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Case: Vaginal Prolapse

Candidate brief

You are an FY2 in a GP surgery running your morning clinic.

Please take a focused history from Jennifer Longmore, a 64-year-old female who has presented with discomfort around the perineum.

15 mins	1. Please take a full history (7 mins) 2. Counsel her with an appropriate management plan (4 mins) 3. Viva with the examiner afterwards (4 mins)
10 mins	1. Please take a full history (7 mins) 2. Viva with the examiner afterwards (3 mins)

Author: Jasmine Zanelli. Final year medical student. University of Warwick.

Reviewers: Priya Abraham, FY1, West Midlands South Deanery.

Patient Brief

(Do not volunteer information unless asked)

Name: Jennifer Longmore
DOB: 10/09/1956 (64 years old)
Job: Medical secretary
Opening statement: "*I thought I should come and see you because I've been having some problems down below for a few months"*

HPC:
I've been having some discomfort down below for about 3 months.

- Would not describe it as a pain. Feels more like **fullness or dragging sensation** in the vagina.
- The heaviness can feel worse after a day of running after the grandchildren or if constipated.
- Did notice **something bulging out** a few times but managed to **push it back in** and it seemed to stay there for a while.
- Stopped having **sex because it has become painful** and husband noticed something different down there and you were embarrassed.
    - Superficial pain.
    - Has been less comfortable since menopause but now even more so.
- Come to see you today because the bulge seems to be appearing **more often.**
- **Starting to really get you down.**

Associated symptoms

- Always struggled with constipation- only go about once a week on average. Was being managed quite well with Docusate but feel like got worse again over last few months.
- No vaginal bleeding.
- No associated discharge.
- No urinary symptoms.

Obs Hx

- 3 pregnancies in the past- 2 spontaneous vaginal deliveries at term. 1 required use of forceps. 1 elective C-section at 36 weeks with twins.
- Twin pregnancy was complicated by gestational diabetes.

Gynae Hx
Period: Last menstrual period: About 15 years ago. Started periods when you were 14. They were mostly regular, can irregular when you were stressed. Your periods weren't particularly heavy and lasted for 5 days.
Smears: Had some 'suspicious cells' once but never had any problems since these were treated.
STIs: Nil.
Contraception: Did not think you needed it now you had 'gone through the change'? Also not really having sex now due to this problem. Used the Mirena coil in your 30s for 5 years.

Menopause: Aged 49 you think. Had some terrible hot flushes but feeling much better now.

PMHx – Type 2 diabetes. Long-term constipation. Occasional haemorrhoids. Some urinary incontinence since your last child and it is getting worse, you are leaking all the time. One doctor once said you had bendy joints but not sure if that is relevant.

DHx - NKDA, Metformin. Docusate Sodium. Allergic to Tramadol and latex. (Took Tramadol when dislocated shoulder about 10 years ago).

FHx – Mum had a stroke in her 80's. No other relevant family history.

SHx –
Smoked for 10 years before having the children.
Shares the odd bottle of Merlot with the husband on the weekend.
Lives at home with husband, one of the twins and the dogs but feels like the house is mostly full of grandchildren.

Other information:

- Other systems review – apart from the constipation have not noticed anything else. Maybe gained some weight over the last few years.

Ideas: You feel like you should not have really come to the doctor about this as it is probably nothing right? But it is starting to really get you down.

Concerns: You are concerned that you will never be able to have sex with your husband again.

Expectations: I expect to be told there is nothing to be done and that it is just a sign of getting old!

Investigations findings (Provide it after history talking or to enquire candidate about differential diagnosis)

INVESTIGATIONS:

BMI – 30kg/m^2

Speculum Examination – On examination there is a prolapse visible. Use of a Sim's speculum shows this is a prolapse of the posterior wall of the vagina. On bearing down the prolapse increases in size. The prolapse is reducible.

Bimanual examination – not done.

Abdominal Examination – abdomen feels full- evidence of faecal loading. Bladder is not palpable. Non-tender and no other masses felt. No organomegaly.

Examiner Brief

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10 mins	1. Please take a full history (7 mins) 2. Viva with the examiner afterwards (3 mins)

- **Please do not** provide **any verbal or non-verbal feedback** for the candidate. This includes nodding to correct answers and shaking head to wrong answers - particularly during the viva.
- **Please provide positive and negative feedback** (both verbal and written) at the end of the session once the examination is complete.
- The questions below are provided as a guide for discussion only. For viva, please ask questions surrounding the case and challenge the candidate where appropriate

Examiners will grade the performance across four domains: **(15 minute station)**

1. Clinical skills
2. Formulation of clinical issues
3. Discussion of management
4. Professional behaviours and patient centred approach

Positive descriptors		**Marks**
History/Clinical skills (17)		
Appropriate introduction, elicit patient details and invite consultation		2
Exploration of PC: Onset, associated symptoms, effect on life.		2
Exploration of constipation: How has this changed? Any lifestyle factors changed?		2
Exploration of urinary incontinence: when it started? Exacerbating factor? Volume and duration.		2
Sensitive exploration on effect on sex life: How has this changed? Effect on mental health. Deep or superficial pain?		2
Menstrual history – menopause and discussion of previous menstrual history.		2
Gynaecological history – menopause, STIs, cervical screening		2
Obstetric history – Gravity, Parity, outcome of pregnancies		2
Enquire about **risk factors**: obesity, chronic cough, connective tissue disorders, obstetric history, previous surgeries.		2
Past medical (surgical) history; drug history, family history, social history		1
Formulation of clinical issue (6)		
Summary and **interpretation** of clinical findings **accurately**		2
Good range of differential diagnoses with exploration of causes of associated features such as superficial dyspareunia, atrophic vaginitis.		1
Discusses types of prolapse, risk factors, staging.		3
Discussion of management (4)		
Consider management of all issues (holistic approach)- offer conservative and surgical options for patient. E.g. pessary rings.		2
Demonstrate MDT approach – need for physiotherapy		1

Understand options of management for prolapse including pessary and surgery.		1
Professionalism and patient centred approach (3)		
Able to elicit patient ideas, concerns, expectations		1
Use empathic behaviour and language Explain accurately, uses everyday language and check for understanding		1
Professional communication to examiner as colleague		1

Viva Questions: (Please ask questions surrounding the case and challenge the candidate where appropriate); **The questions below are provided as a guide for discussion only.**

Resource: BMJ best practice (Please reference this), NICE guidelines (https://pathways.nice.org.uk/pathways/urinary-incontinence-and-pelvic-organ-prolapse-in-women), Green-Top guideline No.46

1. Differential diagnoses:	• Pelvic organs prolapse rectocele most likely but consider:
	  ○ Uterine prolapse
	  ○ Vault prolapse
	  ○ Cystocele.
	• Cervical cancer
	• Colorectal cancer constipation
	• Atrophic vaginitis dyspareunia

2. What are the types of pelvic organ prolapse?	Rectocele - rectum prolapses into the vagina. Uterine prolapse - uterus itself prolapses into the vagina. Vault prolapse - vault of the vagina descends into the vagina (in women who have had a hysterectomy). Cystocele - bladder prolapses into the vagina.
3. What are the risk factors associated with pelvic organ prolapse?	Multiple vaginal deliveries/ deliveries which required instrumental intervention. Obesity Low oestrogen levels post-menopausal. Chronic constipation Conditions which raise intra-abdominal pressure: ascites, chronic cough. Congenital connective tissue disorders Previous pelvic surgery e.g. hysterectomy (For vault prolapse).
4. How would you stage a pelvic organ prolapse?/ What are the stages of a pelvic organ prolapse? **What stage do you think your patient is at? Will this affect management?**	Staging is a clinical diagnosis on speculum examination. Staging using the Pelvic Organ Prolapse Quantitation system. • Stage 0: No prolapse. • Stage 1: The most distal part of the prolapse is >1cm above the introitus. • Stage 2: The most distal part of the prolapse is within 1cm of the introitus (above or below). • Stage 3: The most distal part of the prolapse is >1cm below the introitus but not fully descended.

	• Stage 4: Full descent with eversion of the vagina.
5. What would you do about the patients constipation?	Manage the prolapse and see if this helps with the constipation. Ensure compliant with taking Docusate sodium. Suggest conservative measurements increasing fluid intake, high fibre diet, increasing exercise. Consider altering or adding pharmacological treatment Lactulose, Macrogol.
6. How would you manage this patient conservatively?	Lifestyle changes weight loss, increased fibre/fluid intake to reduce constipation which could improve the rectocele. Physiotherapy pelvic floor exercises. Vaginal oestrogen cream may help improve superficial dyspareunia.
7. What other management options are available to this patient?	Vaginal pessary a silicone (not latex due to allergy) device that is inserted into the vagina to support the pelvic organs. Surgical management – should be offered for women who are symptomatic and after councelling **posterior colporrhaphy**. **+/- mesh.** sacrocolpopexy. NB: Subtotal hysterectomy should not be offered as there is little evidence to show help with symptoms.