Prolapse of the Uterus, Bladder, Bowel, or Rectum

Broad bands of uterine ligaments provide structural support to the uterus and pelvis. The uterine ligaments may weaken, stretch, or spontaneously become compromised. Or they can be damaged or severed during surgery. A loss of structural support can cause the uterus to move down from its natural anatomical position. The drifting down of the uterus into the vagina is called uterine prolapse.

Uterine prolapse is more common in women who have had several vaginal deliveries, had their labor induced or accelerated by drugs like Pitocin, or had vaginal deliveries with a doctor pulling the baby out of the vagina. Prolapse can also be familial, occurring in more than one woman in the same family.

The uterus sits between the bladder and the bowel, supporting them in their natural position. The bladder sits in front of the uterus directly above the pubic bone. If you trace with your finger from your navel (belly button) straight down, the bladder sits slightly to the right just above the pubic bone. The bowel sits behind the uterus. The rectum is behind the bowel.

If the uterus prolapses, it may pull the bladder down from above the pubic bone, and cause it to bulge into the vaginal wall. When the bladder prolapses it is called a cystocele (pronounced sis-toe-seal). A cystocele may cause discomfort, incomplete emptying of the bladder during urination, and unwanted leakage when you sneeze, cough, laugh, or move in any way that puts pressure on the bladder.

When the rectum prolapses, it allows the bowel to slip into the pocket created by the rectal prolapse. This is called a rectocele (pronounced wreck-toe-seal). When there is stool in the bowel the pocket bulges into the vaginal wall. A rectocele may cause discomfort, fecal incontinence, or constipation, which may require inserting your finger into the vagina to gently lift the bowel. Pushing against the rectocele with your finger helps move the stool through the bowel.
Cystocele and rectocele are benign conditions that can be managed mechanically with a device or with surgery. A hysterectomy is not needed for uterine prolapse, cystocele, or rectocele.

Cystocele and rectocele can occur without uterine prolapse, or they may accompany a second or third-degree prolapse of the uterus.

The bladder is supported by anatomical structures in addition to the structural support it gets from the uterus. The bowel, though, is more dependent on structural support from the uterus. Some women develop bladder prolapse whether or not they undergo hysterectomy, but rectocele is a consequence of hysterectomy for the majority of hysterectomized women. Rectocele is less common in women who have not undergone a hysterectomy.

The reason for this is that removal of the uterus causes the displacement of the bowel and rectum. The bowel drifts down and fills the space where the uterus had been, pulling the rectum down with it, which creates a rectocele.

During a hysterectomy, to remove the uterus the blood supply, nerve supply and ligaments that attach to the uterus are severed. When the uterine ligaments are severed and the uterus is removed, prolapse of the bowel and rectum is inevitable. Some diminished support to the bladder is also typical.

Prolapse of the vagina is also possible after hysterectomy. Vaginal prolapse is rare for women who have not been hysterectomized.

Sudden uterine prolapse often occurs during everyday activities such as gardening. Squatting, especially while pulling an object with the arms extended, pulls on the pelvic muscles and ligaments. For this reason, many women first experience uterine prolapse while gardening, often while pulling weeds. Also, lifting that causes pulling in the pelvis may worsen a prolapse.
There are three degrees of uterine prolapse: first degree, second degree, and third degree.

First-degree uterine prolapse is slight and without symptoms. Most women are unaware that they have a first-degree uterine prolapse unless a doctor mentions it during a pelvic exam.

With second-degree prolapse, the uterus descends a little further down into the vagina, and the cervix may be near or at the opening of the vagina.

With a third-degree prolapse, the cervix and sometimes the uterus may protrude slightly or significantly out of the opening to the vagina. Women with a third-degree prolapse sometimes wonder if their uterus might actually drop out between their legs and onto the floor. Although stretched, the ligaments in the pelvis remain attached to the uterus. It is not possible for your uterus to become detached from your body unless it is severed from the ligaments, blood supply, and nerves that attach to it, as it is during a hysterectomy.

Sitting on the floor or on a stool during activities such as gardening will relieve pulling on the pelvis and help avoid worsening of a prolapse. The way you lift heavy objects is also important. When lifting heavy objects that are at waist level, instead of lifting the object with your arms outstretched and pulling it toward you, hug the object close to your body then lift it. If you are lifting a heavy object from the floor, squat and hug the object close to your body, then stand up. When lifting, if you feel any pulling in your pelvis, stop and change the way you are lifting. If you use an upright vacuum, consider changing to a canister type. Each time you pull the vacuum back toward you there is a pulling in the pelvis.

The most common treatment options for uterine prolapse are, from the least invasive to the most invasive, exercises, pessary, and surgical resuspension of the uterus.

Strengthening the muscles of the vagina and pelvis with a modification of the Kegel exercises often improves pelvic muscle tone and uterine
support. You may have heard of Kegel exercises, which may help somewhat, but a simple modification of the Kegel exercises seems to give significant and often total resolution of a second-degree prolapse and will usually reverse a first-degree prolapse.

Instructions for Modified Kegel Exercises
Vaginal muscle control is best obtained when sitting. While sitting, tighten the vaginal and abdominal muscles, then quickly release them. Repeat ten times, quickly tightening and then releasing the vaginal and abdominal muscles. Next, tighten the vaginal and abdominal muscles, but this time hold it for ten seconds. Repeat ten times, tightening and holding the muscles for ten seconds each time. Completing both exercises takes about ten minutes. Perform these exercises three times a day, morning, noon, and night. If you are using a pessary, remove it before starting the exercises. The exercises cannot be done effectively while wearing a pessary.

Most women see an improvement from these simple exercises within a couple of weeks, or, with a more significant prolapse, within a couple of months. They can be done while sitting at a desk, sitting on a couch, or while commuting. And because exercise is non-invasive and there is a good chance it will improve or reverse a first-degree or second-degree prolapse, it is well worth the minimal time and effort to do them three times a day.

It is important that these exercises be performed for 10 minutes three times a day, every day. If you do not experience significant improvement within two to three months, the modified Kegel exercises are probably not going to resolve your prolapse.

If the modified Kegel exercises do not help, a device called a pessary will usually work. With a slight first-degree prolapse, a pessary is not needed—the exercises will reverse the prolapse. With a more significant second or third degree prolapse that was unresponsive to the modification of Kegel exercises, a pessary will usually provide the needed support to the uterus.

Pessaries come in a variety of shapes and sizes. There are nineteen
different types. Some are round and flat, like a diaphragm, others are in the shape of a ring or donut. Some have a lip for bladder and rectal support. There is also an inflatable pessary that usually works if you cannot find another type of pessary that is comfortable. It is important to find the size and shape that works for you.

If a pessary is too small it will fall out. If it is uncomfortable or painful, it is too large. Finding and fitting a pessary is a bit like buying shoes—shoes that are the wrong size or style will either hurt or will not stay on, and if they are the wrong shape they will rub or cause pressure. The same is true when being fitted with a pessary.

Here are some tips on how to insert a pessary. First, thoroughly wash your hands with mild soap. The pessary may be inserted while standing with one foot propped on the tub or toilet, or while lying on your back with your knees bent. Apply a small amount of water-soluble lubricant such as KY Jelly inside your vagina, and on the insertion edge of the pessary. Too much of a lubricant will cause irritation. Then gently push the pessary as far up into the vagina as it will comfortably go. If using a flat pessary, it may help to fold it in half prior to inserting it. Some women find it helps to use the motion of fitting a button through a buttonhole.

To prevent infection, it is important to remove and clean the pessary every six weeks. To clean a pessary, remove it, boil a pot of water, take the pot off the stove, and drop the pessary into the water. When the water and the pessary cool, use a small amount of a lubricant inside your vagina and on the pessary, and then insert the pessary. Before re-inserting the pessary, douche with a tablespoon of white, distilled vinegar diluted into a quart of warm water. If you find it too difficult to remove, clean, and reinsert the pessary yourself, a family doctor, internist, or gynecologist can do it for you.

If you do not find a pessary that works for you, and if the prolapse progresses from second to third degree, you might consider surgical resuspension of the uterus and possible repair of the cystocele and/or rectocele.
Whether a uterine resuspension is possible depends in large part upon the density of the tissues. With age, all tissues become thin. The tissue is usually dense enough for uterine resuspension until ten to fifteen years after menopause. A gynecologist will be able to determine with a pelvic exam if the tissue is dense enough to undergo a uterine resuspension.

During a uterine resuspension, a horizontal incision is made above the pubic bone, or it is done laparoscopically through the belly button. The surgeon shortens the stretched ligaments, sometimes suturing the uterus to soft tissue in the pelvis.

Uterine resuspension is a major operation. It has a success rate of about 70%—“success” meaning that the suspension lasts for more than a year. Few doctors are trained and skilled at performing resuspension of the uterus. Repair of a cystocele or rectocele also requires a high level of skill. You may want to ask your friends and family if they know anyone who had a good outcome with uterine resuspension.

The female organs are vital to every woman’s health and wellbeing. Hysterectomy, surgical removal of the uterus, causes many well-documented, permanent and life-altering problems. For more information, call the HERS Foundation and visit http://hersfoundation.com/anatomy/ to watch the short video “Female Anatomy: the Functions of the Female Organs.”

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