NHS
Bedfordshire
Clinical Commissioning Group

Procedure that requires prior approval

Bedfordshire, Hertfordshire, West Essex and Milton Keynes Priorities Forum statement

Number	79
Subject	Uterine/Vaginal Prolapse (part of Pelvic Organ Prolapse)
Date refreshed	October 2017 – updated July 2018
Date review due	October 2020

GUIDANCE

The Royal College of Obstetricians and Gynaecologists define Pelvic Organ Prolapse (POP) as a weakening of the structures [ligaments and muscles] that hold the organs within a woman's pelvis (uterus, bladder and rectum) in place. This leads to the protrusion of one or more pelvic organ(s) bulging from their natural position into the vagina. These prolapses can be large enough to protrude outside the vagina[1]. More specifically Uterine Prolapse is when the uterus hangs down into the vagina. Vaginal vault prolapse is when the top of the vagina – vault – bulges down after a hysterectomy has been performed. POP is common and 50% of women over 50 will have some symptoms of POP[1].
Patients with POP should usually initially be assessed in primary care and conservative management tried.

Conservative Measures

- **Watchful Waiting** – in cases of asymptomatic/mild prolapse it is appropriate to observe for the development of new symptoms or complications1.
- **Lifestyle Modification** – including losing weight and reducing causes of increased intra-abdominal pressure:, management of chronic cough, avoiding constipation, avoiding heavy lifting and avoiding physical activity such as trampolining or high-impact exercise1. However, it is important to note that even though prolapse is associated with these lifestyle factors, the role of lifestyle modification as a prevention or treatment of prolapse has not been investigated2.
- **Pelvic Floor Exercises** – to strengthen the pelvic floor muscles. A large multicentre RCT (the Pelvic Organ Prolapse Physiotherapy [POPPY] trial)3 showed that one-to-one PFMT for prolapse is effective for the improvement of prolapse symptoms. A Cochrane review in 2011 found that "the largest most rigorous trial to date suggests that six months of supervised Pelvic Floor Muscle Training has benefits in terms of anatomical and symptom improvement (if symptomatic) immediately post-intervention." Four trials compared pelvic floor muscle training (PFMT) with no intervention and found that doing PFMT improved prolapse symptoms.
- **Vaginal Oestrogen Creams** – these are often offered in cases of mild prolapse.

Vaginal Pessaries

Vaginal pessaries are a good way of supporting prolapse and are more likely to support a uterine prolapse than other types of prolapse[1]. A study on the use of pessaries found that up to 60% of women found pessaries to be effective[4].

Pessaries are a good option for women who wish to have children/more children in the future, in cases where a woman does not want surgery or surgery is not recommended and for relief prior to having surgery[1,5]. A pessary is a plastic or silicone device that fits into the vagina to help support the pelvic organs and hold up the uterus. The most common type of pessary used is a ring pessary[1].

- Fitting the correct size of pessary is important and may take more than one attempt[1]
- Pessaries may cause inflammation. Patients should be informed to see their doctor if they experience any unexpected bleeding [1].
- Pessaries should be changed or removed, cleaned and reinserted regularly[1]
- It is possible to have sexual intercourse with some types of pessary although the woman and her partner may occasionally be aware of it[1]
- Complications tend to occur in women who are not regularly followed-up[5]

Surgery

If conservative management has not been successful there are some surgical procedures that can be used to treat prolapse. Indications for surgery are: failure of pessary and other conservative management, prolapse combined with urinary or faecal incontinence and women with moderate to severe prolapse. However, it is important for a woman to be fully informed before she consents to surgery, and that she knows that for surgical treatments to be effective a combination of procedures may be required and re-operation may also be required[5].

Clinical scenarios where referral for specialist assessment will be funded by the CCG:

- Women with symptomatic prolapse (who have moderate or severe prolapse)

OR

- Prolapse combined with urethral sphincter incompetence/ urinary incontinence or faecal incontinence

OR

- Failure of pessary and conservative treatments

OR

- Women with moderate to severe prolapse who want definitive treatment

Clinical scenarios where surgery will not be routinely funded by the CCG

- Asymptomatic pelvic organ prolapse

OR

- Mild pelvic organ prolapse (unless combined with urinary/faecal incontinence)

Patients not meeting the above criteria will only be funded on exceptional clinical circumstances and applications for such funding should be made to the Individual Funding Request team.

Types of Surgical Procedures that will not be funded by the CCG

- Robotic sacrocolpopexy will not be funded by the CCG: RCOG state there is limited evidence on the effectiveness of robotic sacrocolpopexy; therefore, it should only be performed in the context of research or prospective audit following local governance procedures [6].
- High uterosacral ligament suspension (HUSLS) will not be funded by the CCG: RCOG state HUSLS should only be offered as first-line management in women with Post-Hysterectomy Vaginal Vault Prolapse within the context of research or prospective audit following local governance procedures[6].
- Transvaginal Mesh kits/grafts (TVM) - see alert below

IN JULY 2018 the UK Government announced a pause on the use of vaginally inserted mesh and tape to treat stress urinary incontinence and pelvic organ prolapse in England. This follows a recommendation by Baroness Cumberlege, who is chairing an independent review of surgical mesh procedures and has heard from women and families affected by them.

This means the use of synthetic mesh will be highly restricted to certain patient groups under specific conditions as yet to be decided.

An updated NICE guideline is expected in April 2019

Human Rights and Equalities Legislation has been considered in the development of this guidance.

References:

1) Royal College of Obstetricians & Gynaecologists (2013). Pelvic Organ Prolapse [Patient Information Leaflet]. *RCOG*. [online]. Available from: https://www.rcog.org.uk/en/patients/patient-leaflets/pelvic-organ-prolapse/?_t_id=1B2M2Y8AsgTpgAmY7PhCfg%3d%3d&_t_q=pelvic+organ+prolapse+guidelines&_t_tags=language%3aen%2csiteid%3a39338ee9-cb61-4e10-a686-8f4a5e1b76d7&_t_ip=86.12.139.50&_t_hit.id=EPiServer_Templates_RCOG_Models_Pages_PatientGuidelinesDetailsType/_5cdbd05a-3ccf-41d4-a72d-deddfe42ed9c_en&_t_hit.pos=1 [Accessed 07.02.2017]

2) Jelovsek JE, Maher C, Barber MD (2007). Pelvic organ prolapse. *The Lancet*, **369** (9566):1027-38.

3) Hagen S, Stark D, Glazener C, Dickson S, Barry S, Elders A, et al. (2014). POPPY Trial Collaborators. Individualised pelvic floor muscle training in women with pelvic organ prolapse (POPPY): a multicentre randomised controlled trial. Lancet, 383:796–806.

4) Bugge C, Adams EJ, Gopinath D, Reid F (2013). Pessaries (mechanical devices) for pelvic organ prolapse in women. Cochrane Database of Systematic Reviews. [online]. Available from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004010.pub3/epdf [Accessed 07.02.2017]

5) Wright M, Harding M, Cox J. Genitorurinary Prolapse. [online]. *Patient.co.uk/patient plus Professional Reference*. Available from: http://patient.info/doctor/genitourinary-prolapse-pro#ref-9 [Accessed 07.02.2017]

6) Royal College of Obstetricians & Gynaecologists (2015). Post-Hysterectomy Vaginal Vault Prolapse (Green Top Guideline No.46). *RCOG*. [online]. Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-46.pdf [Accessed 07.02.2017].

7) The Use of Mesh in Gynaecological Surgery Scientific Impact Paper No. 19 (2010). *Royal College of Obstetricians and Gynaecologists*. [online]. Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/sip_no_19.pdf [Accessed 07.02.2017].