Pelvic floor disorders include a wide variety of clinical conditions such as urinary incontinence, pelvic organ prolapse, overactive bladder, sexual dysfunction, recurrent urinary tract infections, voiding dysfunction and several chronic pain syndromes of the bladder and vagina. However, of the numerous manifestations of pelvic floor disorder, pelvic organ prolapse and urinary incontinence are the most common. Pelvic organ prolapse is a condition in which a pelvic organ, most commonly the bladder, drops from its normal anatomical position and pushes on the vaginal walls. This causes a vaginal “bulge” and creates the “pressure” commonly described by many women with prolapse. Urinary incontinence is the involuntary leakage of urine. The most common form of urinary incontinence is stress urinary incontinence, or leakage of urine associated with physical exertion such as coughing, sneezing or lifting. Other forms of urinary incontinence include urge urinary incontinence, or leakage of urine associated with urgency, and mixed urinary incontinence, which is a combination of both types.

The single most important thing for a woman with any pelvic floor disorder is to know that you are not alone. In fact, many women may be surprised to know that pelvic floor disorders affect up to half of all adult women, being more common than high-blood pressure, diabetes or depression. For instance, according to the Journal of Urology, the prevalence of urinary incontinence in women increased from 49.5 percent in 2002 to 53.4 percent in 2008. Yet, despite this high incidence, a U.S. survey of multi-ethnic women published in the Journal of Urology revealed that only 45 percent of women with urinary incontinence sought care. So, why are women with pelvic floor problems not getting the help they need? Many women report that they are too embarrassed, or even ashamed, to talk about this sensitive topic. Understandably, this is a very personal issue, as it can have a significant impact on a woman’s body image, confidence, personal relationships and overall quality of life. Moreover, there appears to be a lack of awareness about pelvic floor disorders in both the patient and medical communities. In some instances, women who report pelvic problems have been told by their health care providers that this is “a normal part of getting old” or “you just have to live with it.” While female pelvic floor disorders may become more common with age, they should never be misconstrued as normal or something for which there is no treatment. Consequently, many women living with these disorders are suffering in silence.
Defining Pelvic Organ Prolapse

Pelvic organ prolapse is defined as the herniation of pelvic organs at or beyond the vaginal opening. Pelvic organs, such as the bladder, uterus, and rectum, may press on the walls of the vagina, causing a bulge or protrusion that can be seen or felt at or beyond the vaginal opening. In the case of the bladder, a bulge may develop on the top vaginal wall that causes a “cystocele.” Similarly, the rectum can push upward on the bottom wall of the vagina causing a bulge, otherwise known as a “rectocele.” In women with a uterus, a loss of support may cause the cervix to protrude through the vaginal canal, which is known as “uterovaginal prolapse.” In women who have had a hysterectomy, the apex of the vagina can fall through the vaginal canal creating a “vaginal vault prolapse.” These different forms of pelvic organ prolapse may be difficult to distinguish because they all commonly form a vaginal bulge of some kind, and only a physician can reliably distinguish the type of prolapse by performing a detailed pelvic examination. Importantly, none of the previously mentioned forms of prolapse should be confused with rectal prolapse, where the rectum falls down the anal canal and protrudes through the opening of the anus. Nevertheless, all types of prolapse can have a significant impact on a woman's quality of life, affecting daily activities, body image and sexuality. Approximately 300,000 surgeries are performed annually in the United States for the treatment of pelvic organ prolapse. In fact, between 1979 and 2006, surgical repair of pelvic organ prolapse was the most common surgery performed in women older than 70 years of age. However, this is not limited to post-menopausal women. It is not uncommon to see women who are in their 30s, 40s and 50s experiencing symptoms of pelvic organ prolapse.

What Causes Pelvic Organ Prolapse?

Many patients are curious to know the causes of pelvic organ prolapse. Normally, the pelvic organs are supported by a “hammock” of pelvic floor muscles and interconnective tissues. When this network of pelvic floor muscles (called the levator ani) start to weaken and stretch, the connective tissues can no longer support the pelvic organs. Eventually, gravity wins the battle as the pelvic organs, most commonly the bladder, start to drop, resulting in the vaginal bulge and cystocele detailed above. The most common risk factor for pelvic organ prolapse is vaginal birth deliveries, which further increases when operative measures such as forceps are used. Other risk factors include genetics, obesity, smoking, and chronic cough or straining. Weight loss, smoking cessation, kegel exercises, and avoiding heavy lifting are some of the lifestyle modifications that women can make to help prevent prolapse. Regarding vaginal deliveries, to date there are no good studies to support elective cesarean deliveries to prevent pelvic organ prolapse or stress urinary incontinence.

Diagnosing Pelvic Organ Prolapse

The evaluation of pelvic organ prolapse starts with obtaining a detailed patient history to gather an accurate assessment of a woman’s symptoms. While many women with prolapse may be asymptomatic, those who are symptomatic describe the sensations they are experiencing as “vaginal pressure”; “something is falling out”; “I feel like I am sitting on something”; or, “I have to lean forward to urinate.” Following this detailed history, a pelvic examination must be performed, preferably using the Pelvic Organ Prolapse Quantification Examination. This enables the physician to objectively quantify the severity of the prolapse in the following stages:

- **Stage 0**: no prolapse
- **Stage 1**: prolapse is more than 1cm inside the vaginal opening
- **Stage 2**: prolapse descent is within 1cm of the vaginal opening
- **Stage 3**: prolapse descends more than 1 cm beyond the vaginal opening
- **Stage 4**: complete descent of prolapse outside the vagina

Treatment Options

Assuming your examination reveals pelvic organ prolapse, there are three treatment options. It is important for patients to realize that the factors that influence treatment are based on improving the quality of a woman’s life, not simply out of medical necessity. Therefore, assuming a patient can urinate and empty her bladder, observation and “leaving it alone” is a reasonable option.

For those patients who desire non-invasive treatment, a “pessary” is a fast, safe, and effective option, and can help patients avoid surgery. A pessary is a medical device made of rubber, silicone or plastic, and is placed inside the vagina to help support the pelvic organs. However, there are some disadvantages of the pessary. For example, it may take several...
attempts to find the correct fit, and it does require removal and cleaning every three months. Many women can be taught how to remove, clean and replace the pessary themselves on a daily basis, if necessary, particularly those women who are still menstruating or who are sexually active. It is critical that patients who opt for a pessary follow-up with their physicians regularly, as leaving the implement in place over a long period of time can lead to vaginal ulcersations, infections, and even fistulas (a passageway or connection between two organs that does not normally exist).

Finally, the last option is surgery. There are many surgical options and various approaches to the treatment of pelvic organ prolapse. Surgery can be performed vaginally, abdominally, laparoscopically, robotically, with or without removing the uterus, and with or without supportive graft material. There has been recent controversy in the medical community regarding the use of trans-vaginal synthetic mesh during prolapse surgery. Recently, the Federal Drug Administration (FDA) released a public health notification regarding complications associated with the trans-vaginal mesh such as erosion, infection, and pain during intercourse. However, supporters of the mesh state that it offers advantages over traditional procedures, including long-term durability and reduced incidence of pelvic organ prolapse. This can be a difficult and confusing decision for a patient to make, as the method of surgery may be largely influenced by a physician’s personal bias, training and experience. In choosing a surgery, it is essential that the course of action be individualized, and that the chosen procedure meets a particular patient’s goals, expectations and risk tolerance. Also, patients should ensure that their physician has adequate training and experience in the surgical management of pelvic organ prolapse. Physicians who are licensed and approved to perform these procedures include urologists, gynecologists, and urogynecologists (see sidebar).

Urinary Incontinence

Another common pelvic floor disorder is urinary incontinence. Urinary incontinence is defined as the involuntary leakage of urine. Many women live with the misconception that urinary incontinence is a “normal” part of aging, but this is far from the truth. While urinary incontinence may be common, it is certainly not something a woman should have to live with. While there are many types of urinary incontinence, the two most common manifestations are stress urinary incontinence and urge urinary incontinence. Stress urinary incontinence is described as the leakage of urine associated with coughing, sneezing, laughing, running and lifting. This may be treated with physical therapy to strengthen the pelvic floor muscles, or with surgery. Patients who desire physical therapy are typically referred to a practitioner who is experienced in female pelvic floor disorders. With a physical therapist, patients learn how to recruit the correct muscle groups and build adequate strength to improve their symptoms. This may require one to two months of sessions with a physical therapist as well as a long-term commitment to continuing pelvic floor exercises. Surgically, stress urinary incontinence is treated either with a mid-urethral sling or peri-urethral bulking. Both procedures are minimally invasive and are typically done in surgery centers. However, prior to undergoing surgery, be sure your physician reviews the risks and benefits of each surgery with you carefully.

• Mid-urethral sling: A small, one-centimeter wide portion of mesh is placed underneath the urethra. As patients return to physical exertion, such as coughing, sneezing, running or lifting, the urethra compresses on the sling, which in turn prevents the leakage of urine.

• Peri-urethral bulking: Using a cytoscope (scope allowing your physician to assess the lining of the bladder) a synthetic bulking agent is injected on each side of the urethra at the level of the bladder neck to narrow the urethral opening to prevent leakage.

Different from stress urinary incontinence, urge urinary incontinence is the leakage of urine associate with urgency. Women usually describe a “sudden urge to urinate and cannot make it to the bathroom in time” sensation. This is actually a more severe form of overactive bladder syndrome in which involuntary bladder contractions result in urinary frequency and urgency. Though there are some known causes of overactive bladder, most commonly, the cause is unknown.

Overactive bladder and urge urinary incontinence are both typically treated...
with anti-cholinergic medications, such as oxybutinin and tolterodine. These medications target receptors in the bladder that help prevent involuntary contractions. However, prior to starting medications, a “voiding diary” that documents liquid consumption, voids per day and incontinence episodes per day is a good first-line treatment alternative that can help a patient learn lifestyle modifications and bladder-training techniques that can reduce symptoms. Furthermore, some medications or other health conditions may increase the risk of developing urinary incontinence.

For women in whom medication has not been successful or for those who cannot tolerate the side effects (dry mouth, dry eyes, constipation), there is a surgical alternative to treat overactive bladder and urge incontinence called sacroneuromodulation. This is a procedure that has been approved by the Federal Drug Administration. This is a procedure that has been approved by the Federal Drug Administration.

It is critical that patients with pelvic floor disorders realize that they are not alone and pelvic floor conditions are not simply a normal part of aging.

### Examples of Female Sexual Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypoactive Sexual Desire Disorder</td>
<td>The persistent or recurrent deficiency (or absence) of sexual fantasies/thoughts/desires for or receptiveness to sexual activity, causing personal distress</td>
</tr>
<tr>
<td>Sexual Arousal Disorder</td>
<td>The inability to reach or maintain a satisfactory sexual excitement, resulting in personal distress</td>
</tr>
<tr>
<td>Sexual Aversion Disorder</td>
<td>Phobia or anxiety disorder relative to sexual context</td>
</tr>
<tr>
<td>Orgasmic Disorder</td>
<td>Recurrent or persistent difficulty in experiencing orgasm, resulting in personal distress</td>
</tr>
<tr>
<td>Sexual Pain Disorder</td>
<td>Persistent or recurrent pain with attempted or complete vaginal entry and / or penile intercourse</td>
</tr>
</tbody>
</table>

### Where to Turn

So who can women turn to for help with pelvic floor problems? The Central Valley has many physicians and facilities that can help. Your primary care physician, urologist, gynecologist or urogynecologist is always a good place to start. While many medical providers may be able to help, not all physicians are experienced or comfortable treating pelvic floor disorders. Finding the right health care provider is key to obtaining treatment and improving daily life. Additionally, to improve overall awareness and education, the American Urogynecologic Society (AUGS) has created a support group for women with pelvic floor disorders. At www.voicesforpfd.org, women are encouraged to “take the floor” and air their concerns and experiences. This is just one example of how women are being encouraged to connect, step forward, and to “stop suffering in silence.” It is critical that patients with pelvic floor disorders realize that they are not alone and pelvic floor conditions are not simply a normal part of aging. For women who are embarrassed about these problems, talking with a health care provider with whom you have an established relationship can be a great starting place. However, if your physician tells you that what you are experiencing is not something that can be treated, it may be time to seek a second opinion.

### About the Author

Benjamin J. Steinberg, D.O., is a board-certified Obstetrician/Gynecologist and the only specialist in the Central Valley with three-year fellowship training in Urogynecology and Female Pelvic Reconstructive Surgery. He dedicates 100 percent of his practice to women with pelvic floor disorders and is currently seeing patients at Urology Associates of Central California.