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**What you need to know about:**

# Vaginal Repair Surgery for Prolapse

- **Anterior vaginal repair**
- **Posterior vaginal repair**
- **Vaginal hysterectomy**
- **Sacrospinous ligament fixation**
- **Sacrospinous hysteropexy**
- **Manchester repair**
- **Colpocleiesis**
- **Use of mesh**

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## What is a prolapse?

A prolapse is like a hernia and is caused by the uterus (the ‘womb’) and/or the vagina losing support and ‘dropping down’. A prolapse is usually caused by having children or getting older (‘wear and tear’). Excess weight, family history, excessive lifting or chronic coughing may play a role.

There are various types of prolapse which can happen on their own or often together:

- A prolapse of the front of the vagina is called a ‘cystocele’, often referred as a ‘bladder prolapse’.
- A prolapse of the back of the vagina is called a ‘rectocele’, often referred as a ‘bowel prolapse’.
- A prolapse of the ‘womb’ is called a ‘uterine prolapse’.
- A prolapse of the top of the vagina in women who have had a hysterectomy in the past is called a ‘vaginal vault prolapse’.

## Your surgery explained

### Choice of surgical procedure/repair:

Your surgeon will suggest the most suitable procedure for you depending on the type and severity of prolapse, whether you are having a first or repeat operation, your level of fitness, your age, weight and whether you are sexually active. Sometimes a final decision on the type of surgery needs to be made when you are under anaesthetic, and your surgeon can make a better assessment.

**Anterior vaginal repair** (‘bladder prolapse’ or ‘cystocele’): ‘Folding’ of the tissues behind the front of the vagina. Performed when women have a prolapse of the front of the vagina.

**Posterior vaginal repair** (‘bowel prolapse’ or ‘rectocele’): ‘Folding’ of the tissues behind the back of the vagina. Performed when women have a prolapse of the back of the vagina.

Vaginal hysterectomy:
Removal of the uterus (‘womb’) through the opening of the vagina. Performed when the whole uterus has dropped. An abdominal incision (cut) may be necessary if complications arise. The ovaries are not normally removed (unless a problem is identified before or during the operation). Cervical smears are not usually needed after this operation.

**Sacrospinous ligament fixation:**
‘Suspension’ of the top of the vagina. Performed when women have a prolapse of the top of the vagina (‘vaginal vault prolapse’) after they have had a hysterectomy, or sometimes at the same time. This is an operation where top of vagina or the cervix (neck of womb) is attached to a pelvic ligament (sacrospinous ligament) with a stitch. There are no cuts in the tummy.

**Sacrospinous hysteropexy:**

'Suspension' of the uterus ('womb') when women prefer to avoid a hysterectomy. May be less successful than a hysterectomy.

**Manchester repair**:

Removal of part of the cervix usually combined with an anterior and/or posterior vaginal repair. Performed when the cervix ('neck of the womb') is low but the remainder of the womb is still high. Routine cervical smears will continue to be taken as usual.

**Colpocleiesis:**

This 'tight' repair closes the vagina. It is suitable for some women who are no longer sexually active.

**Use of mesh:**

Mesh has been developed to make repairs stronger, because repairs without mesh may fail or may not last long. Mesh can be made of animal tissues (biomesh) or plastic (synthetic). Using mesh is a relatively new way of performing repairs and doctors are not sure of the long-term effects.

Vaginal mesh is usually used when:

- The patient's own tissues are very weak and the surgeon feels that a repair without mesh might not be successful.
- The top of the vagina needs to be supported as part of a sacrospinous ligament fixation or sacrospinous hysteropexy.

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- Vaginal synthetic mesh are currently restricted for use. The mesh uses are only allowed for procedures call sacrohysteropexy (attachment of uterus to sacrum) or sacrocolpopexy (attachment of vagina to sacrum). Both these procedures are done through the tummy.

- The same type of prolapse has occurred and the patient is having a repair.
- The alternative is doing another operation which might not be suitable or possible.

**Are there any alternatives to surgery?**

- **Do nothing** if the prolapse is not too bothersome treatment is not necessarily needed. If however the prolapse permanently protrudes through the opening to the vagina and is exposed to the air, it may become dried out and eventually ulcerate . even if it is not causing symptoms in this situation it is probably best to push it back with a ring pessary (see below) or have an operation to repair it. Weight reduction in overweight women and avoiding risk factors such as smoking (leading to chronic cough), heavy weight lifting jobs and constipation may help with symptom control. The prolapse may become worse with time but it can then be treated.
- **Pelvic floor exercise (PFE).** The pelvic floor muscles support the pelvic organs. Strong muscles can help to

- prevent a prolapse dropping further. PFE are unlikely however to provide significant improvement for a severe prolapse protruding outside the vagina. A women's health physiotherapist can explain how to perform these exercises with the correct technique. It is important that you try the above to help to manage the symptoms of your prolapse and to prevent it becoming worse. It is also important to continue with your pelvic floor exercises even if you have opted for other treatment options.
- **Pessary**. A vaginal device, a pessary may be replaced in the vagina to support the vaginal walls and uterus. A pessary is usually used continuously and changed by a nurse or doctor every 4 to 12 months depending upon the type used and how well it suits you. Alternatively, if you prefer, you may be taught to replace the pessary yourself. It is possible to lead a normal life with continuation of activities such as bathing, cycling, swimming and in some cases, sexual intercourse. Ongoing care is often at the GP practice but some women will need to be kept under review in the Gynaecology clinic. Pessaries are very safe and many women choose to use one long term rather than have an operation. On occasions their use has to be discontinued due to bleeding, discharge, sexual difficulties or change in bladder function but these all stop quickly after removal. Sometimes it will take several visits to the clinic to determine the best size for you. A pessary is not suitable for all women.

**How is a vaginal repair going to help me?**

The main effect of a repair operation is to treat the uncomfortable bulge that you feel at the entry of the vagina. It may not ease any bladder, bowel and sexual problems that are not related to the prolapse. This will be discussed in detail by your surgeon.

Vaginal pain and backache are not usually due to a prolapse and are not expected to improve.

**How successful is vaginal repair surgery?**

Approximately one in three women who have a vaginal repair will experience a return of the prolapse sooner. Repeat surgery might be needed.

**Preparations before the operation**

- A pre-assessment will determine your fitness for surgery and can take place face-to-face or during a telephone conversation. You will be placed on the waiting list for surgery. You will be given a minimum of one week's notice of the pre-assessment and a minimum of two week's notice of your surgery date.
- You will usually be seen by your surgeon either 1-3 weeks before the operation to sign your consent and discuss details or the consent will be taken in pre-assessment clinic or during consultation at the gynaecology clinic.
- **Personal care**: Shower or bath on the day of surgery, avoiding the use of body creams, talcum powder, deodorants or make-up. Remove nail varnish, all jewellery, and body piercing. A surgeon might ask you to shave, this needs to be done a few days before the operation to avoid scratches on the skin and reduce the risk of infection. You should avoid becoming constipated before your operation; this is to avoid excessive straining afterwards. Use laxatives if necessary.

## What should I bring to hospital?

- Dressing gown, slippers, pyjamas (or night dress) and comfortable clothes (e.g. track suit) to wear while you are recovering.
- A wash bag with toiletries and a small towel.
- Your medicines.
- A small amount of change for the purchase of newspapers and magazines.
- Other items (if used): glasses, contact lenses, hearing aids, dentures, etc.

Avoid bringing valuables as the hospital cannot accept responsibility for loss or damage to any personal property unless it has been handed to staff for safekeeping.

## What happens on the day of my operation?

- **Fasting:** You should not eat for six hours before your operation. This means that if you have a morning operation you should not eat after midnight. If your operation is in the afternoon you can have an early breakfast and should not eat after 7.30 a.m. You can drink water (or any drink cartons provided) before you leave your home.
- Advice on your medications will be given at pre-assessment.

- Admission is usually at 7.00 a.m. for morning surgery and 9.30 a.m. for afternoon surgery.
- Your anaesthetist will usually see you on the day of your operation.
- When your turn comes you will be taken to the operating theatre.
- After the operation you will wake up in recovery with a drip (to receive fluids), a catheter (to empty the bladder) and a vaginal pack (to stop vaginal bleeding).

**What pain-relief is available?**

The degree of pain and discomfort experienced following surgery varies. Often pain-relief is given by mouth, rectally (as a suppository) or by injection. Pain management can also be given by patient-controlled analgesia (an infusion into the arm, which is triggered by the patient pressing a button). After about 12-24 hours the strong pain-relief (containing morphine) will not usually be required and can be stopped. Tablets and suppositories should be sufficient to reduce any discomfort. This will allow you to get out of bed and mobilise, helping to reduce the risk of complications.

**What happens after the surgery?**

**Mobilisation/eating and drinking**

Immediately after the surgery you will be allowed to drink water.

Once the strong (morphine based) pain-relief have been stopped, you should be able to eat and drink freely and get out of bed. The vaginal pack, drip and catheter are usually removed the day after the operation.

**Physiotherapy**

The best way to keep your chest clear and maintain good circulation is getting out of bed and walking, ideally from the first day after your operation. Regular use of pain-relief can help you to move and cough while keeping you comfortable. Perform deep breathing exercises and cough if you have phlegm in your chest. If you need assistance, ask for help.

**Hygiene**

You will probably be able to have a shower on the first or second day following your operation and then daily. Having a short bath will be possible when you can comfortably get in and out.

**Bladder and bowel function**

The bladder might not be able to empty well after surgery. The catheter is usually removed 24-48 hours after the operation, but some patients need it for longer and might need to go home with a temporary catheter (and come back to have it removed at a later date) or need to learn to self catheterise to empty the bladder. After removing the catheter, patients often feel irritation

when passing urine and the flow is slower than before the operation. This condition can last for a few days.
The bowel may also be slow to work and constipation is very common after repair surgery. Laxatives are usually provided. It is very important to avoid hard motions and excessive straining.

**Discharge from hospital**

Patients will usually go home 1 to 3 days after vaginal surgery. Sometimes, after small repairs it is possible to go home the same day. You should be mobile and comfortable and there should be no evidence of complications.

**What happens after discharge from hospital?**

**Wound healing / vaginal discharge**

Pain, discomfort and bruising in the vagina should settle within a week or two. Unusual sensations such as tingling, numbness or itching are common and can be long-lasting. The vagina feels ‘lumpy’. A slight discharge/bleeding is usual for up to 6-8 weeks as the vagina heals and stitches dissolve. It is possible for the discharge to contain threads from dissolving vaginal stitches. Contact your GP if the discharge becomes offensive smelling or bright red/heavy.

**Hygiene**

It is impotant to keep the vagina clean by washing at least twice a day and changing your pads frequently. Showers are fine.

Bathing should be short, avoiding the use of 'bubble bath' in the water.

## Pelvic floor exercises

Pelvic floor muscles support your bladder and bowel and strengthening them may avoid continence problems in the future. You can perform pelvic floor exercises as soon as you feel comfortable. Ask for advice.

## Lifting

Heavy lifting should be avoided for up to three months after your operation to allow for adequate healing. You can lift without concerns anything that can be lifted easily and without a strong effort. When you are lifting, brace your pelvic floor muscles and your stomach muscles to help support your back and the organs in your pelvis.

## Rest and mobility

After surgery it is normal to feel tired and you will need to take it easy and rest for at least two weeks. You may need help for household jobs. However, it is important to remain mobile, get up and walk regularly. It is quite safe to go up and down stairs from the day you go home if you feel well.

If your mobility is reduced for any reason it will be important to move your legs as often as possible to reduce the risk of

thrombosis (developing clots in your legs and lungs). Your doctor may advise you to use your hospital stockings (TEDS) for a few weeks.
Build up your activity gradually and be guided by how your body responds.

**Eating**

Some people find that their appetite changes and they get a ‘bloated’ feeling or indigestion after meals. These symptoms usually clear up by themselves as you become more active. Small meals taken regularly can reduce the likelihood of this happening.

**Driving**

It is usually safe to drive a car 4-6 weeks after your operation but it depends if you are confident to do an emergency stop and whether you can concentrate enough to drive. Check with your insurer first.

**Back to work**

You will need to be off work for 4-6 weeks. If you have a very physical job that requires lots of lifting you may need to be off work for longer, possibly 2-3 months. You will be advised by your surgeon. A medical certificate can be arranged for you at discharge from hospital.

**Sport and activities**

Gentle swimming is good exercise and can be started after 4-6 weeks. More strenuous sports can be started after 12 weeks but should be built up gradually over a few weeks.

**Making love**

You are advised to wait approximately eight weeks after the operation to be sure that the vagina is completely healed. Obviously your husband or partner should be gentle at first. It may also help to use a lubricant such as K.Y. jelly, SILK or YES.

**Post-operative check**

Women will have their post-operative check either in the community with a telephone call from one of our nurses or secretary or via a gynaecological outpatient appointment. Both will take place approximately three months after the operation. If the check is done via telephone, the nurse or the secretary will contact you beforehand to book the time of the call. You will be asked about your progress and given the opportunity to discuss any relevant issues. An appointment can be arranged if necessary.

If you have any concerns beforehand, an earlier telephone call or consultant appointment can be arranged if necessary.

## Complications of surgery

Surgery for prolapse is generally safe but as with all operations risks and complications can occur. You need to know about them for two important reasons:

- To help you and your surgeon make a decision on the most appropriate treatment. This might involve alternatives to surgery.
- To help you recognise the complications early, so that treatment is not delayed.

Risks and complications related to the anaesthesia are rare and will be explained separately by your anaesthetist.
If your risk of complications is increased your doctor will tell you. The risks are generally increased when your operation is more major and / or when you are affected by conditions that make the surgery more risky, for example, diabetes, heart or chest problems, excess weight, etc. Having had surgery before in the same part of the body also increases risk as the tissues will be ‘glued’ together by scars and adhesions.

Many complications are linked to reduced mobility and being unable to get out of bed. It is important that you regain mobility as soon as possible. Pain-relief will be provided and you will get help from nurses and physiotherapists.

All operations (major and minor) can occasionally cause bleeding, infection or thrombosis. In general, the more major the procedure, the greater the risk. These complications can be serious, but are usually easily manageable when detected at an early stage. Blood transfusion can be life-saving and is very safe. If you have objections to blood transfusion you must inform your surgeon at the earliest possible time. Please inform your surgeon if you take medications that can affect blood clotting e.g. aspirin, clopidogrel, warfarin, hormones, etc.

Sometimes after vaginal surgery bruising and bleeding forms a clot behind the vagina, called a 'haematoma'. The blood usually dissolves without treatment, but occasionally a haematoma can cause pain and infection and sometimes the clot needs to be removed with a surgical procedure.

Conversion of vaginal surgery to abdominal surgery, means needing to open your 'tummy' and is occasionally required when unexpected problems arise.

All operations can lead to discomfort and pain. This is usually short-lasting (hours or days), but occasionally scars can lead to long-lasting pain. When scars are in the vagina the result can be pain during intercourse. Prolonged pain due to scars can be difficult to treat.

An operation such as the ‘sacrospinous ligament fixation’ can cause buttock pain (similar to sciatica). The pain occurs because nerves close to stitches can become irritated by bruising or can get caught in the sutures. This type of pain is called a ‘neuralgia’. It is usually temporary and lasts a few days only, but in a few patients the pain can be prolonged and difficult to treat.

The use of mesh materials can increase the risk of prolonged pain, prolong infection, higher repeat surgery rate to deal with mesh complications like mesh extrusion, painful intercourse.

The position required to perform a vaginal operation (legs raised and open) can sometimes cause back problems, such as a disc hernia or worsen existing backache.

Surgery can occasionally cause injury to internal organs that are close to the vagina, womb and ovaries. These are the bladder, the bowel and the ureters (the ‘waterpipes’ that carry urine from kidneys to bladder). The risk is usually very small around 1:100 cases but may be greater when surgery is difficult e.g. if there are scars from previous surgery.

Often these injuries are recognised and treated during the surgery. This can involve more major surgery than originally planned. Unfortunately injury to internal organs sometimes shows

at a later stage, even after discharge from hospital. If you have any concerns you must report them to your GP.

Adhesions might develop after surgery if a vaginal hysterectomy has been performed as part of the repair. Adhesions have the effect of sticking tissue together. Rarely adhesions can result in a bowel blockage. This might happen soon or long after the operation.

**Problems with bladder or bowel function:**
Constipation is common, usually temporary and easy to manage. It is advisable to come for surgery having had a recent bowel motion. Long-lasting constipation is occasionally reported after pelvic surgery. It is advisable to avoid constipation to prevent recurrence of symptoms.
Difficulty with passing urine (urinary retention) is also common and usually temporary. It requires the use of catheters, and patients may be discharged home with a temporary catheter usually fitted for no longer than a week or two, or after learning to use the catheters themselves to empty the bladder (intermittent self-catheterisation).
Prolonged or permanent urinary retention (requiring long-term use of catheters) is rare (around 1% of patients) and usually

occurs in patients who have neurological (‘nerve’) problems e.g. back problems with disc prolapse. It can be difficult for doctors to predict this complication in advance.
Urinary incontinence (a ‘leaky bladder’) can occur after surgery because of infection, nerve irritation or changes in the position of the vagina and the bladder. Sometimes having a prolapse can stop women from leaking urine and treating the prolapse with surgery can ‘unmask’ a leaky bladder. This problem may need further surgery (this is more likely if the prolapse was severe).

Mesh is sometimes used to make vaginal repairs stronger. Using mesh can lead to complications and this depends on the type of mesh used and the type of operation.
Synthetic (plastic) mesh is very strong and permanent. There is evidence suggesting that this type of mesh makes a repair stronger. However, complications such as chronic pain, pain during intercourse or mesh ‘erosion’ on the vaginal surface can occur in up to 10-15% of patients. Problems due to synthetic mesh can be difficult to treat.
Biomesh (mesh derived from animal tissues) is slowly absorbable and is probably not as strong as plastic mesh. However, there is evidence suggesting that this type of mesh also makes vaginal repairs stronger. Complications using biomesh are very uncommon. We generally prefer to use this type of mesh for vaginal repair procedures.

Your surgeon will tell you about any specific concerns which may apply to you personally. Please feel free to discuss your concerns and ask questions when you provide your consent.

| Complication | Very common (up to 1 in 10) | Common (1 in 100 to 1 in 1000) | Uncommom (1 in 100 to 1 in 1000) |
|---|---|---|---|
| Bleeding( mild) | | x | |
| Bleeding(severe) | | | x |
| Infection (mild) | | x | |
| Infection(severe) | | | x |
| Cystitis | x | | |
| Thrombosis | | x | |
| Injury to internal organs | | | x |
| Bladder retention(temporary) | | | x |
| Stress urinary incontinence | x | | |
| Urge urinary incontinence | x | | |
| constipation | x | | |
| Sexual dysfunction | | x | |
| Chronic pain | | x | |
| Mesh erosion | | x | |
| Recurrence of same problem in future* | x | | |

Recurrence rate is 15-30%. Around 3 in 10 women who have operations for prolapse will require treatment for another prolapse.

**Further information**

The Internet is a useful and powerful source of information. We have selected reputable sites where patients can obtain valid information about their condition and proposed surgery.
Please follow the instructions to navigate each site:

**International Urogynecological Association (IUGA)**
http://www.iuga.org Go to 'Patient information' / 'Patient brochures' (remember to 'select language')

Pelvic organ prolapse
Sacrocolpopexy

**British Society of Urogynaecology (BSUG)**
http://www.bsug.org.uk
Go to 'Guidelines and Information' / 'Patient Information'

Sacrocolpopexy for vault prolapse Sacrohysteropexy for uterine prolapse

**MHRA-** The Medicines and Healthcare products Regulatory Agency (MHRA) is a government body for the regulation of medicines and medical devices and equipment used in healthcare and the investigation of harmful incidents. Side effects and complications of mesh such as pain, mesh erosion can be reported to your clinician or to MHRA directly through yellow card scheme.

You can access yellow card scheme via following link

“https://yellowcard.**mhra**.gov.uk”

**Useful contacts:**

**Re-scheduling of surgery**
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Directorate of Women and Child Health
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