1. Although the pelvic organ prolapse quantification (POP-Q) assessment offers a standardized way to quantify the degree and compartment(s) of pelvic organ prolapse, many clinicians rely on clinical determinations of prolapse which are much more subjective. If the goal of treatment of prolapse is the patient’s subjective perception of symptoms, which can be assessed clinically using one of the questionnaires you cite in your article, is there any clinical advantage to doing a POP-Q exam in our nonsurgical patients?

Response from Dr. Culligan:
Short answer—yes. There is an advantage to performing the POP-Q exam for nonsurgical patients, because doing so can give you the best chance of picking up on subtle worsening (or improvements) of the patients’ defects. No other objective assessment method can provide that kind of information as precisely as the POP-Q can. Nonsurgical patients are usually quite interested in their current measurements as compared to their previous measurements.

2. Symptomatic pelvic organ prolapse is associated with obesity, with the degree of symptoms correlating with increasing body mass index (BMI). Furthermore, weight loss is associated with a decrease in symptoms related to POP, at least in the morbidly obese patient. Additionally, weight loss is associated with a decrease in surgical complications. Can you comment on the value of weight loss in the nonsurgical management of prolapse?

Response from Dr. Culligan:

In an ideal world, we would all prefer to operate on patients with non-obese BMI values for all of the reasons you mentioned. However, it may not be fair to expect obese patients with symptomatic prolapse to lose significant amounts of weight—simply because symptomatic prolapse tends to make exercise so much more difficult.

3. Many pessaries work well with apical and anterior compartment prolapse. Management of posterior compartment prolapse with a pessary can be significantly more challenging. Which pessary, or pessaries, is best suited for management of posterior compartment prolapse?

Response from Dr. Culligan:

I agree that treatment of posterior prolapse with a pessary can be quite a challenge – especially when the patient’s treatment goals include improved defecation. However, I still recommend starting with the “ring with support.”

4. You list “vaginal childbirth” as a risk factor for future pelvic organ prolapse. Do you have an opinion on the role of cesarean delivery for the purpose of decreasing the incidence of pelvic organ prolapse?

Response from Dr. Culligan:

In my opinion, a woman should have a right to choose an elective cesarean to protect her pelvic floor as long as she understands the risks and benefits of making that choice. Certainly the strength of the arguments in favor of elective cesarean diminish when considering 3 or more pregnancies for a given patient. The real problem has to do with patient education. I would like to see the American College of Obstetricians and Gynecologists develop a balanced patient education module on the subject so practicing obstetricians could avoid the “time sink” that happens if or when they try to do that education on their own.
5. In patients who develop “unmasked” occult stress incontinence with a particular pessary, is there a role for attempting a different shape of pessary prior to considering the trial of nonsurgical management a failure? What is your experience with one of the “incontinence” pessaries in these cases?

Response from Dr. Culligan:
In my experience, the “incontinence dish” and other pessaries can be an alternative for management of stress incontinence, but they don’t usually work to correct that problem in the face of significant prolapse. Maybe one of our readers will come up with a great new pessary idea for these patients, but right now I don’t think it exists.

6. Vaginal discharge and the development of either ulcerations or granulation tissue is a common problem with long-term pessary use. Although a “pessary holiday” is a management option, patients may be quite distressed by the return of their prolapse symptoms. Can you comment on the use of either vaginal estrogen or vaginal gels (such as Trimo-San or AminoCerv) on a routine basis, with the pessary in place, to minimize the discharge or undesired epithelial changes?

Response from Dr. Culligan:
I usually reserve these products for treatment rather than prevention. I don’t put every pessary patient on a vaginal cream or gel. When I notice worsening discharge or granulation tissue I will try to treat the problem with the products you mentioned—usually starting with estrogen cream. However, patient compliance tends to be a problem whenever you ask them to use a vaginal cream or a gel on a regular basis. One other useful estrogen product is the estrogen ring. I will often place the ring along with the pessary in an effort to mitigate these problems.
7. In the paper by Braekken, it appears the greatest benefit was to patients with Stage II prolapse, with much smaller degrees of improvement with Stage I and Stage III prolapse. This seems logical in the sense that patients with Stage I prolapse probably tend to have stronger muscles at baseline, and Stage III prolapse may be “too far gone” to show clinically significant improvement in strength. Considering there is cost to pelvic floor muscle training (both financial and patient time), would you recommend restricting referrals for pelvic floor muscle training to patients with Stage II prolapse or offer it to all patients?

Response from Dr. Culligan:
That’s a good point, and I can’t really argue with your logic. However, patients with Stage III prolapse who do pelvic floor muscle training may benefit even if they don’t reverse their prolapse. Simply getting more strength may make their surgery more successful—but we really don’t know.

8. Frequent visits to a specialist present a significant barrier to care for many patients. Does PFMT require specialized equipment to achieve maximum benefit, or can the principles be applied to general office practice?

Response from Dr. Culligan:
The most important factor is the dedication and knowledge of the individual doing the training. Much can be accomplished without special equipment of any kind.

9. There is increasing emphasis on “value based” medicine. In the Braekken study there is only a net of 10–11% of patients who achieved objective benefit (19% treated vs. 8% controls). Pelvic floor muscle training is very costly. The objective benefits of pelvic floor muscle training are limited to a small number of patients and are generally temporary. Most therapeutic options in medicine with similar cost/benefit ratios are eventually abandoned. Since most patients eventually end up as therapeutic failures, doesn’t it make sense to abandon pelvic floor muscle training and offer treatments which are proven to be more effective?
Response from Dr. Culligan:

I hope that we don’t reach a point where “value based” medicine trumps patient choice—especially when that choice is for a nonsurgical option. I think that rare dedicated patient who works hard and “fixes” her own prolapse through exercise (even if those results are temporary) deserves the right to make that choice.