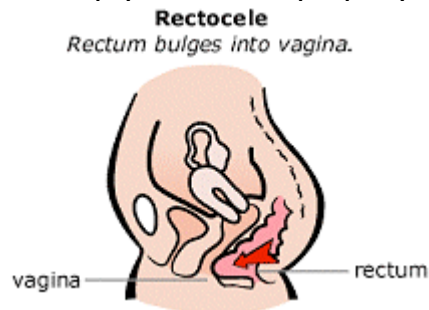


# Pelvic Floor Repair with or without Vaginal Hysterectomy for Prolapse

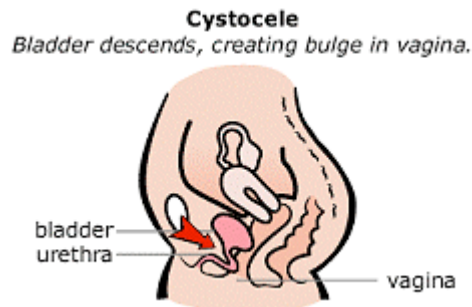
## Patient Information Leaflet

What is a prolapse?

Sometimes the vagina is no longer held up properly, leading to a weakness or bulge called a prolapse or rectocele. A prolapsed rectum (back passage) may drop down onto the back of the vagina making you feel uncomfortable or perhaps making it difficult to empty the bowel properly.

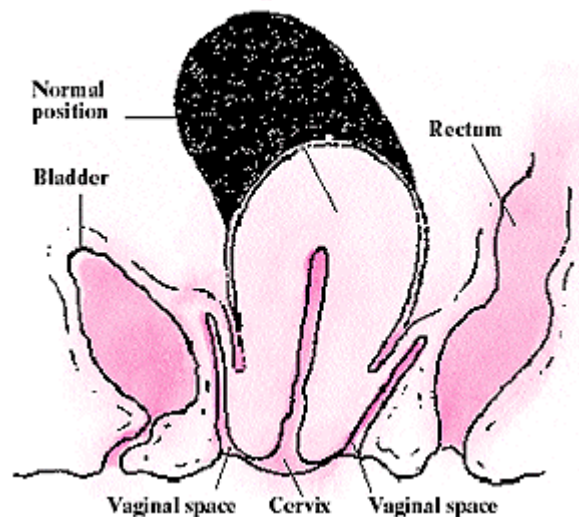


A weakness at the front of the vagina can cause similar problems with discomfort and may cause trouble with emptying the bladder, urine infections or the need to pass urine often. It is another type of prolapse and called a cystocele.



Weakness of the supports which hold up the uterus (womb) may cause the cervix (neck of the womb) or the whole uterus to bulge through the opening of the vagina. This is called a uterine prolapse.

## Uterine Prolapse



### What is prolapse surgery?

Women who suffer from symptoms related to prolapse of the vaginal wall may be offered pelvic floor repair. This is called an anterior repair if the front wall of the vagina (between the bladder and the vagina) is to be repaired. If it involves the back wall of the vagina (between the rectum (back passage) and vagina) it is called a posterior repair.

Where the uterus (womb) is prolapsing a vaginal hysterectomy may be considered as part of the operation. Sometimes additional procedures are included to try and reduce the risk of the prolapse returning. These will be discussed with you separately.

In a vaginal wall repair operation you will be offered either a general anaesthetic (where you will be completely asleep) or a regional block eg spinal anaesthetic (where the part of your body being operated on is completely numb and you feel no pain). A small cut is made in the skin of the vagina and the supports to the bladder or rectum are shortened with stitches. Sometimes a patch of synthetic mesh or a supporting tissue is used to achieve a stronger result especially if your own tissues are very weak. The bulging part of the vaginal skin is removed and the vaginal wound is stitched up with dissolving stitches. You are likely to have a catheter (tube) placed in your bladder for a day or two after the operation to make you more comfortable. Sometimes a vaginal pack (like a large tampon) will be left in immediately after your operation to reduce bleeding. You are likely to be in hospital for 3-5 nights until you are passing urine and able to empty your bowels normally.

In a vaginal hysterectomy the uterus is removed through the vagina. The blood vessels and ligaments that support the uterus are cut and stitched and the top of the vagina is supported. If you have been having periods up to the time of your

operation these will obviously stop and you will not be able to have any more children. As the cervix (neck of the womb) is removed with the uterus you will no longer need smear tests unless you have been advised to continue with these because of abnormal smears before the surgery. The ovaries are not usually removed but this is sometimes possible.

### **What are the alternatives to surgery?**

If you leave things as they are they may remain as they are or the prolapse may slowly get bigger. If your symptoms worsen you may then decide that you would like to reconsider the options including surgery. In some women a pessary (ring or shelf) can be fitted into the vagina to provide a comfortable support. A pessary is a plastic device which is fitted by the doctor. Once in place you should not feel it at all. It and the vagina need to be checked every 3-6 months. If you have reached the menopause you may also be advised to use either estrogen cream or a small estrogen tablet in the vagina regularly to keep the skin healthy and reduce chafing and discharge. Some women with prolapse may benefit from physiotherapy which can help to strengthen the vaginal supports. A prolapse is not a serious disease but it can cause nuisance symptoms.

### **Intended benefits of surgery**

Prolapse surgery is to improve or resolve the symptoms of prolapse.

### **Serious or frequently occurring risks**

- ◆ Damage to bladder/urinary tract
- ◆ Damage to bowel
- ◆ Excessive bleeding requiring transfusion or return to theatre
- ◆ Long term disturbance of bladder function
- ◆ Pelvic abscess
- ◆ Venous thrombosis or embolism (clots in the legs or lungs)
- ◆ Dyspareunia (painful sexual intercourse)
- ◆ Pain in the vagina
- ◆ Failure to achieve desired results; recurrence of prolapse (about 1:3 lifetime risk of the prolapse coming back)

### **Frequent risks include**

- ◆ Urinary retention
- ◆ Vaginal bleeding
- ◆ Frequency of passing urine or infection
- ◆ Pain

### **Any extra procedures that may become necessary during the procedure**

- ◆ Blood transfusion: 2 women in every 100 undergoing vaginal hysterectomy will require blood transfusion during the operation
- ◆ Other procedures

- ◆ Repair of bladder and bowel damage
- ◆ Laparotomy and conversion to abdominal approach

Where serious complications arise during the course of operation other procedures will only be performed if they are necessary to preserve life or prevent serious harm to future health.

### After the operation –In Hospital

You will have an intravenous drip to give you salt sugar and water until you are back to eating and drinking normally. You may have a bladder catheter in place for a day or two. There may be a pack in the vagina. The wound may be painful. You may receive painkillers by injection or tablet or you may have a button switch (PCA Patient Controlled Analgesic) on a wrist band to press when you have pain. You will have a blood stained discharge which will settle over a few weeks as the wounds in the vagina heal. There is usually very little bleeding by the time you leave hospital. The stitches dissolve but there will sometimes be a little more bleeding when the knots fall off. Do not use tampons for 6 weeks as these will increase bleeding and slow healing. You can take a bath or shower as often as you wish

### At home

You may feel tired and need to rest more than usual. This will improve and it is important to gradually return to normal activities. You can drive as soon as you can make an emergency stop without discomfort-generally around 3-6 weeks. You can start sexual relations before you return for the six week check at the hospital if you feel comfortable enough and have no blood loss. You should be able to return to a light job after about 6 weeks. Leave a heavy or busy job until 12 weeks.

After a repair operation it is sensible to keep your weight down, avoid heavy lifting, straining with constipation or heavy jobs, smoking and the resultant cough-which may cause recurrence of the prolapse.

This leaflet has been prepared based on advice produced by the Royal College of Obstetricians and Gynaecologists, representatives of the British Society of Urogynaecology, Professional Standards Committee and RCOG Consumers' Forum.

#### **Acknowledgements**

Dr Alison Love, Lagan Valley Hospital

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