

Pelvic organ prolapse in women: An overview of the epidemiology, risk factors, clinical manifestations, and management

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Literature review current through: Jul 2016. | **This topic last updated:** Apr 11, 2016.

INTRODUCTION — Pelvic organ prolapse (POP), the herniation of the pelvic organs to or beyond the vaginal walls, is a common condition. Many women with prolapse experience symptoms that impact daily activities, sexual function, and exercise. The presence of POP can have a detrimental impact on body image and sexuality [1]. Treatment of POP requires significant healthcare resources; the annual cost of ambulatory care of pelvic floor disorders in the United States from 2005 to 2006 was almost \$300 million [2] and surgical repair of prolapse was the most common inpatient procedure performed in women older than 70 years from 1979 to 2006 [3]. The health care impact of prolapse is likely to expand, based upon estimates of an increasing prevalence in the growing population of elderly women [4].

The epidemiology, risk factors, clinical manifestations, and general principles of management are reviewed here. Management of prolapse with vaginal pessaries and choosing a primary surgical procedure for prolapse repair are discussed separately. (See "[Vaginal pessary treatment of prolapse and incontinence](#)" and "[Pelvic organ prolapse in women: Choosing a primary surgical procedure](#)".)

TERMINOLOGY

- Pelvic organ prolapse (POP) – The herniation of the pelvic organs to or beyond the vaginal walls.

Commonly used terms to describe specific sites of female genital prolapse include:

- Anterior compartment prolapse – Hernia of anterior vaginal wall often associated with descent of the bladder (cystocele) ([figure 1](#)).
- Posterior compartment prolapse – Hernia of the posterior vaginal segment often associated with descent of the rectum (rectocele) ([picture 1](#)).
- Enterocele – Hernia of the intestines to or through the vaginal wall.
- Apical compartment prolapse (uterine prolapse, vaginal vault prolapse) – Descent of the apex of the vagina into the lower vagina, to the hymen, or beyond the vaginal introitus ([picture 2](#)). The apex can be either the uterus and cervix, cervix alone, or vaginal vault, depending upon whether the woman has undergone hysterectomy. Apical prolapse is often associated with enterocele.
- Uterine procidentia — Hernia of all three compartments through the vaginal introitus.

The terms anterior vaginal wall prolapse and posterior vaginal wall prolapse are preferred to cystocele and rectocele because vaginal topography does not reliably predict the location of the associated viscera in POP [5,6].

Division of the vagina into separate compartments is somewhat arbitrary, because the vagina is a continuous organ and prolapse of one compartment is often associated with prolapse of another. As an example, approximately half of anterior prolapse can be attributed to apical descent [7].

ANATOMY OF PELVIC SUPPORT — Anatomic support of the pelvic organs in women is provided by an interaction between the muscles of the pelvic floor and connective tissue attachments to the bony pelvis (figure 2). The levator ani muscle complex, consisting of the pubococcygeus, puborectalis and iliococcygeus muscles, provides primary support to the pelvic organs, providing a firm, yet elastic-base upon which the pelvic organs rest (figure 3 and figure 4). The endopelvic fascial attachments, in particular condensations of the endopelvic fascia referred to as the uterosacral and cardinal ligaments, stabilize the pelvic organs in the correct position so that the pelvic muscles can provide optimal support (figure 5) [8].

Levels of pelvic organ support — A system of three integrated levels of vaginal support has been described by DeLancey (figure 6) [9,10]. All levels of support are connected through a continuous supporting network of endopelvic fascia:

All levels of vaginal support are connected through a continuous endopelvic fascia support network:

- Level 1 – Uterosacral/cardinal ligament complex, which suspends the uterus and upper vagina to the sacrum and lateral pelvic side wall. Level 1 support represents vertical fibers of the paracolpium that are a continuation of the uterosacral/cardinal ligament complex which inserts variably into the cervix and vagina (figure 6) [11]. In a magnetic resonance imaging (MRI) study of asymptomatic women, the uterosacral ligaments were found to originate on the cervix in 33 percent, cervix and vagina in 63 percent, and vagina alone in 4 percent [12]. Loss of level 1 support contributes to the prolapse of the uterus and/or vaginal apex.
- Level 2 – Paravaginal attachments along the length of the vagina to the superior fascia of the levator ani muscle and the arcus tendineus fascia pelvis (also referred to as the “white line”). Loss of level 2 support contributes to anterior vaginal wall prolapse (cystocele).
- Level 3 – Perineal body, perineal membrane, and superficial and deep perineal muscles, which support the distal one third of the vagina. Anteriorly, loss of level 3 support can result in urethral hypermobility. Posteriorly, loss of level 3 support can result in a distal rectocele or perineal descent.

Nerve supply — The innervation of the pelvic region derives from the S2, S3, and S4 segments of the spinal cord, which fuse to form the pudendal nerve. The pudendal nerve innervates the external anal sphincter, whereas the levators, coccygeus muscles, and urogenital diaphragm appear to be innervated by a direct connection of S2, S3, and S4 nerve fibers [13].

PREVALENCE — The exact prevalence of POP is difficult to ascertain, for several reasons: (1) different classification systems have been used for diagnosis; (2) studies vary by whether the rate of prolapse reported is for women who are symptomatic or asymptomatic; and (3) it is unknown how many women with POP do not seek medical attention [14]. (See "[Pelvic organ prolapse in women: Diagnostic evaluation](#)", section on 'Classification of pelvic organ prolapse'.)

The distinction between symptomatic and asymptomatic POP is clinically relevant, since treatment is generally indicated only for women with symptoms. However, there are few high quality data regarding the prevalence of symptomatic POP. (See "[Pelvic organ prolapse in](#)

[women: Choosing a primary surgical procedure", section on 'Women with symptomatic prolapse'.\)](#)

In a cross-sectional study, the United States (US) National Health and Nutrition Examination Survey (NHANES), 1961 women aged 20 to 80 years were interviewed. The authors defined symptomatic prolapse as a positive response to the question, "do you experience bulging or something falling out you can see or feel in the vaginal area?" and reported a 2.9 percent prevalence of symptomatic POP [15]. The question used in this study was derived from the Pelvic Floor Distress Inventory; a positive response correlates with the presence of a vaginal bulge on examination. However, the question has higher specificity than sensitivity for POP based on examination [16]. Population based surveys have found that 6 to 8 percent of women report symptoms of POP; no physical examination to assess prolapse was performed in these studies [17,18]. Prolapse estimates using only questionnaires underreport the true prevalence of prolapse based on clinical examination as surveys are likely to only identify women with advanced prolapse.

A higher prevalence of symptomatic POP is suggested by the number of women who undergo surgical prolapse repair. Approximately 200,000 inpatient surgical procedures for prolapse are performed annually in the United States [19,20]. Population based studies report an 11 to 19 percent lifetime risk in women undergoing surgery for prolapse or incontinence [21,22]. These data likely underestimate the number of women with symptomatic POP, since many women do not undergo surgery.

Rates of asymptomatic POP are probably even higher. Several studies have used clinical examination to assess the prevalence of POP in a community-based setting. One study included 497 women who were seen in an outpatient clinic for routine gynecologic care and were assessed using the Pelvic Organ Prolapse Quantitation (POP-Q) system. The overall distribution of POP-Q system stages was as follows: stage 0, 6.4 percent; stage 1, 43.3 percent; stage 2, 47.7 percent; and stage 3, 2.6 percent. No subjects examined had POP-Q system stage 4 prolapse. The distribution of the POP-Q system stages in the population revealed a bell-shaped curve, with most subjects having stage 1 or 2 support. Few subjects had either stage 0 (excellent support) or stage 3 (moderate to severe pelvic support defects) [23].

In the Women's Health Initiative study, which used a non-validated physical examination to assess pelvic organ support in postmenopausal women, the overall rates for prolapse in this population were 41 percent for women with a uterus and 38 percent posthysterectomy [24]. Anterior vaginal wall defects (33 to 34 percent) were significantly more common than posterior wall (18 percent) or apical defects (14 percent); it is important to note that the vagina is a continuous organ and defects in the apex contribute to anterior and posterior vaginal wall prolapse [7]. This study, however, did not assess women who had undergone previous surgeries other than hysterectomy and so women who have undergone prolapse surgery may have been included in this study population.

In another study of younger women, the total rate of prolapse on pelvic examination in women was 31 percent, with only 1.6 percent of women with prolapse to the hymen and none beyond the hymen [25].

RISK FACTORS — Established risk factors for POP include parity, advancing age, and obesity [26,27]. (See "[Urinary incontinence and pelvic organ prolapse associated with pregnancy and childbirth](#)").

Parity — The risk of POP increases with increasing parity [15,28,29]. As an example, the Oxford Family Planning study, a prospective cohort study of more than 17,000 women followed for 17 years found that, compared with nulliparity, the risk of hospital admission for POP increased markedly after the first (4-fold) and second birth (8-fold), and then increased less rapidly for subsequent births (third: 9-fold; fourth: 10-fold) [29]. Among parous women, it has been estimated that 75 percent of prolapse can be attributed to pregnancy and childbirth [30].

Obstetric factors in addition to parity can influence the risk of prolapse. POP can develop during pregnancy prior to delivery. Vaginal delivery is associated with a higher incidence of POP than cesarean. A detailed discussion of the effects of pregnancy and childbirth on POP can be found separately. (See "[Urinary incontinence and pelvic organ prolapse associated with pregnancy and childbirth](#)", section on 'Prevalence in parous women'.)

Advancing age — Older women are at an increased risk for POP [31]. A progressive increase in the rate of prolapse with age was reported in one study among 1000 women presenting for an annual gynecological exam; every additional 10 years of age conferred an increased risk of prolapse of 40 percent [32]. In contrast, in the NHANES study described above, the proportion of women with symptomatic prolapse was lowest in young women and then remained fairly constant over age 40 years: ages 20 to 39 (1.6 percent); 40 to 59 (3.8 percent); 60 to 79 (3.0 percent); and ≥80 (4.1 percent) [15].

Obesity — Overweight and obese women (body mass index >25) have a two-fold higher risk of having prolapse than other women [32]. While weight gain is a risk factor for developing prolapse, it is controversial whether weight loss results in prolapse regression. A study of 16,608 postmenopausal women found no association with weight loss and regression of POP [33]. However, there are reports of POP regression in women after bariatric surgery [34].

Hysterectomy — Hysterectomy is associated with an increased risk of apical prolapse. Factors that may influence the risk of prolapse after hysterectomy are age and the surgical route (abdominal or vaginal). A detailed discussion of the risk of prolapse after hysterectomy can be found separately. (See "[Choosing a route of hysterectomy for benign disease](#)".)

Race and ethnicity — Data suggest that African-American women have a lower prevalence of symptomatic POP than other racial or ethnic groups in the US [18,24,35]. In a prospective cohort study of 2270 women, the risk in Latina and white women was four- to five-fold higher than in African-American women [35]. In contrast, other studies have found no relationship between POP and race or ethnicity [15,36].

Other risk factors — Chronic constipation is a risk factor for POP, likely due to repetitive increases in intraabdominal pressure [37,38]. Data conflict regarding whether the risk of prolapse is increased in women with occupations that involve heavy lifting [32,39].

Some connective tissue disorders (eg, Ehlers-Danlos syndrome) or congenital abnormalities (eg, bladder exstrophy) contribute to POP [40-42].

A systematic review of 16 studies found a 2.5-fold increased risk of prolapse in women with a family history of the condition [43]. There are few data regarding a genetic component of prolapse [44].

PREVENTION — Prolapse prevention strategies have not been extensively studied. Although vaginal childbirth is associated with an increased risk of prolapse, it is unclear that cesarean delivery will prevent the occurrence of prolapse. (See "[Urinary incontinence and pelvic organ](#)

[prolapse associated with pregnancy and childbirth", section on 'Approach to obstetric management'.\)](#)

Prevention of progression of prolapse has not been well studied. Some data suggest that women with prolapse who use a vaginal pessary have a lower stage of prolapse on subsequent exams [45]. Interventions such as weight loss, treatment of chronic constipation, and avoidance of jobs that require heavy lifting are potential interventions to avoid the development or progression of POP and deserve further investigation.

A systematic review of six randomized trials evaluated the effects of estrogens or medications with estrogenic effects (eg, selective estrogen receptor modulators), either alone or in conjunction with other treatments, for prevention of POP [46]. Regarding prevention, the only finding with sufficient data for meta-analysis was that use of [raloxifene](#) in women who were 60 years or older resulted in a significant reduction in the proportion of women who subsequently underwent surgery (0.8 versus 1.5 percent; OR 0.5, 95% CI 0.3-0.8); no significant association between raloxifene and surgery was found in women who were less than 60 years. Further study is needed of the role of estrogenic agents in the prevention of POP.

CLINICAL MANIFESTATIONS — Patients with POP may present with symptoms related specifically to the prolapsed structures, such as a bulge or vaginal pressure or with associated symptoms including urinary, defecatory or sexual dysfunction [26]. Symptoms such as low back or pelvic pain have often been attributed to POP, but this association is not supported by well-designed studies [47,48].

Severity of symptoms does not correlate well with the stage of prolapse [32,49-53]. Symptoms are often related to position; they are often less noticeable in the morning or while supine and worsen as the day progresses.

Many women with prolapse are asymptomatic; treatment is generally not indicated in these women. (See "[Pelvic organ prolapse in women: Choosing a primary surgical procedure](#)", section on '[Women with symptomatic prolapse](#)'.)

Bulge or pressure symptoms — Women with POP often present with the complaint of vaginal or pelvic pressure and/or the sensation of a vaginal bulge or something falling out of the vagina.

In a study of 1912 women presenting to a pelvic floor disorder clinic, symptoms of “a bulge or that something is falling out of the vagina” had a sensitivity of 67 percent and a specificity of 87 percent for POP at or past the hymen [54]. Although complaints of a bulge are associated with the presence of prolapse, it is only weakly correlated with prolapse stage, and does not predict site of prolapse [49].

The anatomic threshold for symptomatic prolapse appears to be the hymen. The specificity of vaginal bulge symptoms for predicting prolapse beyond the hymen is high (99 percent to 100 percent); however, the sensitivity is low (16 percent to 35 percent) because even some women with advanced prolapse report an absence of symptoms [55,56]. A cross-sectional study of women older than 40 years undergoing gynecologic and urogynecologic examinations using POP-Q examinations to assess support and Pelvic Floor Distress Inventory questionnaires to assess symptoms determined that the anatomic threshold of 0.5 cm distal to the hymen had sensitivity (69 percent) and specificity (97 percent) for protrusion/bulge symptoms [50].

Some women are able to see a protrusion of the prolapse beyond the introitus ([picture 3](#)). Protrusion of the vagina may result in chronic discharge and/or bleeding from ulceration.

Urinary symptoms — Loss of support of the anterior vaginal wall or vaginal apex may affect bladder and/or urethral function. Symptoms of stress urinary incontinence (SUI) often coexist with stage I or II prolapse [49,57].

As prolapse advances, women may experience improvement in SUI, but increased difficulty voiding. Advanced anterior or apical prolapse, the prolapse may “kink” the urethra, thereby resulting in symptoms of obstructed voiding, such as a slow urine stream, the need to change position or manually reduce (splint) the prolapse to urinate, a sensation of incomplete emptying and, in rare cases, complete urinary retention [26]. The correlation of obstructive symptoms with advancing prolapse was illustrated in the study of women presenting to a pelvic floor clinic described above, in which urinary splinting was reported by 5 to 12 percent of women with stage II anterior prolapse and 23 to 36 percent of those with stage III or IV anterior prolapse [54]. (See '[Bulge or pressure symptoms](#)' above.)

Thirteen to 65 percent of continent women develop symptoms of SUI after surgical correction of prolapse. Elevation of prolapse during pelvic examination may unmask “occult” SUI. (See '[Pelvic organ prolapse and stress urinary incontinence in women: Combined surgical treatment](#)', section on '[POP with no symptoms of SUI](#)'.)

Women with POP have a two- to five-fold risk of overactive bladder symptoms (urgency, urgency urinary incontinence, frequency) compared with the general population [58,59]. Data are mixed regarding whether the anatomic site (apical, anterior, posterior) and severity of prolapse correlate with the presence of such symptoms.

In addition, some women with POP experience enuresis or incontinence with sexual intercourse [60-62].

Defecatory symptoms — The most common bowel symptom associated with prolapse is constipation [49,51]. Other defecatory symptoms include fecal urgency and fecal incontinence and obstructive symptoms, eg, incomplete emptying, straining, or the need to apply digital pressure to the vagina or perineum (splint) to completely evacuate; some women report fecal incontinence during sexual intercourse [26,62].

Defecatory symptoms may be present in women with any anatomic site of prolapse, although they tend to be found more commonly associated with posterior or apical defects [37,49]. In the study of women presenting to a pelvic floor clinic described above, women with stage I prolapse were the least likely to require splinting to defecate (8 to 15 percent), but the likelihood of splinting symptoms did not continue to increase with advancing prolapse (stage II: 21 to 38 percent; stage III to IV: 26 to 29 percent) [54]. (See '[Bulge or pressure symptoms](#)' above.)

Effects on sexual function — Prolapse does not appear to be associated with decreased sexual desire or with dyspareunia, although reports vary according to whether POP is associated with adverse effects on orgasm or sexual satisfaction [62,63]. Some women report that they avoid sexual activity because of fear of discomfort or embarrassment associated with POP, particularly those with urinary or fecal incontinence during sexual activity [64,65].

DIAGNOSIS AND CLASSIFICATION — POP is diagnosed using pelvic examination. A medical history is also important to elicit prolapse-associated symptoms, since treatment is generally indicated only for symptomatic prolapse. Since its introduction in 1996 and adoption by the Society of Gynecologic Surgeons, American Urogynecologic Society, and International Continence Society, the Pelvic Organ Prolapse Quantitation (POPQ) system has become the most commonly used prolapse staging system.

A detailed discussion of the diagnosis and classification of prolapse can be found separately. (See "[Pelvic organ prolapse in women: Diagnostic evaluation](#)".)

NATURAL HISTORY — Prolapse has traditionally been regarded as a progressive disease, with mild prolapse inexorably leading to more advanced disease. However, data suggest that the course is progressive until menopause, after which the degree of prolapse may follow a course of alternating progression and regression [66-68]. Prolapse regression was demonstrated in a prospective cohort study of 249 women who were followed over a three-year period [66]. Prolapse increased by at least 2 cm in 11 percent of women and regressed by the same amount in 3 percent of women.

APPROACH TO MANAGEMENT

Indications for treatment — Treatment is indicated for women with symptoms of prolapse or associated conditions (urinary, bowel, or sexual dysfunction). Obstructed urination or defecation or hydronephrosis from chronic ureteral kinking are all indications for treatment, regardless of degree of prolapse [26]. Treatment is generally not indicated for women with asymptomatic prolapse [67].

Establishing patient goals — Treatment is individualized according to each patient's symptoms and their impact on her quality of life. Studies have demonstrated that patient satisfaction after pelvic reconstructive surgery correlates highly with achievement of self-described, preoperative surgical goals, but poorly with objective outcome measures [69-71].

Management options — Women with symptomatic prolapse can be managed expectantly, or treated with conservative or surgical therapy. Both conservative and surgical treatment options should be offered. There are no high quality data comparing these two approaches.

The choice of therapy depends upon the patient's preferences, as well as the ability to comply with conservative therapy or tolerate surgery. Some data suggest that age, the degree of POP as measured by descent of leading edge of prolapse, preoperative pelvic pain scores, and prior prolapse surgery are independently associated with treatment choices. In a study of 152 women, older patients and those with increased preoperative pelvic pain scores were more likely to choose pessary over surgery [48]. On the other hand, the likelihood of choosing surgery was increased in women with more severe prolapse or a prior POP repair.

Expectant management — Expectant management is a viable option for women who can tolerate their symptoms and prefer to avoid treatment.

Women with symptomatic or asymptomatic prolapse who decline treatment, particularly stage III or IV, should be evaluated on a regular basis to assess for the development or worsening of urinary or defecatory symptoms and/or findings.

Conservative management — Conservative therapy is the first line option for all women with POP, since surgical treatment incurs the risk of complications and recurrence [72]. However, prolapse is typically a chronic problem, and many women ultimately prefer surgery to conservative therapy since successful surgery does not require ongoing maintenance.

Vaginal pessary — The mainstay of non-surgical treatment for POP is the vaginal pessary. Pessaries are silicone devices in a variety of shapes and sizes, which support the pelvic organs. Approximately half of the women who use a pessary continue to do so in the intermediate term of one to two years. Pessaries must be removed and cleaned on a regular basis. (See "[Vaginal pessary treatment of prolapse and incontinence](#)".)

Pelvic floor muscle exercises — Pelvic floor muscle exercises (PFME) appear to result in improvements in POP stage and POP-associated symptoms. Randomized trials have demonstrated the benefit of PFME, particularly with individualized training and/or supervision [73-76]. As an example, one trial included 109 women with stage I to III prolapse who were assigned to either PFME for six months with regular supervision by a physical therapist or to a control group [74]. Women in the PFME group had significant reductions in the frequency and both of most prolapse, bladder, and bowel symptoms (exceptions were urgency urinary incontinence symptoms, difficulty with stool emptying, and solid stool fecal incontinence). Improvement in POP stage was found more frequently in the PFME group (19 versus 8 percent). Further study is needed of the effect of PFME on POP.

Estrogen therapy — There are few data about the use of estrogen therapy for treatment of symptomatic POP. Use of estrogenic agents (in this study, [raloxifene](#)) appears to be associated with a decrease in the likelihood of undergoing surgery for POP, according to a systematic review of randomized trials described above (see '[Prevention](#)' above) [46]. Recent research supports that perioperative topical vaginal estrogen increases the generation of mature collagen, decreases degradative enzyme activity, and increases vaginal wall thickness [77]. These lab findings need to be substantiated with clinical outcomes. Currently, no data exist to support systemic or topical estrogen as a therapy as a primary treatment of POP.

Surgical treatment — Surgical candidates include women with symptomatic prolapse who have failed or declined conservative management of their prolapse. There are numerous surgeries for prolapse including vaginal and abdominal approaches with and without graft materials.

Surgical prognosis depends upon the severity of symptoms, extent of the prolapse, physician experience, and patient expectations. Surgery has traditionally been associated with a recurrence/reoperation rate of up to 30 percent after the initial surgery [21,78], with some centers reporting reoperation in over 50 percent of patients who have undergone at least two prior surgical procedures for prolapse [79].

A detailed discussion of choosing a surgical therapy for prolapse can be found separately. (See "[Pelvic organ prolapse in women: Choosing a primary surgical procedure](#)".)

Pregnant women — Women may present with new symptoms or an exacerbation of POP during pregnancy. These women are managed conservatively. This condition may manifest initially during the pregnancy; however, in the majority of cases, prolapse is a preexisting condition. This is a rarely reported condition in the United States; the overall incidence of cervical prolapse in pregnancy has been estimated to be 1 case per 10,000 to 15,000 deliveries. Higher prevalence and more severe stages of POP in pregnancy have been reported in other countries with high childbirth rates. The management of POP in women with concomitant pregnancy should be individualized based on symptomatology and clinical findings. These women are managed conservatively with either pelvic floor exercises or pessary management [80,81].

INFORMATION FOR PATIENTS — UpToDate offers two types of patient education materials, "The Basics" and "Beyond the Basics." The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written

at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or e-mail these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on “patient info” and the keyword(s) of interest.)

- Basics topics (see ["Patient information: Pelvic muscle \(Kegel\) exercises \(The Basics\)"](#) and ["Patient information: Pelvic organ prolapse \(The Basics\)"](#))
- Beyond the Basics topics (see ["Patient information: Pelvic floor muscle exercises \(Beyond the Basics\)"](#))

SUMMARY AND RECOMMENDATIONS

- Pelvic organ prolapse (POP) is the herniation of the pelvic organs to or beyond the vaginal walls. (See ['Terminology'](#) above.)
- Estimates of the prevalence of symptomatic POP range from 3 to 11 percent of women. (See ['Prevalence'](#) above.)
- Risk factors for POP include: increasing parity, advancing age, obesity, and hysterectomy. Women with chronic constipation, those who have jobs that involve heavy lifting, and Latina and white women may also have an increased risk of POP. (See ['Risk factors'](#) above.)
- The most common symptom of prolapse is a sensation of pelvic pressure/heaviness or protrusion of tissue from the vagina. Patients frequently describe this as “feeling a bulge” or like something is “falling out of the vagina.” Women with prolapse commonly have other pelvic floor disorders, including urinary, bowel and sexual complaints. (See ['Clinical manifestations'](#) above.) Women with symptomatic prolapse can be managed expectantly, or treated with conservative or surgical therapy. Treatment is generally not indicated for women with asymptomatic prolapse. (See ['Approach to management'](#) above.)
- Conservative treatment options for women with POP include vaginal pessaries and pelvic floor muscle exercises. (See ['Conservative management'](#) above.)
- Surgical candidates include women with symptomatic prolapse, who have failed or declined conservative management of their prolapse. There are numerous surgeries for prolapse, including vaginal and abdominal approaches (open, laparoscopic, or robotic) and with and without graft materials. (See ['Surgical treatment'](#) above.)

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