clinicians can expect prolapse stage to both increase and decrease over time.[42] Home pelvic floor muscle exercises and pelvic floor physical therapy may be helpful for some women. A 2013 review of conservative management of incontinence and POP from the *5th International Consultation on Incontinence* cited 4 trials that revealed symptom improvement as well as improvement in anatomical defects of prolapse with physical therapy.[43] This review included a multicenter trial of 447 women with symptomatic prolapse randomized to an individualized program for pelvic floor muscle training or an educational pamphlet. The pelvic floor muscle training group had significantly greater reduction of prolapse symptoms.[44] Another study found women with stages I to III prolapse who were randomized to pelvic floor muscle training, and 19% of these women improved 1 POP-Q stage compared with only 8% of controls.[45]

PESSARY

For women who proceed with treatment, a pessary should be considered.[46] If possible, patients should be taught how to remove and insert the pessary themselves. Patients who do not wish to change their own pessary or are physically unable to do so should be seen regularly for removal and cleaning of the pessary and a vaginal examination. The best time interval between visits is not known, but many experts recommend 3 months. Pessaries have been shown to be effective. In a randomized control trial comparing ring and Gellhorn pessaries that used validated questionnaires to measure outcomes, pessaries were found to reduce prolapse symptoms significantly for 60% of women without differentiation between the 2 types.[47] A recent trial noted an improvement that is greater than 90% in bulge symptoms and an improvement of 50% in urinary symptoms; however, 20% of women developed stress incontinence.[48] Given this information, it is important to counsel patients on the possibility of OSUI.

Patients who desire a pessary will undergo a fitting process. Characteristics that have been found to be associated with unsuccessful fittings include a larger genital hiatus and shorter vaginal length.[49,50] Patients with an isolated rectocele are also less likely to be successful with a pessary.[51] Patients with these findings can be counseled that pessary placement may not be successful, but fitting can still be attempted.

Women may wonder if using a pessary is an option for long-term POP management. Women aged 65 years and older are more likely to continue use of the pessary at 1 year. Women who wanted surgery at their initial visit, women with advanced posterior wall prolapse, and those with shortened vaginas from previous surgery were less likely to continue with their pessary.[52] It has been found that women who achieved their patient-selected goals were more likely to continue pessary use.[53] Although elderly women may be more likely to continue use of a pessary, this population may face more challenges with pessary self-care. Family members or caretakers should be aware of the presence of the pessary to ensure that elderly women receive ongoing maintenance and care.

SURGICAL TREATMENT

When considering surgical options, the patient's age, medical problems, functional status, and treatment goals should be considered. Perioperative management of active medical issues is essential. The American College of Surgeons National Surgical Quality Improvement Program has created a surgical risk calculator that is available online (www.riskcalculator.facs.org), and surgeons can consider using this calculator to estimate perioperative morbidity and mortality. Nearly 1.5 million patients including gynecology and urology patients were used in the development of the calculator.[54]

Before surgical treatment of POP, patients should be counseled regarding the expected effect on bulge symptoms, urinary and bowel symptoms, as well as sexual function. This will include a discussion of possible need for further testing and types of concomitant treatment that may be offered. Patients may incorrectly assume that correcting their prolapse will address all urinary and bowel symptoms. Limitations of surgery should be discussed, including that symptoms may not resolve completely even if anatomy is corrected. It may be reasonable to offer stress urinary incontinence surgery to women with anterior vaginal wall prolapse without stress urinary incontinence, but there are additional risks associated with these procedures, which the patient should understand before reaching a decision.[55–57]

When counseling patients on their surgical options, the following 2 broad categories can be considered: obliterative versus reconstructive surgeries. Obliterative surgery is only an option for women who are certain that they will not desire vaginal intercourse in the future because the surgery significantly shortens and narrows the vagina and should be considered irreversible. Obliterative surgery has several advantages including a high level of efficacy while being associated with fewer complications and less blood loss.[58–64] It can also be performed under regional or, in some cases, local anesthesia.[60] These features make it desirable for women with serious medical comorbidities. This procedure can be performed with the uterus left in place (LeFort colpocleisis) or in patients with a previous hysterectomy (colpectomy). A concomitant hysterectomy can be performed if required, although this may increase the risk of complications.[61,64]

If obliterative surgery is not desired by the patient, native tissue or graft-augmented repair reconstructive surgery should be discussed. Patients may have strong preferences when it comes to use of graft, and this should be discussed. If synthetic mesh is considered, the 2011 FDA safety communication on transvaginal mesh should be discussed.[65] Patient preference is also important when considering hysterectomy versus uterine preservation for women with uterine prolapse. The choices of procedures provide optional use of native tissue and/or grafts, retention or removal of the uterus, and vaginal or abdominal (open, laparoscopic, and robotic-assisted) approaches. Surgeons offering various surgical treatments should be aware of the data on efficacy and complications of those procedures and offer these data to the patient during counseling.

CONCLUSIONS AND RECOMMENDATIONS

Women with prolapse should have an examination to quantify the loss of anatomic support and should be evaluated for associated bladder, bowel and prolapse symptoms, as well as associated bother. Treatment options should be tailored to meet the patient's medical health and personal functional goals. In most cases, women should be informed of the range of treatment options including observation as well as nonsurgical and surgical management.

For patients presenting with POP,

1. Determine the duration and severity of pelvic symptoms and associated bother.
2. Ask specifically about urinary, bowel, sexual symptoms, and previous treatments.
3. Obtain a medical and surgical history including previous pelvic surgery.
4. Perform a physical examination including a POP-Q examination and assessment of pelvic floor muscle function.
5. Quantify the extent of the prolapse using the POP-Q examination and confirm that the examination findings reflect the patient's experience.
6. Assess for abnormal vaginal bleeding.
   a. Document the patient's denial of vaginal bleeding.