

Vaginal Prolapse Repair Surgery

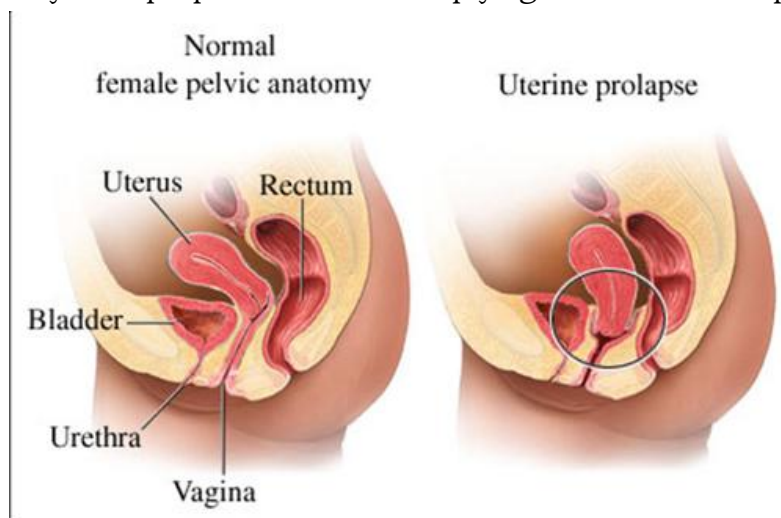
Your doctor has recommended a vaginal reconstructive procedure to treat your condition. The operation involves surgery to reattach the vagina to its original supports.

In some instances your doctor may suggest removal of the uterus as part of your operation to correct prolapse.

Definition of Prolapse

This term refers to weakness in vaginal supports which results in a protrusion of the vaginal wall(s). This is more likely to occur during activities which increase the pressure inside the abdomen and pelvic floor such as heavy lifting or straining, coughing or sitting on the toilet to pass a bowel action. This may result in a noticeable bulge, lump or dragging sensation in the vagina. The lump may be due to a weakness in the front, back or top of the vagina or a combination of all three.

The bladder sits in front of the vagina, the bowel (rectum) sits behind the vagina and the cervix and uterus lie at the top of the vagina. A lump that comes out of the vagina can consist of one or more of these organs. This is why some people have trouble emptying their bladder or opening their bowels.



Occasionally prolapse can distort the anatomy causing obstruction to the urinary tract masking incontinence. Surgery to repair a prolapse, in correcting this obstruction, may occasionally result in stress incontinence post operatively. Sometimes a simple additional procedure to prevent this happening is performed at the same time. Your specialist can discuss whether this might be appropriate for you.

Both prolapse and urinary incontinence are more common in women who have had children. It is thought that tissue damage due to childbirth worsens with age, leading to the gradual onset of prolapse symptoms.

Some women seem particularly prone to developing prolapse.

There are many surgical procedures that can correct your problem.

Your doctor will discuss various options with you to help you decide what is likely to be the best solution.

Types of procedures:

Anterior and Posterior Repair (Front and back wall of the vagina)

- This operation involves incisions inside the vagina which enables the surgeon to access the tissue supporting the vagina. This tissue (fascia) is strengthened with stitches and reattached to the supporting structures within the pelvis.
- This may involve the front or the back walls of the vagina or both, depending on the type of prolapse you have.
- The incisions inside the vagina are then closed with stitches that will dissolve in a few weeks
- At the end of the operation a catheter will be placed into your bladder to drain urine and a gauze pack will be placed in the vagina to prevent bleeding. These will remain in place for 1-2 days. They are easily removed by the nursing staff.

Sacrospinous Fixation

- This operation is performed to elevate and support the top part of the vagina.
- Usually 2 permanent stitches are placed into a tough fibrous structure known as the sacrospinous ligament. The stitches are then secured to the top of the vagina just beneath the skin.
- Sometimes the procedure is done on both sides and usually performed along with one of the other procedures listed on this page.
- This stitch may cause some temporary discomfort in the buttock which may persist for up to three months.

Laparoscopic Vault Suspension

- From within the abdomen and using keyhole instruments, permanent stitches are placed between the top of the vagina and the supportive structures adjacent to it.
- This can be performed as a stand alone procedure or at the same time as a Total Laparoscopic Hysterectomy to correct vault prolapse.
- This approach allows good visualisation of the tissues to be repaired, does not involve opening the vagina (unless a hysterectomy is done at the same time) and avoids shortening or narrowing the vagina.

Vaginal Mesh

- Sometimes the overstretched vaginal wall tissues forming the prolapse (bulge) may not be suitable for a standard repair particularly when a prior vaginal repair has failed, the fascia is weak and the prolapse is very large.
- Current recommendations are that vaginal mesh placement only be considered for women over the age of 50 years with large and recurrent prolapses, particularly where other risk factors for failed traditional repair are present such as chronic cough or straining with very weak supporting tissues.
- Mesh should be avoided in the presence of pre-existing chronic pelvic pain or infection and prolonged steroid use and caution exercised in the presence of multiple other risk factors such as smoking, morbid obesity and diabetes.
- Your specialist will be happy to discuss the pros and cons of vaginal mesh use in your prolapse repair with you. (See Vaginal Mesh Surgery Information Sheet)

Success Rates for Prolapse Surgery

It is generally believed that between 10–30% of women may require a second operation to treat prolapse in the future.

This may be due to the recurrence of an old prolapse or development of a new type of prolapse.

Complications after Surgery for Prolapse or Incontinence

These risks of surgery can be divided into general risks associated with any operation and risks specific to the surgery you are having.

General risks of surgery

These include	Risk
• wound, chest or urinary tract infection,	2–11%
• major haemorrhage requiring blood transfusion,	1–4%
• blood clots in the legs or lungs	<1%
• risks of the anaesthetic including heart attacks or strokes.	<1%

Risks specific to prolapse or incontinence surgery

These include	Risk
• Injury to adjacent organs including, Bowel or Ureter	<1%
Bladder	<1%
• Pelvic haematoma (blood clot)	1–2%
• Chronic Pelvic Pain	2–5%
• Abnormal scarring of the vagina can also occur causing painful intercourse in approximately 2–7% and in rare cases make sex difficult or impossible. This may be more common with Mesh augmentation.	
• When laparoscopic surgery is planned an open (abdominal) operation may occasionally be required to complete the surgery due to technical difficulties..	
• The above list is not exhaustive and does not include all possible risks	

Length of stay in hospital

- With a vaginal or laparoscopic pelvic floor repair surgery you will usually go home within 2–3 days of surgery.

Recovery

- 6–8 weeks

- Pelvic floor exercises, weight reduction may all reduce the incidence of recurrence of prolapse.
- These conservative measures alone may be enough to treat prolapse symptoms.
- Pelvic floor exercises should be taught and supervised by a physiotherapist who specialises in pelvic floor defects.
- Ideally these should be initiated prior to having surgery to maximise your pelvic floor function and reduce the potential for recurrent prolapse.
- Please speak to our reception staff for contact details or a referral.

What to expect after prolapse surgery

Hospital Stay

Length of stay

- With a vaginal or laparoscopic pelvic floor repair surgery you will usually go home within 2-4 days of surgery.

Post operative pain

- Within a day of your vaginal or laparoscopic operation, most patients require only oral pain medications and are usually up and walking around.

Urinary Catheter

- A soft latex tube (catheter) may be required to drain the bladder for 24-36 hours to allow it to rest after surgery.
- After incontinence surgery a small number of women may have ongoing difficulty emptying their bladder and thus require a catheter for a longer period of time.
- In these cases you can go home with a urinary drainage bag and return a week or 2 later to have the catheter removed.
- Alternatively you may be taught to insert a small catheter to empty your bladder on a regular basis until your bladder function returns to normal.

Vaginal bleeding

- A small amount of vaginal bleeding is common after vaginal surgery and it may persist for up to 6 weeks. It can sometimes be associated with an unusual odour.
- Have some ultrathin sanitary pads on hand – do not use tampons

For the first two weeks following discharge from hospital

- Restrict your activity – no washing, ironing, vacuuming, changing bed linen etc
- Rest as much as possible – have an afternoon lie down for 1 – 2 hours
- Very short, frequent walks around the house
- Do not lift anything heavier than 2-3kgs
- You may have a sudden, moderate vaginal loss around eight to ten days, which should then stop
- Please tell your doctor about any vaginal discharge that is offensive, becomes heavier than a period, or is associated with a fever and feeling unwell.

For the next two to four weeks (weeks 4-6 of your recovery)

- It is important that you do not do any heavy work or lift more than 4-5kgs including shopping bags, washing baskets and children!
- Frequent short walks increasing over time is beneficial (i.e. 5-10 minutes building to 20-30 minutes)
- Avoid playing sport and impact exercises such as jogging and jumping
- You may notice some stitch fragments on your pad – this is normal
- You may return to non-strenuous employment within 4-6 weeks of surgery.

General Advice

- As a general rule, if it hurts do not do it!
- Take regular pain relief until discomfort/pain has resolved – codeine based pain relief can cause constipation so best to be avoided.
- Intercourse should not be resumed until eight weeks after surgery (assuming all bleeding and discharge has settled) or following
- It is advisable not to drive a car until completely comfortable and feeling well. This may be anywhere between 2-6 weeks. Do not plan a long trip even as a passenger for at least a couple of weeks after your discharge from hospital.
- Gentle swimming is fine once all vaginal discharge has settled
- **Prevent constipation** – Avoid straining when opening your bowels. If this is a problem increase your fibre and fluid intake (have at least 1-1½ litres of water per day). Coloxyl tablets (1-2 tablets once or twice a day) may also be useful.
- **Pelvic floor exercises** may be commenced when they can be done comfortably. Remember to flex your pelvic floor muscles with any exertion (i.e coughing, sneezing, laughing etc).