The perineum and the psyche

Consultant Gynaecologist Mr Nicholas Morris discusses the common problem of prolapse in postnatal women and the treatments available

Traumatic vaginal birth can lead to damage to the fascial and the ligamentous supports of the pelvic organs, weakening the perineal body and potentially triggering the development of vaginal prolapse. Such trauma can have a major impact on a woman's quality of life, including the sexual relationship with her partner.

There is a direct relationship between the first vaginal delivery childbirth and obstetric trauma. Subsequent vaginal deliveries, as well as the loss of oestrogen at the time of menopause, will reduce collagen bulk and result in worsening vaginal prolapse.

Women aged over 30, giving birth for the first time, are at greater risk of vaginal prolapse. Further risk groups include women who are hyper mobile, smokers, overweight or obese and diabetics. There are also genetic risk factors with vaginal prolapse that are more prevalent in women from South Asia.

The fundamental changes in vaginal function result in the development of perineal weakness, rectocele and cystocele development. This can result in urinary or faecal incontinence and loss of the frictional sensation during sexual intercourse.

What can a GP do?

General practitioners play a vital role, particularly at the time of postnatal visits. By making a full clinical evaluation of any pelvic floor damage, referring presenting patients to a perineal clinic and

asking them about any postnatal sexual difficulties, these measures will help reduce subsequent morbidity.

Simple steps, such as assessing stool consistency using the Bristol chart, encouraging a high fibre diet and a daily two litre water intake, may make a difference in reducing symptoms and avoiding worsening pelvic floor disease.

Sexual dysfunction

In a study from St Georges, 85 per cent of postnatal mothers experienced sexual problems at three months, dropping to 64 per cent at six months. However, the striking finding in this study is that only 15 per cent of mothers had discussed this with a health care professional. In women with pelvic organ prolapse [POP], the posterior compartment is affected in nearly 75 per cent.

Patients with rectocele may present with an asymptomatic bulge or may have significant complaints ranging from "bulge" symptoms to defaecatory and sexual dysfunction. Some women also complain of the need to interdigitate during defecation. They often feel open and exposed and report air trapping during sex, resulting in psychological problems in relationships and sexual performance.

Sexual dysfunction in women with urogenital prolapse

The actual presence of an obstructive bulge in the vagina or a sense of vaginal laxity may lead to sexual dysfunction, particularly in more severe degrees of prolapse. Common sexual dysfunctions include:

• Urogenital atrophy (lack of oestrogen)

• Obstruction caused by physical presence of the prolapse

• Lack of physical sexual response, leading to discomfort/pain, often aggravated by lack of lubrication and genital swelling

• A short or narrow vagina or a tense, contracted pelvic floor

• A decreased vaginal length, width or reduced elasticity caused by prolapsed vaginal tissue, scarring from previous surgery or a mesh insertion, can cause dyspareunia.

Psychological symptoms that can develop from urogenital prolapse

• Lack of libido

• Negative thoughts associated with sex

• Embarrassment

• Fear of incontinence

Medical treatment

Depending on the severity of the case, certain women can benefit from a variety of medical options that can help with the symptoms of prolapse. These patients will gain from a multidisciplinary team approach, with dietary, physiotherapy and psychological support, prior to and post surgery.

Surgical treatments

In regards to surgical treatment options, gynaecologists and many colorectal surgeons prefer the transvaginal approach (posterior colporrhaphy). Other options to consider include a transanal and perineal approach, with vaginal mesh not used in any primary procedure.

Posterior colporrhaphy is commonly performed in conjunction with a perineoplasty to address a relaxed perineum and widened genital hiatus. This involves refashioning and placating the levator ani after mobilization of the rectum. This will improve defecation, and reduce the cavernous diameters of the vagina. Although surgery is effective, patients need to be aware of the risk of recurrence and vaginal scar-induced dyspareunia.

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