NICE National Institute for Health and Care Excellence

NICE Pathways

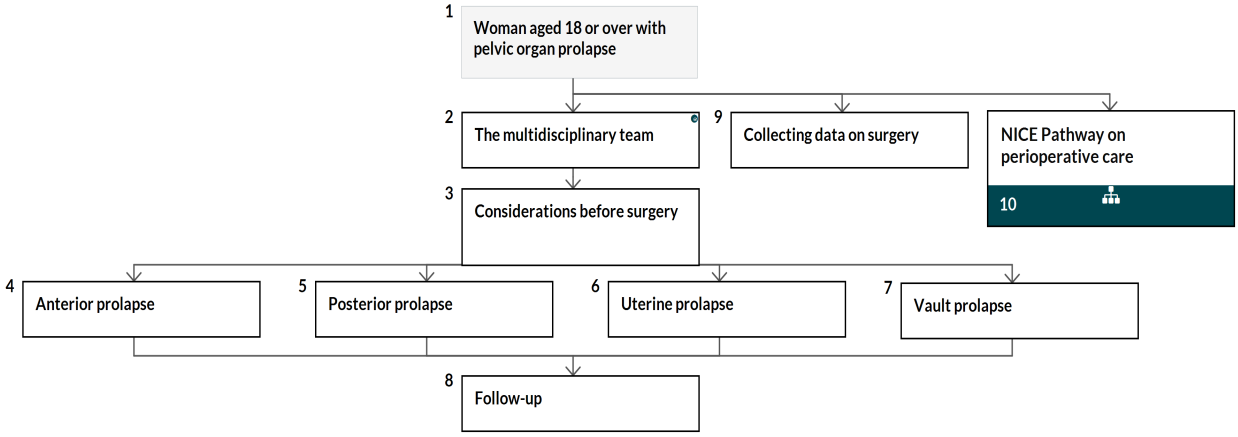
Surgery for pelvic organ prolapse

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/urinary-incontinence-and-pelvic-organ-prolapse-in-women
NICE Pathway last updated: 03 September 2020

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



1 Woman aged 18 or over with pelvic organ prolapse

No additional information

2 The multidisciplinary team

Local

Local MDTs for women with primary SUI, OAB or primary prolapse should:

- review the proposed treatment for all women offered invasive procedures for primary SUI, OAB or primary prolapse
- review the proposed management for women with primary SUI, OAB or primary prolapse if input from a wider range of healthcare professionals is needed
- work within an established clinical network that has access to a regional MDT. (NHS England consulted on specialised gynaecology surgery and complex urogynaecology conditions service specifications in 2018.)

Local MDTs for women with primary SUI, OAB or primary prolapse should include:

- 2 consultants with expertise in managing UI in women and/or POP
- a urogynaecology, urology or continence specialist nurse
- a pelvic floor specialist physiotherapist

and may also include:

- a member of the care of the elderly team
- an occupational therapist
- a colorectal surgeon.

Members of the local MDT should attend all local MDT meetings.

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

Regional

Regional MDTs that deal with complex pelvic floor dysfunction and mesh-related problems should review the proposed treatment for women if:

- they are having repeat continence surgery
- they are having repeat, same-site prolapse surgery
- their preferred treatment option is not available in the referring hospital
- they have coexisting bowel problems that may need additional colorectal intervention
- vaginal mesh for prolapse is a treatment option for them
- they have mesh complications or unexplained symptoms after mesh surgery for UI or prolapse
- they are considering surgery and may wish to have children in the future.

Regional MDTs that deal with complex pelvic floor dysfunction and mesh-related problems should include:

- a subspecialist in urogynaecology
- a urologist with expertise in female urology
- a urogynaecology, urology or continence specialist nurse
- a pelvic floor specialist physiotherapist
- a radiologist with expertise in pelvic floor imaging
- a colorectal surgeon with expertise in pelvic floor problems
- a pain specialist with expertise in managing pelvic pain

and may also include:

- a healthcare professional trained in bowel biofeedback and trans-anal irrigation
- a clinical psychologist
- a member of the care of the elderly team
- an occupational therapist
- a surgeon skilled at operating in the obturator region
- a plastic surgeon.

Regional MDTs that deal with complex pelvic floor dysfunction and mesh-related problems should have ready access to the following services:

- psychology
- psychosexual counselling
- chronic pain management
- bowel symptom management
- neurology.

Members of the regional MDT should attend regional MDT meetings when their specific expertise is needed.

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Urinary incontinence in women

7. Multidisciplinary team review before surgery or invasive treatment

3 Considerations before surgery

There is public concern about the use of mesh procedures. For all of the procedures recommended in this flowchart, including mesh procedures, there is evidence of benefit, but limited evidence on long-term adverse effects. In particular, the true prevalence of long-term complications is unknown.

Offer surgery for POP to women whose symptoms have not improved with or who have declined non-surgical treatment.

If a woman is thinking about a surgical procedure for POP, use a decision aid, (use the NICE patient decision aids on surgery for uterine prolapse and surgery for vaginal vault prolapse where they apply) to promote informed preference and shared decision making. Discussion with the woman should include:

- the different treatment options for POP, including no treatment or continued non-surgical management
- the benefits and risks of each surgical procedure, including changes in urinary, bowel and sexual function
- the risk of recurrent prolapse
- the uncertainties about the long-term adverse effects for all procedures, particularly those involving the implantation of mesh materials
- differences between procedures in the type of anaesthesia, expected length of hospital stay, surgical incisions and expected recovery period
- the role of intraoperative prolapse assessment in deciding the most appropriate choice of

- surgical procedure.

Do not offer surgery to prevent incontinence in women having surgery for prolapse who do not have incontinence.

Explain to women considering surgery for anterior or apical prolapse who do not have incontinence that there is a risk of developing postoperative UI and further treatment may be needed.

If the woman's chosen procedure for POP is not available from the consulting surgeon, refer her to an alternative surgeon.

If mesh is to be used in prolapse surgery:

- explain to the woman about the type of mesh that will be used and whether or not it is permanent
- ensure that details of the procedure and its subsequent short- and long-term outcomes are collected in a national registry (see collecting data on surgery [See page 10]).
- give the woman written information about the implant, including its name, manufacturer, date of insertion, and the implanting surgeon's name and contact details.

Providers must ensure that data on surgical procedures for POP are recorded in the national registry (see collecting data on surgery [See page 10]).

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

See also the NICE Pathway on preoperative tests.

Surgery for stress urinary incontinence and pelvic organ prolapse

Consider concurrent surgery for SUI and POP in women with anterior and/or apical prolapse and SUI.

When considering concurrent surgery for SUI and POP, discuss the options for treatment (see above and patient information and support for SUI) and explain to the woman:

- that there is uncertainty about whether the combined procedure is effective for treating SUI beyond 1 year, and that SUI might persist despite surgery
- the risk of complications related to having surgery for SUI at the same time as prolapse surgery compared with the risk of complications related to having sequential surgery.

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

4 Anterior prolapse

Discuss the options for treatment (see considerations before surgery [See page 5]) including non-surgical and surgical options, with women who have anterior prolapse.

Offer anterior repair without mesh to women with anterior vaginal wall prolapse.

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

NICE has published interventional procedures guidance that transvaginal mesh repair of anterior or posterior vaginal wall prolapse should only be used in the context of **research**.

5 Posterior prolapse

Offer posterior vaginal repair without mesh to women with a posterior vaginal wall prolapse.

See the NICE guideline to find out why we made this recommendation and how it might affect practice.

NICE has published interventional procedures guidance that transvaginal mesh repair of anterior or posterior vaginal wall prolapse should only be used in the context of **research**.

6 Uterine prolapse

Discuss the options for treatment (see considerations before surgery [See page 5]), including non-surgical options, hysterectomy and surgery that will preserve the uterus, with women who have uterine prolapse.

For women considering surgery for uterine prolapse:

- discuss the possible complications and the lack of long-term evidence on the effectiveness of the procedures
- use the NICE patient decision aid on surgery for uterine prolapse to discuss the benefits and risks of treatment, including non-surgical options.

For women with uterine prolapse who have no preference about preserving their uterus, offer a choice of:

- vaginal hysterectomy, with or without vaginal sacrospinous fixation with sutures **or**
- vaginal sacrospinous hysteropexy with sutures **or**
- Manchester repair.

Also include the option of sacro-hysteropexy with mesh (abdominal or laparoscopic) in this choice but see considerations before surgery [See page 5] for specific guidance on the use of mesh in prolapse surgery.

For women with uterine prolapse who wish to preserve their uterus, offer a choice of:

- vaginal sacrospinous hysteropexy with sutures **or**
- Manchester repair, unless the woman may wish to have children in the future.

Also include the option of sacro-hysteropexy with mesh (abdominal or laparoscopic) in this choice but see considerations before surgery [See page 5] for specific guidance on the use of mesh in prolapse surgery.

If a synthetic polypropylene mesh is inserted, the details of the procedure and its subsequent short- and long-term outcomes must be collected in a national registry (see collecting data on surgery [See page 10]).

Ensure the proposed treatment is reviewed by a regional MDT (see the multidisciplinary team [See page 3]) if the woman wishes to have children in the future.

Consider colpocleisis for women with vault or uterine prolapse who do not intend to have penetrative vaginal sex and who have a physical condition that may put them at increased risk of operative and postoperative complications.

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

Interventional procedures

NICE has published guidance on uterine suspension using mesh (including sacrohysteropexy) to repair uterine prolapse with **standard arrangements** for clinical governance, consent and audit.

NICE has published guidance on the use of the following procedures with **special arrangements** for clinical governance, consent and audit or research:

- infracoccygeal sacropexy using mesh to repair uterine prolapse
- sacrocolpopexy with hysterectomy using mesh to repair uterine prolapse.

NICE has published guidance that the following procedures should only be used in the context of **research**:

- bilateral cervicosacropexy (CESA) or vaginosacropexy (VASA) using mesh for pelvic organ prolapse
- laparoscopic mesh pectopexy for apical prolapse of the uterus or vagina.

7 Vault prolapse

Discuss the options for treatment (see considerations before surgery [See page 5]) including non-surgical and surgical options, with women who have vault prolapse.

For women considering surgery for vault prolapse:

- discuss the possible complications and the lack of long-term evidence on the effectiveness of the procedures
- use the NICE patient decision aid on surgery for vaginal vault prolapse to discuss the benefits and risks of treatment, including non-surgical options.

Offer women with vault prolapse a choice of:

- vaginal sacrospinous fixation with sutures **or**
- sacrocolpopexy (abdominal or laparoscopic) with mesh.

See considerations before surgery for specific guidance on the use of mesh in prolapse surgery.

If a synthetic polypropylene mesh is inserted, the details of the procedure and its subsequent short- and long-term outcomes must be collected in a national registry (see collecting data on surgery [See page 10]).

Consider colpocleisis for women with vault or uterine prolapse who do not intend to have penetrative vaginal sex and who have a physical condition that may put them at increased risk of operative and postoperative complications.

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

Interventional procedures

NICE has published guidance on sacrocolpopexy using mesh to repair vaginal vault prolapse with **standard arrangements** for clinical governance, consent and audit.

NICE has published guidance on infracoccygeal sacropexy using mesh to repair vaginal vault prolapse with **special arrangements** for clinical governance, consent and audit or research.

NICE has published guidance that the following procedures should only be used in the context of **research**:

- bilateral cervicosacropexy (CESA) or vaginosacropexy (VASA) using mesh for pelvic organ prolapse
- laparoscopic mesh pectopexy for apical prolapse of the uterus or vagina.

8 Follow-up

Offer women a review 6 months after surgery for POP. Ensure that the review includes a vaginal examination and, if mesh was used, check for mesh exposure.

Providers should ensure that women who have had surgery for POP have access to further referral if they have recurrent symptoms or suspected complications. See also assessing and managing complications associated with mesh surgery.

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

See also review for long-term use of absorbent containment products.

9 Collecting data on surgery

Ask women having surgery for SUI or POP, or who have experienced complications related to these types of surgery, for their consent to enter the data listed below into a national registry. Give each woman a copy of her data.

Providers must ensure that the following data are collected in a national registry of surgery for

UI and POP:

- the woman's NHS number
- hospital and consultant identifiers
- date and details of the procedure
- for procedures involving mesh, the mesh material, manufacturer, product unique identification code and type of sutures used
- for procedures involving colposuspension, the type of sutures used
- for procedures involving bulking agent, the bulking material, manufacturer and product unique identification code
- date and details of any investigation for complications
- date and details of any surgical or non-surgical intervention for complications.

The national registry of surgery for UI or POP in women must ensure that follow-up data are collected on key short- and long-term (at least 5 years) outcomes, including:

- validated relevant outcome measures
- adverse events including pain
- suspected and confirmed mesh-related complications.

The national registry of surgery for urinary incontinence and pelvic organ prolapse in women should report annually and be quality assured.

Rationale and impact

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

10 NICE Pathway on perioperative care

See perioperative care

Glossary

Manchester repair

(an operation used to treat uterine prolapse: the neck of the womb (the cervix) is shortened; it involves shortening the cervix (neck of the womb) and supporting the womb in its natural position)

POP

pelvic organ prolapse

Sacrocolpopexy

(a type of surgery used to treat vaginal vault prolapse; plastic mesh is used to attach the vagina to a bone at the bottom of the spine)

Sacro-hysteropexy

(an operation to treat uterine prolapse; plastic mesh is used to attach the womb (the uterus) to a bone at the bottom of the spine)

SUI

stress urinary incontinence

UI

urinary incontinence

Vaginal sacrospinous fixation

(a type of surgery used to treat vaginal vault or uterine prolapse: the top of the vagina is stitched to a ligament in the pelvis; it is done through a cut on the inside of the vagina)

Vaginal sacrospinous hysteropexy

(an operation used to treat uterine prolapse: the cervix is stitched to a ligament in the pelvis; it is done through a cut on the inside of the vagina)

Sources

Urinary incontinence and pelvic organ prolapse in women: management (2019) NICE guideline NG123

Your responsibility

Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the

recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.