

2.2 Pelvic organ prolapse-related problems

Pelvic organ prolapse (POP) refers to the descent of the bladder, uterus, or rectum into or beyond the vaginal canal due to impairment of the supportive structures of the anterior vaginal wall, apex, or posterior vaginal wall. Connective tissue remodeling during pregnancy, sustained pelvic floor loading, and excessive stretching or avulsion of the levator ani muscle, as well as obstetric trauma during childbirth, are important antecedents. Vaginal delivery-particularly instrumental delivery or a prolonged second stage of labor, can significantly increase the risk of early postpartum anterior and posterior compartment prolapse. Studies have shown that approximately 9% of women may develop stage II prolapse involving the anterior and/or posterior vaginal wall at 6-8 weeks postpartum, with higher risk among those with vaginal delivery, multiparity, advanced age, higher BMI, and larger fetal birth weight (Gao et al., 2024). Although the proportion of early symptomatic prolapse may be relatively low, objective anatomical descent may indicate a gradually progressive prolapse process in the future.

Clinically, early-stage prolapse often presents with nonspecific symptoms, such as perineal heaviness, a sensation of vaginal bulging, or lower abdominal discomfort, and may be accompanied by urinary, bowel, and sexual dysfunction as the condition progresses. More importantly, symptomatic postpartum prolapse is significantly associated with impaired quality of life, psychological well-being, and sexual health. Compared with women without prolapse, those with prolapse are more likely to experience dyspareunia, reduced sexual satisfaction, impaired body image, and poorer psychological distress indicators (VanWiel et al., 2024). However, prolapse symptoms may be underestimated due to feelings of embarrassment or normalization beliefs. Therefore, nursing assessment should combine standardized questionnaires with targeted symptom inquiry, such as asking about vaginal bulging or heaviness and the need for manual assistance during defecation, while using tools such as the PFDI-20 and pelvic floor impact questionnaires to quantify symptom distress and functional impact. This approach provides a basis for conservative management (e.g., pelvic floor muscle training) and referral to urogynecology services (Gao et al., 2024; Beamish et al., 2024).

2.3 Sexual dysfunction and bowel function abnormalities

Sexual dysfunction and bowel function abnormalities are relatively concealed yet equally important components of postpartum PFD. Due to cultural factors, privacy concerns, and stigma, these issues are infrequently discussed, resulting in insufficient nursing assessment. Postpartum sexual dysfunction may manifest as dyspareunia, decreased libido, disorders of sexual arousal or orgasm, a sensation of vaginal laxity, and reduced sexual satisfaction. Its occurrence is influenced by multiple factors, including perineal trauma, hormonal changes, body image concerns, psychological distress, and alterations in pelvic floor neuromuscular function (Jansson et al., 2024; Sitaraman et al., 2025). Studies among primiparous women indicate that among those who resume sexual activity at 6-10 weeks postpartum, up to two-thirds report dyspareunia, and nearly half perceive sexual problems as significantly distressing. These findings suggest that “resumption of sexual activity≠restoration of sexual health,” highlighting the need for more nuanced nursing assessment and support. In addition, longitudinal evidence suggests that while some urinary symptoms may improve within the first postpartum year, sexual function may decline over time, underscoring its dynamic and complex nature (De Amorim et al., 2025). Systematic reviews further demonstrate consistent associations between PFD and adverse postpartum mental health outcomes, such as depression and anxiety, emphasizing the importance of integrating sexual health and psychological health into routine assessment frameworks (VanWiel et al., 2024).

Postpartum bowel dysfunction includes fecal incontinence, flatus incontinence, constipation, straining during defecation, incomplete evacuation, and anorectal discomfort. These conditions are primarily associated with injury to the anal sphincter complex, pelvic floor muscles, and pudendal nerve during childbirth, with higher risk among women who have undergone episiotomy or sustained obstetric anal sphincter injuries (Sitaraman et al., 2025). Research indicates that the incidence of anal incontinence during the first postpartum year ranges from approximately 2% to 15%, while an even larger proportion of women experience constipation, abnormal flatus, and anorectal discomfort. However, due to high levels of stigma, these problems are often concealed, resulting in long-term unmet nursing care needs (Sitaraman et al., 2025). Therefore, nursing assessment should, within a framework of privacy-respecting and culturally sensitive communication strategies, incorporate items related to