Pelvic Organ Prolapse

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Abstract: In recent years, more and more attention has been paid to the issues of prolapse of the genital organs. This is largely due to increase in women's life expectancy and the need to provide them with a decent quality of life, since quite often; prolapse is accompanied by dysfunction of the pelvic organs. In the literature of recent years, there are many the body of information relating to this problem. However, most of these researches considers therapeutic or vertebral neurological problems, while the widespread. This pathology causes the need for additional studies, which will make it possible to determine the choice of subsequent treatment.

Keywords: anatomical and functional failure, cystorectocele, genital organs, gynecology, pelvic floor, prolapse.

Introduction

Pelvic organ prolapse is a disease that combines a group of disorders of the ligamentous apparatus of the uterus and vagina, leading to prolapse and prolapse of the internal genital organs, manifested by displacement of the genitals to the vaginal inlet or prolapse beyond its redistribution.

This pathology has the greatest practical significance among the anomalies in the position of the genital organs [1, 2]. This is a polyetiological disease, in the development of which physical, genetic and psychological factors play a role. Due to the anatomical proximity and commonality of supporting structures, this disease often causes anatomical and functional failure of adjacent organs and systems (urinary incontinence, anal sphincter failure). Genital prolapse (PG) should be considered as a type of pelvic floor hernia that develops in the area of the vaginal entrance. In the terminology of prolapse and prolapse of the internal genital organs, such synonyms as "genital prolapse", "cystorectocele" are widely used; use the following definitions: "omission", incomplete or complete "prolapse of the uterus and vaginal walls" [4]

Etiology and pathogenesis of pelvic organ prolapse

Despite the efforts of many generations of gynecologists, surgeons, anatomists and doctors of other specialties, there is still no consensus on the etiology and pathogenesis of this condition. A number of authors believe that pelvic organ prolapse develops due to insufficiency of the pelvic floor muscles and should be considered as a type of pelvic hernia. Insufficiency of the pelvic floor muscles is due to a decrease in the tone of the muscular-fascial structures or their defects, which can be traumatic and non-traumatic (functional). [3]

The producing factor in the development of this pathology is an increase in intra-abdominal pressure of an exogenous or endogenous nature, and the predisposing factor is the insolvency of
the pelvic floor, in the occurrence of which 4 main reasons can be distinguished (their combination is possible):

1. Post-traumatic damage to the pelvic floor;
2. Failure of connective tissue structures in the form of "systemic" insufficiency;
3. Violation of the synthesis of sex hormones;
4. Chronic diseases, accompanied by a violation of metabolic processes, microcirculation, a sudden frequent increase in intra-abdominal pressure. [6]

Under the influence of one or more of these factors, functional failure of the ligamentous apparatus of the pelvic floor occurs. With an increase in intra-abdominal pressure, the pelvic organs begin to be squeezed out of its limits. Close anatomical connections between the bladder and the vaginal wall contribute to the fact that against the background of pathological changes in the pelvic diaphragm, there is a combined omission of the anterior wall of the vagina and the bladder, which becomes the contents of the hernial sac, forming a cystocele. The cystocele also increases under the influence of its own internal pressure in the bladder, resulting in a vicious circle. These changes are accompanied by stress incontinence in every second patient with pelvic prolapse.

Similarly, a rectocele is formed. There is a combined prolapse of the posterior wall of the vagina and rectum, which becomes the contents of the hernial sac, forming a rectocele. Proctological complications develop in every third patient with the above pathology. [8,9]

**Classification**

There are several classifications of GHGs (Figure-1). POP-Q (Pelvic Organ Prolapse Quantification) is the most up-to-date classification of GHGs. It has been adopted by many urogynecological societies around the world (International Continence Society, American Urogynecologic Society, Society of Gynecologic Surgeons, etc.) and is used to describe most studies on this topic. This classification is difficult to learn, but has a number of advantages: 1) reproducibility of results (first level of evidence); 2) the position of the patient has practically no effect on determining the stage of prolapse; 3) accurate quantification of many defined anatomical landmarks (and not just the definition of the outlier point itself) [4,5].

**Figure 1. Staging of Prolabs**

Once all measurements have been made the stage of the prolapse can be identified in relation to hymen;

- **Stage 0**: No prolapse is observed (points Aa, Ba, C, D, Ap and Bp are all < / = -3cm).
Stage 1: The most proximal portion of prolapse is greater than 1 cm above the level of the hymen (points Aa, Ba, C, D, Ap and Bp are all < -1cm).

Stage 2: The most proximal portion of prolapse is found between 1 cm higher than hymen and 1cm beneath hymen (points Aa, Ba, C, D, Ap and Bp can set at -1cm and +1cm).

Stage 3: The most distal part of the prolapse extends more than 1cm beneath the hymen but no further than 2 cm, resulting in no measurement larger than TVL (points Aa, Ba, C, D, Ap and Bp can be >/= +2cm and </= TVL -3cm).

Stage 4: Vaginal eversion has taken place or eversion to with 2cm of TVL (points Aa, Ba, C, D, Ap and Bp can be >/= to TVL -2cm) [4,5]

Clinical manifestations of pelvic organ prolapse

Patients suffering from prolapse or prolapse of the genital organs may feel a "foreign body" in the area of the vulvar ring, they may be disturbed by a feeling of discomfort and "heaviness" in the perineum and lower abdomen. The feeling of discomfort usually increases in the evening and decreases or disappears after rest or after the reduction of the lowered organs.

Pain is not typical for this contingent of patients; only with a large enterocele, severe pain in the abdomen can occasionally occur due to traction of the mesentery. Pain in the lower abdomen appear in case of acute urinary retention. A significant number of patients have manifestations of sexual dysfunction and (or) dyspareunia.

The gaping of the genital slit increases the likelihood of infection of the genital tract, therefore, patients with prolapses are characterized by recurrent colpitis and (or) non-inflammatory leucorrhea. Contact of the prolapsed cervix (vaginal walls) with linen, coupled with circulatory disorders, infection and maceration lead (more often in elderly patients) to the formation of decubital ulcers on the mucous membranes. [11]

Omission of the anterior wall of the vagina, urethrocele and cystocele can cause urinary disorders. For paravaginal, central, distal defects of the pubocervical fascia, stress urinary incontinence is characteristic. The transverse defect is not accompanied by incontinence; it is more typical for it to increase the amount of residual urine.

Clinical practice shows that with small degrees of prolapse of the walls of the vagina, urinary incontinence or pollakiuria can be observed more often. For incomplete and complete prolapse of the genital organs, an obstructive type of urination is more characteristic, up to episodes of acute urinary retention. In this case, most often the condition of the urinary tract itself in patients with genital prolapse corresponds to that in patients with urinary incontinence, but the prolapsed tissues compress and sometimes bend the urethra, which leads to diametrically opposite symptoms of stranguria. If during the operation (for example, vaginal extirpation) in such patients the vesicourethral segment is not set in the correct position, the hypermobility of the urethra is not eliminated, etc., then after the operation, urinary incontinence may occur, which was not observed before. Preoperative detection of this so-called occult urinary incontinence in a patient with genital prolapse or prolapse can be facilitated by a cough test with a barrier (i.e., while holding the posterior fornix in the correct position with the inserted Simps posterior speculum).

Urodynamic disorders, especially urinary stasis and vesicoureteral reflux, lead to infection of the genital tract, the formation of hydro ureteral nephrosis, hydro nephrosis, and the frequent development of urolithiasis with corresponding clinical manifestations.
Patients with severe rectocele usually suffer from rectal dysfunction such as colitis, stool and gas incontinence, and stool and gas retention. Frequent stool retention leads to tension, increased intra-abdominal pressure and, as a result, to further progression of prolapse and rectocele.

The omission and prolapse of the genital organs refers to diseases that disrupt the social activity of women, worsening the quality of life.

**Diagnosis of genital prolapse**

Diagnosis of the degree of prolapse and prolapse of the uterus and vagina is carried out in the position of the patient lying on her back at its maximum severity (usually this is achieved during the Valsalva test). Measurements of parameters are carried out with a centimeter ruler, a uterine probe or a forceps with a centimeter scale. Additionally, it is necessary to perform ultrasound of the pelvic organs, urodynamic examination (if indicated) and proctography (if indicated).

**Methods of surgical treatment of genital prolapse**

Surgical correction as the only adequate treatment for this disease is no longer the subject of discussion. Currently, significant experience has been accumulated in this area, namely: there are more than two hundred methods of surgical treatment of genital prolapse, including using new technologies [6]. The most complete and convenient is the classification of methods for the surgical treatment of pelvic floor insufficiency, pelvic organ prolapses and their functional disorders, systematized according to the anatomical principle in seven groups of surgical technologies proposed by V.I. Krasnopolsky (1997) [14]:

Group 1: Plastic surgery aimed at strengthening the pelvic floor.

Group 2: Operations using various modifications to strengthen and shorten the round ligaments of the uterus and fix the body of the uterus.

Group 3: Operations to strengthen the fixing apparatus of the uterus and change its position.

Group 4: Operations with rigid fixation of the internal genital organs (vaginal fornix) to the walls of the pelvis.

Group 5: Operations with the use of alloplastic materials to strengthen the ligamentous apparatus of the uterus and pelvic fascia.

Group 6: Operations to create a complete or partial obliteration of the vagina.

Group 7: Radical operations performed by various surgical approaches in combination with operations from groups 4 and 5

**Conclusion.** Thus, the problem of genital prolapse is multifactorial and polyetiologic. When solving it, significant technical difficulties often arise, associated not only with the surgical reconstruction of the pelvic floor, but also with the problem of choosing the least traumatic and effective method of surgical intervention. The long-term, progressive nature of the disease, leading to aggravation of functional disorders, necessitates a reasonable choice (on the one hand, standardized, and on the other hand, individual) method of surgical correction for each patient. Such an integrated approach will improve the results of surgical treatment of patients with genital prolapse, reduce the frequency of recurrence of this disease and the risk of immediate and long-term adverse results of surgical intervention.

**References:**


