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# Pathogenesis, Diagnosis, Treatment, Rehabilitation and Surgical Correction of Genital Prolapse and Sexual Dysfunction in Women During Peri- and Menopause

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**Abstract** The modern methods of a regenerative physical, psychological aftertreatment, surgical correction at women are investigated. Possibilities of application of hormonal therapy, change of a way of life and rising of physical activity are exhibited. The important condition of exercise of a successful regenerative aftertreatment of women is rising their physical activity, use of the modern methods of a physical, physiotherapeutic and psychological aftertreatment in conditions of a sanatorium resort therapy.

**Keywords** Menopause, Genitals, Prolapse, Rehabilitation, Correction, Hormones, Therapy, Urogenital, Sexual, Disorders

## 1. Introduction

There is no doubt that every woman who has entered the age of pre- and menopause wants to remain healthy, in excellent physical and moral shape, to be beautiful, sexy, attractive and charming. However, not all women are familiar with such concepts as urogenital disorders (UGR), female sexual dysfunction (FSD), prolapse and prolapse of the genital organs and other associated diseases of the menopause. It is assumed that by 2030 there will be a fourfold increase in the population of 80-year-old women compared to data for today. This will undoubtedly lead to an increase in the occurrence of urogynecological disorders, female sexual dysfunction, prolapse of the internal genitalia, osteoporosis and other disorders associated with menopause, and only women are aware of the problems of this age [1,2,3]. The sexual health of a woman who has entered the period of peri- and menopause is an important aspect of her personal life, it has a versatile influence on her attitude towards society, family and her surroundings. The older generation, as you know, is not used to taking the initiative in sex, and women, having crossed the threshold of fifty, often become passive participants in the discussion of this problem. Fear of painful sexual intercourse in menopausal women can lead her to completely refuse sex. Meanwhile, it is known that the continued sexual activity of premenopausal and menopausal women is very important for maintaining the health and quality of life of a woman. As for the age limit in intimate life, it simply does not exist.

Over the years, the appearance of the female body may gradually deteriorate, but not the sexual ability. Of course, the sex life will not be the same as in the period of its heyday, but a lot of warm human relationships in our time are known, surprising with examples of harmony and happiness of many married couples, up to old age. The conversation of an obstetrician-gynecologist, urologist, sexologist, the most authoritative urologist believes, should be conducted with women suffering from urogenital disorders and sexual dysfunction (FSD) exclusively correctly, confidentially and in easy communication with the clarification of the sexual, medical, social and psycho-sexual characteristics of her sexual life. Indeed, often women, especially in peri- and menopause, are not inclined to discuss their sexual problems with a specialist. [4,14]. It is sometimes quite difficult to achieve a clear and clear idea for a gynecologist, urologist, psychoneurologist, specialist about the features of a woman’s sexual health disorders, also because they rarely seek help from doctors with intimate complaints. Today there is an urgent need for gynecologists, urologists, neuropsychiatrists and other specialists to begin to study in detail the problem of urogenital disorders and FSD together with patients, since many women do not want to bring this problem up for discussion. The sexual health of a woman in pre- and menopause is a very important aspect of her life and adversely affects not only her sexual deviations, but also the fullness of life in general. A woman's knowledge of the modern clinical manifestations of the disease, its treatment and rehabilitation of such disorders as genital prolapse, as well as urogynecological disorders associated with it, female sexual dysfunction, the possibilities of physical,

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physiotherapeutic, psychosexual methods and methods of rehabilitation, helps them avoid many tragic cases of denouement in intimate life of married couples [1,2,4,14]. Female sexual dysfunction (FSD) is available for research, but today remains a little-studied area. In recent years, the diagnostic focus and treatment has changed significantly towards strict objectivity. Ultrasonic duplex scanning of the blood flow of the vulva and clitoris against the background of video sexual stimulation, the study of vaginal secretion, vibration and temperature sensitivity of the vulva and vagina, research and treatment, and others have been widely used [4,5,8]. Many, if not the vast majority, of the problems of sexual dysfunction, including menopausal women, remain open.

Today it is difficult to find a woman over 50 who does not experience any symptoms of urogenital disorders or female sexual dysfunction. Age-related changes in the urogenital tract, "urogenital aging" in premenopause and menopause begin with mild manifestations, but with an increase in the duration of postmenopause, not only their frequency increases, but also their severity. Many women try to remain silent about their problems associated with urogenital atrophy, FSD, considering them an integral part of the menopause and aging [2,4,14,18]. Urogenital aging and FSD in pre- and menopause represent a symptom complex of secondary complications associated with the development of atrophic and dystrophic processes in estrogen-dependent tissues and structures of the lower third of the genitourinary tract: the bladder, urethra, vagina, ligamentous apparatus of the pelvic organs and pelvic floor muscles. All this combination of symptoms causes the frequent manifestation of atrophic vaginitis, cystourethritis in most women in menopause. With a menopause duration of more than 10 years, the number of cases of various urogenital disorders, atrophic vaginitis and female sexual dysfunction increases up to 73% [2,4,14].

The role of estrogen deficiency in the development of atrophic vaginitis, cystourethritis and other urogenital disorders is obvious. Age-related physiological changes occurring in menopause, due to a deficiency of estrogens and other hormones, lead to a decrease in sexual activity and FSD, dyspareunia, various climacteric forms of urinary incontinence, lack of sexual desire and orgasm in women [10,11,12,13,14].

## 2. Purpose of the Study

To improve the application of modern methods and methods of physical, physiotherapeutic, psychological, hormonal, surgical correction and rehabilitation in cases of genital prolapse in pre- and menopausal women.

## 3. Research Results

Appeared UGR in a quarter of cases acquire a long and often severe course (pain during sexual intercourse, itching and burning in the vagina, increased urination and various manifestations of urinary incontinence). There is pollakiuria - frequent urination during the day (more 6-8 episodes per day), with the release of a small amount of urine with each urination. Cystalgia - frequent, painful urination cuts in the urethra. Nocturia - increased urge to urinate at night (more than one episode). The term "nocturia" in urology is used to refer to any awakenings during sleep followed by urination. Symptoms of nocturia in pre- and menopause worsen with age and entail structural abnormalities sleep and daytime sleepiness, which, together with frequent awakenings at night, predispose to falls, injuries, and fractures, especially with the concomitant development of menopausal osteoporosis in women [1,2,4,13,14]. Urinary incontinence adversely affects women's sexual health. Urinary incontinence was significantly associated with low libido, vaginal dryness, and dyspareunia regardless of age, education, and race, while pelvic genital prolapse was not associated with any of the sexual complaints. Women with urinary incontinence are more distressed about their sex life than women without urinary incontinence. The fear of losing urine during sex significantly reduces sexual health [1,2].

The state of sexual dysfunction in these patients is the strongest predictor of quality of life loss among these women [1,2,13,14]. It should be noted that pathological personality disorders caused by the sexual sphere are a key component of female sexual dysfunction [13,14,19]. The main symptoms in this case were pollakiuria, cystalgia, nocturia accompanied by an imperative urge to urinate and the syndrome of an overactive bladder and IC [4,13,14]. In addition, in more than two-thirds of menopausal women with severe (II-III degree) genital prolapse, there were violations of the urodynamics of the upper urinary system, which contributed to ascending infection. Confirmation of this was revealed in 75% of the examined patients pyuria. Stress urinary incontinence and others the above urogynecological disorders occurred in more than a third of menopausal women with prolapse of the internal genitalia, which was confirmed during their clinical examination and preparation for surgical correction. This was established after a test with a tampon applicator. Consequently, the valvular mechanism of urinary incontinence in menopause occurred in every third woman with stress urinary incontinence [10,11]. The syndromes of urogenital disorders described by us in menopausal women (pollakiuria, nocturia, cystalgia), female sexual dysfunction are considered by many authors in close connection with estrogen deficiency and subsequent atrophic changes occurring in the urogenic and vascular systems of the urethra [1,2,4,15]. It has also been proven that the proximal urethra, Lieto's triangle, vagina, distal urethra, paraurethral glands are closely related, both embryologically, anatomically and functionally. So endoscopically, one can observe an adequate pale atrophic mucosa of the urethra, urinary bladder and vagina with translucent multi-layered capillaries that bleed when touched. An endoscopically similar picture is also identical in the vaginal epithelium in senile colpitis [1,2,10,11]. Estrogen deficiency in menopause

is the most important factor affecting the composition of connective tissue, its structure and biochemical characteristics. Consequently, the progressive decrease in the level of estrogens in menopause gradually leads to the development of both prolapse of the internal genitalia and various urogenital disorders associated with it and female sexual dysfunction with all its clinical manifestations.

However, it is clear that estrogen deficiency can play its restorative role up to a certain point. Then its actions are significantly aggravated, metabolic changes in tissues become irreversible, limiting the pathogenetic effect of the late use of HRT, which indicates the need for timely its implementation. All this can often lead to the development in menopausal women of the so-called hyperactive detrusor function, characterized by involuntary contractions of the detrusor during bladder filling phases. In such cases, urine loss can occur both spontaneously and provoked (with its rapid filling, change in posture, coughing, fast walking, jumping, etc.) [13]. In perimenopause and late menopause, in cases of severe urological disorders, women completely or almost completely lose urine. Relaxation of the pelvic floor muscles occurs when moving from a horizontal to a vertical position, for example, during intercourse and even in a dream. The listed combination of urogynecological disorders, female sexual dysfunction and other pathologies (genital prolapse, psychosexual disorders, dementia) in menopause occur in 78% of women [10,11]. Urogenital disorders in menopausal women more often corresponded to various stages of partial or complete prolapse of the internal genital organs. At the same time, the older the women were, the more often urogenital disorders were observed [10,11,13,14]. Impaired support of the anterior segment of the vagina with the involvement of the bladder, we have identified more than two-thirds of women in menopause, accompanied by functional disorders of the urinary system in 83% of women. With a duration of menopause of more than 10 years, the number of cases of urogenital disorders increases and atrophic vaginitis (up to 76%). Our clinical and rehabilitation experience shows that 84% of women need the use of modern methods and methods of surgical correction, gynecological massage, modern physical and hormonal rehabilitation, especially in the initial stages of genital prolapse, which allows 2.5 times to reduce the risk of developing urogynecological disorders, female sexual dysfunction and maintain quality of life in menopause [10,11]. It is known that menopausal women suffering from urogynecological disorders fall into a vicious circle: due to painful sensations, they limit themselves in physical activity, become inactive, lead a passive lifestyle, and do not exercise. While women who actively continue to exercise have fewer urogynecological disorders and symptoms of female sexual dysfunction than those who do not exercise at all. Insufficient physical activity in menopausal women contributes to obesity, osteoporosis, reduces the sensitivity of skeletal muscles, pelvic floor muscles, perineum, the manifestation of urogynecological disorders, prolapse of the internal genital organs and female sexual dysfunction. Under the condition of good physical condition, the absence of well-known contraindications: high blood pressure, normal electrocardiogram, we recommend [10,11,12] women of menopausal age actively engage in physical exercises and modern methods of physical rehabilitation.

First of all, you can and should do physical exercises that are feasible for your age, be sure to do morning exercises or jog, go to the pool or gym three times a week, walk at a fast pace for half an hour. At the same time, we recommend that you take seriously the development of methods of breathing exercises according to K. S. Strelnikova and especially according to K. P. Buteyko [17,19]. Our recommendations should adhere to the available complex of modern physical rehabilitation. This is, first of all, to observe a healthy lifestyle, to fulfill the regime of work and rest, to sit less in front of the TV, especially in an uncomfortable position, to give up bad habits (smoking, alcohol, etc.). Achieve overcoming stress with the help of active physical movement, relaxation, autogenic training in conjunction with breathing exercises, active psychological and social activities. Hygienic gymnastics in the morning can be performed while standing, lying in bed, with the obligatory inclusion of all muscle groups in the work. It is necessary to perform physical exercises easily, adhering to caution and self insurance.

In the sanatorium and resort conditions, water procedures or local massage (hydromassage, Charcot shower, Scottish shower), elements of psycho regulation and correction, relaxing and soothing herbal medicine with fragments of modern music therapy, modern methods of physical and physiotherapeutic rehabilitation are successfully carried out. One of the most important conditions for the effectiveness of the rehabilitation program should be the patient's trust in the doctor of exercise therapy, a rehabilitation specialist, a positive attitude towards exercise therapy, health fitness, regular morning exercises, walking, aerobics, aqua aerobics and hardening. A positively colored effect has on the psychological and emotional state of the patient during physical rehabilitation classes and medical control over her condition. Physical rehabilitation, an active lifestyle, a sanatorium regimen and treatment allow the most successful combination of hormonal therapy, physical, physiotherapeutic therapeutic and rehabilitation measures with a favorable and benevolent psychological environment on the part of a gynecologist, urologist, psychoneurologist, rehabilitation specialist and nurses of the sanatorium department. All this contributes to the successful treatment and rehabilitation of women with urogynecological disorders and female sexual dysfunction in menopausal syndrome. A change of scenery during sanatorium treatment, a change in lifestyle, the absence of a number of unfavorable home and family conditions, allow a woman to focus on the treatment and rehabilitation process and successfully master modern methods of her recovery [7,10,11,12].

## 4. Conclusions

The problem of prolapse of the pelvic internal genital organs, concomitant urogenital diseases, sexual dysfunction and other disorders that occur in women over the age of 50 and have further developed in menopause and postmenopause remain completely unexplored. Urogenital aging and FSD in menopause is a symptom complex of secondary complications associated with the development of atrophic and dysplastic (dystrophic) processes.

In estrogen-dependent tissues and structures of the lower third of the genitourinary tract: bladder, urethra, vagina, ligamentous apparatus of the genital organs of the small pelvis and pelvic floor muscles.

An important condition for the successful rehabilitation of women is the modern surgical correction of genital prolapse, the elimination of urological disorders, female sexual dysfunction, and lifestyle changes. Increasing their physical activity, using modern methods of physical, physiotherapeutic and psychological rehabilitation in the conditions of sanatorium-and-spa treatment. Further studies are expected to be carried out in the study of the long-term consequences of the treatment of this pathology in women.

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