



# The Prolapse Self-Exam

Christine Ann Kent, RN  
Whole Woman Inc.

As useful and necessary as routine gynecologic care most certainly is, it is also important for women to “acquaint themselves with the constitution of their own bodies”.<sup>1</sup> This is particularly true for women with prolapse because ironically, even as we are dependent upon professional diagnoses to tell us exactly what has prolapsed where, no one is better equipped with the sensory apparatus necessary to gain a clear understanding of the problem than ourselves.

In fact, it is quite difficult for a practitioner to accurately assess pelvic organ prolapse, regardless of the position of the patient. Even while bearing down in the lithotomy position the pelvic architecture is nowhere near the configuration of standing posture and therefore does not reflect the true anatomy of the condition. Furthermore, as the well-known urogynecologist, Linda Brubaker, explains, examining an upright patient offers little benefit over dorsal lithotomy:

“The standing position offers the advantage of assessing pelvic organ support with greater stress. Practically, however, it is difficult to identify individual sites in the vagina with the patient erect.”<sup>2</sup>

Given these realities, it is no wonder so many women are confused by the variable diagnoses they receive from second, third, and fourth opinions. A recent editorial highlights the astonishing fact that pelvic organ prolapse continues to lack a clinically relevant definition:

“Despite this, researchers in the field of urogynecology...continue to report on surgical cure rates and epidemiologic risk factors for pelvic organ prolapse despite having no clear cut uniformly recognized definition for the disease.”<sup>3</sup>

No doubt the field of reconstructive pelvic surgery has generated a tremendous amount of confusion surrounding prolapse.

“About 10-15 years ago it was common knowledge that pelvic organ prolapse was associated with symptoms of urinary and fecal incontinence, splinting to either defecate or void, and pelvic pain and pressure that were worse with standing. Subsequent research has shown that only the presence of a vaginal bulge and the sense of pressure are consistently associated

with worsening pelvic organ prolapse.”<sup>4</sup>

The authors of the textbook *Office Urogynecology* offer their perspective on defining prolapse:

“Keep in mind that pelvic support is a continuum from perfectly supported to maximally prolapsed. There is not an arbitrary point where experts agree that support is ‘abnormal’, especially in the vaginally parous woman (a woman who has birthed vaginally)”.<sup>5</sup>

Because no reasonable, agreed-upon description of prolapse exists anywhere in the medical literature, I propose the following Whole Woman™ definition:

**“Pelvic organ prolapse in the human female is a subjective disorder described as an annoying protrusion at or near the vaginal opening, which may or may not be accompanied by perineal pressure that is aggravated by standing and relieved by lying down.”**

- Additional symptoms may also be associated with prolapse such as urine retention and alterations in bowel function.
- Stress urinary incontinence is a relatively uncommon finding in women with advanced cystocele.<sup>6</sup>
- Rectocele is not a cause of constipation, but rather is aggravated by constipation.<sup>7</sup>
- Although some women manifest “dramatic” perineal descent during straining, quantifying such movement is thought to be “not necessary for clinical care”, while appropriate medical treatment remains “uncertain”.<sup>8</sup>
- Significant pelvic organ prolapse is often completely asymptomatic.

Two important conclusions can be drawn from over a century of gynecologic study and surgical experimentation of prolapse:

- Pelvic organ prolapse is not a gynecologic problem;
- These conditions are not generally improved by gynecologic treatment.

Although we must continue to seek help, support, and professional diagnoses from our trusted doctors, only we can do the work of stabilizing and reversing these common conditions. A logical first step to self-care of prolapse is the vaginal self-examination:

1. After a bath or shower and while standing with your feet shoulder width apart, bend your knees slightly and tuck your tailbone under to best access your vagina.
2. In this position your pelvic organs are more mobile than while standing with your lumbar curve in place.
3. Insert the first two fingers of your dominant hand into your vagina.
4. Feel your front vaginal wall. A cystocele will feel like a smooth and squishy bulge at the front of your vagina. This is only a protrusion of the vaginal wall; therefore you will be able to feel from one side of the bulge to the other, not all the way

around the bulge to where the actual bladder exists.

5. Gently bear down and feel for any descent of the bladder. A stage II cystocele (Fig. 1) will come down to the vaginal opening. Varying degrees of vaginal wall thickness will determine how well you will be able to feel the bladder itself, which is soft and spongy.
6. While gently bearing down, move your fingers to the top, or apex, of your vagina. Your cervix will feel like a firm, mobile bulb with an indentation in the middle.
7. A stage II prolapse of the cervix/uterus (Fig.2)\* will extend to the vaginal opening. You will be able to move your fingers all the way around the cervical neck, which feels very strong and muscular.
8. If your cervix is low, feel how easily it is pushed all the way to the top of your vagina.
9. Feel your back vaginal wall. A stage I rectocele feels like a soft pillow in the back wall that extends forward with bearing down. A stage II rectocele (Fig. 3)<sup>9</sup> presents at the vaginal opening as a noticeable bulge.
10. If your cervix is low, conclude the exam by gently pushing it up toward the apex. Remove your fingers, bend forward at the waist and strongly contract the muscles of your pelvic outlet.
11. See your doctor. Give him or her a mighty hug and rejoice in the truth that pelvic organ prolapse is not a disease.



Figure 1



Figure 2

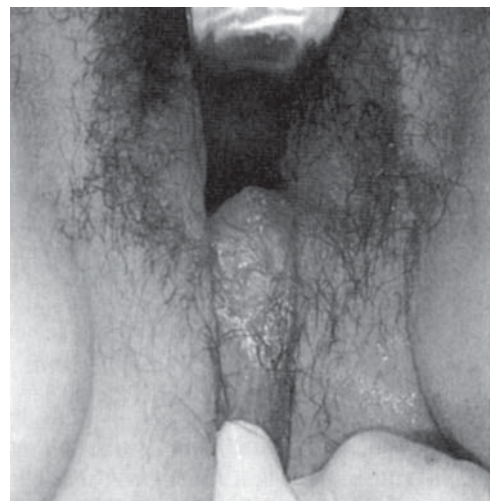


Figure 3

---

\* This photograph may represent an early stage of post-hysterectomy prolapse of the vaginal vault rather than uterine prolapse. The positioning at the vaginal opening would likely be the same for both conditions.

## REFERENCES

---

1. Stevenson, Sarah Hackett M.D. *The Physiology of Woman – Embracing Girlhood, Maternity and Mature Age*. Fairbanks Palmer & Co. 1882 p.26-27.
2. Brubaker L Saclarides *The Female Pelvic Floor – Disorders of Function and Support* F.A. Davis Company 1996 p.44
3. Swift S Pelvic organ prolapse: is it time to define it? *International Urogynecology Journal* 16: 425-427 2005
4. Ibid
5. Weber A Brubaker L Schaffer J Togliola M *Office Urogynecology* McGraw-Hill 2004 p.512
6. Rock JA Thompson JD TeLinde's *Operative Gynecology* Lippincott Williams & Wilkins 1997 p.960
7. Ibid
8. Weber et al 2004 p. 259
9. Photographs: Ibid p. 213-215