



CYSTOCELE

A cystocele is one of many pelvic organ support problems. Each year many women endure pelvic organ support problems (pelvic organ prolapse), and many undergo surgical procedures for correction of these problems. These disorders usually are the result of trauma to the pelvic connective tissue and muscles, and may be the result of childbirth. The surgical procedures to correct these defects are considered elective since women are at no medical risk with these problems.

Q. WHAT IS A CYSTOCELE?

A. A cystocele is a downward displacement of the bladder into the vagina. This pelvic organ defect often occurs in conjunction with other pelvic organ defects including rectocele (downward displacement of the rectum), enterocele (displacement/herniation of the small bowel into the vagina), and uterine prolapse (a downward displacement of the uterus and cervix toward the vaginal opening). A cystocele actually occurs when there is a defect in the anterior vaginal wall with subsequent lack of support of a portion of the bladder.

Women may notice various symptoms with a cystocele including frequency (the need to void more often than usual), dysuria (painful urination), difficulty initiating urination, incomplete bladder emptying, or incontinence of urine. Some women notice a vaginal bulge or pressure, especially when bearing down, such as having a bowel movement. Some women have no symptoms at all.

A common condition associated with a cytocele is stress urinary incontinence. This is when a woman leaks urine with any sudden increase in intraabdominal pressure, such as jumping, coughing, sneezing, etc. The association of the two conditions has to do with inadequate support of the pelvic tissues.

Q. WHO IS MOST LIKELY TO GET A CYSTOCELE?

A. A cystocele results from pelvic floor trauma. Often, this is the result of childbirth. During the second stage of labor (the pushing stage), some of the tissues that normally support the pelvic organs (the pelvic fascia and ligaments) are stretched and damaged. This weakens support of the pelvic organs. As a woman ages the problems may be worsened by loss of tissue integrity from decreased levels of the female hormone estrogen.

Other causes of loss of pelvic support include excess intraabdominal pressure over a prolonged period of time such as heavy lifting, excessive coughing often seen in long-term smokers, or chronic constipation and straining with bowel movements.

DIAGNOSIS OF CYSTOCELE

The diagnosis of a cystocele is made during a clinical exam by a physician. A woman usually visits her physician with one or more of the above listed symptoms. To make an accurate diagnosis your doctor will get your complete medical history, and will perform a pelvic exam. If you are having problems with either incontinence or initiating urination, your physician may order several additional tests. These include cystoscopy, which involves looking inside your bladder with a small light, and urodynamics, which involves detailed studies of the function of both the bladder and urethra that gives an indication of the ability of the bladder to properly store and empty urine.

TREATMENTS FOR A CYSTOCELE

Your physician may offer a variety of different treatments for your cystocele ranging from just watching the problem to see if it worsens, to basic lifestyle changes, to exercises in an attempt to strengthen your pelvic floor muscles, to surgery.

Many women with cystoceles are asymptomatic. If you have no leaking of urine or difficulty initiating voiding, have no discomfort with intercourse, and are not bothered by a vaginal bulge, then it is reasonable to just watch your cystocele with no further treatment. A cystocele has no associated medical problems that must be addressed if you are asymptomatic.

Many women with cystoceles notice improvement in their urinary symptoms with basic lifestyle changes. Often by changing their voiding habits, adjusting their diets, and reducing certain exacerbating drugs such as caffeine, women notice significant improvement in their symptoms.

Another potential treatment for a cystocele is Kegel's exercises. These exercises strengthen the pelvic floor muscles. To perform these exercises a woman is asked to squeeze the pubococcygeus muscle (which is done by squeezing the muscles around the vagina that would be used to try to hold a tampon in place). These muscles are contracted for 10 seconds and then relaxed for 10 seconds. This repetitive activity is done in sets of 10 to 20 about 3 to 5 times a day. Maximum results are obtained in 3 to 6 months.

Due to the increased deterioration of the integrity of the pelvic tissues, your physician may ask you to start a regimen of estrogen if you are postmenopausal. Estrogen replacement therapy has many potential benefits for the postmenopausal woman including a decrease in osteoporosis (thinning of the bones), as well as improvement in pelvic support. Estrogen replacement therapy may be prescribed in many different forms, including pills or a transdermal patch. If you have not had a hysterectomy, progesterone therapy will be necessary as well to prevent endometrial hyperplasia (a precursor to endometrial cancer).

Your physician may suggest a pessary for support of the vaginal vault and relief of the symptoms of your cystocele. A pessary is a rubber device that is inserted into the vagina. It is fitted to conform to the vaginal walls. Your physician will teach you

how to insert and remove your pessary, and you will need to remove and clean your pessary on a regular basis.

Finally, your physician may suggest surgery as an option for correction of cystocele. This surgery is usually done from a vaginal approach. An anterior colporrhaphy may be performed by your physician, which involves mobilization of the vaginal tissues with reapproximation of the weakened facial tissue. There is no entry into the abdominal cavity during this procedure, and you are often allowed to go home after one to two nights in the hospital. Continuous bladder drainage is often necessary for several days after your surgery. When the catheter is removed, your physician will want to be certain that your bladder is not becoming overly distended and placing tension on the sutures. Therefore, he or she may ask you to catheterize yourself several times after voiding to be sure that the residual urine left in your bladder is less than 50 milliliters.

Recovery after an anterior colporrhaphy is usually complete in 4 to 6 weeks. Most patients feel well enough to return to work in approximately 2 weeks.

PREVENTION OF CYSTOCELES

Cystoceles are commonly the result of obstetrical trauma and/or tissue deterioration due to aging. At this point there is no recommendation for prevention of cystocele, except avoidance of prolonged increased abdominal pressure, such as excessive coughing and straining or activities that lead to coughing such as smoking.

THOMAS G. STOVALL, M.D.

Dr. Stovall is a Clinical Professor of Obstetrics and Gynecology at the University of Tennessee Health Science Center in Memphis, Tennessee and Partner of Women's Health Specialists, Inc.

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Health Information Provided by Women's Health Specialists

7800 Wolf Trail Cove, Germantown, TN 38138, (901) 682-9222, www.whsobgyn.com

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