AOGD BULLETIN

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WITH HER: HEAL, EMPOWER, RESPECT- EVERY STEP OF THE WAY

Theme:

The Evolving Landscape of Pelvic Organ Prolapse Management



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From the President's Desk



Dear Members and Colleagues,

It gives me immense pleasure to welcome you to the September 2026 issue of the AOGD Bulletin, dedicated to an important and evolving area of women's health—"**The Evolving Landscape of Pelvic Organ Prolapse Management**."

Pelvic organ prolapse is far more than an anatomical disorder. It can affect mobility, bladder and bowel function, sexual health, self-esteem, social participation and, ultimately, the quality of life of women. With increasing longevity and a growing emphasis on healthy ageing, the need to address pelvic floor disorders comprehensively has never been greater.

The management of prolapse has also undergone a remarkable transformation. Our approach is progressively moving away from a one-size-fits-all surgical paradigm towards **individualised, evidence-based and patient-centred care**. Conservative measures, pelvic floor rehabilitation, pessary use, native tissue repairs, uterine-preserving procedures and appropriately selected reconstructive surgeries now form an integrated spectrum of care.

This issue of the AOGD Bulletin brings together diverse perspectives on these developments—from the evolving role of three-dimensional pelvic anatomy and contemporary pessary practice to prevention in young women, native tissue versus mesh-augmented procedures, and pregnancy following uterus-preserving prolapse surgery. The inclusion of a patient information section and a clinical case vignette further reinforces an important principle: **good clinical care must combine scientific evidence with effective communication and shared decision-making**.

As obstetricians and gynaecologists, we are uniquely placed to recognise pelvic floor disorders early, counsel women appropriately and ensure timely referral when specialised urogynecological expertise is required. Prevention, early recognition and appropriate treatment should therefore become an integral part of women's healthcare across the life course.

I congratulate the editorial team and all the contributors for bringing together this timely and clinically relevant issue. I hope that this bulletin stimulates reflection, discussion and continued learning among our members.

Let us continue to advance towards pelvic floor care that is evidence-based, compassionate, individualised and centred on what matters most to every woman—her health, dignity and quality of life.

With warm regards,

Dr Neena Malhotra

Professor and Head, Department of Obstetrics and Gynaecology

AIIMS New Delhi

From the Secretarial Desk



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Joint Secretary

Dear Members,

It is my pleasure to present the September 2026 issue of the AOGD Bulletin, which focuses on "**The Evolving Landscape of Pelvic Organ Prolapse Management.**"

Pelvic organ prolapse remains a common and often under-recognised condition encountered across the spectrum of women's healthcare. Although it is frequently perceived primarily as a surgical problem, contemporary management emphasises a much broader approach encompassing prevention, lifestyle modification, pelvic floor rehabilitation, pessary use, appropriate surgical intervention and long-term follow-up.

The theme of this issue is particularly relevant because the expectations of our patients are changing alongside advances in medical science. Women today increasingly seek treatment that not only corrects anatomical prolapse but also preserves function, addresses urinary and bowel symptoms, considers sexual health and, where appropriate, preserves reproductive potential.

The articles included in this bulletin provide a valuable overview of several important aspects of modern prolapse care. The discussion on **three-dimensional pelvic anatomy** highlights the importance of understanding pelvic support beyond traditional compartment-based concepts. The review of the **current role of pessaries** reminds us of the continuing importance of effective non-surgical management. The comparison of **native tissue repair and mesh-augmented procedures** addresses a subject that continues to generate considerable clinical discussion.

Equally important are the perspectives on **prevention and management of prolapse in young women**, pregnancy following uterus-preserving prolapse surgery, and the practical patient information section. Together, these contributions remind us that urogynecology extends well beyond the operating theatre.

I congratulate the editorial team and the authors for their valuable contributions to this issue and thank our members for their continued enthusiasm and participation in the academic activities of AOGD.

I hope this issue enriches your knowledge and contributes to better care for women with pelvic floor disorders.

With best wishes,

AOGD Secretariat

From the Editor's Desk


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Reframing Pelvic Organ Prolapse: From Anatomy to Individualised Care

Dear Readers,

Pelvic organ prolapse is one of the most visible manifestations of pelvic floor dysfunction, yet its impact often extends far beyond what can be appreciated on examination. Symptoms, functional impairment, body image, sexual wellbeing, reproductive aspirations and personal expectations may differ considerably between women with apparently similar anatomical findings.

This changing understanding forms the basis of our September 2026 issue, "**The Evolving Landscape of Pelvic Organ Prolapse Management**."

The traditional approach to prolapse management was predominantly anatomy-driven: identify the affected compartment, define the stage and select an appropriate surgical repair. Contemporary urogynecology has moved considerably beyond this framework. We now recognise pelvic support as a complex three-dimensional and dynamic system, and treatment increasingly needs to be tailored not merely to the prolapse stage but to the woman behind the diagnosis.

This issue explores several facets of this evolution. An understanding of **three-dimensional pelvic anatomy** provides the foundation for appreciating mechanisms of support and failure. At the same time, the continued role of **pessary treatment** reminds us that successful prolapse management does not necessarily require surgery. For women who require operative intervention, the debate surrounding **native tissue repair versus mesh-augmented procedures** illustrates the importance of balancing anatomical success, durability, complications, regulatory considerations and patient preferences.

Perhaps one of the most important shifts is the recognition that prolapse is not exclusively a disorder of later life. The sections addressing **young women, prevention and uterus-preserving surgery** highlight the need to consider reproductive goals, future pregnancy and long-term pelvic floor health when making treatment decisions.

The patient's voice must remain central to this evolution. Anatomical correction is only one component of success. A meaningful outcome is one in which the woman understands her condition, participates in choosing treatment and experiences improvement in the symptoms and functions that matter to her.

Through this issue, we hope to encourage clinicians to look beyond the prolapse stage and ask broader questions: What does this prolapse mean to this woman? What are her priorities? What treatment offers the best balance of benefit and risk for her circumstances? And how can we prevent recurrence while preserving function and quality of life?

I sincerely thank all the contributors and reviewers who have helped bring this issue together. I would like to extend my heartfelt gratitude to our guest editor, Rajesh Kumari and Richa Vatsa for her invaluable contribution to the issue. I hope these articles stimulate discussion, challenge established practices where appropriate and encourage us to continue evolving our approach to pelvic floor care.

Happy reading!

The Editorial Team

Evolving role of 3D Anatomy of Pelvis Relevant to Uterovaginal Prolapse

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INTRODUCTION

Pelvic Organ Prolapse (POP) refers to the downward displacement of the pelvic organs, which results in protrusion of the uterus and/or the different vaginal compartments and their surrounding organs, such as the bladder, the rectum, or the small/large bowel.[1]

Patient can present with 'a vaginal bulge', pelvic pressure or discomfort, discharge, splinting or digitation for urination or defecation, and low backache. There is a poor correlation between these symptoms and the severity and site. Signs include descent of one or more of the following: the anterior vaginal wall, posterior vaginal wall, uterus and cervix, vaginal apex, or the perineum. The Pelvic Organ Prolapse Quantification (POP-Q) system[2] provides an objective, standardized, and reproducible method for describing the site and extent of POP.

Although the definition and POP-Q classification provide a robust description of prolapse, they neither identify the underlying pattern of support failure nor directly guide selection of the most appropriate treatment due to many inherent limitations e.g. lack of width measurements.

CURRENT UNDERSTANDING OF PELVIC SUPPORT AND RECENT DEVELOPMENTS

The most accepted theory of pelvic support by De- Lancey[3] provides a framework of understanding levels of supports. Level I – Apical Suspension includes cardinal and uterosacral ligaments, suspending the upper vagina vertically from the lateral pelvic walls. Level II- Mid- Vaginal attachment that includes Pubocervical fascia and rectovaginal fascia, anchoring vagina to arcus tendineus fasciae pelvis and Level III support- including perineal body, perineal membrane and levator ani muscles.

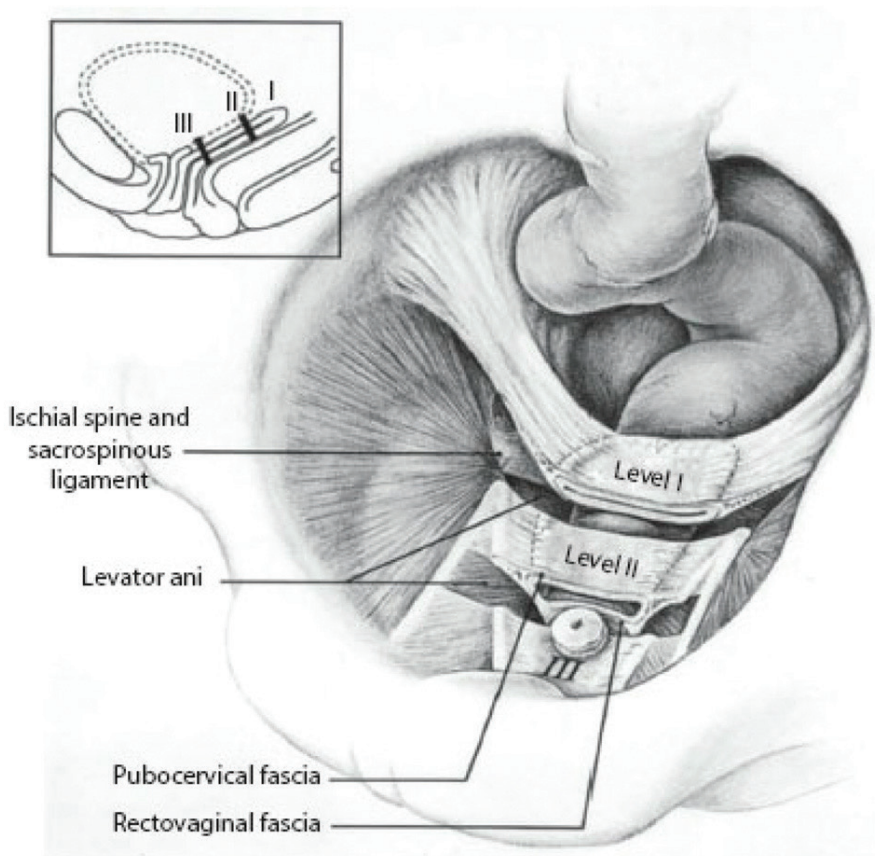


Figure 1: Level I (suspension) and level II (attachment). In level I, the paracolpium suspends the vagina from the lateral pelvic walls. Fibers of level I extend both vertically and posteriorly toward the sacrum. In level II, the vagina is attached to the arcus tendineus fasciae pelvis and superior fascia of levator ani. (Reproduced from DeLancey JOL, Am J Obstet Gynecol, 166, 1717, 1992)

Contemporary three-dimensional anatomy recognizes that anterior, apical, posterior, and hiatal defects. DeLancey's functional anatomy work[4] emphasizes that pelvic organ support depends on the interaction between levator ani muscles and connective tissues attaching the uterus and vagina to the pelvic sidewalls. When the levator hiatus opens, the vagina and uterus may become exposed to abnormal pressure differentials, creating traction on the cardinal and uterosacral ligaments. Therefore, Prolapse is not only a downward movement of the uterus; it is a spatial and dynamic failure of the pelvic support system.

One of the most important recent developments is the renewed focus on the urogenital hiatus. The urogenital hiatus is not merely a passive anatomical opening; it is increasingly understood as a dynamic closure system. The 2026 'Urogenital Hiatus Closure System'[5] framework explains how the levator ani muscle, neuromotor control, and Level III connective tissues of the perineal complex interact to maintain or fail to maintain hiatal closure. This model is important because it moves prolapse theory away from single-structure explanations. It proposes a redundancy or "multi-hit" principle: failure of one component may not enlarge the hiatus, but combined failures can exceed compensatory capacity and result in failure. The model also links Level III mechanics to Level I and II support by showing that an open hiatus increases forces on apical and paravaginal tissues, contributing to a feed-forward cycle of prolapse dilation and muscle elongation.

Adapted from DeLancey JOL, Ashton-Miller JA, LaCross J, Schmidt P, Masteling M, Pipitone F, et al. Urogenital Hiatus Closure System: a framework for understanding how muscle, motor control, and fascial connections interact in normal and failed closure. Int Urogynecol J. 2026;37:1491-1501 under CC BY 4.0

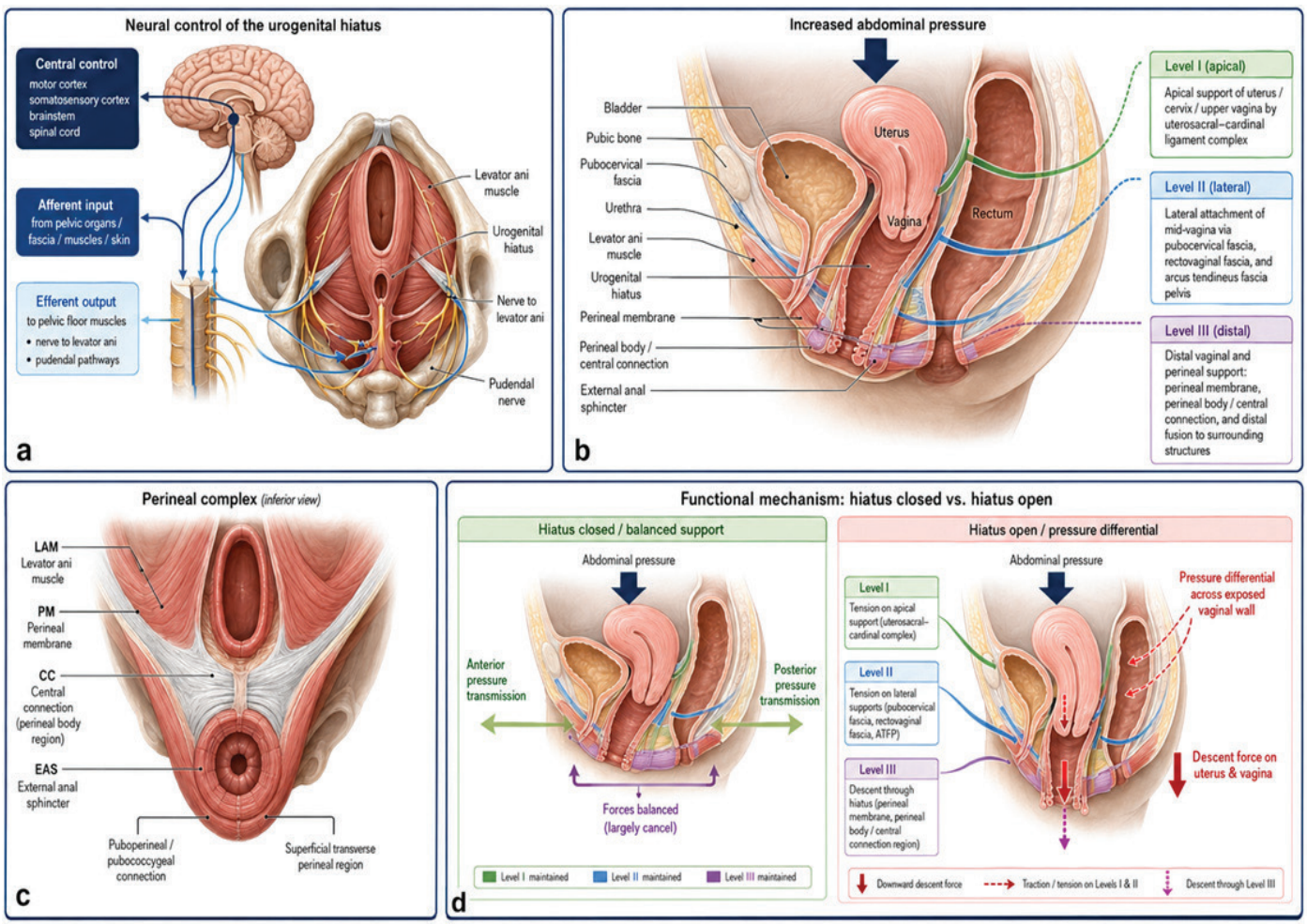


Fig. 2. The urogenital hiatus control system in pelvic support and uterovaginal prolapse. (a) Neural control includes afferent and efferent pathways linking pelvic floor structures with spinal and cortical centers. (b) Mid-sagittal support anatomy showing Delancey Levels I, II and III. (c) Perineal complex showing the levator ani muscle (LAM), perineal membrane (PM), central connection (CC), and external anal sphincter (EAS). (d) When the hiatus is closed, abdominal pressure is balanced; when the hiatus opens, a pressure differential across the exposed vaginal wall places Level I and II supports under tension and contributes to uterovaginal descent through the Level III region.

In practical terms, this means that a patient with uterovaginal prolapse may not be adequately understood by assessing the cervix and vaginal walls alone. Hiatal size, levator function, perineal complex integrity, and dynamic closure during strain are also relevant. This has implications for prognosis, recurrence risk, pelvic floor rehabilitation, surgical planning, and counselling.

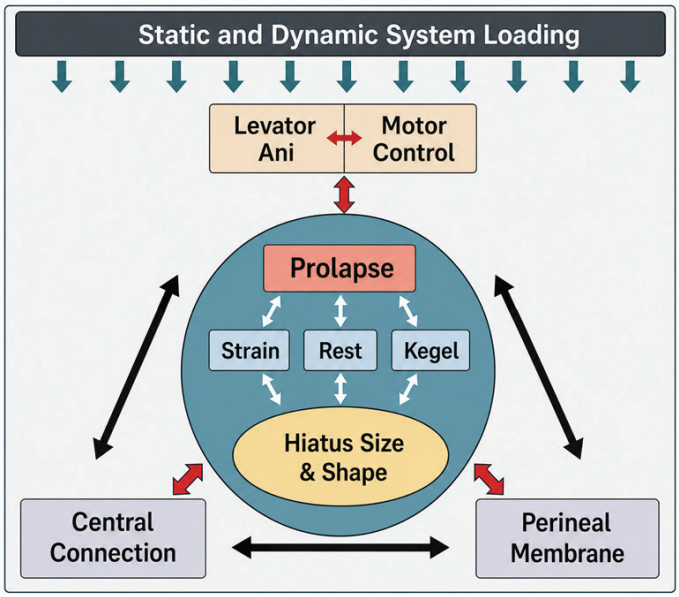


Fig. 3 Factors associated with hiatal function. Schematic diagram of interactions among structures that influence hiatal size and shape during system loading, including the effects of prolapse and muscle activation state (rest, strain, and Kegel).

Adapted from DeLancey JOL, Ashton-Miller JA, LaCross J, Schmidt P, Masteling M, Pipitone F, et al. Urogenital Hiatus Closure System: a framework for understanding how muscle, motor control, and fascial connections interact in normal and failed closure. Int Urogynecol J. 2026;37:1491-1501 under CC BY 4.0

ROLE OF IMAGING IN UTEROVAGINAL PROLAPSE AND RECENT EVIDENCE

Imaging is an adjunct to clinical examination and POP-Q, particularly when the anatomical defect is complex or preoperative delineation is required. Dynamic magnetic resonance imaging provides superior soft-tissue detail and simultaneously demonstrates uterine, vaginal, bladder, rectal, and pelvic floor movement at rest, during contraction, Valsalva, and evacuation. Pelvic organ descent is assessed relative to the pubococcygeal line, while the H-line and M-line quantify levator hiatal widening and pelvic floor descent. Translabial ultrasonography offers a less expensive, real-time alternative for assessing compartmental descent, bladder neck mobility, levator ani integrity, and hiatal dimensions during Valsalva. Thus, imaging extends POP-Q assessment by identifying the structural and functional pattern underlying the clinically observed prolapse.

In the domain of Clinical research High-resolution MRI and 3D reconstruction is being used to study the normal, abnormal anatomy and recently used to measure support structures quantitatively. DeLancey[5] demonstrated that anterior vaginal wall descent results from interaction between levator ani impairment and loss of apical support from the cardinal–uterosacral ligament complex, with combined impairment producing more severe prolapse than either defect alone. Bai et al.[6] studied 3D MRI-derived biomarkers of the cardinal ligament and uterosacral ligament for pelvic organ prolapse risk and severity.

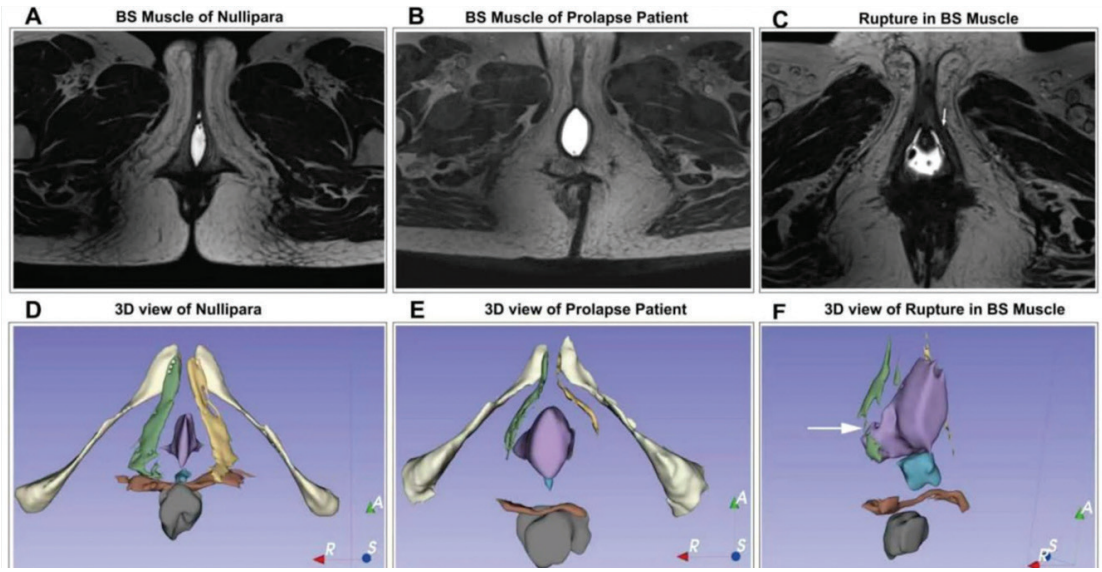


Fig 4. Representative MRI and 3D reconstruction of the bulbocavernosus muscle in a pelvic organ prolapse (POP) patient and a nulliparous control. A The representative T2 axial image from the nulliparous group. B The representative T2 axial image from the POP group. C The representative T2 axial image from the POP group; the arrow indicates the bulbocavernosus muscle (BCM) rupture. D The axial plane of 3D reconstruction image of the superficial perineal musculature from A. E The axial plane of the 3D reconstruction image of the superficial perineal musculature from B. F Side view of a 3D reconstruction in the POP group, with a white arrow indicating the site of the BCM rupture.

(Reproduced from Liu Y, Zhou Y, Zhang M, Geng J, Tan C, Yang X. A comparative MRI study of superficial perineal musculature in women with pelvic organ prolapse, and in parous and nulliparous controls. Int Urogynecol J. 2026;37:1689-1697.)

MRI-based 3D studies have further defined the different orientation and load-sharing roles of the cardinal and uterosacral ligaments, while finite-element models permit controlled simulation of muscular, ligamentous, and pressure-related defects.[7,8]

Three-dimensional imaging may help distinguish between patients whose prolapse is driven predominantly by cardinal ligament attenuation, levator injury, hiatal enlargement, perineal complex defects, or combined failure patterns.[9,10]

CLINICAL AND SURGICAL RELEVANCE

To safely perform procedure in a female pelvic floor, it is imperative that surgeon has a good three-dimensional understanding of anatomy of the region. This includes a full appreciation of various where important blood vessels and nerves travel, and relationship between various structure used to support the viscera. The practical value of 3D anatomy is that it encourages defect-specific thinking. A surgeon treating uterovaginal prolapse must restore apical support while respecting the spatial relationships of the ureter, bladder, rectum, sacrospinous ligament, uterosacral ligament, cardinal ligament complex, vaginal axis and pelvic sidewall. A purely compartment-based approach may miss the interaction between apical descent, anterior wall descent, hiatal enlargement and perineal failure.

This has implications for procedure selection and counselling. Uterosacral ligament suspension, sacrospinous fixation, sacrocolpopexy and hysteropexy are not merely alternative routes to lift the apex; they alter load distribution across the pelvic support system. If a patient has severe levator injury or persistent hiatal enlargement, recurrence risk may remain higher even after technically sound apical repair. Three-dimensional assessment may therefore help classify patients according to dominant failure patterns: apical ligament attenuation, hiatal ballooning, levator injury, paravaginal failure, perineal complex damage or combined defects.

EDUCATION AND PATIENT-SPECIFIC CARE

Three-dimensional anatomy is also becoming teachable. The POP-Q system is standardized, but its 3D nature can be difficult for learners. The interactive pelvic organ prolapse model was developed to improve understanding of POP-Q and to demonstrate procedures such as sacrocolpopexy, uterosacral ligament suspension and sacrospinous ligament fixation. Training with such models has been shown to improve learner confidence and POP-Q performance.[11]

The same principle is now entering conservative care. Patient-specific pessaries fabricated using 3D-printed molds represent a clinical translation of individualized pelvic geometry. In a pilot study.[12] pessaries were designed using patient input, physician input and anatomical measurements, and were associated with improved prolapse distress and satisfaction over a short home trial. This does not prove prolapse pathophysiology, but it shows the direction of travel: from standard shapes and trial-and-error fitting toward personalized pelvic floor devices guided by anatomy and patient priorities.

KEY POINTS

- Advanced imaging, 3D reconstruction, modeling and 3D printing now allow clinicians to develop an expert mental model to be visualized, measured, tested, taught and formalizes clinical judgement.
- Current evidence supports a shift from seeing prolapse as simple uterine descent toward seeing it as dynamic failure of an integrated pelvic support system.
- Future prolapse care is likely to combine clinical examination with imaging biomarkers, biomechanical modeling, structured teaching tools and patient-specific conservative or surgical solutions.

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Calendar for AOGD Monthly Clinical Meeting 2026-2027

25th September 2026	VMMC &Safdarjung Hospital
30th October 2026	DDU Hospital
27th November 2026	MAMC & LNJP Hospital
18th December 2026	Sir Ganga Ram Hospital
29th January 2027	Dr RML Hospital
26th February 2027	UCMS & GTB Hospital
19th March 2027	LHMC & SSK Hospital
30th April 2027	ESI, Basaidarapur Hospital

Re-establishing the role of pessary in management of prolapse

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BACKGROUND

Pelvic organ prolapse (POP) is one of the commonest pelvic floor disorders in females, with rising prevalence due to ageing populations, longer life expectancy, obesity, and greater awareness of pelvic floor dysfunction; overall prevalence approaches 30%, with around half of females over 50 affected.

POP is defined as **descent of one or more of the anterior, posterior, or apical vaginal compartments to or beyond the hymen on maximal Valsalva, with bothersome symptoms such as vaginal bulge, or functional compromise.**

Instead of treating conservative and surgical therapy as competing pathways, current practice favours individualized, shared decision making, tailored to symptom severity, prolapse stage, comorbidity, fertility plans, sexual activity, and preference of the patient.

RECENT UPDATE

The vaginal pessary has regained prominence in current management of prolapse. The updated UK Clinical Guideline for the Best Practice in the Use of Vaginal Pessaries, developed jointly by the British Society of Urogynaecology **(BSUG)**, the United Kingdom Continence Society, and the Pelvic Obstetric and Gynaecological Physiotherapy group, with endorsement from **IUGA** (International Urogynaecological Associattion), clearly recommends that all females with symptomatic pelvic organ prolapse (POP) who wish to avoid or delay surgery should be offered pessary treatment, unless there are specific contraindications.[1] This recommendation is also supported by the 2025 IUGA Consultation on pessary management.[2] and the **AUGS–SUNA** (American Urogynaecologic Society and Society of Urologic Nurses and Associates) clinical consensus statement.[3]

Pessaries are not only meant for older females or those who are unable to undergo surgery. They are also a suitable option for younger females who wish to preserve fertility, females waiting for reconstructive surgery, those with recurrent prolapse, and females who prefer a non-surgical approach.

PATIENT SELECTION

Successful pessary management starts with careful patient selection. The updated UK guideline 2026 recommends that all females who are not undergoing surgery immediately for prolapse repair should be offered pessary unless they have any of the following contraindications.[1]

Contraindications to pessary use include

- Active pelvic infection
- Unexplained vaginal bleeding
- Genital tract malignancy
- Non-biological mesh erosion
- Vaginal stenosis or atrophy severe enough to preclude fitting
- Cognitive ability, manual dexterity, and willingness to attend follow-up or self-manage are also factors to consider.[1] Where atrophy is present, a course of topical vaginal estrogen before fitting is advised to improve tissue quality and comfort.[1,3]

PESSARY CHOICE

One single device is not fit for all.

- Ring pessaries, with or without support, remain first-line because they are simple to fit, are self-removable, and allow intercourse.[1]
- For females with more advanced or recurrent prolapse, or those with a wide genital hiatus, space-occupying pessaries such as the Gellhorn, cube, or donut provide better support but generally require clinician-led insertion and follow-up.[1] Advanced prolapse should not discourage a trial of pessary therapy. Zhou et al. reported an overall successful fitting rate of 82.8% in females with stage IV pelvic organ prolapse.
- A higher number of vaginal deliveries, prior hysterectomy, and a vaginal introitus-to-total-vaginal-length ratio above 0.6 were found to be independent predictors of fitting failure, favouring an early switch to a space-occupying pessaries like Gellhorn in these females.[4]

FITTING PRINCIPLES

Successful pessary fitting also depends on correct technique.

- The largest pessary that is comfortable for the patient should be selected.
- After insertion, the female should be asked to cough, perform a Valsalva manoeuvre, walk, and empty her bladder to ensure that the pessary remains in place, is comfortable, and does not interfere with voiding before she leaves the clinic.[1,4]

- If the initial pessary is unsuccessful, adjusting the size or changing to a different type is recommended rather than discontinuing the pessary.

FOLLOW-UP, SELF-MANAGEMENT AND PREVENTION OF COMPLICATIONS

The updated UK guideline moves away from a single fixed review interval, instead recommending an individualised follow-up schedule based on pessary type, self-management ability, vaginal health, and complication history.[1] As a technical minimum, good practice dictates that the follow-up interval should not exceed **six months** for females receiving clinic-based care, while competent, complication-free self-managing females can be safely stepped down to annual review.[1]

Every female should receive structured verbal and written information on pessary care, expected symptoms, warning signs, and how to seek help between visits.[1] A central recommendation of the 2025/26 update is the expanded promotion of **self-management**.[1] Motivated, physically able females should be taught insertion, removal, cleaning, and reinsertion, with competency formally assessed before independent use, following the guideline's structured training and competency framework for clinicians and patients alike.[1] Teaching females to manage their own pessary, when appropriate, improves confidence and independence, reduces the need for hospital visits, and is associated with better long-term continuation of pessary use.

The role of pessary self-management has been strengthened by evidence from the **TOPSY trial** 2020, a large UK multicentric randomized controlled trial involving 340 females. The study demonstrated that females who were trained to self-manage their pessaries had quality of life outcomes that were non-inferior to those receiving clinic-based follow-up, while reducing healthcare utilisation and being cost-effective.

Most of the complications are minor and managed conservatively. These include

- Increased vaginal discharge
- Mild bleeding
- Superficial vaginal erosions
- Constipation, urinary symptoms and temporary discomfort during pessary changes.

Management involves

- Reassurance
- Treatment of any infection
- Temporary pessary removal
- Resizing: changing to a different pessary type.

In postmenopausal females with vaginal atrophy, topical vaginal estrogen is recommended to improve tissue health.[1,3] Persistent vaginal ulceration should be biopsied to exclude malignancy, and unexplained vaginal bleeding should be investigated according to appropriate cancer referral pathways.[1]

Serious complications, such as an embedded pessary, fistula formation, or sepsis, are rare and usually associated with neglected pessaries or prolonged loss to follow-up.[1,3]

CLINICAL EFFECTIVENESS AND COMPARISON WITH SURGERY

Vaginal pessaries are an effective treatment for symptom relief of pelvic organ prolapse, including the sensation of a vaginal bulge, pelvic pressure, and bladder or bowel dysfunction. Overall, successful pessary fitting is achieved in **70–90%** of females, and high patient satisfaction has been reported even among females with stage IV prolapse.[1]

Although many females continue pessary use successfully in the long term, some eventually choose surgery because of persistent symptoms, difficulties with pessary use, or personal preference rather than because the treatment has failed. Surgery generally provides better anatomical correction and symptom relief for females with more advanced prolapse, but pessaries give meaningful symptom relief without the risks of anesthesia/surgery or a long recovery.[2,3]

Ultimately, treatment success should be judged by improvement in symptoms, daily functioning, and quality of life, rather than by anatomical correction alone.[1,2]

FUTURE DIRECTIONS

Pessary care is evolving in line with the trend towards personalised prolapse management. Updated guidelines emphasise standardised clinician training, patient education, and regular audits to ensure safe and effective care. Emerging advances like 3D-printed pessaries, biomaterials, digital follow-up platforms, and self-management programs aim to enhance comfort, safety, and long-term use. With appropriate patient selection, individualised fitting, follow-up, and shared decision-making, pessaries remain an essential and effective method of modern urogynecological practice.

TAKE-HOME MESSAGES

1. Pessaries should be offered as first line management before any surgery to all suitable females with symptomatic prolapse without contraindications (as per BSUG, AUGS, IUGA).
2. Success depends on choosing the right patient, the correct device, and fitting it properly. There is a gap in training of gynecologic residents in prolapse fitting techniques and it should be urgently addressed.
3. Pessary follow-up should be individualized, with clinic

reviews at least every 6 months and longer intervals (up to yearly) for females who successfully self-manage.

4. Self-management should be taught and encouraged.
5. Advanced prolapse does not preclude pessary treatment; even in stage IV prolapse, successful fitting is achieved in over 80% of women with Gellhorn pessary appearing to be more successful than ring pessary in some cases.[4]

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Native Tissue Repair versus Mesh-Augmented Procedures in Pelvic organ prolapse: Where Do We Stand in 2026?

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INTRODUCTION

Pelvic organ prolapse (POP) is herniation of pelvic organs through urogenital diaphragm outside vagina. It is common condition among women with an estimated lifetime risk of 20-30% and impacts quality of life due to pelvic discomfort, voiding, defecatory and sexual dysfunction.[1] Bulge symptoms become more severe in grade III and IV prolapse, which occurs in approximately 2% of cases and requires surgical management.[2]

Surgical management aims to reinforce the weakened pelvic compartment, with or without hysterectomy. It can be performed either as native-tissue repair (NTR), with patient's own fascia and ligaments for support, or as graft-augmented repair using synthetic or biological materials for mechanical support.

NATIVE TISSUE REPAIR

It relies on restoring support using patient's own fascial layers and ligaments. Surgeries commonly done for POP as native tissue repair are-

- Anterior colporrhaphy (plication and attenuation of the pubocervical fascia) for anterior compartment prolapse.
- Posterior colpoperineorrhaphy (plication and midline re-approximation of the rectovaginal fascia and levator ani muscles) for posterior compartment prolapse.
- Apical support procedures:
  - Transvaginal McCall Culdoplasty: Plicating uterosacral ligament medially to obliterate the cul-de-sac.
  - Uterosacral Ligament Suspension: Suspending vagina to the uterosacral ligaments.
  - Sacrospinous Ligament Fixation: Attaching the vaginal vault or cervix to the sacrospinous ligament.
  - Iliococcygeus Fixation: Attaching the vaginal vault to the fascia overlying the iliococcygeus muscle.
  - Uterine-Preserving Sling Surgeries: Native tissue procedures such as Purandare cervicopexy.

MESH IN PROLAPSE SURGERY

Surgical mesh is a prosthetic material implanted to provide additional mechanical support to weakened pelvic tissues. They can be synthetic absorbable (polyglycolic acid), and synthetic non-absorbable (polypropylene, polyester, Currently recommended synthetic mesh for pelvic surgeries is type 1 monofilament and macroporous (pore size>75µm) polypropylene mesh. It facilitates better macrophage infiltration, neovascularization, and tissue integration, thereby reducing bacterial persistence and foreign-body reaction.[2,3]

Pelvic organ prolapse was managed primarily through native-tissue repair; however, in 1990s, gynaecologists began using mesh for transvaginal POP repair after successful outcome of mesh in abdominal hernia surgery. The U.S. Food and Drug Administration (FDA) cleared mesh for use in POP surgery in 2002.[4] With widespread use of mesh in pelvic surgeries, some serious complications like mesh exposure, pelvic pain, dyspareunia, infection, urinary and bowel injury, need for reoperation were reported. So, FDA reclassified use of mesh in POP surgery from Class II (moderate risk) to Class III (high risk), and recommended its use after weighing risks, benefits, and available alternatives. Concerns about transvaginal mesh complications have echoed internationally, prompting major professional societies to issue cautionary recommendations on mesh use. These developments have prompted a renaissance of native-tissue repair techniques.[4]

Currently surgeries performed using mesh for POP are abdominal procedures-

- Sacral Colpopexy or Sacral Hysteropexy: Suspension of the vagina or cervix to the anterior longitudinal ligament over the sacral promontory (open, laparoscopic, or robotic).
- Pectopexy: Suspending the vaginal vault or cervix to Cooper's ligament.

CLINICAL EVIDENCE- NATIVE TISSUE REPAIR OR SURGICAL MESH FOR POP SURGERY

Primary prolapse repair-Transvaginal repair using NTR is preferred surgical management of primary anterior/ posterior compartment prolapse. The landmark PROSPECT trial (Glanzer et al) compared native tissue versus surgical mesh in anterior and posterior compartment prolapse repair. Following outcome was reported-

- 2-Year Outcome: Anatomical and functional outcome was comparable between NTR and mesh groups, demonstrating no distinct clinical advantage of mesh

in primary repair.[5]

- Complication Rates: Synthetic mesh was associated with 12% complication rate compared to <1% in the NTR group.
- 6-Year Follow-up: Long-term data confirmed that mesh augmentation offers no superior durability in primary repair for prolpase while unnecessarily exposing patients to long-term implant morbidity.[6]

Vaginal vault prolapse- Management options include transvaginal NTR (SSLF or iliococcygeus fixation) and abdominal sacral colpopexy (ASC) with synthetic mesh. Both SSF and iliococcygeus fixation have comparable success rates with few complications.

- Efficacy and outcome- Cochrane review (Maher et al.) demonstrated that ASC provides superior anatomical durability and lower recurrence rates (3.5% vs. 15.3%) and lower post-operative dyspareunia (15% vs. 49%) compared to SSF at 2-year follow-up.[7]
- Morbidity-ASC had higher risk of vascular and nerve injury, postoperative bowel obstruction, and mesh-related complications, along with longer operative times, slower postoperative recovery, and greater cost.[7]
- So, choice between abdominal mesh repair and vaginal native tissue repair for vault prolapse should be individualised, considering factors such as age, menopausal status, sexual function and surgeon's expertise.

UTERINE PRESERVATION SURGERIES

- Uterine preserving transvaginal native tissue repair surgeries are Manchester repair, uterosacral ligament colpopexy and sacrospinous hysteropexy. Abdominal sling procedures using native tissue for uterine preservation, such as Purandare cervicopexy, provides effective apical support while avoiding permanent mesh-related complications, with reported short- to intermediate-term prolapse-free rates of approximately 90–100%.[8]
- Surgical mesh based uterine preserving surgery is abdominal sacral hysteropexy (ASH) using polypropylene mesh. Gomaa et al. (2022) compared ASH with vaginal sacrospinous hysteropexy using NTR in women with apical uterine prolapse. At 1-year follow-up, ASH demonstrated lower rate of recurrence compared with SSHP (5.4% vs. 20.0%) and was associated with significantly fewer re-surgeries (21.6% vs. 45.7%), suggesting superior anatomical outcome of mesh-augmented apical suspension. However, these benefits were accompanied by perioperative disadvantages like longer operative time, intraoperative blood loss, prolonged hospitalization and mesh exposure in 3.8% cases.[9]
- Pectopexy has emerged as an alternative mesh-based apical suspension technique. Early comparative studies and meta-analyses show comparable short-term anatomical and functional outcomes compared to sacral hysteropexy or sacral colpopexy, with reduced operative time, bowel-related complications and postoperative morbidity.[10]

RISK VERSUS BENEFIT OF NTR AND SURGICAL MESH

The choice between native-tissue repair and mesh-augmented surgery should be individualized according to the site and severity of prolapse, previous surgical history, patient characteristics like age, menopausal status, desire for sexual function, medical comorbidities, treatment preferences as well as surgeon's expertise.

- Native-tissue repair should be favoured for primary anterior or posterior vaginal wall prolapse and in women at lower surgical risk, who prefer to avoid permanent implant or have concerns regarding mesh-related complications.
- Abdominal mesh surgery may be considered in women with advanced apical prolapse, recurrent prolapse, or previous failure of native-tissue repair.
- The potential benefits of better anatomical durability obtained with mesh should be balanced against risks and complications after shared decision-making.

Aspects	NTR	Synthetic mesh
Indication	Primary anterior/ posterior/apical prolapse	Advanced apical prolapse, recurrent prolapse, previous failure of native-tissue repair
Advantage	• Good anatomical and functional outcome • Short operating time • Fast recovery • No mesh complication	• Superior long-term anatomical durability • Lower recurrence rate
Disadvantage	• Slightly higher recurrence • Dyspareunia in some cases	• Longer operating time • Mesh exposure/ erosion • Increased cost • Prolonged hospital stay

Mesh complications substantially impair women's physical, sexual, psychological health and overall quality of life. Managing mesh complications postoperatively negatively affects the physical as well as psychological health of the patient. To reduce mesh complication in pelvic surgeries, following points should be kept in mind.[11]

- Vaginal estrogen cream in postmenopausal women before and after surgery to improve vascularity and wound healing, reducing the risk of mesh erosion through vagina.
- Use lightweight, macroporous polypropylene mesh for

synthetic graft augmentation.

- Ensure that the mesh lies flat and avoid folding, bunching, or wrinkling to reduce tissue tension and mesh erosion.
- Avoid overzealous trimming of the vaginal mucosa and trim mesh appropriately.
- Consider abandoning mesh placement if excessive blood loss occurs or inadvertent injury to the urethra, bladder or bowel.

CURRENT RECOMMENDATION OF SURGICAL MESH FOR PROLAPSE SURGERIES

Society	Recommendation
ACOG/AUGS (2019)[12]	• Surgical mesh not recommended for transvaginal repair of anterior and posterior compartment prolapse. • Mesh procedures should be performed only by surgeons who have undergone structured training in mesh implantation and treatment of mesh-related complications.
NICE (2019)[13]	• NTR recommended for anterior and posterior vaginal wall prolapse. Transvaginal mesh repair can only be done in context of research. • When surgical mesh is used, details of surgery and its subsequent short and long-term outcomes must be updated in a national registry.
FDA (2021)[4]	• Surgical mesh is currently only indicated for abdominal surgeries for prolapse- open, laparoscopic or robotic sacral colpopexy or hysteropexy.
EUGA Position Statement (2023)[14]	• Vaginal NTR should be first-line approach for POP repair. • Transvaginal mesh can only be considered when other surgical procedures have already failed or are expected to fail. (age < 60, stage 3 or 4 prolapse, BMI > 26)

CONCLUSION

- N**ative tissue repair is the treatment of choice for anterior and posterior vaginal wall prolapse.**
- For vault prolapse, decision for SSF or ASC may be considered based on tissue factor, patient factors and surgeon expertise. Recurrent prolapse may warrant more durable reconstructive options with selective use of mesh.
- In uterine prolapse with uterine preservation, native-tissue hysteropexy, sling surgery or ASH should be individualized through shared decision-making depending on severity of prolapse, previous surgical history, patient desire for sexual and reproductive function, medical comorbidities, treatment preferences as well as surgeon's expertise.

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Prevention and Management of Utero-Vaginal Prolapse in Young Women

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INTRODUCTION

Utero-vaginal prolapse (UVP) is traditionally regarded as a disorder of later life, but it can occur in women of reproductive age and may have major physical, sexual, reproductive and psychological consequences.[1] Young women may present with vaginal bulging, pelvic pressure, urinary or bowel dysfunction, dyspareunia and restriction of physical activity. The problem is particularly challenging when the woman has not completed her family and wishes to preserve fertility and the uterus.

The management of UVP in young women should therefore follow a patient-centred, fertility-conscious and pelvic-floor-oriented approach, rather than automatically proceeding to hysterectomy.

AETIOLOGY AND RISK FACTORS IN YOUNG WOMEN

Pelvic organ support depends on the levator ani musculature, endopelvic fascia, uterosacral-cardinal ligament complex and their attachments to the pelvic sidewall. Prolapse develops when these supporting structures are stretched, damaged, weakened or inadequately functioning.

Important risk factors include:

- Pregnancy and vaginal childbirth
- Multiparity
- Prolonged or difficult labour
- Operative vaginal delivery
- Obstetric pelvic-floor trauma
- Macrosomic baby
- Chronic constipation and repeated straining
- Chronic cough
- Obesity
- Heavy lifting and physically demanding work
- Previous pelvic surgery
- Genetic or connective-tissue abnormalities
- Family predisposition to pelvic-floor dysfunction.

RCOG[2] recognises pregnancy and childbirth, overweight, persistent constipation, chronic coughing and heavy lifting as important contributors to pelvic organ prolapse. It also recognises that a natural predisposition may contribute, with several factors often acting together.

In a young nulliparous woman with significant prolapse, an unusually early presentation should prompt careful consideration of underlying pelvic-floor or connective-tissue weakness, previous pelvic surgery, neurological disorders and other uncommon causes.

PREVENTION

Prevention should begin before pregnancy and continue throughout reproductive life. Modern pelvic floor care increasingly emphasises education, identification of risk factors and early intervention rather than waiting until advanced prolapse develops.

1. **Pelvic-Floor Muscle Training**

   Pelvic-floor muscle training (PFMT) is central to prevention and conservative management.

   The objective is not simply to perform repeated contractions but to develop appropriate strength, endurance, coordination and relaxation of the pelvic-floor musculature. Ideally, women should receive instruction from a trained pelvic-floor physiotherapist.

   NICE[3] recommends supervised PFMT for at least four months in women with symptomatic prolapse that does not extend more than 1 cm beyond the hymen on straining. Women who benefit should continue the exercises subsequently. Evidence from the 2021 Cochrane review[4] indicates that PFMT improves prolapse symptoms and may improve prolapse stage. In pooled data, PFMT increased the chance of improvement in prolapse stage by approximately 17% compared with no intervention. However, evidence for prevention of prolapse in previously unaffected women remains limited.

   Thus, PFMT should be regarded as an important strategy for pelvic-floor health and management of early symptomatic prolapse, but it should not be presented as a guaranteed method of preventing future prolapse.

2. **Optimisation of Obstetric Care**

   Pregnancy and childbirth represent important periods of potential pelvic-floor injury.

   Preventive obstetric care should include:

   - Antenatal pelvic-floor education

- Identification of women at increased risk
- Appropriate management of prolonged labour
- Avoidance of unnecessary operative vaginal delivery
- Appropriate management of obstetric anal sphincter injuries
- Postpartum pelvic-floor assessment when clinically indicated.

This does not mean that caesarean section should routinely be performed to prevent prolapse. Caesarean delivery has its own maternal and neonatal risks and should be based on established obstetric indications.[5,2]

Following childbirth, women should be educated about pelvic-floor rehabilitation, particularly after difficult or instrumental vaginal delivery.

3. Prevention and Treatment of Constipation

Repeated straining increases intra-abdominal pressure and may place additional stress on pelvic support structures.

Preventive measures include:

- Adequate dietary fibre
- Appropriate fluid intake
- Regular physical activity
- Treatment of chronic constipation
- Avoidance of prolonged straining during defaecation.

NICE[3,6] specifically recommends preventing or treating constipation as part of lifestyle management for women with pelvic organ prolapse.

4. Weight Management

NICE[5] includes weight management among lifestyle interventions for pelvic organ prolapse.

Weight reduction should be viewed as part of long-term pelvic-floor health rather than simply as a preoperative intervention

5. Smoking Cessation and Treatment of Chronic Cough

Chronic coughing produces repetitive increases in intra-abdominal pressure. Smoking cessation and appropriate treatment of respiratory disease are therefore reasonable components of prolapse prevention. RCOG[2] specifically recommends stopping smoking and managing persistent cough as part of lifestyle measures for prolapse.

6. Occupational and Physical Activity Advice

NICE[6] states that there is insufficient evidence that unsupervised activities such as walking or swimming worsen pelvic-floor dysfunction. However, women with symptomatic prolapse may benefit from reducing repetitive heavy lifting or activities that clearly exacerbate their symptoms.

7. Nutrition

Nutrition may have an important supportive role in the prevention of uterovaginal prolapse in young women, although direct evidence linking specific nutrients to prolapse prevention remains limited. A balanced diet that maintains a healthy body weight may reduce excessive intra-abdominal pressure and mechanical stress on the pelvic floor, while adequate dietary fibre and fluid intake can prevent chronic constipation and repeated straining, an important modifiable risk factor for pelvic-floor dysfunction. As per RCOG[2] adequate intake of protein and micronutrients such as vitamin C, vitamin D, calcium, zinc and iron supports muscle, collagen and connective-tissue health, although supplementation beyond recommended dietary requirements has not been shown to specifically prevent prolapse.

Current NICE[3] guidelines recommend a healthy diet, adequate fibre and appropriate fluid intake as part of pelvic-floor health, while acknowledging that evidence for specific dietary interventions in preventing pelvic-floor dysfunction remains limited.

8. Caesarean for Prevention of Prolapse

Although caesarean delivery is generally associated with a lower risk of pelvic organ prolapse than vaginal delivery, the protective effect of caesarean delivery should not be considered absolute. With increasing numbers of pregnancies and caesarean deliveries, cumulative pregnancy-related changes to the pelvic floor may contribute to prolapse risk; therefore, a higher number of caesarean deliveries may potentially approach the risk associated with vaginal delivery in some women, although this association has not been definitively established.[7]

CLINICAL ASSESSMENT

A young woman presenting with suspected prolapse should undergo a detailed history and pelvic examination.

Important symptoms include:

- Vaginal bulging
- Feeling of something coming down
- Pelvic heaviness or dragging
- Backache
- Urinary frequency or urgency
- Stress urinary incontinence
- Difficulty emptying the bladder

- Recurrent urinary infection
- Constipation or incomplete bowel evacuation
- Dyspareunia
- Sexual dysfunction.

The impact of symptoms on quality of life should be documented because anatomical prolapse and symptomatic prolapse may not be synonymous.

NICE[3] recommends specialist examination assessing the anterior, central and posterior compartments using POP-Q, together with assessment of pelvic-floor muscle activity and vaginal tissues. Routine imaging is not necessary when prolapse is evident clinically. The POP-Q terminology and staging system are standardised in the IUGA/ICS joint report.[8]

A detailed history should include parity, mode of delivery, birth trauma, previous pelvic surgery, constipation, chronic cough, occupational lifting, urinary and bowel symptoms, sexual function and future reproductive plans.

Urinary symptoms should be specifically evaluated. A stress test after reduction of the prolapse may reveal occult stress urinary incontinence, which is important when planning surgery.

MANAGEMENT

1. Observation

Asymptomatic or minimally symptomatic prolapse does not necessarily require treatment.

A woman with mild prolapse can be managed with education, pelvic-floor training, lifestyle modification and follow-up.

RCOG[2] emphasises that prolapse is not life-threatening, and that mild prolapse may not require treatment.

2. Conservative Treatment

Pelvic-Floor Muscle Training

For symptomatic stage I and stage II prolapse, supervised PFMT is an appropriate first-line treatment.

NICE[3] recommends at least 16 weeks of supervised PFMT for symptomatic POP-Q stage I or II prolapse.

The Cochrane evidence[4] supports improvement in symptoms and some improvement in anatomical stage, although long-term evidence remains limited.

Vaginal Pessary

A vaginal pessary provides mechanical support to the prolapsed uterus and vaginal walls.

It is particularly useful for a young woman who:

- Desires future pregnancy
- Wishes to postpone surgery
- Does not want surgery
- Has medical contraindications to surgery
- Requires temporary support while awaiting definitive treatment.

Bohiltea et al.[1] specifically identify pessaries as useful in women planning pregnancy and as a temporary measure before surgery. However, the authors note that long-term use can be problematic in sexually active women because of discharge, ulceration and dyspareunia.

Modern evidence supports pessaries as an important non-surgical option, although the certainty of evidence comparing pessaries with other treatments remains limited.

NICE[3] recommends discussing potential discharge, bleeding, expulsion and difficulty removing the pessary, with regular removal and follow-up.

3. Surgical Management

Surgery should be considered when:

- Symptoms are significant
- Conservative treatment has failed or is unacceptable
- Prolapse is advanced
- Quality of life is substantially impaired.

NICE[3] recommends offering surgery when symptoms have not improved with, or the woman has declined, non-surgical treatment. Decision-making should incorporate age, desire for future childbearing, site of prolapse, previous surgery, lifestyle and the risks and benefits of individual procedures.

In young women, uterine preservation should be actively discussed.[1,9]

UTERINE-PRESERVING SURGERY

Historically, vaginal hysterectomy was commonly performed for uterine prolapse. However, removal of the uterus is not essential for correction of the underlying pelvic-support defect.

Sacrohysteropexy

Abdominal or laparoscopic sacrohysteropexy is one of the principal uterus-preserving procedures.

The procedure suspends the uterus/cervix to the sacral promontory, usually using mesh in an abdominal or laparoscopic approach.[10,11]

In the prospective series by Schroder et al.[10], 90 women with ≥ grade II uterovaginal prolapse underwent abdominal sacrohysteropexy. Mesh-assisted sacropexy was associated with high apical success rates and favourable patient-

reported outcomes at 12 months. Complication and reoperation rates were low within the observed follow-up period. However, longer-term data are required to fully evaluate durability and safety.

Although these results are encouraging, the small sample size means that they should not be interpreted as definitive evidence of superiority.

Long-term observational evidence has also supported abdominal sacrohysteropexy as an effective uterus-preserving procedure in young women.[11]

Mesh Considerations

Mesh requires particularly careful counselling.

Importantly, the FDA's regulatory action needs to be stated precisely. In 2019, the FDA [11] ordered manufacturers to stop selling and distributing transvaginal surgical mesh devices intended for pelvic organ prolapse repair in the United States. This action did not constitute a ban on all mesh used in prolapse surgery. The FDA continues to distinguish transvaginal POP mesh from mesh used in transabdominal procedures such as sacrocolpopexy.

For a young woman considering mesh-based sacrohysteropexy, counselling should cover:

- Mesh exposure/erosion
- Infection
- Pelvic pain
- Dyspareunia
- Need for future intervention
- Possibility of recurrence
- Uncertainty regarding very long-term outcomes.

RCOG[2] similarly emphasises that mesh procedures require detailed counselling regarding complications and should be performed by appropriately trained specialists.

OTHER UTERINE-SPARING PROCEDURES

Depending on the anatomical defect and surgical expertise, other options include:

- Vaginal sacrospinous hysteropexy
- Uterosacral ligament hysteropexy
- Manchester procedure in selected women with cervical elongation
- Laparoscopic hysteropexy
- Native-tissue vaginal hysteropexy.

The choice should be determined by the site of the anatomical defect rather than simply by age.[9] Systematic evidence suggests that several forms of hysteropexy can achieve satisfactory short-term anatomical outcomes, but comparative long-term evidence remains limited.[9]

CONCLUSION

Utero-vaginal prolapse in young women requires a different philosophy from prolapse management in older women. The objectives are not simply anatomical correction but preservation of pelvic-floor function, quality of life, sexuality and reproductive potential.

Prevention should focus on lifelong pelvic-floor health, supervised PFMT where indicated, appropriate obstetric care, prevention and treatment of constipation, weight optimisation, smoking cessation and management of chronic cough.

Once prolapse develops, treatment should be determined by symptoms and quality-of-life impact rather than anatomical stage alone. POP-Q examination provides standardised documentation, while urinary, bowel and sexual symptoms should be actively assessed.

PFMT and pessaries remain important first-line options, particularly in women wishing to postpone surgery or pregnancy. When surgery is required, uterine preservation should be offered as an option to appropriately selected women who desire it. Evidence supports several uterus-preserving operations, particularly sacrohysteropexy, although long-term evidence specifically in very young women remains limited.

However, procedure selection should be individualised according to the anatomical defect, reproductive plans, surgical expertise and the patient's preferences.

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Pregnancy After Uterus-Preserving Prolapse Surgery: Evidence and Recommendations

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INTRODUCTION

Pelvic organ prolapse (POP) is commonly associated with ageing and previous childbirth, but it can also affect women during their reproductive years. Uterine prolapse in younger or nulliparous women may be associated with congenital connective-tissue weakness, cervical elongation, chronic increases in intra-abdominal pressure, neurological disorders, or previous obstetric trauma. Symptoms may include vaginal bulging, pelvic pressure, urinary or bowel dysfunction and sexual difficulties. Although hysterectomy with apical suspension remains an established treatment for uterine prolapse, it is inappropriate for women who wish to preserve fertility.

Uterus-preserving prolapse surgery, also termed hysteropexy, retains the uterus while restoring apical support. Procedures include sacrohysteropexy, sacrospinous hysteropexy, uterosacral hysteropexy, pectineal ligament suspension, abdominal cervicopexy and selected sling procedures. These may be performed using native tissue or synthetic mesh. The principal concern is that a subsequent pregnancy may place considerable stress on the repair and increase the risk of recurrent prolapse, preterm birth or complications during labour.

This article reviews the available evidence and provides practical recommendations.

EVIDENCE BASE AND ITS LIMITATIONS

Evidence regarding pregnancy after uterus-preserving prolapse surgery remains limited. The American Urogynecologic Society (AUGS) clinical guidance document reviewed the literature up to 2018 and concluded that the available studies were insufficient to support formal clinical practice guidelines.[1] Most publications were case reports, case series and small retrospective cohorts.

A more recent systematic review by Bhatia et al. identified 18 observational studies involving 126 pregnancies after uterine-preserving prolapse surgery.[2] Six studies were prospective, nine were retrospective and three were case series. The mean follow-up was 37.2 months. Native-tissue repairs accounted for 64.3% of pregnancies and mesh-augmented procedures for 35.7%. Although this review provides the largest contemporary synthesis, it remains limited by small samples, heterogeneous procedures, variable definitions of recurrence and possible publication bias. No randomised controlled trials have evaluated pregnancy outcomes after hysteropexy.

Earlier systematic reviews also support the feasibility of pregnancy but emphasise low-certainty evidence. Barba et al. identified 151 pregnancies among 1518 uterine-sparing procedures, while Pitsillidi et al. reviewed 26 pregnancies after laparoscopic hysteropexy.[3,4] These figures should not be interpreted as pregnancy rates because the studies were not designed to assess fertility, and many women may have used contraception or completed childbearing after surgery.

CHOOSING SURGERY IN WOMEN WHO DESIRE PREGNANCY

Conservative management should generally be offered first. Pelvic-floor muscle training and pessary treatment may control symptoms and allow the woman to defer surgery until her family is complete. Deferring definitive surgery is desirable because pregnancy may compromise the durability of a repair, and the long-term consequences of pregnancy after hysteropexy are uncertain.[1,5]

Surgery may nevertheless be appropriate for severe or advanced symptomatic prolapse, ulceration, urinary retention, recurrent infections, bowel dysfunction or failure of pessary treatment. In such circumstances, the operation should be selected through counselling involving urogynecology and obstetrics.

The general surgical principle is to choose a **suspension procedure that preserves cervical length and function**, rather than an amputative or obliterative operation. Sacrohysteropexy and sacrospinous hysteropexy are the most frequently reported procedures internationally. Uterosacral hysteropexy and pectineal ligament suspension are additional options. In the Indian context, abdominal sling procedures such as Purandare, Shirodkar, Khanna, Sonawala, Joshi and Virkud operations have historical importance, particularly for young women with uterovaginal prolapse. However, pregnancy data for these procedures are derived from small institutional series and should be regarded as illustrative rather than definitive.

The Manchester–Fothergill operation requires special caution. The traditional procedure includes cervical amputation, which may result in cervical stenosis, reduced cervical length, cervical insufficiency, preterm birth, cervical dystocia and difficulty with cervical assessment. NICE guidance recommends that Manchester repair should not normally be offered to women who may wish to have children in the future.[5] A modified Manchester procedure,

which avoids cervical amputation, may have a different risk profile, but pregnancy outcome data remain limited. Le Fort colpocleisis and other obliterative procedures are inappropriate for women who wish to retain vaginal intercourse and fertility.

During the primary operation, excessive tension should be avoided to permit uterine enlargement. The surgeon should preserve uterine and cervical vascularity, avoid unnecessary dissection and document the fixation points and, if used, the exact position of the mesh. Anterior mesh or mesh encircling the cervix may have greater implications for uterine expansion and caesarean delivery than posterior mesh, although current evidence is insufficient to establish the safety of one configuration over another.

OBSTETRIC OUTCOMES AFTER PROLAPSE SURGERY

The available obstetric outcomes are generally reassuring. In the Bhatia review, 55 of 58 pregnancies with documented gestational age, or 94.8%, reached term.[2] Three deliveries were preterm, including two twin pregnancies. One pregnancy ended at 17 weeks after preterm premature rupture of membranes following a Manchester procedure. An additional first-trimester loss occurred after laparoscopic sacrohysteropexy.

No neonatal complications were reported in the 126 pregnancies included in the main analysis, and no singleton infants were classified as small for gestational age.[2] These findings do not prove that the procedures are free from fetal risk because outcome reporting was inconsistent and the sample size was small. However, there is currently no convincing evidence that mesh hysteropexy causes fetal growth restriction.

Maternal complications were uncommon but clinically important. In one case, mesh was encountered over the lower uterine segment during caesarean delivery. The hysterotomy had to be placed at the upper limit of the lower uterine segment, and blood loss was approximately 1000 mL.[2] Other case reports describe third-trimester pelvic pain attributed to mesh tension, difficulty with bladder dissection and postpartum haemorrhage. These reports highlight the importance of reviewing the operative notes before pregnancy and planning delivery in an appropriately experienced unit.

Adverse pregnancy outcomes should not be described as a single phenomenon of "premature prolapse." Possible mechanisms include cervical insufficiency after cervical surgery, spontaneous preterm labour, preterm premature rupture of membranes, recurrent prolapse with cervical ulceration or infection, and cervical dystocia or laceration during labour. Recognising these as separate mechanisms is clinically useful because they require different preventive strategies.

PROLAPSE RECURRENCE AFTER PREGNANCY

Recurrent prolapse is the major long-term concern. Pregnancy increases uterine weight and intra-abdominal pressure, while delivery may cause further muscular, fascial and neurological injury. The true recurrence rate is uncertain because studies used different definitions and follow-up periods.

In the updated systematic review, recurrence occurred in 14 of 120 women with available recurrence data, giving an overall rate of 11.7% over a mean follow-up of approximately three years.[2] Recurrences occurred after both caesarean and vaginal delivery: eight followed caesarean birth and six followed spontaneous vaginal birth. Native-tissue repairs had recurrence in 7 of 47 women, or 14.9%, compared with 5 of 41 women, or 12.2%, after mesh-augmented repair.[2]

These findings should not be interpreted as proof that mesh is more durable or that caesarean delivery is protective. The groups were not comparable, and women with mesh repairs were more likely to undergo planned caesarean delivery. Furthermore, a non-pregnant control group was not available. A 2024 systematic review also found no significant difference in recurrence according to delivery mode after hysteropexy.[6]

The AUGS review described recurrence after sacrohysteropexy, uterosacral hysteropexy and sacrospinous hysteropexy, although the number of pregnancies was very small.[1] Recurrence may involve the original apical compartment or a different compartment, particularly the anterior vaginal wall. Therefore, postpartum assessment should include symptoms and, where appropriate, objective POP-Q examination rather than focusing only on the cervix.

ANTENATAL CARE AND DELIVERY PLANNING

Women who conceive after prolapse surgery should ideally receive joint care from obstetrics and urogynecology. At the first antenatal visit, clinicians should obtain the original operative report, identify whether mesh was used and establish its location. Baseline pelvic support and cervical anatomy should be documented.

Routine antenatal care is appropriate for many women, but additional surveillance may be reasonable after cervical surgery, a Manchester procedure, previous mid-trimester loss or preterm birth. Serial transvaginal cervical-length assessment between approximately 16 and 24 weeks may be considered in women at increased risk. Cerclage should not be performed routinely after every hysteropexy. It should be guided by obstetric history, cervical length and clinical examination in accordance with cervical-insufficiency guidance.[7]

If prolapse recurs during pregnancy, treatment is generally conservative. A vaginal pessary may reduce pressure and support the cervix. Any exposed or ulcerated cervix should be kept moist and protected, and urinary retention or infection should be treated promptly. Evidence for bed rest is weak, and prolonged activity restriction should not be routinely prescribed.

The mode of delivery remains controversial. In the updated review, 75 of 114 deliveries with known mode, or 65.8%, were by caesarean section.[2] Most caesareans were elective and reflected provider preference or concern about the previous repair. Among separately analysed mesh-based case reports, caesarean delivery occurred in 85.7% of cases.[2]

Planned caesarean delivery is commonly considered after mesh sacrohysteropexy, especially when mesh encircles or is attached close to the cervix. The rationale is to avoid difficult cervical dilatation, excessive traction on the repair and possible mesh avulsion. However, this recommendation is based mainly on theoretical concerns and case reports. Caesarean delivery carries its own risks and has not been shown to eliminate prolapse recurrence.

Vaginal delivery may be reasonable after selected native-tissue procedures when the cervix is accessible, there is no significant recurrent prolapse or obstruction, and the repair is considered sufficiently flexible. The decision should be individualised and documented antenatally. Instrumental delivery on a scarred, oedematous or prolapsed cervix should be avoided unless clinically necessary.

RECOMMENDATIONS

1. When future pregnancy is desired, offer pessary treatment and pelvic-floor rehabilitation as primary modality of management of prolapse where appropriate.
2. If surgery is required, counsel regarding possible recurrence, caesarean delivery and limited evidence , regarding outcome of pregnancy.
3. Prefer cervical-preserving suspension procedures over cervical amputation or obliteration.
4. Avoid Manchester surgery and colpocleisis when future pregnancy is desired, unless adequate length of cervix (2-2.5 cm) is left behind exceptional circumstances apply. [8]
5. Document mesh type, location and fixation points clearly in operative notes after mesh augmented repair.
6. Consider allowing approximately 6–12 months between surgery and conception, while acknowledging that this interval is based on clinical practice rather than trial evidence.
7. Manage pregnancy through multidisciplinary obstetric and urogynecological care.
8. Consider cervical-length surveillance after cervical surgery or in women with relevant obstetric history.
9. Consider planned caesarean after mesh sacrohysteropexy, but do not regard it as mandatory for every hysteropexy.
10. Reassess prolapse at six weeks postpartum and subsequently if symptoms develop; defer further definitive surgery until childbearing is complete where possible.

CONCLUSION

Pregnancy after uterus-preserving prolapse surgery is feasible and is usually associated with term birth and favourable neonatal outcomes. Nevertheless, the evidence remains low certainty and is based mainly on small observational studies. Recurrent prolapse occurs in approximately 12% of women with reported follow-up, and it may occur after either vaginal or caesarean delivery. Mesh procedures introduce additional concerns regarding pelvic pain, uterine expansion and surgical difficulty at caesarean delivery, while cervical-amputating procedures may increase the risk of cervical insufficiency and preterm birth.

The most appropriate approach is individualised counselling. Conservative treatment should be prioritised when possible, and surgery should be deferred until family completion if symptoms permit. When surgery is necessary, a cervical-preserving suspension procedure should generally be selected. Antenatal surveillance and delivery planning should involve both obstetric and urogynecological specialists. Further prospective multicentre studies using standardised definitions of recurrence and long-term follow-up are needed.

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Journal Scan

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Primary Treatment of Pelvic Organ Prolapse in Women Aged Over 80 Years: Pessary Versus Surgery

Yu Q, Li M, Zhou Y. Int Urogynecol J. 2026;37:1733–1741. | DOI: 10.1007/s00192-026-06562-2

QUESTION In women ≥80 years with symptomatic POP, can pessary treatment provide long-term outcomes comparable to surgery?

STUDY DESIGN

- Prospective single-centre cohort; Nov 2013–May 2023.
- 148 women ≥80 years with symptomatic POP.
- Patient preference: surgery n=23; pessary n=125.
- Surgery: Le Fort colpocleisis n=22; total colpocleisis n=1.
- Pessary: ring 88%; Gellhorn 12%.
- Median follow-up 696 days (range 287–3277).

PATIENT PROFILE

- Mean age: 81.7 y surgery vs 82.4 y pessary.
- Stage III predominated; Stage IV more common in pessary group.
- Vaginal bulge: 100% in both groups.
- Heaviness/dullness: 67.1%; voiding dysfunction: 64.2%.
- High comorbidity burden, including hypertension, diabetes and cardiovascular/cerebrovascular disease.

Primary outcome Subjective patient-reported improvement measured with the patient global impression of improvement scale (PGI-I)

Secondary Outcome Remission of prolapse-related symptoms and adverse events.

SYMPTOM OUTCOMES AFTER ≥1 YEAR

Outcome	Surgery	Pessary	P value / interpretation
Vaginal bulge remission	100%	84.0%	P=0.072
Heaviness/dullness remission	77.8%	89.3%	P=0.29
SUI remission	71.4%	64.2%	P=0.70
UUI remission	75.0%	70.0%	P=1.00
Voiding dysfunction remission	100%	89.2%	P=0.59
Splinting remission	100%	97.6%	P=1.00
PGI-I improvement	94.7%	87.6%	P=0.70

ADVERSE EVENTS

- Pessary: Discharge 26.4%; bleeding/erosion/ulceration 13.3%; pain 11.5%, difficult defecation: 4.4%
- Surgery: Discharge 5.3%, difficulty defecating 21.1%; bleeding/erosion/ulceration 15.8%.
- Discharge P=0.0068; defecation difficulty P=0.030.

CONTINUATION

- 79.6% continued pessary ≥1 year.
- Ring 80.8%; Gellhorn 71.4%.
- Self-management: 68.3% ring vs 50.0% Gellhorn.
- 3.5% switched to surgery; expulsion 7.1%.

CLINICAL TAKE-HOME

Pessary is an effective and safe treatment for symptomatic POP in elderly women with no significant difference in subjective improvement and symptom remission compared with surgery.

STRENGTHS: long follow-up • ≥80-year population • specialist standardized care
LIMITATIONS: preference-based treatment • small surgical group • mainly colpocleisis

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Complications in Pelvic Organ Prolapse With 3-Month Versus 6-Month Pessary Care

Giorgenon GV, Galhardo LM, Araujo CC, et al. Urogynecology. 2025;31:1043–1053.

OBJECTIVE To determine whether cleaning and vaginal examination every 6 months is as safe as every 3 months for women using a ring pessary.

METHODS

- Open-label randomized clinical trial; 1:1 allocation.
- 38 women with POP-Q stage 2–4 using a ring pessary were followed for 12 months.
- 3-month group: removal, cleaning and vaginal examination every 3 months.
- 6-month group: same procedure every 6 months.
- All participants used vaginal estriol 3×/week.
- Primary outcomes: vaginal ulceration and discharge; secondary urinary/sexual symptoms and QoL.

FOLLOW-UP

- 3-month: 18 randomized; 16 completed 12 months.
- 6-month: 20 randomized; all 20 completed 12 months.
- 7 participants were lost overall.
- No significant baseline difference in most characteristics; the 6-month group was older.
- No participant self-managed the pessary.

3 MONTHS vs 6 MONTHS — KEY OUTCOMES

Outcome at 12 months	3-month	6-month	Interpretation
Vaginal ulceration	25%	20%	No difference; P=1.0
Ulcer >1 cm	6.2%	5%	No difference
Vaginal discharge	31.2%	45%	No significant difference; P=0.400
Bacterial vaginosis	6.2%	40%	**Higher with 6-month care; P=0.026**
Candidiasis	11.1%	10%	No difference; P=1.000
Satisfaction	93.7%*	90%*	No significant difference

OTHER FINDINGS

- Both groups improved urinary incontinence and OAB measures.
- QUID showed a significant group × time interaction (P=0.005), with greater improvement in the 6-month group.
- ICIQ-SF and ICIQ-OAB improved over time.

QUALITY OF LIFE

- P-QoL improved significantly in both groups.
- Improvements included prolapse impact, functional/social limitations, emotions and symptom severity.
- No significant between-group difference.

CLINICAL MESSAGE

For selected ring-pessary users who do not self-manage, 6-monthly review did not increase ulceration over 12 months — but BV was more frequent.

TAKE-HOME • 6-monthly cleaning/examination appears feasible in selected women, but should not mean "no surveillance." Vaginal discharge, odor, bleeding or discomfort should prompt earlier review.

*Satisfaction categories were not statistically different.

Case Vignette: A Case-Based Insight into Diagnosis and Management of Prolapse in Young Females

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INTRODUCTION

Pelvic organ prolapse (POP) is defined by the International Continence Society (ICS) as the descent of one or more of the anterior vaginal wall, posterior vaginal wall, the uterus, or the apex of the vagina (vaginal vault after hysterectomy)(1). While pregnancy and childbirth are prominent risk factors, prolapse can also occur in nulliparous women, although less frequently. In India, nulliparous women account for 1.5% to 2% of POP cases, while among young women who have delivered one or two children, the incidence is even higher (5–8%), making it one of the highest rates globally(2). In young women, prolapse may present as isolated apical compartment prolapse with uterine descent, multi-compartment prolapse with cystocele, rectocele or enterocele, and cervical elongation with or without uterine descent or as infravaginal cervical elongation with or without descent of the vaginal comaprtments (Fig 1). Surgical management in young women is challenging as it should focus on preserving future fertility and sexual function while ensuring satisfactory and durable anatomical outcomes.



Fig 1. From left to right, (a) isolated apical compartment prolapse with uterine descent, (b) multi compartment prolapse with cystocele, uterine descent, enterocele and rectocele, (c) cervical elongation

CASE PRESENTATION

An 18-year-old unmarried female presented with complaints of something protruding from the vagina for the past two years. The onset was insidious, and symptoms were more pronounced during squatting, but the mass could be reduced on lying down. She also reported lower backache. There were no urinary or bowel complaints, nor any abnormal vaginal discharge or bleeding.

On local examination, grade III uterine descent was observed without evidence of cystocele or rectocele. Levator tone was 5/5, and the perineal body measured 3 cm in length. Per vaginal examination revealed a normal-sized, retroverted uterus, with bilateral fornices free and non-tender.

DISCUSSION

Q1: What should be included in the history of a young patient with prolapse?

The history should begin with detailed documentation of the presenting complaints, such as the sensation of a vaginal bulge, mass, or the feeling of something 'coming down'. Associated symptoms like pelvic heaviness or a dragging sensation should be noted. It is important to ascertain the onset and duration of symptoms, whether they worsen on standing, squatting, or lifting weights, and if manual reduction of the prolapse is necessary. The impact on daily activities should also be explored.

Comprehensive urinary history is essential, including symptoms of stress urinary incontinence, urgency, urge incontinence, increased frequency, nocturia, hesitancy, weak or intermittent stream, feeling of incomplete bladder emptying, need for splinting to void, and recurrent urinary tract infections.

Bowel symptoms should also be enquired, such as constipation, diarrhoea, urgency, straining, sensation of incomplete evacuation, digital splinting, and anal, faecal, or flatal incontinence.

Sexual history must include whether the patient is sexually active and the impact of prolapse on intercourse, such as dyspareunia, obstructed intercourse, and negative body image.

A detailed obstetric history is important, covering parity, age at first delivery, mode of deliveries, instrumental deliveries, birth weight, prolonged second stage, perineal tears, episiotomy, location of delivery (home vs hospital), interval since last childbirth, postpartum onset of symptoms, and future fertility desires.

Significant gynaecological history should be reviewed, including abnormal bleeding, vaginal discharge, known fibroids or ovarian masses, previous pessary use, or prior prolapse surgery.

The patient's past medical history should cover chronic cough, constipation, diabetes, obesity, and neurological disorders such as spinal injury or multiple sclerosis.

In young women, it is especially important to ask about connective tissue disorders and symptoms like joint hypermobility, frequent dislocations, hyperextensible skin, easy bruising, hernias, varicose veins, poor wound

healing, and any family history of Marfan syndrome or Ehlers-Danlos syndrome.

Enquire about family history of prolapse in the mother or sisters, as well as personal habits such as smoking, alcohol intake, and socioeconomic status to assess nutritional status.

Finally, the use of validated questionnaires such as PFDI-20, PFIQ, and PISQ-IR is advised to gauge symptom severity and the impact on quality of life.

Q2: How should a detailed examination be performed in a young patient with symptoms of prolapse?

General physical examination should include assessment of the patient's height, weight, BMI, nutritional status, and presence of pallor or oedema.

Look for signs of connective tissue disorders, such as joint hypermobility (using the Beighton score), hyperextensible skin, easy bruising, varicose veins, hernias, arachnodactyly, marfanoid habitus, and measure arm span.

A thorough systemic examination should be conducted, including neurological evaluation to assess gait, mobility, and any neurological deficits. Routine chest and cardiovascular examination should be performed, as well as abdominal examination for masses, surgical scars, or hernias.

A detailed local pelvic examination should be performed after obtaining proper consent and ensuring adequate exposure. The patient should be positioned in the dorsal lithotomy position, or sometimes at a 45-degree semi-recumbent angle for more accurate assessment(4). If the severity of symptoms reported exceeds what is observed on examination, a repeat assessment in the standing position is recommended.

The pelvic examination should begin with inspection of the perineal and vulvar skin, assessment of architecture, and observation of the urethra and vaginal introitus. Look for visible prolapse at rest, excoriation, ulceration, colour changes, hyperkeratinisation, scars from episiotomy or tears, and perineal body deficiency.

The patient should be asked to perform the Valsalva manoeuvre or cough to assess for stress urinary incontinence and to evaluate the maximal descent and involved compartments. Each vaginal compartment (anterior, posterior, and apical) must be evaluated. Use a single blade of the speculum to retract the posterior wall to assess the anterior compartment, and vice versa for the posterior compartment.

The POP-Q (Pelvic Organ Prolapse Quantification) system should be used to document the stage of prolapse, as recommended by various international organisations. The 9-item POP-Q is a topographical assessment that measures the location of specific vaginal points in relation to the hymen during maximal strain, thus quantifying the degree of prolapse(5).

In young women, particular attention should be paid to point 'D' in the POP-Q system, which represents the attachment of the uterosacral ligaments. Prolapse of point C with preservation of point D is used to describe cervical elongation, though there is no universally accepted definition. One study defined hypertrophic cervical elongation as a difference between point C and point D greater than 8 cm(6). Noting cervical elongation is important as it influences surgical options

Examination of the pelvic floor should include assessment of the anal and bulbocavernous reflexes. Levator ani muscle tone should be evaluated transvaginally and graded using the modified Oxford score.

A digital per rectal examination should be performed at maximal straining to differentiate between high rectocele and enterocele, as well as to measure perineal descent.

Q3: What investigations should be conducted in a young patient with prolapse?

Pelvic organ prolapse is primarily a clinical diagnosis, and investigations are generally not required for diagnosis. Imaging modalities, such as translabial ultrasound (TLUS) and pelvic MRI, can be utilised to detect underlying defects in cases with prolapse. Imaging is particularly useful in posterior compartment prolapse, where differentiating between rectocele and enterocele can be challenging. Cervical elongation can also be measured with ultrasound and MRI, although a definitive definition is lacking. Levator avulsions, if suspected, can also be identified using TLUS and MRI.

Magnetic resonance imaging (MRI), offers the highest sensitivity in measuring cervical elongation, though practical limitations and high cost necessitate use of the more feasible POP-Q system, particularly effective for stage 2 and 3 prolapse cases. Transvaginal ultrasound measurement of cervical length using the location of the uterine artery is also found to have strong correlation to anatomical cervical length and this technique can also be utilized to measure cervical length accurately.[7]

If connective tissue disorders such as Marfan or Ehlers-Danlos syndrome are suspected, genetic testing, skeletal X-rays, and echocardiography may be indicated.

Cervical cancer screening is recommended in sexually active women over 30 years of age. If surgical treatment is planned, routine preoperative investigations should be performed. In cases where infertility is an issue,

targeted investigations for both partners should be undertaken.

Q4: What non-surgical treatment options can be offered to young women with prolapse?

Non-surgical treatment is generally considered for women with prolapse of POP-Q stage 2 or less. All patients should be advised supervised pelvic floor muscle training (Kegel's exercises), with a recommendation of at least eight contractions of ten seconds each, three times daily, with gradual increases over time. A systematic review found that supervised PFMT significantly improves patient-reported outcome measures compared to educational material alone. Enhanced benefit occurs with biofeedback or electrical stimulation combined with PFMT (8)

Vaginal pessaries can be offered to women with symptomatic prolapse who do not wish to undergo surgery, or to pregnant women with prolapse. Ring pessaries are most commonly used, allowing for sexual intercourse while in situ, and are easy to insert and remove. Women should be taught self-management of pessaries if possible; if not, regular follow-up every three to four months is advised(9).

Lifestyle modifications including weight management, constipation treatment, smoking cessation, and management of chronic cough address modifiable risk factors.

Q5: What surgical treatment options are available for young women with prolapse?

The choice of surgery depends on the compartment involved, the patient's desire for future fertility, the presence of cervical elongation, and the surgeon's expertise. Uterine preservation is preferred in women under 40 years of age. Isolated anterior and posterior compartment prolapse is rare in nulliparous women, but, if present, can be repaired as in older women—cystocele repairs by classical anterior colporrhaphy and rectocele repairs by posterior colpoperineorrhaphy. (Figure 2)

For uterine and apical prolapse in young women, conservative uterine-sparing surgical options include:

1. **Abdominal, Laparoscopic, or Robotic Sacrohysteropexy:** A widely performed standard procedure where a synthetic mesh is anchored to the posterior cervix/isthmus and fixed to the anterior longitudinal ligament over the sacral promontory.
2. **Laparoscopic Pectopexy:** An increasingly preferred alternative to sacrohysteropexy, utilizing the bilateral iliopectineal (Cooper's) ligaments for mesh fixation, which is technically advantageous and associated with shorter operating times and lower risk profiles in patients with challenging sacral anatomies.
3. **Uterosacral Ligament Suspension:** Restores apical support via high attachment of the uterosacral ligaments.
4. **Uterine-Preserving Sling Surgeries:** Traditional native tissue slings described in literature include Purandare's, Shirodkar's, Virkud's, Khanna's, Soonawala's, and Joshi's procedures. Among these, Purandare's sling surgery utilizes an autologous rectus sheath strip to suspend the uterus and remains a relevant native-tissue option.
5. **Manchester-Fothergill Repair:** A vaginal procedure historically preferred for women with infravaginal cervical elongation, combining cervical amputation with cardinal-uterosacral ligament plication. However, it carries a significant subsequent risk of cervical incompetence and preterm birth, making it less ideal for patients who still desire future uncompromised childbearing.
6. **Sacrospinous Hysteropexy:** Anchoring the cervix/uterus unilaterally (usually to the right) to the sacrospinous ligament via a vaginal approach, providing another effective native-tissue or graft-sparing apical suspension option

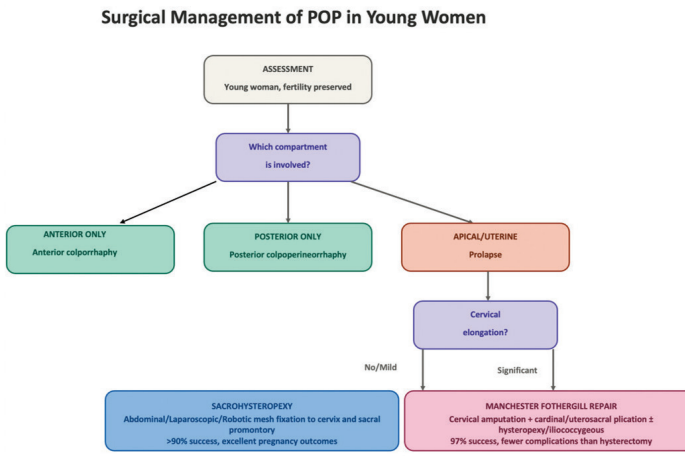


Figure 2: Surgical options

CONCLUSION

Management of prolapse in young women requires an individualised approach integrating clinical assessment, shared decision-making, and evidence-based conservative and surgical options. Contemporary evidence supports staged management, initiating with conservative approaches and progressing to uterine-conserving surgical techniques when indicated, thereby preserving fertility, sexual function, and long-term anatomical durability.

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FORTHCOMING EVENTS







Her Story….Her Words….

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Pelvic organ prolapse, though commonly associated with advancing age and multiparity, can also affect **young women**, with significant physical, emotional and social consequences. Treatment decisions may be challenging, requiring a balance between **symptom relief, uterine preservation, recurrence risk and future fertility.** Here, a 25-year-old woman shares her experience of developing prolapse at 19, following the birth of her second child, living with the condition for six years, and now facing a difficult treatment decision.

Q1. When did you first notice this problem, and what did you do when you realized something was wrong?

My problem started after the birth of my second child. I was 19 years old then. Around 20–25 days after my delivery, I noticed that something was coming out through my vagina. Initially, I did not tell anyone about it. I did not really understand what was happening, and it was also not something that I felt comfortable talking about. But gradually, when it started causing problems in my daily work and routine, I told my mother. My mother took me to a dai. She examined me and told me that I needed to go to a hospital.

Q2. When you initially sought treatment, what were you told about your condition and the treatment options?

I first consulted a local doctor, who advised **removal of the uterus**. Having seen relatives undergo the same surgery and feel better, I believed this was the only solution, although I was scared of surgery. At another hospital, I was advised exercises, but they did not improve my symptoms and the prolapse continued to worsen. I was also told about a **chhalla**, but I was uncomfortable with the idea of repeated removal and replacement. *"Woh toh chhaati mein chadh jaati hai na, ma'am? So I don't feel safe about it."* By the time I reached GTB Hospital, I had already decided that I wanted my **uterus removed**, believing this was the only way to get lasting relief.

Q3. You have been living with this problem for almost six years. What problems has it caused in your day-to-day life?

I have continuous pain in my lower abdomen. Sometimes the pain and discomfort are so much that I am not even able to walk properly. I still have to do all my household work, look after my children and go to work. It has also affected my married life. I am not able to be intimate with my husband normally because intercourse is very painful for me. Because of the pain, I usually avoid it. We may have intercourse only once in two or three months. I have been living with all of this for the last six years.

Q4. What did the doctors at GTB Hospital explain to you about the treatment options, and what did you think about them?

The doctors explained that, because I was only 25, they wanted to preserve my uterus if possible. They explained that the supports holding the uterus had become weak and that another operation could tighten these supports and lift the uterus back into place. They also explained that the prolapse could recur, especially with heavy work or lifting. They told me that removing the uterus would be permanent and could take away the possibility of having another child in the future. I understood the options, but I needed some time to think about what would be best for me and my family.

Q5. Why does the possibility of recurrence make this decision particularly difficult for you?

Because **I cannot avoid lifting weights**. I have small children to care for, household responsibilities, and I also work in factories carrying heavy loads of jeans to earn a living. If I undergo surgery, I may need to take one or two months off work. My concern is that after going through the surgery and losing that income, I may still have to return to heavy work—and the prolapse could recur. How can I stop lifting weights when lifting weights is part of my life and my work?

Q6. What finally made you agree to the treatment recommended by the doctors?

Initially, I was very clear that I wanted my uterus removed. I felt that after suffering for so many years, I wanted a treatment that would give me relief.

But the doctors explained to me why they were recommending a uterine-preserving operation at my age and what the surgery involved. After discussing everything with them, I decided to trust their advice and undergo the sling surgery.

Although it was different from what I had initially wanted, I understood the reasons for their recommendation and was comfortable proceeding with it.

Q7. After undergoing the surgery, how do you feel about the decision you made?

I feel relieved. The feeling of something coming down and the pain and discomfort that had become part of my everyday life have improved significantly. I can walk and carry out my routine activities more comfortably. I also feel more confident in my daily life. I am happy that I decided to go ahead with this treatment.

Q8. What would you like to tell another young woman who is diagnosed with prolapse?

I would tell her **not to feel embarrassed or suffer in silence**. I did not speak about my problem initially and lived with it for years. I would also tell her that **removing the uterus is not necessarily the only option**. As a young woman, there may be other ways to manage prolapse. Every woman's situation is different. **Talk openly to your doctor, understand all the available options, and choose what is best for your age, family, work and future plans.**

CONCLUSION

This story highlights the **profound physical, social and emotional impact of pelvic organ prolapse in a young woman**. After six years of symptoms, achieving lasting relief has become as important to her as uterine preservation and future fertility. While treatment should be individualised based on age, reproductive goals and long-term outcomes, this case emphasises the importance of **understanding the woman's lived experience and priorities**. Open, empathetic counselling and discussion of all treatment options can help women make informed decisions that balance their present needs with their future goals.

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Prolapse in Young Females: A Patient Information Leaflet

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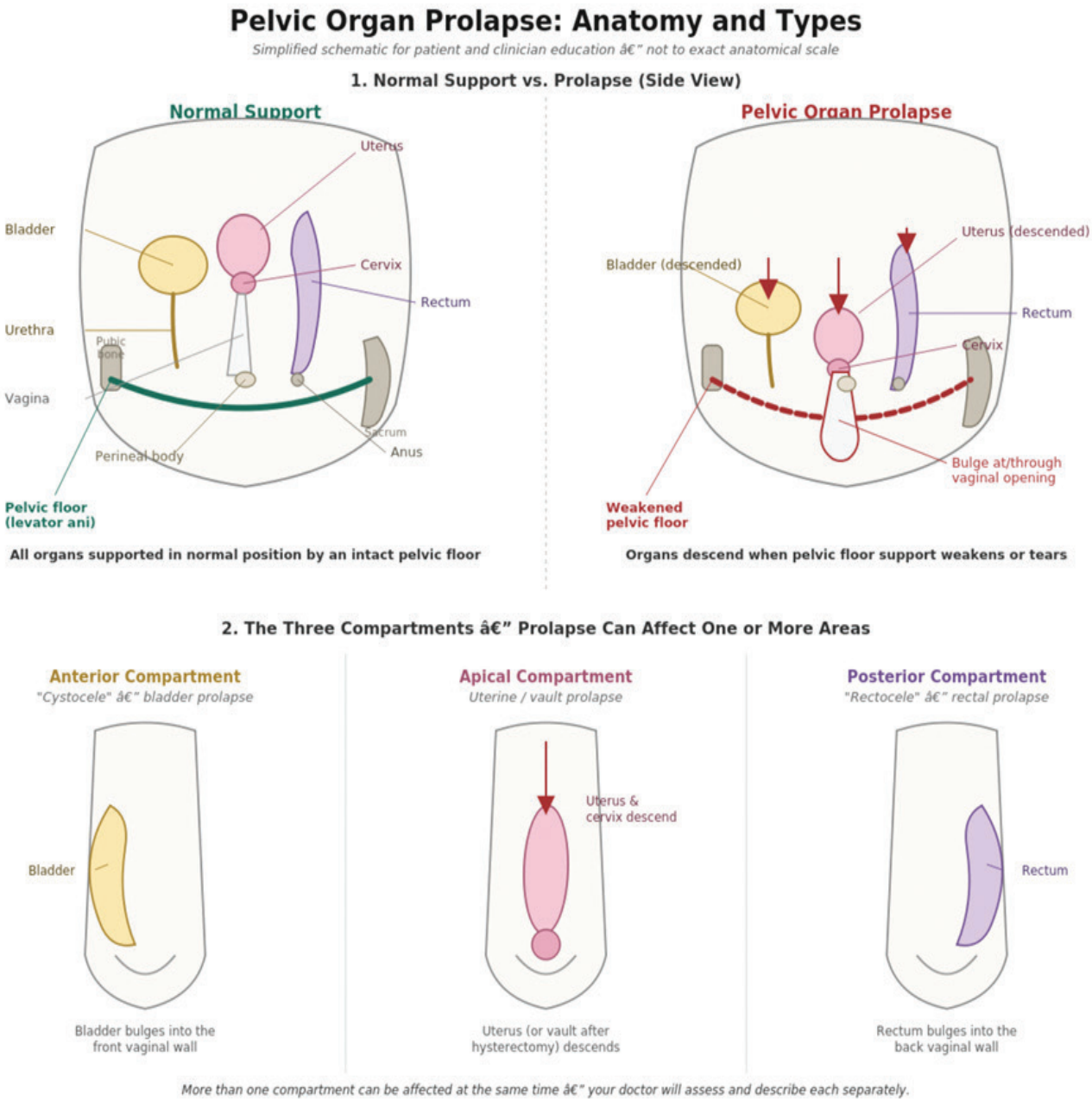
ABOUT THIS INFORMATION

This leaflet is for young women who have, or are worried they may have, pelvic organ prolapses. It aims to help you understand your condition and treatment options. Your gynaecologist is there to answer your questions and support you in making the decision that is right for you.

What is pelvic organ prolapse?

Inside your pelvis, your bladder, womb (uterus), and back passage (rectum) are held in place by a hammock of muscles and ligaments called the pelvic floor. When this support weakens, one or more of these organs can bulge down into the vagina- this is called pelvic organ prolapse.

You may have heard that this only happens to older women after several children. This is not true. Prolapse can affect women in their 20s and 30s, including women who have never been pregnant.



Can pelvic organ prolapse happen in young females?

Yes, and it is more common than most people realise. Global estimates suggest 40–60% of women experience some degree of prolapse in their lifetime, though only 18–50% ever seek medical attention; examination-based studies show prevalence of 10–50%, rising to 65% with combined assessment methods.[1]

Younger women are far from exempt. A UK study of over 1,400 women with prolapse found more than a quarter (27%) were aged 50 or younger, with significantly greater symptom severity and distress than older women despite less advanced prolapse on examination.[2] A national cohort study similarly found symptomatic prolapse was actually highest in nulliparous women aged 25–34 years, at 9.8%, falling to 6.1% by ages 55–64, the opposite of what many expect.[3]

India's age-standardised incidence was estimated at 400.06 per 100,000 women in 2019, among the highest of the BRICS nations.[4] Uttarakhand field data links prolapse to early marriage (17.3y) and early childbearing (20.5y); roughly half of affected women blamed manual labour alone, and 64% believed the condition untreatable.[5]

If you have been told you are "too young" for this, the evidence says otherwise and this leaflet aims to reduce the existing knowledge gap.

What are the causes of pelvic organ prolapse in young females?

There is rarely one single cause. Contributing factors include:

- Naturally looser connective tissue, which can run in families
- Pregnancy and childbirth, especially a long labour, a large baby, or an assisted (forceps/vacuum) delivery
- Long-standing constipation, a persistent cough, or heavy lifting
- Being significantly overweight
- Joint hypermobility ("double-jointedness")
- For many young women, it is a combination of these factors- not something you did wrong.

What are the different types of prolapse?

There are different types of prolapse depending on which organ is bulging as shown in Table 1 and it is common to have more than one type at the same time.

Table 1. The main types of pelvic organ prolapse.

Type	Also called	What happens
Anterior wall prolapse	Cystocele	The bladder bulges into the front wall of the vagina
Posterior wall prolapse	Rectocele	The back passage (rectum) bulges into the back wall of the vagina
Uterine prolapse	—	The womb itself drops down into the vagina
Vault prolapse	—	The top of the vagina bulges down; can happen after a removal of woumb

Your doctor will examine you to identify exactly which type(s) you have, and how advanced (staged 1 to 4) the prolapse is, since this affects your treatment options. Stage 1 is mild, often with no or few symptoms and rarely needing treatment; higher stages mean more advanced descent.

How does it affect your health?

Your symptoms depend on the type and severity of your prolapse. You may notice:

- A feeling of heaviness, dragging, or a bulge in the vagina, often worse by evening
- Backache
- Needing to pass urine more often or urgently, leaking with coughing or exercise, or a sense of incomplete emptying
- Difficulty fully emptying your bowels, or needing to press on the bulge to help
- Some women have no symptoms at all

Prolapse is not dangerous or life-threatening, but it can affect your day-to-day comfort and confidence. It is best understood as a lifestyle-related condition, tied to work, exercise, and general health rather than a disease and it usually responds well to lifestyle changes and treatment.

How does it affect my reproductive life?

Prolapse does not cause infertility and does not harm a baby in pregnancy. However, pregnancy and vaginal delivery can worsen an existing prolapse or cause it to return after treatment, which is why treatment timing is often planned around your family plans.

Prolapse can also affect your sex life such as some women notice discomfort, reduced sensation, or feel self-conscious, which can strain a relationship. This is a common, legitimate concern. So please raise it with your doctor rather than staying silent. Physiotherapy, a well-fitted pessary, or simply changing position can often help.

Can I become pregnant with prolapse?

Yes. Prolapse does not prevent you from becoming

pregnant or carrying a healthy pregnancy. A pessary or physiotherapy does not stand in the way of conceiving. A pessary is simply removed before delivery and refitted afterward. Many women manage symptoms conservatively until their family is complete and then consider surgery only if still needed. Tell your doctor your family plans so treatment can be planned around them.

What are the treatment options for me?

Your options depend on the type and severity of your prolapse, your symptoms, and whether you are planning to have children. Conservative measures are explained in Table 2.

Table 2. Conservative (non-surgical) treatment options.

Option	What it involves	Best suited to
Lifestyle changes	Losing excess weight; treating constipation or cough; avoiding heavy lifting	Everyone, alongside other options
Pelvic floor exercises	Supervised physiotherapy, usually 3–6 months; most notice improvement in 8–12 weeks	Often the first step for most women
Vaginal pessary	Silicone/plastic device supporting prolapsed organs; reviewed every 3–6 months	Avoiding or delaying surgery; preserving fertility

Surgery: usually considered when symptoms are significant or other options have not helped. Common operations, explained simply:

- **Pelvic floor repair:** Stitching and tightening the stretched vaginal walls to rebuild support, done through the vagina.
- **Vaginal hysterectomy:** Removing the womb through the vagina, without any cut on the tummy.
- **Sacrohysteropexy:** Tucking the womb up and fixing it to the lower back bone (sacrum) with stitches or mesh — a good option if you wish to preserve fertility.
- **Sacrocolpopexy:** Lifting the top of the vagina and fixing it to the lower back bone (sacrum), usually through keyhole surgery.
- **Sacrospinous fixation:** stitching the top of the vagina to a strong ligament in the pelvis, avoiding any mesh.

Not all surgery uses mesh; many operations use your own tissue. If mesh is suggested, your surgeon should discuss its risks and benefits, since mesh procedures need special accreditation. Recovery usually means avoiding heavy lifting and sex for about 6 weeks.

What if I choose not to undergo any treatment?

You do not have to have any treatment. If your prolapse is mild or not bothering you, a "watch and wait" approach with lifestyle changes may be reasonable. Prolapse is not dangerous, and symptoms may stay the same, improve, or occasionally worsen over time. That said, earlier treatment, especially physiotherapy, tends to work best before prolapse advances further.

Can I develop this condition again after surgery?

Yes, prolapse can recur, even after successful surgery more likely with a further pregnancy and vaginal delivery, being overweight, long-standing constipation or a cough, or heavy physical work. It does not mean the surgery failed or that you did anything wrong. Continuing pelvic floor exercises, maintaining a healthy weight, and treating constipation promptly all help reduce this risk. If symptoms return, contact your gynaecologist rather than waiting.

How is this condition diagnosed?

Diagnosis involves a gentle internal examination using a speculum, sometimes lying down, sometimes standing. If you feel anxious, please tell your healthcare professional. You are entitled to a female doctor, a chaperone, and an explanation at each step and can ask for the examination to stop at any time.

When should I see a doctor?

See your gynaecologist if you notice a bulge or heaviness in the vagina, difficulty passing urine or stools, or any pelvic symptom affecting your daily life, sex life, or exercise. You do not need to wait until symptoms worsen, as earlier evaluation means more treatment choices.

KEY POINTS

- Pelvic organ prolapse is common in young women, including those who have never been pregnant because you are not "too young" for this.
- It does not cause infertility and does not harm a baby in pregnancy.
- Treatment does not need to wait until your family is complete.
- Options range from lifestyle changes and physiotherapy to a pessary or surgery.
- Prolapse can affect your sex life and relationships; this is worth raising with your doctor.
- Prolapse may return after treatment, especially with a further pregnancy. This does not mean the treatment failed.
- Speaking to a gynaecologist early, rather than staying silent, is the most useful step you can take.

Emsella: A Non-invasive Approach to Pelvic Floor Rehabilitation and Urinary Incontinence

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INTRODUCTION

Magnetic pelvic-floor stimulation has emerged as a non-invasive treatment option that can activate pelvic floor musculature without requiring vaginal instrumentation. Emsella® (Fig 1A & 1B) is a chair-based system that uses high-intensity focused electromagnetic (HIFEM) technology to produce repeated involuntary contractions of the pelvic floor muscles. Unlike intravaginal electrical stimulation, treatment does not require insertion of a vaginal probe, and the patient remains fully clothed. This makes it an attractive option for women seeking a convenient, non-invasive form of pelvic floor rehabilitation.



Fig 1A. Front View of EMSELLA



Fig 1B. Back view

How does Emsella work?

The Emsella chair generates a focused electromagnetic field of up to 2.5 Tesla that penetrates the pelvic tissues and stimulates the motor nerves supplying the pelvic floor. A standard treatment session lasts approximately 28 minutes and produces thousands of pelvic floor contractions. This produces repeated pelvic floor contractions, with the aim of improving muscle strength, endurance and neuromuscular coordination.[1,2]

It is important to understand that Emsella is primarily a functional rehabilitation treatment. It strengthens or activates the pelvic floor but does not directly repair damaged vaginal fascia or provide the anatomical correction achieved by prolapse surgery.

How is the treatment performed?

Emsella is an outpatient treatment option and does not require anaesthesia, vaginal instrumentation or an incision. A commonly reported regimen consists of:

- Six treatment sessions
- Usually two sessions per week
- Treatment intensity progressively increased according to tolerance
- No routine recovery period after treatment[1,2]

Comfortable clothing is preferable, while thick or metallic clothing should be avoided. Jewellery and loose metallic objects should be removed before treatment. The operator should ensure correct positioning throughout the session because appropriate positioning is important for effective pelvic floor stimulation.

During treatment, patients generally experience repeated rhythmic contractions of the pelvic floor. Most studies report good tolerability, and patients can usually resume normal activities immediately following treatment.

PATIENT SELECTION AND INDICATIONS

The best-supported indication is mild-to-moderate SUI associated with pelvic floor muscle weakness. Potential candidates include women with urinary leakage following childbirth, pelvic floor weakness associated with ageing or menopause, and women who have difficulty performing effective PFMT.[1,2]

Another potential role is as an adjunct to pelvic floor exercises for pelvic organ prolapse.[3] However, its role in this setting should be carefully explained. It may improve pelvic floor muscle function and associated urinary symptoms, but it should not be considered equivalent to reconstructive surgery for anatomical prolapse.

CONTRAINDICATIONS AND PRECAUTIONS

Pregnancy, cardiac pacemakers, implanted neurostimulators or defibrillators, implanted drug pumps and certain metallic implants. Active malignancy and significant cardiac disease are also important considerations.[2]

Points to remember:

1. Best suited: selected women with mild-to-moderate SUI and pelvic floor weakness.
2. Treatment: commonly six 28-minute sessions, usually twice weekly.
3. PFMT remains important: Emsella can be used as an adjunct rather than replacing pelvic floor exercises.
4. Screen carefully: particularly for pacemakers, implanted electronic devices, pregnancy and relevant metallic implants.
5. Set realistic expectations: symptom improvement is more predictable than complete cure.
6. POP: Emsella may improve functional symptoms but should not replace surgery when definitive anatomical correction is required.
7. Long-term efficacy: remains incompletely established.

CONCLUSION

Emsella represents a promising non-invasive approach to pelvic floor rehabilitation, particularly for women with SUI and pelvic floor weakness. At present, Emsella is best regarded as a conservative or adjunctive treatment option, rather than a replacement for PFMT or reconstructive surgery.

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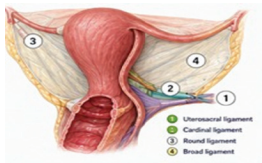
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Brain Boost Zone

Muntaha Khan
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1. A woman has-

Stage III uterine prolapse



- Minimal cystocele
- Minimal rectocele
- Cervix is the leading point

Q. Which support defect is primarily responsible?

A. Pubocervical fascia
B. Rectovaginal fascia
C. Cardinal-uterosacral complex
D. Perineal body

2. A patient has

- POP-Q Stage IV
- Stress urinary incontinence absent

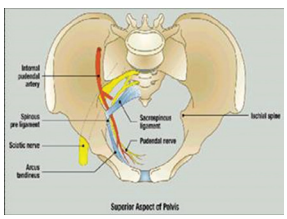
After successful prolapse surgery, she develops severe stress urinary incontinence

Q. What is the diagnosis?

3. Gold standard operation for sexually active women with post-hysterectomy vault prolapse?

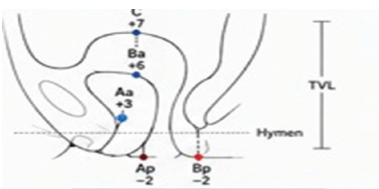
A. Sacrospinous fixation
B. High uterosacral suspension
C. Abdominal/laparoscopic sacrocolpopexy
D. Lefort repair

4. Which nerve is most vulnerable during sacrospinous fixation?



A. Pudendal nerve
B. Sciatic nerve
C. Inferior gluteal nerve
D. Peroneal nerve

5. A POP-Q diagram showing:



- Aa +3
- Ba +6
- C +7
- Ap –2
- Bp –2

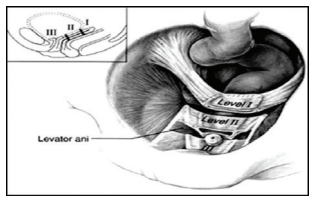
Q. What is the most dependent point in prolapse?

A. Ba rectocele
B. Ba cystocele
C. C point with cervical descent
D. Bp point in rectocele

6. Pelvic anatomy with numbered ligaments.

Numbers:

1. Uterosacral
2. Cardinal
3. Round
4. Broad



Q. Which ligament complex is primarily responsible for preventing uterine prolapse?

7. Four instruments- image-based

A. Breisky-Navratil retractor



B. Miya hook



C. Deschamps needle



D. Capio suturing device



Q. Name the instrument which is not used for sacrospinous fixation.

8. Use a clinical photograph with the prolapse reduced.

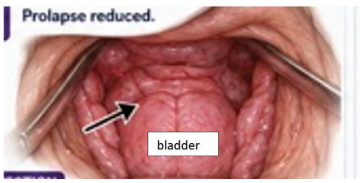
Q. Identify the POP-Q point marked by the arrow.

A. Aa

B. Ba

C. C

D. D



9. What complication of procidentia is demonstrated?



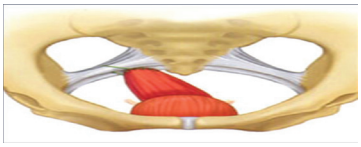
10. Bonus "Guess the Surgery

Identify the procedure.

a. Mesh attached to anterior longitudinal ligament



b. Sutures into sacrospinous ligament



c. Bilateral uterosacral sutures

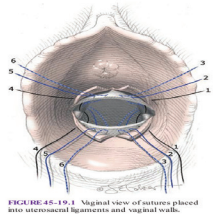
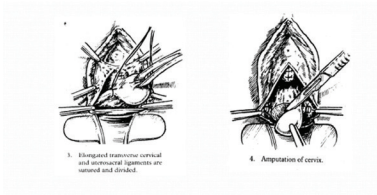
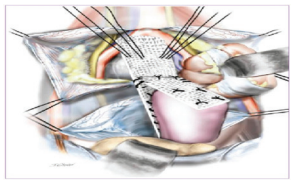


FIGURE 45-19.1 Vaginal view of sutures placed into uterosacral ligaments and vaginal walls.

d. Cervical amputation with plication



e. Mesh around vault

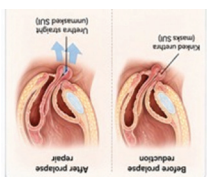


Answer

1. C. Loss of Level I support (cardinal and uterosacral ligaments) results in apical prolapse.

2. Occult urinary incontinence

Occult stress urinary incontinence was masked by urethral kinking from the prolapse. Correction of the prolapse unmasks the incontinence.



3. C. Abdominal/laparoscopic sacrocolpopexy

4. A. Pudendal nerve

5. B.

6. Cardinal–uterosacral complex.

7. Deschamps needle

8. Ba

9. Hydroureteronephrosis secondary to ureteric kinking

10 a. Sacrocolpopexy **b.** Sacrospinous fixation

c. Uterosacral ligament suspension

d. Manchester procedure **e.** Sacrocolpopexy

AOGD Clinical Meeting from AIIMS Hospital, New Delhi held on 27.08.2026

SOWN AT SURGERY; REAPED AS MALIGNANCY A LATE ONCOLOGICAL SEQUALAE

Pooja Yadav[1], Seema Singhal[2], Neena Malhotra[3]
[1]Senior Resident, [2]Professor, [3]HOD and Professor
Dept of Obs and Gynae, AIIMS, New Delhi

Introduction

Malignant transformation of scar endometriosis into clear cell carcinoma is a rare but recognized complication, with fewer than 200 cases reported worldwide. This transformation often presents diagnostic challenges due to its insidious nature and variable clinical presentation.

Case Presentation

We present two patients with clear cell carcinoma arising from abdominal wall scar endometriosis. First case includes a 46-year-old woman with primary amenorrhea presented with a 20×15 cm abdominal wall mass 30 years following hysterectomy. She underwent extensive cytoreductive surgery with en bloc resection of abdominal wall mass, partial cystectomy with bladder repair, colorectal and ileoileal resection, right salpingo-oophorectomy, omentectomy and pelvic lymphadenectomy, achieving CC0 resection. She received six cycles of adjuvant carboplatin and paclitaxel after which she has been disease free for 11 months. The second case was a 51-year-old postmenopausal woman, with LSCS 26 years ago, presented with a 15×15 cm abdominal wall mass. Abdominal wall excision with primary cytoreductive surgery including total abdominal hysterectomy, bilateral salpingo-oophorectomy, bilateral pelvic and inguinal lymphadenectomy, total omentectomy, mesh reconstruction and pedicled ALT flap was performed achieving CC0 resection.

Discussion

Malignant transformation typically occurs after prolonged disease duration, with both iatrogenic and embryonic mechanisms implicated. Imaging and histopathological evaluation, including immunohistochemistry, are essential for diagnosis. Complete surgical resection with negative margins remains the mainstay of treatment, often supplemented by platinum-based chemotherapy. Long-term surveillance is vital due to the tumour's aggressive behaviour and potential for recurrence.

Conclusion

Although exceedingly rare, scar endometriosis can undergo malignant transformation even decades after initial surgery. Early recognition, thorough preoperative assessment, and aggressive multidisciplinary surgical management are key to improving survival. Vigilant long-term follow-up of scar endometriosis is essential for early detection and intervention of this formidable complication.

INDIVIDUALIZED MULTIMODAL MANAGEMENT FOR FERTILITY PRESERVATION IN PREGNANCY AT AN UNCOMMON LOCATION

Priyanka Das[1], Neha Varun[2], Neeta Singh[3]
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Department of Obstetrics & Gynecology, All India Institute of Medical Sciences, New Delhi

Background

Cervical ectopic pregnancy (CEP) is a rare and potentially life-threatening condition carrying a high risk of torrential haemorrhage. While systemic methotrexate is one of the established first-line therapy for hemodynamically stable patients, resistant cases with advancing gestational age and unfavourable cervical architecture pose a significant management challenge, often necessitating a shift toward combined interventional and surgical approaches to preserve fertility.

Case Presentation

A 38-year-old woman, G3P1L1A1 with one full-term lower-segment caesarean section and one medically managed second-trimester termination and two staged laproscopic and hysteroscopic myomectomy, presented with spotting per vaginum at 6 weeks of gestation. Transvaginal ultrasonography confirmed a CEP. Patient came to OPD (self-referred) after receiving one systemic methotrexate (80 mg IM) in a private hospital. At presentation, the patient was hemodynamically stable, with a β-hCG of 78,638 mIU/mL and examination revealed a papery-thin, hyperaemic, ballooned cervix, harboring a live, growing cervical pregnancy corresponding to a CRL of 9 weeks on ultrasound. A second dose of systemic methotrexate was administered. In view of twice systemic methotrexate injection and increased vascularity of cervix with viable live pregnancy, the patient underwent uterine artery embolization followed by ultrasound-guided suction evacuation, with hysteroscopy. Blood loss was negligible and patient was discharged in a stable condition.

Conclusion

This case highlights that a multidisciplinary, stepwise combination of systemic methotrexate, uterine artery

embolization and ultrasound-guided suction evacuation can effectively manage highly vascular cervical ectopic pregnancy. This fertility-preserving approach minimizes catastrophic haemorrhage, avoids hysterectomy and offers successful uterine conservation in carefully selected women desiring future reproductive potential.

Keywords

Cervical ectopic pregnancy, methotrexate, uterine artery embolization, fertility preservation, hysteroscopy

BEYOND PMOS: TUMOUR BEHIND THE MASK

Swati Tomar[1], Ayushi Negi[2], Reeta Mahey[3], K Aparna Sharma[3]

[1]Assistant Professor, [2]Senior Resident, [3]Professor,
Department of Obstetrics and Gynaecology, All India Institute of Medical Sciences, New Delhi

Background

Polyendocrine Metabolic Ovarian Syndrome (PMOS) is a common cause of anovulatory infertility and is characterised by elevated serum anti-Müllerian hormone (AMH). Granulosa cell tumours (GCTs) are rare sex-cord stromal ovarian neoplasms that secrete oestrogen, inhibin B and AMH and may therefore mimic PMOS. We report two women labelled as PMOS-related infertility in whom a solid ovarian mass and disproportionately elevated AMH led to the diagnosis of GCT.

Case 1

A 30-year-old P1L1 woman presented with secondary infertility of three years and irregular, progesterone-dependent cycles. She had undergone multiple failed ovulation induction (OI) cycles with letrozole and gonadotrophins. Her BMI was 19 kg/m^2, with no hirsutism. Examination revealed a 4×4 cm right fornicial mass. Transvaginal ultrasonography (TVS) showed a 5.5×4.8×5.2 cm solid vascular right ovarian mass. LH:FSH ratio was 4.8, testosterone was normal, while AMH (>18.7 ng/mL) and inhibin B (>1025 pg/mL) were markedly elevated. Other tumour markers were normal. MRI demonstrated a predominantly solid ovarian lesion with cystic areas, suspicious for malignancy.

Case 2

A 37-year-old nulligravida presented with secondary infertility of two years and irregular, progesterone-dependent cycles. She had three failed OI cycles and one failed IVF cycle. BMI was 31 kg/m^2 without hirsutism. A 5×5 cm left fornicial mass was palpable. TVS showed a 4.5×4.5×5.9 cm solid-cystic ovarian mass. LH:FSH ratio was 2.04, with markedly elevated AMH (>25.2 ng/mL) and inhibin B (>1025 pg/mL). MRI confirmed a solid-cystic ovarian lesion.

Both women underwent multidisciplinary counselling followed by laparoscopic fertility-sparing staging, including peritoneal wash cytology, systematic abdominal and pelvic assessment, affected adnexal removal, infracolic omentectomy and multiple peritoneal biopsies. Histopathology confirmed adult GCT, FIGO stage IA, in both cases. Adjuvant therapy was not indicated. Following surgery, AMH and inhibin B levels declined markedly and spontaneous menses resumed within one month. Case 1 conceived during the first OI cycle within three months and delivered a healthy baby. Case 2 had a biochemical pregnancy and subsequently underwent IVF, with nine blastocysts cryopreserved.

Discussion

Only about ten such cases have been reported to date, typically presenting with infertility and secondary amenorrhoea resistant to OVI, elevated AMH and LH:FSH ratio, solid ovarian mass and persistent ovarian enlargement, with return of spontaneous menses and conception after surgery.

Conclusion

A solid ovarian mass with disproportionately elevated AMH should prompt consideration of a hormone-producing ovarian tumour in women presumed to have PMOS, particularly when infertility or amenorrhoea is resistant to treatment. TVS is crucial in such patients. Early recognition of GCT permits fertility-sparing surgery and can result in excellent reproductive outcomes

AOGD 2026

48th Annual Conference of AOGD

Organized by:
Department of Obstetrics and Gynaecology , AIIMS, New Delhi

12th & 13th September 2026 | Venue: India Habitat Centre, New Delhi

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CONFERENCE REGISTRATION FEES

CATEGORY	Early Bird (Till 31th July 2026)			Regular (1st Aug to 31st Aug 2026)			Onwards/On-spot		
	Amount	GST 18%	Total	Amount	GST 18%	Total	Amount	GST 18%	Total
☐ AOGD Member	6000	1080	7080	6500	1170	7670	7000	1260	8260
☐ Non-Member	7000	1260	8260	7500	1350	8850	8000	1440	9440
☐ PG Students	5000	900	5900	5500	990	6490	6000	1080	7080
☐ AOGD Member (above 70yrs)	Complimentary (Kindly email duly filled Registration Form along with age proof on our official email id mentioned below)								

Pre-Conference Workshop - 10th-11th September 2026

Early Bird (Till 31thst July 2026)			Regular (1st Aug to 31st Aug 2026)			Onwards / On spot		
Amount	GST 18%	Total	Amount	GST 18%	Total	Amount	GST 18%	Total
1500	270	1770	1800	324	2124	2000	360	2360

Opting For: 10th ☐ 11th ☐ Both Days ☐

Note: This registration form is intended exclusively for senior citizens who are not comfortable using computers or digital technology. All other delegates are kindly requested to register online through www.aogd2026.com.

Pre-Conference - 10th September 2026 (Tick your choice of workshop)

Sub-Committee	Session	Chairperson	Title	Venue
☐ Menopause & Geriatrics	Pre-lunch	Dr. Meenakshi Ahuja	Menopause and Ageing Skills Lab: Beyond the lecture	To be Updated
☐ Fetal Medicine and Genetics	Pre-lunch	Dr. Upma Saxena	Precision Prenatal Care in the Second Trimester: Early Risk Prediction Integrating Fetal Anatomy, Doppler and Genetics for Adverse Pregnancy Outcomes	VMMC old LT
☐ Safe Motherhood	Post-lunch	Dr Ratna Biswas	Safe Motherhood: Life-Saving Obstetric Interventions and Best Practices Across All Stages of Labour – A Video- Workshop	LHMC
☐ Infertility & Reproductive Endocrinology	Post-lunch	Dr Bindu Bajaj	IVF Decoded: From Basics to Breakthroughs	VMMC and Safdarjung Hospital
☐ QI Obst & Gynae Practice	Full Day	Dr Surveen Ghumman	Vision 2026: Building an ethos of Quality and Precision Care in OB/GYN	To be Updated

Pre-Conference - 11th September 2026 (Tick your choice of workshop)

Sub-Committee	Session	Chairperson	Title	Venue
☐ Urogynaecology	Pre-lunch	Dr Sonal Bhatla	Urogyn Video Surgical Workshop 2026 Real Cases, Real Challenges, Real Solutions	To be Updated
☐ Medico-legal	Pre-lunch	Dr Susheela Gupta	Bridging clinical excellence and legal safety: protecting patients, protecting practice Title for Medico-legal workshop	Fortis Hospital Shalimar Bagh Auditorium
☐ Adolescent Health / Community Health & Public Awareness	Pre-lunch	Dr Dipti Nabh Dr Divya Singhal	Adolescent gynaecology 360°: New Perspectives, New Paradigms	To be Updated
☐ Endoscopy / Endometriosis	Post-lunch	Dr Kanika Jain Dr Rita Bakshi	Surgical precision through camera vision: A hands-on video workshop	Sir Ganga Ram Hospital
☐ Oncology	Post-lunch	Dr Bindiya Gupta	INCISE Workshop: Shaping Skills in Gynae Oncology	UCMS and GTB hospital
☐ Research Methodology	Post-lunch	Dr. Neena Malhotra	Think, Design, Discover: A Hands-on Research Workshop	AIIMS

Note:

- Conference registration is mandatory for workshop registration.
- Delegates may select one workshop per session (Pre-lunch/Post-lunch) on each day of the two-day pre-conference workshop schedule.
- Workshop registration fees will be charged separately for each workshop selected.
- Post graduates to attach a certificate from HOD and also should be a member of the AOGD in order to attend and present a paper.
- Membership number is mandatory for registration in membership category. For any queries related to membership, you may contact **Ms. Sarita** (+91 92116 56757).
- For spot registrations, payment will be accepted via Cash, Card, or UPI only (cheques will not be accepted). Delegate kits will be provided subject to availability.
- Delegate kits will be handed over only to registered delegates.
- Registration is non transferable.
- No delegate kit, workshop material, or any other conference material will be distributed to Delegates, Associate Delegates, or PG Students after the conference.

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Cancellation & Refund Policy

1. All cancellation requests must be submitted in writing to the AOGD Secretariat.
2. Cancellation requests received on or before 15th July 2026 will be eligible for a 75% refund of the registration fee paid.
3. Cancellation requests received between 16th July 2026 and 14th August 2026 will be eligible for a 25% refund of the registration fee paid.
4. No refund will be provided for cancellations received on or after 15th August 2026.
5. The refund process will commence 30 days after the conclusion of the conference.

NOTE: The Organizing Committee of AOGD 2026 shall not be liable for any delay, modification, postponement, or cancellation of the conference due to circumstances beyond its reasonable control, including but not limited to natural disasters, acts of God, terrorism, labor disputes, war, civil unrest, or government restrictions.

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Previous Events, August, 2026

Public Awareness Program on "LIQUID GOLD -Let the Neonate Bloom" was conducted by Public Awareness Committee , AOGD in collaboration with Clinical Research Committee, FOGSI and Breast & Puerperal Committee, FOGSI on 5th August 2026 at Sir Ganga Ram Hospital, New Delhi. Street play by nursing students and poster competition was done.



SIR GANGA RAM HOSPITAL
Trust of Generations

PUBLIC AWARENESS CME
ON
"LIQUID GOLD - Let The Neonate Bloom"

Organized by
Institute of Obstetrics & Gynaecology, Sir Ganga Ram Hospital
and Under the aegis of
Clinical Research Committee of FOGSI
Public Awareness Committee of AOGD
Breast & Puerperal Committee, FOGSI

Convenor : Dr. Mala Srivastava,
Co-convenor : Dr. Divya Singhal,

Time : 9:00 am - 1:00 pm
Date : August, 5th 2026 (Wednesday),
Venue : Hall - A, Auditorium, SGRH

TIME	TOPIC	SPEAKER	CHAIRPERSON
9:30 AM	INAUGURATION	CHIEF GUEST : DR. VANDANA BAGGA DR. GEETA MEDIRATTA	
9:40 - 10:40 am	A Panel on Challenges of Breast Feeding	Moderators : Dr. Divya Singhal & Dr. Dipika Loganey Experts : Dr. Mala Srivastava & Dr. Rita Bakshi Panelists :- Dr. Yukti, Dr. Gargi, Dr. Preeti Gaur & Dr. Surekha Jain	
10:40 - 11:00 am	TEA BREAK		
11:00 - 11:20 am	Practical Tips on Breast Feeding : Talk by Lactation Expert	Dr. Priya Gandhi	Dr. Kanwal Gujral Dr. Geeta Mediratta Dr. Chandra Mansukhani
11:20 - 12:20 pm	PROGRAME : NUKKAD/ STREET PLAY BY NURSING STUDENTS OF SGRH Judges : Dr. Kanwal Gujral, Dr. Harsha Khullar, Dr. Mamta Dagar, Dr. Punita Bhardwaj, Dr. Kanika Jain & Dr. Ruma Satwik		
12:20 - 12:40 pm	POSTER PRESENTATION BY NURSING STUDENTS Experts : Dr. Indu Chugh, Dr. Divya Singhal, Dr. Shweta Mittal & Dr. Renuka Brijwal		
12:30 pm onwards	LUNCH Break		





The Department of Obstetrics & Gynaecology, Lady Hardinge Medical College under the aegis of Safe-motherhood Subcommittee organized a public awareness programme on "Breastfeeding for Sustainable Development in Life: Strengthen What Works" on 3rd August in ANC OPD, 2nd Floor , New OPD Building.



An awareness and educational session on breastfeeding and its importance was organized for antenatal women attending the OPD at VMMC & Safdarjung Hospital in collaboration with the FOGSI Perinatology Committee, FOGSI Public Awareness Committee Initiative, Public awareness Subcommittee AOGD and Rajkumari Amrit Kaur College of Nursing (RAKCON) on 7th August, 2026.





A 7 day CME for nurses and public was held at Jaipur Golden Hospital , Rohini in collaboration with Community Health & Public Awareness Subcommittee, AOGD.



Awareness talks for nurses & healthcare professionals was conducted on 7th August,2026 at MCD Hospital under the aegis of Safe motherhood subcommittee.









"Laparoscopic Video workshop" was organized by the Department of Obstetrics & Gynaecology, VMMC & Safdarjung Hospital, in collaboration with Endoscopy subcommittee AOGD & FOGSI on 08th August, 2026.



FOGSI REACH CME on "PMOS unplugged" was conducted by Department of Obstt & Gynae AIIMS , New Delhi under the aegis of AOGD & FOGSI on 12th August 2026 at Hyatt Hotel.

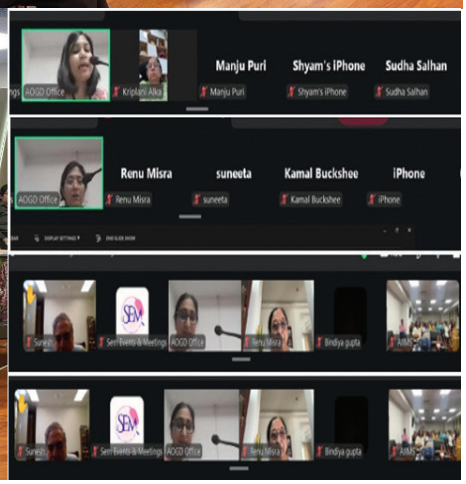


The AOGD Monthly Clinical Meeting (Hybrid mode) was conducted by the Department of Obst & Gynae, AIIMS, New Delhi on 27th August, 2026.









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*** Life membership on or after 1st January, 2022 shall have to renew the life membership after 20 years. The minimum renewal amount will be 25% of the prevailing subscription fee at time of renewal.**

Note: 18% GST will be applicable as FOGSI requires it.

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Pre-Conference Workshops	Conference

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