Surgical Threshold Policy

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Management of Female Pelvic Organ Prolapse

Scope

This policy covers the management of women with pelvic organ prolapse. It does not cover referral for suspected malignancy or for surgery conducted for trauma immediately following a birth.

Policy

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Referral proforma should be attached to the patient notes to aid the clinical audit process and provide evidence of compliance with the policy. For patients not meeting the policy criteria, clinicians can apply for funding to the Exceptional Cases Panel by completing the exceptional funding section of the referral proforma*: Click **policies** to access the CCG clinical policies web page:*

Surgery for asymptomatic pelvic organ prolapse is not funded by the CCG. The management should involve reassurance.

Symptomatic prolapse, including urinary incontinence, should be managed as follows:

1. Risk factor reduction: weight loss, treat chronic cough, treat constipation.
2. Inadequate response to supervised physiotherapy including pelvic floor muscle training for a minimum of 3 months.
3. All appropriate women should be offered a pessary (ring or shelf) taking into account sexual activity, past surgical history and tolerability (woman are allowed to decline at any time).
4. Consider topical oestrogen therapy if post-menopausal and signs of vaginal atrophy

Note: urinary incontinence should be managed according to the urology pathway: http://www.camurology.org.uk/collaborative-pathways/

The CCG will fund surgery for pelvic organ prolapse for women with any of:

- Symptomatic prolapse when conservative management: 1 to 4 above has failed. **OR**
- Presence of associated faecal incontinence. **OR**
- Symptomatic prolapse that is visible at or below the vaginal introitus.

NICE IPG 599[10] states that current evidence on the safety of transvaginal mesh repair of anterior or posterior vaginal wall prolapse shows there are serious, but well-recognised safety concerns. Evidence of long term efficacy is inadequate in quality and quantity. Therefore, this procedure should only be used in the context of research and will not be routinely funded.

Note:
Patients who smoke should be advised to attempt to stop smoking and referred to stop-smoking services – **see stop smoking policy.**

Evidence and Rationale

Pelvic organ prolapse can be managed conservatively depending on the severity. Pelvic floor exercises[1], topical oestrogen[2] and the use of pessaries [3& 4] are all likely to improve symptoms and quality of life of women affected. For those with severe symptoms or where conservative measures fail, surgical options are available. NICE recommends that women with prolapse at or further than the vaginal introitus be referred for surgery[5]. This threshold is necessary as although surgery improves quality of life[6] there is a chance of failure (9-29%[7]) and the need for a repeat surgical procedure (1-9%[7]) or complications[7 & 8].

Numbers of People Affected

Half of women over 50 years will have some symptoms of pelvic organ prolapse and by the age of 80 more than one in ten will have had surgery for prolapse[9].

References

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2. Oestrogens for treatment or prevention of pelvic organ prolapse in women. Ismail S I, Bain C and Hagen S. 9, sl: Cochrane Database of Systematic Reviews, 2009.
3. Vaginal Pessary in Women With Symptomatic Pelvic Organ Prolapse: A Randomized Controlled Trial. Cheung R Y K, et al. 1, sl: Obstetrics & Gynecology, 2016, Vol. 128.
4. Pessaries (mechanical devices) for pelvic organ prolapse in women. Bugge C, et al. 2, sl: Cochrane Database of Systematic Reviews, 2013.
5. NICE. Urinary incontinence in women: management Clinical Guideline [CG171]. sl: NICE, 2015.
6. Management of pelvic organ prolapse and quality of life: a systematic review and meta-analysis. Doaee M, et al. 2, sl: International Urogynaecology Journal, 2013, Vol. 25, pp. 153-163.
7. NICE Guidelines. Surgi repair of vaginal wall prolapse using mesh: Interventional procedures guidance [IPG267]. sl: NICE, 2008.
8. Complication and Reoperation Rates After Apical Vaginal Prolapse Surgical Repair: A sytematic review. Diwadkar G B, et al. sl: Obstetrics and Gynecology, 2009, Vol. 113, pp. 367-73.
9. RCOG. Pelvic organ prolapse. Royal College of Obstetricians and Gynaecologists. [Online] 22 March 2013. [Cited: 16 January 2017.] https://www.rcog.org.uk/en/patients/patient-leaflets/pelvic-organ-prolapse/
10. NICE IPG 599. https://www.nice.org.uk/guidance/ipg599/chapter/1-Recommendations

Glossary

Faecal incontinence:	The inability to control bowel movements, causing stool (faeces) to leak unexpectedly from the rectum.
Pessary:	A device inserted into the vagina to provide structural support.
Prolapse:	Bulging of one or more of the pelvic organs into the vagina.
Vaginal introitus:	The entrance/opening of the vagina.

Policy effective from	Policy update ratified by CCG Governing Body on 3 July 2018 Policy update approved by CEC on 12 June 2018 Policy update approved by CPF on 8 May 2018 New policy ratified by CCG GB on 5 September 2017 September 2017
Policy to be reviewed:	September 2019
Reference:	*onedrive\CPF Pols & Working Area\Surg Threshold Pols - Draft and Agreed\CCG Policies\agreed\prolapse - female pelorg\ PROLAPSE SURGERY JULY 2018 V2 – NICE update*