à 1 an :
  - 73 % ont tjrs pessaire
  - 27 % chirurgie

- Caractéristiques des femmes ayant conservé le pessaire :
  - Age élevé (76 vs 61 ans - p<0.001)
  - Risque chirurgical élevé (26 % vs 0 % - p=0.03)

- Caractéristiques des femmes ayant accepté la chirurgie :
  - Activité sexuelle (81 vs 26 % -p<0.001)
  - Incontinence urinaire d'effort (44 vs 16 % - p=0.03)
  - Rectocèle stade III-IV (44 vs 16 % - p=0.03)
  - Désir de chirurgie à la 1ère visite (63 vs 12 % - p<0.001)

- Age > 65 ans est le meilleur critère de sélection entre les 2 groupes

Conclusion - 1

Quelque soit le type anatomique:
Meilleure efficacité sur les symptômes des prolapsus des étages antérieurs et moyens

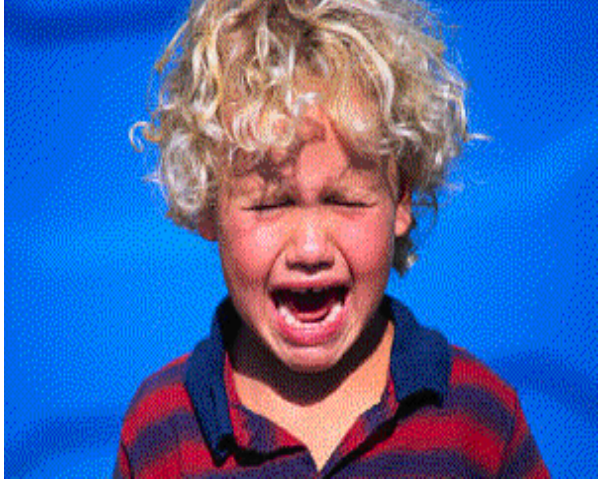
Quelque soit le stade:
Malgré échec probable en cas d'éversion vaginale complète

Quelque soit l'âge:
Ne pas le réserver aux femmes âgées inopérables

Respecter le refus, mais insister sur l'intérêt d'un **test au pessaire** avant chirurgie:
•En cas de douleur
•En cas de troubles urinaires (dysurie, IU): fr prédictif pour la chirurgie
Test au pessaire et dysurie: Se 87%, Spe 80%, VPP 94%(*)
•Chez les patientes indécises

Facteurs limitants:
- Mauvaise compliance au suivi avec les anneaux
- IU démasquée
- Déficience des releveurs et béance vulvaire

Conclusion - 2

- RISQUES D' ECHEC
  - Femme jeune
  - Femme désirant une chirurgie
  - Antcd d' hystérectomie **totale, POP**
  - Vagin court, béance vaginale
  - Rectocèle 3- 4
  - Incontinence de novo

MEDECINS
CHIRURGIENS !!
J'accuse!