Pelvic Symptoms in Women With Pelvic Organ Prolapse

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OBJECTIVE: To assess symptoms of bladder, bowel, and sexual function in women with pelvic organ prolapse and to compare symptoms by different degrees of prolapse.

METHODS: This retrospective study used data from 352 women with prolapse or urinary incontinence. The pelvic organ prolapse quantification measurements, as well as responses to 3 self-administered questionnaires assessing urinary, bowel, and sexual function were used. For each individual, pelvic organ prolapse quantification measures of prolapse were obtained in centimeters in relation to the hymen for 3 compartments: anterior vagina, vaginal apex or cervix, and posterior vagina. Data were analyzed by comparing the frequency of symptoms to centimeter measures of the most advanced prolapse (regardless of site) and the other compartments of prolapse.

RESULTS: Of the 330 patients available for analysis, 2.4% had stage I, 46.1% had stage II, 48.2% had stage III, and 3.3% had stage IV prolapse. The average age was 58.8 years (± 12.1), with a median parity of 3. Forty-eight percent were postmenopausal and taking estrogen, 27% were postmenopausal and not taking estrogen, and 25% were premenopausal. Patients who had stress incontinence symptoms had less advanced prolapse (median 5 cm less prolapse in the apical compartment) than patients without stress incontinence. Women who required manual assistance to urinate had more advanced prolapse (median 3.5 cm more prolapse in the most advanced compartment) than those who did not. Patients with urinary urgency and urge incontinence also had less advanced prolapse, although the differences were smaller than for stress incontinence (median 3 cm difference or less). There were no clinically significant differences in any compartment for symptoms related to sexual or bowel function.

CONCLUSION: Women with more advanced prolapse were less likely to have stress incontinence and more likely to manually reduce prolapse to void; however, prolapse severity was not associated with sexual or bowel symptoms. (Obstet Gynecol 2004;104:982–8. © 2004 by The American College of Obstetricians and Gynecologists.)

LEVEL OF EVIDENCE: II-2

Approximately 200,000 inpatient surgical procedures are performed in the United States annually for pelvic organ prolapse.[1] Women with prolapse may be asymptomatic with regard to concomitant pelvic floor pathology such as bladder, bowel, and sexual dysfunction, or they may present with a variety of complaints. Few studies have looked at the association between specific symptoms and prolapse. Ellerkmann et al[2] reported pelvic symptoms in 237 women with prolapse and found weak correlations between prolapse and individual symptoms. Mouritsen and Larsen[3] found that bladder, bowel, and sexual symptoms were common in women with prolapse; however, there was little correlation between individual symptoms and specific prolapsed compartments.

Many women with prolapse have lower urinary tract symptoms such as urgency, frequency, urinary incontinence, and difficulty voiding. To date, few studies have evaluated the relationship between prolapse and a patient's reported symptoms; some studies have focused on urodynamic findings.[4,5] Romanzi et al[6] found that lower urinary tract symptoms such as urgency, frequency, urge incontinence, and difficulty voiding were more common in women with more advanced prolapse.

The relationship between prolapse and female sexuality is not well understood. Women with prolapse may suffer from dyspareunia, decreased orgasmic capacity, decreased libido and embarrassment or fear of their altered anatomy. Some studies have found that prolapse negatively affected sexual functioning.[7,8] Other reports found an improvement after surgical repair of the prolapse.[9]

Anorectal dysfunction is probably the least well-studied pelvic symptom in women with prolapse. These patients may experience pain with defecation, the need to splint or strain to have a bowel movement, or anal incontinence. In a study on bowel symptoms in women

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with prolapse, Weber et al[10] found a weak association ($r = 0.23$) between symptoms and the extent of posterior vaginal prolapse. Meschia et al[11] found a 2-fold increased risk of anal incontinence in patients with a rectocele greater than grade 2.

In June 2001, the National Institute of Child Health and Human Development (NICHD) outlined topics of priority for research on female pelvic floor disorders, including studies on the "type and frequency of symptoms in women with symptomatic prolapse."[12] The aim of our study was to describe bladder and bowel symptoms as well as sexual functioning in women with pelvic organ prolapse and to compare the frequency of specific pelvic symptoms by the severity of prolapse.

METHODS

This retrospective study used a database of 352 women who had surgery for pelvic organ prolapse or urinary incontinence at the Cleveland Clinic Foundation from June 1996 to August 2000. All women provided written informed consent for participation. Some of these data have been reported elsewhere, regarding sexual function before and after surgery in 165 women[9] and bowel function and prolapse in 143 women.[10]

The database contained the patient's pelvic organ prolapse quantification measurements[13] as well as responses to 3 nonvalidated, self-administered questionnaires assessing urinary, bowel, and sexual function (see Appendix). Given the number of subjects available in the database, we expected to be able to estimate the frequency of a given symptom within a confidence interval (CI) of 10%. For example, in this database, the symptom of stress urinary incontinence occurred in 59% of subjects, with a 95% CI of 54–64%. This study received approval from the Cleveland Clinic and Magee-Women's Hospital Institutional Review Boards.

The questionnaires assessed symptom occurrence with 4 possible responses: never or rarely, less than once a week, more than once a week but less than once a day, and once a day or more. Each symptom was analyzed individually as an ordinal variable. Symptoms were also analyzed in a dichotomous fashion. In those who answered "never or rarely" to a given symptom, the symptom was considered absent; for any other response, the symptom was considered present.

For each individual, pelvic organ prolapse quantification measures of prolapse were obtained in centimeters (to the nearest half centimeter) in relation to the hymen for 3 compartments: the anterior vagina, the vaginal apex or cervix, and the posterior vagina. We compared centimeter measures of the most advanced prolapse (regardless of site) and the other compartments of prolapse with symptoms (present or absent) and with the frequency of symptoms (ordinal responses on the questionnaires). Because of the variability inherent in pelvic organ prolapse quantification measurements, differences in prolapse of 1 cm or less were judged not likely to be of clinical significance although, in some cases, differences of this magnitude achieved statistical significance.

All statistical analyses were performed with SPSS 10.1.4 (SPSS Inc, Chicago, IL). The median centimeter measurements of prolapse (most advanced, anterior, apical, and posterior) did not appear to follow a normal distribution when graphically displayed. In addition, the values of the skewness, kurtosis, and Shapiro-Wilk test statistics indicated a significant departure from normality. Therefore, nonparametric methods were used to evaluate these data. The Mann-Whitney *U* test was used to evaluate differences in the median centimeter measurements of prolapse (most advanced, anterior, apical, and posterior) between women with and those without each symptom. The Kruskal-Wallis test was used to evaluate the differences between the median centimeter measurements of prolapse and the severity of symptoms (ordinal responses on the questionnaires). Records with missing data for the symptom in question were excluded from analysis. All statistical tests were evaluated at the 0.05 level of significance.

RESULTS

Of the 352 patients in the database, 22 patients did not complete the questionnaires, leaving 330 who were appropriate for analysis. The characteristics of these women are provided in Table 1. Race was not recorded in the database; however, almost all women were white.

Table 2 provides centimeter measures of prolapse at maximum and in individual compartments for each urinary symptom. Consistent with clinical experience, the most prolapsed compartment was progressively more advanced as the severity of symptoms worsened in patients who required manual assistance to urinate (Table 3). Conversely, women with symptoms of stress incontinence had less advanced prolapse anteriorly and at the vaginal apex. As with stress incontinence, urgency and urge incontinence occurred more often in women with less advanced prolapse, although the magnitude of the differences was lower than for stress incontinence. One hundred and sixty-eight women (51%) used pads for urinary incontinence and had 3 cm less prolapse in the most advanced compartment than those who did not use pads ($P = .001$). Among those who used pads, there was no relationship between the number of pads used per day and the amount of prolapse.

Table 1. Characteristics of Women Planning to Undergo Surgery for Prolapse or Urinary Incontinence (n = 330)

Age, mean ± SD (y)	58.8 ± 12.1 y
Parity (median)	3
Stage of prolapse at presentation	
Stage I	8 (2.4)
Stage II	152 (46.1)
Stage III	159 (48.2)
Stage IV	11 (3.3)
Site of most advanced prolapse	
Anterior	212 (64.3)
Apical	77 (23.3)
Posterior	41 (12.4)
Menopausal status*	
Premenopausal	77 (24.4)
Postmenopausal without estrogen	86 (27.5)
Postmenopausal with estrogen	151 (48.1)
Prior hysterectomy	150 (47.8)
Prior procedure for urinary incontinence	49 (15.7)
Prior procedure for prolapse	46 (14.7)

SD, standard deviation.
Data are expressed as n (%) except where indicated otherwise.
* Menopausal status missing for 16 women.

The association between prolapse and specific sexual symptoms is shown in Table 4. Of the 330 patients with prolapse, 169 (52%) were sexually active and responded to these questions. Among those who were sexually active, 47 (20%) reported urinary incontinence with intercourse. These 47 women had a median 2 cm less prolapse in both the maximum and apical compartments compared with women who were not incontinent with intercourse ($P < .001$). Among those who felt their vagina was too long, their median total vaginal length was 11.0 cm, whereas patients who felt their vaginal length was not a problem or who felt it was too short had a median measurement of 10.0 cm ($P = .2$). Patients who either felt that their vagina was too loose (n = 61) or that the size was not a problem (n = 102) had a median genital hiatus measurement of 3.0 cm, whereas the 8 patients who felt their vagina was too tight had a median measurement of 2.5 cm ($P = .03$). The association between bowel functioning and individual prolapsed compartments is shown in Table 5.

DISCUSSION

The most important finding of this study was that overall, there were few strong associations between the specific symptoms assessed and the severity of prolapse. This suggests that clinicians may have difficulty predicting which symptoms will be alleviated after surgical repair. Many symptoms associated with prolapse are nonspecific and are experienced by women with adequate pelvic support.

Table 2. Median Amount of Prolapse for Specific Urinary Symptoms

Symptom	n (%)	Maximum (cm)*	Anterior (cm)	Apical (cm)	Posterior (cm)
Dysuria					
Yes	34 (10)	+0.5	0.0	−5.5†	−1.0
No	295 (90)	+2.0	0.0	−4.0	−1.0
Urgency					
Yes	226 (68)	+1.0	0.0	−5.0†	−1.0
No	104 (32)	+2.0	0.0	−3.0	−1.0
Urge incontinence					
Yes	197 (60)	+1.0‡	0.0	−5.0†	−1.0
No	133 (40)	+2.0	0.0	−2.0	−1.0
Stress urinary incontinence					
Yes	194 (59)	0.0‡	0.0‡	−5.0‡	−2.0‡
No	135 (41)	+3.0	+1.0	0.0	0.0
Need for manual assistance					
Yes	68 (21)	+4.5‡	+3.0‡	+1.5‡	−1.0
No	261 (79)	+1.0	0.0	−5.0	−1.0
Incontinence with intercourse					
Yes	47 (20)	0.0‡	0.0	−6.0‡	−2.0
No	186 (80)	+2.0	0.0	−4.0	−1.0
Enuresis					
Yes	24 (7)	0.0†	0.0	−6.0†	−2.0‡
No	306 (93)	+2.0	0.0	−4.0	−1.0
Pad use					
Yes	168 (51)	0.0‡	0.0	−5.0‡	−2.0‡
No	161 (49)	+3.0	0.0	−2.0	−1.0

* Represents the median value for the group of the centimeter measure of the most dependent extent of the prolapse.
† Statistically significant compared with those without the symptom, $P < .05$.
‡ Statistically significant compared with those without the symptom, $P < .001$.

Table 3. Centimeter Measures of Maximal Prolapse in 329 Women With Symptoms of Stress Urinary Incontinence and the Need to Manually Assist Urination*

	n (%)	Maximum prolapsed compartment, median (cm)
Need to manually assist urination†	68/329 (21)	
Once a day or more	37 (11)	+6.0
Once a week but less than once a day	19 (6)	+3.0
Less than once a week	12 (4)	+3.0
Never or rarely	261 (79)	+1.0
Stress urinary incontinence†	194/329 (59)	
Once a day or more	108 (33)	0.0
Once a week but less than once a day	50 (15)	0.0
Less than once a week	36 (11)	+2.0
Never or rarely	135 (41)	+3.0

* Data are missing for 1 subject.
† $P < .001$.

Prior literature indicates that many women with mild prolapse have stress urinary incontinence.[6] Alternatively, patients with advanced prolapse commonly do not have stress urinary incontinence but are more likely to have difficulty voiding.[14] Our findings also suggest that patients with advanced prolapse are less likely to have stress urinary incontinence than those who did not have this symptom. Additionally, those who required manual assistance to urinate had significantly more prolapse than patients who did not have this symptom. This supports the theory that advanced prolapse obstructs voiding and the manifestation of stress incontinence in some women. It might be expected that women with advanced prolapse and possible obstructed voiding would have more irritative symptoms, such as urgency; however, we found that patients with urgency and urge incontinence had less advanced prolapse than patients without these symptoms.

Table 4. Median Amount of Prolapse for Specific Sexual Symptoms

Symptom	n (%)	Maximum* (cm)	Anterior (cm)	Apical (cm)	Posterior (cm)
Sexually active					
Yes	169 (52)	+1.0	0.0	−5.0†	−1.0
No	158 (48)	+2.0	0.0	−2.0	−1.0
Dyspareunia					
Yes	58 (35)	0.0†	0.0	−5.0	−2.0
No	110 (65)	+1.0	0.0	−5.0	−1.0
Vaginal dryness interfering with sexual activity					
Yes	78 (46)	0.0	0.0	−5.0	−1.0
No	90 (54)	+1.0	0.0	−5.0	−2.0
Satisfied with size of vaginal opening					
Vagina too loose	61 (35)	+1.0	0.0	−4.0	−1.0
Vaginal size not a problem	102 (60)	0.0	0.0	−5.0	−2.0
Vagina too tight	8 (5)	+0.5	0.0	−5.5	−2.0
Satisfied with vaginal length					
Vagina too long	9 (5.5)	+4.0‡	2.0	−2.0	0.0
Length not a problem	145 (85)	0.0	0.0	−5.0	−1.0
Vagina too short	16 (9.5)	+2.0	0.0	0.0	−1.5
Ability to achieve orgasm					
Yes	146 (86)	+1.0	0.0	−5.0	−1.0
No	24 (14)	0.0	0.0	−5.5	−2.0
No change in orgasm					
Yes	85 (50)	+1.0	0.0	−5.0	−1.0
No	84 (50)	+1.0	0.0	−5.0	−1.0
Satisfied with sexual relationship					
Yes	141 (83)	0.0	0.0	−5.0	−1.0
No	29 (17)	+2.0	0.0	−4.0	−1.0

* Represents the median value for the group of the centimeter measure of the most dependent extent of the prolapse.
† Statistically significant compared with those without the symptom, $P < .001$.
‡ Statistically significant compared with those without the symptom, $P < .01$.

Table 5. Median Amount of Prolapse for Specific Bowel Symptoms

Symptom	n (%)	Maximum* (cm)	Anterior (cm)	Apical (cm)	Posterior (cm)
Need to strain					
Yes	204 (63)	+2.0	0.0	−4.0	−1.0
No	122 (37)	+2.0	0.0	−4.0	−1.0
Digital assistance					
Yes	95 (29)	+2.0	0.0	−4.0	−0.5†
No	230 (71)	+1.0	0.0	−4.0	−1.0
Fecal incontinence					
Yes	46 (14)	+2.0	0.0	−4.0	−1.0
No	280 (86)	+1.0	0.0	−4.0	−1.0
Bowel movement more than twice a week					
Yes	301 (93)	+2.0	0.0	−4.0	−1.0
No	23 (7)	0.0	0.0	−5.0	−2.0

* Represents the median value for the group of the centimeter measure of the most dependent extent of the prolapse.
† Statistically significant compared with those without the symptom, $P < .01$.

Our data show that prolapse had little correlation with sexual activity. In spite of having prolapse, half the women in this study were sexually active. Some authors have found that prolapse has a negative impact on sexual function.[7] However, our findings are consistent with those of Weber et al[15] who found that measures of sexual function were similar in women with and without prolapse. Assessing sexual activity in this population can be challenging because there may be circumstances other than prolapse precluding sexual activity, such as functional impairments and spousal limitations.

The extent of prolapse was not predictive of bowel symptoms except for the need for manual assistance during defecation. Although this finding achieved statistical significance, it is not likely to represent a clinically significant difference. We expected that patients with more advanced posterior compartment prolapse would have this symptom. Interestingly, the difference between those who did and those who did not have this symptom was only 0.5 centimeters.

This study has many of the limitations inherent in a retrospective study. The subjects were women who sought treatment for their prolapse and/or urinary incontinence. Thus, our results are affected to some degree by selection bias. Women with less advanced prolapse were more likely to present with urinary symptoms as their primary complaint. However, because urinary symptoms and prolapse coexist in so many women, it would be difficult to find a clinical population of women who had only prolapse. Additionally, objective measures such as office bladder testing to correlate with subjective findings were not available, and validated questionnaires were not used.

In conclusion, our findings are similar to what other authors have found: pelvic organ prolapse measurements do not correlate strongly with many pelvic symptoms. We found the greatest difference in prolapse status for women with stress incontinence symptoms (less advanced prolapse) and the need to manually assist urination (more advanced prolapse). Defining pelvic symptoms in women with prolapse is essential for evaluating procedures for treating this condition. Although objective postsurgical evaluations of pelvic support are important, the patient's subjective reports are as important and require baseline data for comparison. Prospective studies using validated instruments as well as objective assessments are needed to fully characterize symptoms in women with prolapse.

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APPENDIX A: QUESTIONNAIRE FOR URINARY FUNCTION

1. Do you have burning or pain with urination?
   a. Yes
   b. No
2. Do you have urgency (the sensation to empty your bladder that is so strong that you are worried that you will leak urine)?
   a. Never or rarely
   b. Less than once a week
   c. More than once a week but less than once a day
   d. Once a day or more
3. Do you ever leak urine when you have urgency?
   a. Never or rarely
   b. Less than once a week
   c. More than once a week but less than once a day
   d. Once a day or more
4. Do you ever need to help urine out by pushing with a finger in the vagina or by pushing on the lower abdomen?
   a. Never or rarely
   b. Less than once a week
   c. More than once a week but less than once a day
   d. Once a day or more
5. Do you ever leak urine with a cough, sneeze or laugh?
   a. Never or rarely
   b. Less than once a week
   c. More than once a week but less than once a day
   d. Once a day or more
6. Do you ever leak urine with sexual intercourse?
   a. Never or rarely
   b. Less than once a week
   c. More than once a week but less than once a day
   d. Once a day or more
7. Do you ever lose control of your bladder while you are sleeping (wet the bed)?
   a. Never or rarely
   b. Less than once a week
   c. More than once a week but less than once a night
   d. Once a night or more
8. Do you wear a pad for leaking urine?
   a. Yes
   b. No
9. If you wear a pad for leaking urine, how many times a day do you need to change it?

APPENDIX B: QUESTIONNAIRE FOR SEXUAL FUNCTION

1. Are you currently sexually active?
   a. Yes
   b. No, no sexual partner
   c. No, because of my medical problems
   d. No, for other reasons

IF YOU ARE NOT CURRENTLY SEXUALLY ACTIVE, PLEASE GO ON TO THE NEXT QUESTIONNAIRE.

2. How frequently do you and your partner have sexual intercourse or activity?
   a. More than once a day
   b. Once a day
   c. Every other day
   d. Twice a week
   e. Once a week
   f. Less than once a week
   g. Not at all
3. Do you feel any pain or burning in your vagina or genital area during or after sexual activity?
   a. Never or rarely
   b. Sometimes
   c. Usually

d. Always
4. Do you feel vaginal dryness is a problem?
   a. Never or rarely
   b. Sometimes
   c. Usually
   d. Always
5. Do you feel there is any problem with the size of the vaginal opening?
   a. Vagina too loose
   b. Vaginal size not a problem
   c. Vagina too tight
6. Do you feel there is any problem with the length of the vagina?
   a. Vagina too long
   b. Vaginal length not a problem
   c. Vagina too short
7. If you try, is it possible for you to reach orgasm with sexual activity?
   a. Never or rarely
   b. Sometimes
   c. Usually
   d. Always
8. Have you noticed a change in the intensity and pleasure of your orgasms?
   a. More intense and pleasurable than in the past
   b. The same as in the past
   c. Less intense and pleasurable than in the past
9. Overall, how satisfactory to you is your sexual relationship with your partner?
   a. Very satisfactory
   b. Satisfactory
   c. Unsatisfactory
   d. Very unsatisfactory

APPENDIX C: QUESTIONNAIRE FOR BOWEL FUNCTION

1. How frequent are your bowel movements?
   a. More than once a day
   b. Once a day
   c. Every other day
   d. Twice a week
   e. Once a week
   f. Less than once a week
2. Do you need to strain to have a bowel movement?
   a. Never or rarely
   b. Sometimes
   c. Usually
   d. Always
3. Do you ever need to help stool out by pushing with a finger in the vagina or rectum?
   a. Never or rarely
   b. Sometimes
   c. Usually
   d. Always
4. Do you ever lose control of stool?
   a. Never or rarely
   b. Less than once a month
   c. More than once a month, but less than once a week
   d. More than once a week, but less than daily
   e. Daily