INTRODUCTION

Prolapse (from the Latin prolapsus, a slipping forth) refers to the falling or slipping out of place of a part or viscous. Pelvic organ prolapse is descent of the pelvic organs into the vagina, often accompanied by urinary bowel, sexual, or local pelvic symptoms. The incidence of genital prolapse is difficult to determine, as many women do not seek medical advice. It has been estimated that a half of parous women lose pelvic floor support, resulting in some degree of prolapse, and that of these women 10-20% seek medical care ***(Beck, 1983).***

Uterine and genital prolapse may rarely be caused by congenital (inherited) weakness of the pelivc floor (muscles, ligaments, fascias that support the pelvic floor and prevent pelvic organs from dropping down). ***(Thaker and Stanton, 2002).***

More commonly, genital prolapse is caused by damage to the pelvic floor during vaginal deliveries (especially those with protracted labour), instrumental deliveries (forceps, vacuum extraction), and vaginal delivery of large babies. Aging and menopause can weaken the pelvic floor in part because of diminished estrogen levels as well as by aging itself. The tissues comprising the pelvic floor are weakened in the absence of sufficient estrogen levels ***(Jackson and Smith, 1997).***

Increased intra-abdominal pressure on a long-term basis can contribute to genital prolapse, for example: heavy manual labour, heavy lifting, use of a tight abdominal girdle. Chronic coughing and straining during bowel movements because of chronic constipation are also important contributing factors in genital prolapse ***(Thaker and Stanton, 2002).***

Prolapses can occur in the anterior, middle, or posterior compartment of the pelvis : Anterior compartment prolapses are prolapse into the vagina of the urethra (urethrocele) or bladder (cystocele) or both (cystourethrocele). Middle compartment prolapses are uterine or vault descent and enterocele (herniation of the pouch of Douglas). Posterior compartment prolapse is prolapse of the rectum into the vagina (rectocele). Enteroceles may contain small bowel and omentum. Cystourethrocele is the most common type of prolapse, followed by uterine descent and then rectocele. Urethroceles are rare ***(Jackson and Smith, 1997) .***

Traditionally uterine descent is graded as 1 st degree (within the vagina), 2nd degree (descent to the introitus), or 3rd degree (descent outside the introitus) ***(Thaker and Stanton , 2002).***

Symptoms depend on the genital organs involved in the prolapse as well as the degree of the prolapse. Mild degrees of uterine prolapse, cystocele, or rectocele may not cause any discomfort. A more significant uterine prolapse may cause pelvic pain or pressure, a feeling of something falling in the vagina, and low back pain. It may also interfere with sexual function. There may pain or a feeling of something blocking penetration. Sex may also be less fulfilling because of loss of vaginal tone ***(Tamara,2003) .***

Cystocele may cause pelvic discomfort and sexual dysfunction and may involve urinary stress incontinences. Rectocele can cause rectal pressure and constipation. Prolapse which results in a protrusion of the uterus and/or vagina out of the vaginal introitus may lead to irritation, ulceration, and infection. Enterocele may cause low back pain and painful defecation ***(Thaker and Stanton , 2002).***

Conservative treatment should always be offered before referral to hospital. Pelvic floor exercises such as kegels may limit prolapse and alleviate mild prolapse symptoms such low backache and pelvic pressure ***(Davilla, 1999).***

For many years vaginal pessaries have been used to treat prolapse, although their use has decreased with advances in anaesthesia and surgical techniques ***(Pott and Newcomer, 2001).*** Estrogen replacement therapy (combined with a progestin)and estrogen cream can improve the strength of the pelvic floor ligaments and muscles, bringing an improvement in symptoms, and increase the effectiveness of Kegel exercises ***(Davilla, 1999).***

The aims of surgical correction of prolapse are relief of symptoms, restoration of normal vaginal anatomy, and preservation of coitus and urinary and anal continence. Operation can be classified by compartment and approach ***(Thaker and Stanton , 2002).***

Operations in the anterior compartment are anterior colporrhaphy and colposuspension. Anterior colporrhaphy rectifies a cystourethrocele . Mesh may be placed in the anterior wall of the vagina for additional support when a previous repair has failed. The operation is no longer the treatment of choice for major urethral sphincter incompetence; instead tension free vaginal tape (TVT) may be inserted with anterior repair. Colposuspension is indicated for urethral sphincter incontinence associated with a 2nd or 3rd degree cystourethrocele ***(Webber,2000).***

Operations in the middle compartment; vaginal hysterectomy is considered to be most effective treatment for uterine prolapse. This can be combined with an anterior or posterior repair (or both) if a cystocele or

rectocele is present ***(Thaker and Stanton , 2002).*** Manchester, Extended Manchester procedures are an alternatives to vaginal hysterectomy in absence of uterine pathology but have a high rate of recurrence. Shirodkar procedure is an effective mean of restoring the uterus to a normal anatomic state in patients with symptomatic uterovaginal prolapse and remains a valid alternative to more recent pelvic reconstruction procedures ***(Dubernard et al., 2003).***

Several authors have recommended the abdominal approach in the management of utero vaginal prolapse in young women. Long lasting anatomic restoration and normal vaginal axis are efficiently achieved by sacrohysteropexy with mersilene, gore tex, Teflon or polytetra fluoroethylene mesh ***(Leron and Stanton, 2001).***

Sacrospinous fixation holds the uterus up by stitching it to sacrospinous ligament using sutures only; no mesh. The procedure is done vaginally,but has lower success rates than sacrohysteropexy ***(Tamara,2003).***

Abdominal Sling operations are indicated when the ligaments are extremely weak as in nulipara , young women and to preserves reproductive function. Types of abdominal sling operations are Shirodlkar's posterior sling, Purandar's anterior cervicopexy, Khanna's sling and Virkud's composite sling ***(Panda, 2002).***

Kovace and Cruikshank (**2001),** successfully performed sacrospinous fixation of the uterosacral ligaments in 19 patients who desired either uterine preservation or future childbearing.More recently, Laparoscopic utero sacral plication and shortening were reported ***(Maher et al., 2001).***

Operation for vault prolapse and enterocele; The choice is between sacrospinous fixation, iliococcygeal hitch, and pubocervical rectovaginal fascia repair. In abdominal or larparoscopic sacrocolpopexy the vaginal vault is attached by a mesh to the longitudinal ligament over the sacrum. ***(Fox and Stanton, 2000).***

Sacrospinous fixation supports the vagina by attaching the vaginal vault to sacrospinous ligament. The procedure is done vaginally using sutures only; no mesh ***(Tamara,2003).***

Operations in the Posterior compartment; Rectocele can be repaired by levator plication or by repair of discrete fascial defects ***(Kahn and Stanton,1997).*** When surgery for prolapse has been done before, a mesh may placed in the posterior vaginal wall for additional support ***(Fox and Stanton,2000).*** Recently there has been a renewed interest in the repair of isolated defects in the fascia ***(Kenton et al.,1999).***

All types of prolapse can be treated by laparosopic surgery. Anterior or posterior lower vaginal repairs if needed can also be done vaginally before or after laparoscopic surgery ***(Panda, 2002)***