

Management of Pelvic Organ Prolapse for Doctors

Facilitator's Guide
September 2015



Government of Nepal
Ministry of Health and Population
National Health Training Center

Management of Pelvic Organ Prolapse

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Acknowledgement

The risk factors for Pelvic organ prolapse (POP) include pregnancy, childbirth, and menopause resulting in weakness of the pelvic floor. In Nepal, the prevalence of POP is relatively high. Although Pelvic Organ Prolapse is treatable condition, many women do not receive quality care, particularly in many low-income countries like Nepal. This could be due to lack of awareness about treatment options and lack of control over when to seek medical treatment. Furthermore, access to quality services from trained service providers is limited in most of the remote places in Nepal. Therefore, in Nepal, it is estimated that only about 25% of women with Pelvic Organ Prolapse receive treatment because of these barriers to quality health care.

In order to provide quality services to the women suffering from this morbidity the National Health Training Center in coordination with Family Health Division, UNFPA and Jhpiego has developed this competency based training package for service providers. This package will be used to provide training to Gynecologists so as to enable them to provide quality care in POP management, adhering to national standard. The package has adopted a combined approach of individualized learning and clinical practicum sessions. Thus the training approach is a blended learning approach in which the participants do individual learning (theory session) at their own work site for two weeks, followed by 6-days clinical practicum at designated training centers.

I would like to thank Family Health Division, Jhpiego Corporation and UNFPA for their technical support and also express my gratitude to UNFPA for the financial support in developing this training package. I would like to acknowledge with much appreciation Dr Kiran Regmi for her guidance during the process. Special thanks to Dr. Shilu Adhikari, RH Specialist, UNFPA; Ms. Neera Thakur, RH Officer, UNFPA; Dr. Kusum Thapa, ANE Regional Technical Advisor, Jhpiego; Dr. Blami Dao, Director, Maternal and Newborn Health, Jhpiego/Baltimore and Ms. Julia Bluestone, Sr. Technical Advisor, Global Learning Office Jhpiego/Baltimore for their valuable technical inputs in the document. Thanks to Ms. Sandhya Limbu, Program Officer, Jhpiego for her support for coordination.

I would like to thank and acknowledge all the national experts who have provided their valuable input during the various workshops organized during the drafting and finalization of this training package.

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PREFACE

Pelvic organ prolapse (POP) is a significant reproductive morbidity among postmenopausal and women of reproductive age in Nepal. Pelvic Organ prolapse (POP) is widely prevalent all over Nepal and with overall prevalence of 10% among women of reproductive age group (15-49 years). In Nepal an estimation of 600,000 Nepali women are suffering from varying degrees of uterine prolapse. Approximately one third of the women suffer prolapse severe enough to warrant reconstructive surgery. The huge burden of prolapse in Nepal ranks high on the public health agenda as a priority program for the government of Nepal and related stakeholders.

Till date, there was no competency based training package for standardizing surgery skills of gynecologists. The current approach of surgery camp programs was started without standardized technique to perform prolapse. Hence this package is designed to develop the capacity of the gynecologists to provide quality-assurance standards of care for women undergoing surgery for prolapse.

I am very pleased to introduce this long awaited competency based training package which would definitely help gynecologists to practice standardized surgical skills to perform Pelvic Organ Prolapse management. An ultimate goal of developing this competency based training package is to provide quality of services and help prevent women from social, physical and emotional isolation from family and society and live normal lives.

I would like to commend National Health Training Center for developing this package and also would like to appreciate the partners, UNFPA and Jhpiego Corporation for providing support in the process of developing this competency based training package.

I would like to thank all the national and international experts from various organizations for their contribution in development and publication of this package.


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Tips for the Facilitator

Tips on Mobile Facilitation

You or the coordinator will call the learners twice a week to check progress and answer any questions. During each call you will:

1. Introduce yourself and ask if they have a few minutes to talk; if they do not, arrange a time to call them later or vice versa.
2. Ask them about progress—are they on track with the schedule? What have they been able to complete so far? Do they have any related questions?
3. Set up a time for the next call.

Note: Refer to the following page for the call schedule and questions to ask during each week of calls. Cell phone text messages and calls would be more user-friendly and practical.

Tips on Clinical Practice Portion

There are a few considerations for this “apprenticeship” type of structured training:

- Patient safety is your number one priority. You and your facility are ultimately accountable. Be sure that your learner has adequate supervision as learner and supervisor, both are committed to patient safety while facilitating learning.
- Make sure that learner understands what you are trying to explain. Encourage the learner to ask questions and ensure a good level of understanding throughout the learning process.
- Help your learners to increase their independence, gradually needing less supervision over time. You begin by explaining, instructing, guiding, and then providing clues as to what to do next. Ask probing questions to help them make decisions and help them reflect on their experience.
- Ensure that your learner tracks his or her experiences in the **logbook** and uses it to debrief after each case.

Tips on Clinically Integrated Teaching

Whether you are teaching through chart review or bedside teaching or case study presentation or side-by-side teaching during surgery, you will follow a simple process. Before each clinically integrated teaching session, be sure to:

- Identify appropriate patients.
- Set goals for the session and review the objective(s) of the session and previous activities.

Follow the five-step process for bedside teaching (Raskin, H.S. *The One-Minute Preceptor*. 2001; 5 (2): 36-38). You can teach at the bedside in front of clients. When you do, be sure to: greet the client and introduce all people present, explain the purpose of the teaching and what you will be doing for the client, and confirm their permission. Tell the client that they can ask questions throughout and answer any questions they have.

4. Get a commitment

Ask the learner to 1) describe his/her diagnosis or plan for treatment, based upon the client history and symptoms they have just identified; and 2) commit to a probable diagnosis or differential diagnosis list to provide a specific commitment to respond to. You can ask: “What do you think is going on?” or “What do you think is the best course of action for this client?”

5. Probe for supporting evidence

Ask the learner to explain how they reached their conclusion. Listening to their reasoning will help you respond appropriately to their knowledge level. You can ask questions like: “What are the major findings that led to your diagnosis?” or “What else did you consider?”

6. Reinforce what was done well

Ask the learner to identify what they think they did well. Offer specific feedback rather than a general statement such as, “Good diagnosis.” Be specific, “You did an excellent job of explaining the test in a simple way and checking her understanding...”

7. Give guidance for errors and omissions

Make corrections specific and give the learner the opportunity to identify any errors they think they may have made. Make sure the feedback is constructive. For example, you can provide more specific plans for improvement: “Next time this happens, try this...”

8. Summarize the encounter with a general principle

Review the objective and summarize key points. Choose one or two general principles from the clinical teaching session as the key points to reinforce. This approach helps the learner remember and apply what was learned to other situations. You can provide guidance like this: “When this happens, do this...” “The key features that indicate this diagnosis are...”

After the clinical teaching, debrief privately. During this debrief you should:

- Review and summarize key points. Use the case-based discussion form to document learning.
- Solicit questions from the learner and discuss any identified problems.
- Offer specific positive and constructive feedback.

With the learner, agree on an area of improvement and formulate a plan for how to improve.

Schedule	Call Topic
Beginning of week 1	<ul style="list-style-type: none">• Did materials arrive?• Have they completed the self-assessment quiz? <p>Day 1: Please inform if any of you have had trouble accessing your materials.</p> <p>Day 3: All of you have done your self-assessment—what do you want to focus on during clinical practice? What are you really good at that you could demonstrate for others?</p>

Schedule	Call Topic
End of week 1	<ul style="list-style-type: none"> • By now they should have completed modules 1-5. What questions do they have? <p>Day 5: What are your favorite primary prevention strategies that you use in your work?</p> <p>Day 6: Share your most inspiring story or greatest success in treating or managing pelvic organ prolapse. (Remember—no patient personal data please!)</p>
Week 2	<ul style="list-style-type: none"> • Discuss the infection prevention reflection form—what did they say? What have they observed about infection prevention practices? • Finalize plans for clinical practice, when are they arriving, which skills do they need to practice the most? <p>Day 8: Did they find anything surprising in the infection prevention module? How have they been able to improve infection prevention practices in their own facility? Have they noticed a difference in infection rates post-op?</p> <p>Day 11: Share a case that was a great learning experience for you, what is the key lesson? (No patient personal data please!)</p>

Knowledge Assessment—Answer Key

Knowledge Assessment = criterion reference passed score=80%

Module One. Epidemiology and Risk Factors

1. A UNFPA/IOM study in Nepal in 2006 identified a POP prevalence in women of reproductive age group of:

- a. 5%
- b. **10%**
- c. 60%

2. The following are established risk factors for POP:

Conditions	True	False
1. Chronic urinary retention		√
2. Infant birth weight of 4650 g	√	
3. History of C-section		√
4. Obesity	√	

3. Studies of POP in Nepal identified that women with prolapse suffered for an average of:

- a. 2–5 years
- b. 5–7 years
- c. **7–11 years**

Module Two. Anatomy of the Uterus, Vagina, and Pelvic Floor

4. The levator ani is composed of:

- a. **Pubococcygeus and iliococcygeus**
- b. Pubococcygeus and sacrococcygeus
- c. Iliococcygeus and sacrococcygeus

5. Level I support of pelvic organ is:

- a. Perineal body
- b. **Cardinal ligament**
- c. Broad ligament

6. The anterior part of the levator ani muscle complex:

- a. **Acts as a sling around the mid-urethra, vagina, and rectum**
- b. Elevates and stabilizes the upper vagina
- c. Forms a sling around the upper urethra, vagina, and rectum

7. Which of the following are functions of the levator ani muscle?

Function	True	False
1. Narrows the genital hiatus	√	
2. Relaxes the genital hiatus		√
3. Facilitates urinary and fecal continence	√	
4. Suspends the uterus		√

Module Three. Infection Prevention

8. Select the best answer, the primary objective of infection prevention in the health care facility (hospitals and clinics) is to:

- a. Minimize the cost of drugs and supplies used in surgery
- b. Develop standards for use of prophylactic antibiotics
- c. Minimize transmission of infection**

9. Which of the following is a **physical** barrier to prevent infection during surgery?

- a. Personal protective equipment**
- b. Handwashing
- c. Using antiseptic to cleanse the skin

10. The surgical scrub includes rubbing the hands and forearms vigorously for:

- a. 3-5 minutes**
- b. 7 minutes
- c. 10 minutes

11. Which of the following is correct about handwashing?

- a. Perform before putting gloves on**
- b. It is not critical after glove removal if gloves are intact
- c. Perform randomly in case your hands have been contaminated

12. Antiseptics are chemicals that can be used:

- a. Safely on skin to kill or reduce microorganisms**
- b. To disinfect and decontaminate inanimate surfaces
- c. For routine hand washing

13. Surgical instruments that have been decontaminated and thoroughly cleaned can be sterilized by:

- a. Heat (autoclave or dry heat sterilizer)**
- b. Soaking them for 30 minutes in fresh 1% chlorine solution
- c. Exposure to ultraviolet light for 1 hour

Module Four. Assessment of women with POP

14. Which of the following is a common symptom attributed to uterine prolapse:
- a. Rectal bleeding
 - b. Sensation of bulge or protrusion**
 - c. Polymenorrhagia
15. Fecal incontinence in women with POP is present in:
- a. 5–10%
 - b. 15–20%**
 - c. 25–30%
16. In POP-Q staging, Point A is located on the anterior vaginal wall:
- a. Approximately 3 cm proximal to the urethral meatus**
 - b. Almost all the way up to anterior vagina
 - c. Approximately halfway up to anterior vagina
 - d. Just inside the anterior vagina
17. Which of the following indicates POP-Q stage II? The most distal portion of prolapse is:
- a. 1 cm or less proximal to or distal to the plane of the hymen**
 - b. 2 cm below the plane of the hymen
 - c. more than 3 cm above the plane of the hymen
18. Which is correct about pelvic examination when assessing for POP?
- a. Sterile gloves are mandatory
 - b. You must perform a test for rebound tenderness
 - c. Ask the patient to perform the Valsalva maneuver**

Module Five. Non-surgical POP management

19. There is evidence that correct performance of Kegel exercises will:
- a. Reduce urinary and fecal incontinence symptoms**
 - b. Decrease the strength, bulk, and tone of pelvic muscle
 - c. Have no effect on the stage of POP

20. Pelvic floor exercises should be performed at least:

- a. Once a day
- b. Twice a day
- c. Thrice a day**

21. The BEST advantage of a silicon pessary over rubber pessary is:

- a. Reduced absorption of odors and secretions**
- b. A shorter half life
- c. Reduced chance of allergic reaction

22. Which of the following are indications for pessary use?

Condition	Indication	Not indication
1. POP-Q Stage 3		√
2. 80-year-old with heart disease and stage 2	√	
3. Temporary relief during pregnancy	√	
4. Vaginal erosion		√

23. After insertion of pessary, women who are not able to perform self-care should be advised to attend the outpatient department for a change of pessary at:

- a. 2-week interval
- b. 1-month interval
- c. 3-month interval**

24. The approximate size of pessary required is determined by:

- a. Digital assessment of the length of vagina**
- b. Degree of prolapse
- c. Weight of the patient

25. After first insertion of a ring pessary, the patient should be advised of the following potential side effects.

Side Effects	Yes	No
1. Foul-smelling discharge	√	
2. Coital difficulty	√	
3. Heartburn and nausea		√

26. Improvement of symptoms of incontinence for a patient performing pelvic floor exercises is expected after:

- a. 6 weeks
- b. 8 weeks
- c. 12–16 weeks**

27. How should a silicone pessary be cleaned?
- Soak in Dettol for 30 minutes every month
 - Wash with soap and water every 6 months**
 - Boil it for 30 minutes every other month

Module Six. Surgical management of POP

28. Which step is included for anterior vaginal repair?

- Dissection of vaginal epithelium**
- Plication of levator ani
- Lateral plication of the vaginal muscularis

29. Which steps are included in a posterior compartment defect repair?

Steps	Includes	Does not include
1. Separation of the vaginal epithelium from rectovaginal septum	√	
2. Plication of levator ani for all women		√
3. Routine trimming of excess vaginal mucosa		√

30. Enterocele repair:

- Is routinely performed during pelvic organ surgery
- Needs special expertise
- Should be done only when indicated**

31. Indicate the correct answers for preoperative preparation for vaginal hysterectomy:

	Includes	Does not include
1. Involves routine shaving of operative area		√
2. Requires routine administration of prophylactic antibiotics	√	
3. Physical examination by surgeon is mandatory	√	
4. Routine ECG		√

32. During use of the WHO safe surgical checklist, which of the following questions do you ask immediately before the induction of anesthesia?

	Ask	Do not need to ask
1. Patient identity	√	
2. History of allergy	√	
3. Difficulty in bowel habits		√
4. Risk of bleeding	√	

Module VII. Management of complications of surgery for POP

33. Secondary hemorrhage usually occurs between:
- 1–2 days of surgery
 - 3–5 days of surgery
 - 7–10 days of surgery**
34. Immediate post-operative period vaginal bleeding below the cuff is managed by:
- Re-opening of incision
 - IV fluids and careful observation
 - Suturing the bleeding site**
35. Intra-operative methylene blue test is used to identify suspected:
- Bladder injury**
 - Rectal injury
 - Ureteral injury
36. Intraoperative bladder injury is managed by repairing it into two layers with 2-0:
- Absorbable continuous suture and continuous catheter for 7–10 days
 - Delayed absorbable continuous suture and continuous catheter for 7–10 days**
 - Non-absorbable continuous suture and continuous catheter for 7–10 days
37. Women may develop early menopausal symptoms if one of the following procedure is performed during POP surgery:
- Anterior colporrhaphy
 - Posterior colpoperineorrhaphy
 - Removal of uterus with bilateral ovaries**
38. Signs of post-surgical complications include:

	True	False
1. Suprapubic pain	√	
2. Flank pain	√	
3. Epigastric pain		√
4. Constipation		√
5. Incontinence of urine	√	

39. Following prolapse surgery, women should:
- Rest in bed for 1 month
 - Abstain from intercourse for 6 weeks**
 - Perform abdominal palpation every 6 hours for 24 hours

40. During post-operative 6-week, follow-up visit, the following should be performed:

	True	False
1. Ask about urinary and fecal incontinence	√	
2. Perform pelvic exam	√	
3. Perform routine urine analysis		√
4. Ask about foul-smelling vaginal discharge	√	

Module One: Epidemiology Pathophysiology and Strategies for Prevention of Pelvic Organ Prolapse

Answer Key for Exercises

1. What is the global prevalence of POP in women under 45?
Answer: 2–20%
2. Risk factors for POP include:
 - a. **Axis of vagina lying in horizontal plane (anorectal angle)**
 - b. Decrease in intra-abdominal pressure
 - c. Older age at first childbirth
3. According to the Nepal Demographic and Health Survey (2011), what is the prevalence of POP in the reproductive age group?
Answer: 67%

4. List risk factors that contribute to the high prevalence of POP in Nepal.

Answers:

- Lack of skilled care during birth
- Harmful traditional birthing practices in which traditional birth attendants use push-and-pull methods
- Socioeconomic factors such as poverty, poor nutrition
- Young age at delivery
- Multiparity
- Inadequate rest in the postpartum period
- Early resumption of household and field work postpartum
- Lifetime of heavy lifting, carrying, including immediate resumption postpartum

5. What is the strongest risk factor for developing POP?

Answer: Parity or vaginal delivery

6. Match the following with the correct description.

a. Skilled care during childbirth (b)	a. Tertiary level of prevention
b. Fitting ring pessary in early stage of prolapse (c)	b. Primary level of prevention
c. Discourage pregnancy after conservative surgery for prolapse (a)	c. Secondary level of prevention
d. Obesity (e)	d. Potential risk factor for POP
e. Heavy weight lifting (d)	e. Established risk factor for POP
	f. Definitive treatment for POP

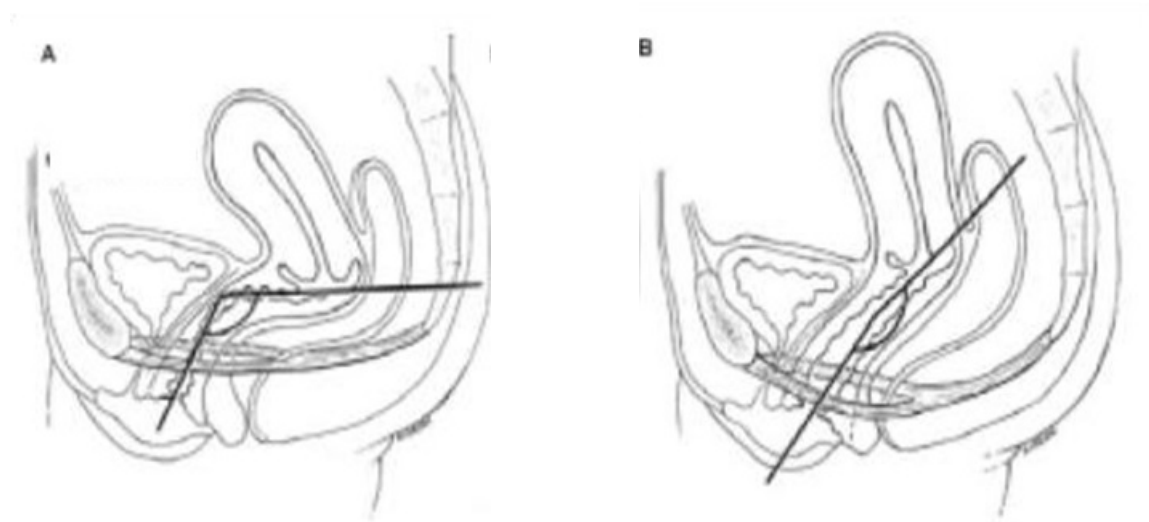
Module Two: Anatomy of the Uterus, Vagina, and Pelvic Floor

Answer Key for Exercises

1. Match the following function with anatomy.

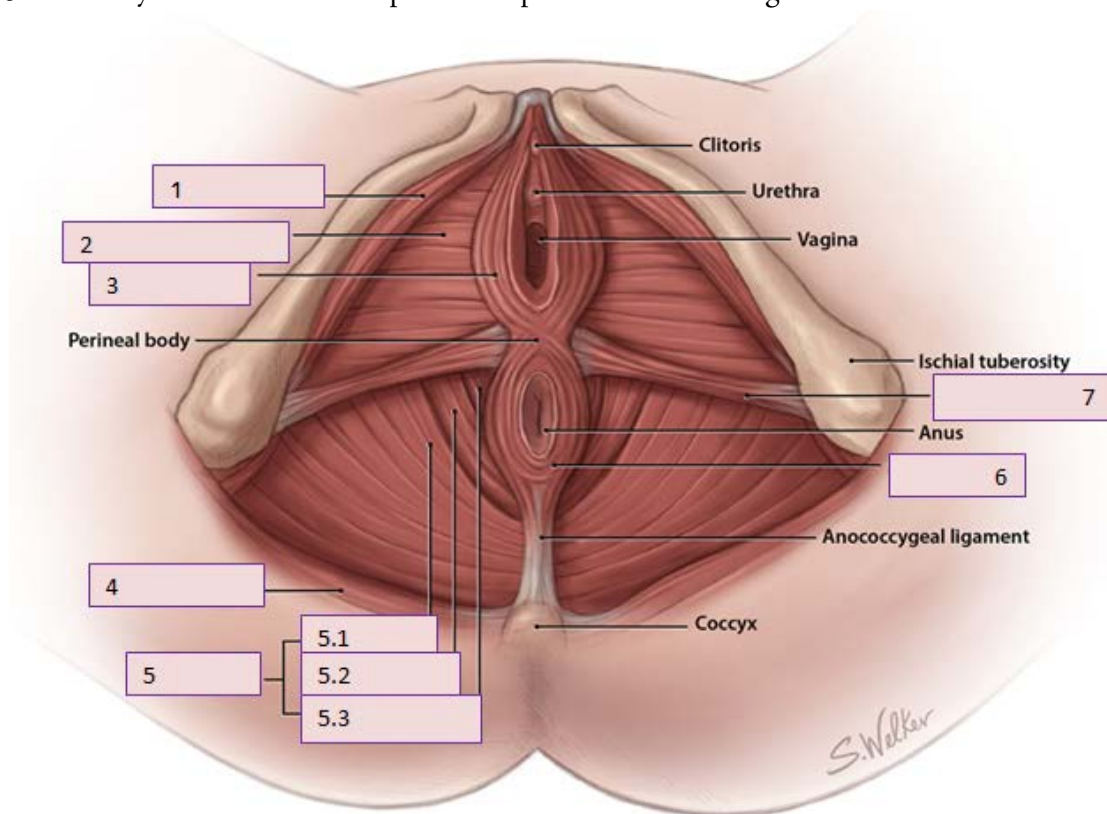
a. Pelvic diaphragm (b)	a. Level II support
b. Levator ani (e)	b. Muscular floor of pelvis
c. Urogenital diaphragm (d)	c. Attach the uterus to the pelvic sidewall
d. Cardinal ligament (c)	d. Ischio/bulbocavernosus and superficial transverse perineai
	e. Pubococcygeus and ilioccygeus

2. Which anorectal angle (among figures A and B) promotes POP?



Answer: Figure B

3. Identify the muscles of the pelvis and perineum in the diagram.



Answer:

1	Ischiocavernosus
2	Deep transverse perineal
3	Bulbospongiosus
4	Gluteus maximus
5	Levator ani
5.1	Iliococcygeus
5.2	Pubococcygeus
5.3	Puborectalis
6	Anal sphincter

Module Three: Infection Prevention

Reflective Practice

Date of completion: _____

Date of review by facilitator: _____

1. Do you think it is important to use personal protective equipment? What percentage of time do you use it? Is it similar or dissimilar to the types of PPE described in Chapter III of the standards?
2. What are the similarities and dissimilarities that you follow on handwashing practices as those described in Chapter III?
3. Have you known anyone in your profession who has had a bloodborne infection? How could it have been prevented?

Module Four: Assessment of Women

Answer Key for Exercises

1. Which of the following should be performed when assessing a client with POP?

	Indicated	Not Indicated
1. Pelvic examination with Valsalva maneuver	√	
2. Full neurological exam		√
3. 24-hour urine collection		√
4. Post-void residual urine	√	
5. Stool hematocrit		√
6. Ask about bowel habits	√	

2. Pelvic muscle function assessment is done in following position:

- a. Lithotomy
- b. Semiprone
- c. Trendelenberg

3. In which of the following condition is surgical management indicated?

	Indication	Non Indication
1. Minimal symptoms or no symptoms		√
2. Frequency or in between pregnancies		√
3. Not fit for surgery		√
4. Stage III	√	
5. Stage IV	√	
6. Failed pessary	√	

Answer Key for Case Studies

Directions

Read and analyze this case study by yourself thoroughly. Consider the steps in clinical decision-making as you answer the questions.

Case Study 1: Non-Surgical Management of POP

Objective: To be able to provide correct non-surgical management of POP

Scenario

Ramkala Gurung is a 57-year-old patient from Dolakha presenting with complaints of difficulty in passing urine. Upon taking her history, here are key results. She resumed household work immediately following all of her deliveries. She has been a chronic smoker since her teens and has been treated frequently for chest infections. She gives a history of having had a mass in her vagina for the last 10 years. The mass had not bothered her much until the past few months, when she developed problems in passing urine.

OB: Gravida 8, Para 5, all home deliveries

Medical: No medical conditions, chronic smoker

History:

Q1. What specific examination will help you to reach a diagnosis?

Physical examination:

- Head to toe examination
- Per abdominal examination was normal
- During local pelvic examination, a mass of less than 1 cm protruding out of the plane of the hymen was noted
- Per vaginal examination, showed a normal-sized uterus, retroverted with free fornices, and no tenderness

Q2. What laboratory tests will you perform?

Laboratory examinations:

- Urine R/M/E and C/S
- Hb, PCV
- If possible, an abdominal scan

Q3. Based on the above findings what will be your diagnosis?

POP-Q Stage II

Q4. What would be the appropriate management for the above case?

Conservative approach—pessary management

Case Study 2: Surgical Management

Objective: To be able to provide correct surgical management of POP

Scenario

Harimaya Limbu, 48 years old, has been diagnosed to have stage III POP by a doctor at a primary health center in her village and has been referred her to Ramechap District Hospital for further treatment.

What will you do in your initial assessment?

History

She is a 48 year old woman from Ramechap with seven children, all home deliveries, and has had three spontaneous abortions in the past. She resumed household work immediately following all of her deliveries including carrying water and firewood from a distance of about 4 kms. She has been a chronic smoker since her teens and has been treated frequently for chest infections. She gives a history of having had a mass in her vagina for the last 10 years. The mass had not bothered her much until the past few years when she has had to reposition the mass for complete evacuation of her bladder. She has had no problems in passing stool.

Q1. What specific examination will help you to reach a diagnosis?

Physical examination:

- Head to toe examination
- Per Abdominal examination was normal
- During local pelvic examination, a mass of more than 1 cm protruding out of the plane of the hymen was noted.
- Per vaginal examination, showed a normal-sized uterus, retroverted with free fornices, and no tenderness
- 1 x 1 cm decubitus ulcer at the posterior lip of the cervix

Q2. What laboratory tests will you perform?

Laboratory examinations:

- Urine R/M/E and C/S
- Hb, PCV, blood grouping, CBC ,RFT,LFT
- HBsAg
- X-ray of chest
- ECG
- If possible, an abdominal scan

Q3. Based on the above findings what will be your diagnosis?

POP-Q Stage III

Q4. What would be the appropriate management for the above case?

Surgical management— anterior colporrhaphy and posterior repair with vaginal hysterectomy

Case Study 3: Surgical Management

Objective: To be able to provide correct surgical management of POP

Scenario

Seti Maya Rai, 42 years old, has been diagnosed by a doctor at a primary health center in her village to have stage III POP with dribbling of urine while coughing and has been referred her to Bharatpur Hospital for further treatment.

What will you do in your initial assessment?

History:

She is a 42-year-old woman from Mangalpur VDC with four children, all home deliveries, and has had one spontaneous abortion in the past. She resumed household work immediately following all of her deliveries including carrying water and firewood from a distance of about 3 kms. She has been a chronic smoker since her teens. She gives a history of having had a mass in her vagina for the last 15 years and has dribbling of urine on coughing, laughing, and while changing her position, which has been gradually increasing.

Q1. What specific examination will help you to reach a diagnosis?

Physical examination:

- Head to toe examination
- Abdominal examination was normal
- During local pelvic examination, a mass of more than 1 cm protruding out of the plane of the hymen was noted.
- Per vaginal examination, showed a normal sized uterus, retroverted with free fornices, and no tenderness
- 1 x 1 cm decubitus ulcer at the posterior lip of the cervix
- After repositioning the mass, the woman was asked to cough and dribbling was seen on cough impulse

Q2. Based on the above findings what will be your diagnosis?

POP-Q Stage III with SUI

Q3. What would be the further management for the above case?

Refer to a higher health care center.

Module Five: Non-Surgical Management of POP

Answer Key for Exercises

1. Insertion of ring pessary is appropriate management for POP in the following situations:

Case	Yes	No
1. 35-year-old with Down's syndrome brought to facility by her elderly mother from remote village		√
2. 82-year-old female with severe arthritis of the hip	√	
3. 24-year-old female desiring further pregnancy	√	
4. Patient with offensive vaginal discharge		√
5. 60-year-old female with decubitus ulcer in cervix desiring surgical management	√	
6. 30-year-old female, gravida 4 at 10 weeks gestation.	√	

For each situation (a–f), list the advantages, disadvantages of pessary and any other possible management option:

2. What are the possible side effects of having a vaginal ring pessary?

Example	True	False
1. Slight vaginal discharge	√	
2. Back pain		√
3. Vaginal irritation	√	
4. Frothy blood-stained vaginal discharge	√	

Module Six: Surgical Management of POP

Reflective Practice—Surgical Skill Assessment

Date of assessment: _____

Date of review by facilitator: _____

What are the similarities or dissimilarities in your intra-operative care compared to the WHO surgical safety checklist? How might you use the surgical safety checklist in your practice?

Does your surgical practice differ from the tasks included in the checklist on vaginal hysterectomy? If so, why? What is your rationale?

Does your surgical practice differ from the tasks included in the checklist on anterior compartment defect repair? If so, why? What is your rationale?

Does your surgical practice differ from the tasks included in the checklist on posterior compartment defect repair? If so, why? What is your rationale?

What surgical skills related to POP do you feel you need practice in?

Module Seven: Post-Surgical Management and Follow-Up

Answer Key for Case Studies

Objectives:

- To identify post-operative complications of intra-peritoneal hemorrhage
- To be able to manage hemorrhagic shock
- To be able to perform exploratory laparotomy, identify bleeding source, and correct it

Case I

Mrs. A, who is 65 years old, underwent vaginal hysterectomy for POP. Eight hours following surgery she was found to be pale. Her pulse was 120/min and blood pressure was 80/40 mm of Hg. She had abdominal distension. Her vaginal pack was fully soaked with blood. Her urine output in the last 8 hours was 100 ml.

Q1. What is your provisional diagnosis?

- Intra-peritoneal hemorrhage

Q2. What immediate management would you do for this patient?

- Management of shock

Q3. What investigations would you do to come to your diagnosis?

- Hb, cross matching of blood, RFT, ultrasound/peritoneal tapping

Results as follows:

- Hb – 5 gm%, RFT – WNL
- USG – fluid collection in the peritoneal cavity

Q4. What is your definitive management?

- Start blood transfusion
- Exploratory laparotomy

Case II

Objectives:

- To be able to diagnose vaginal vault infection
- To be able to manage vaginal vault infection

Mrs. B, who is 50 years old, underwent a vaginal hysterectomy and pelvic floor repair two weeks ago. Her intra and immediate post-operative period had been uneventful. She has now come to the outpatient gynecology department with complaints of foul-smelling vaginal discharge and mild lower abdominal pain.

Q1. What specific examination would you do of this patient?

- Vitals
- Abdominal examination
- Local examination
- Pelvic examination

Q2. What investigations would you send for?

- CBC (total count – 18,000 cumm)
- High vaginal swab for c/s
- Ultrasound
- Speculum examination (blood-stained purulent discharge)
- Vagina looked unhealthy
- Pelvic examination (revealed small, tender mass at vault)

Q3. What is your clinical diagnosis?

- Vaginal vault infection

Q4. How would you manage this case?

- Broad spectrum antibiotic
- Betadine instillation and pericare

Case III

Objectives:

- To be able to diagnose vaginal vault prolapse

Mrs. C, a 50-year-old farmer, underwent vaginal hysterectomy and pelvic floor repair 6 months ago. She resumed her work two weeks after surgery. She started feeling something coming out of her vagina, which was more prominent while lifting heavy weight. With this complaint, she presented outpatient gynecology department. On examination, the apex of the vault was 3 cm below the hymenal remnant.

Q1. What is your diagnosis?

- Vaginal vault prolapse

Q2. What is the management for this condition?

- Vault suspension

Q3. What precautions should be taken to prevent this condition?

- Pre-operative—proper evaluation
- Intra-operative
- Identify enterocele and repair, McCall culdoplasty
- Post-operative—prevent vault infection
- Proper counseling regarding timing of resumption of work
- Pelvic floor exercise

