Prolapse *Surgery*

Anterior Repair

Posterior Repair

Vaginal Hysterectomy

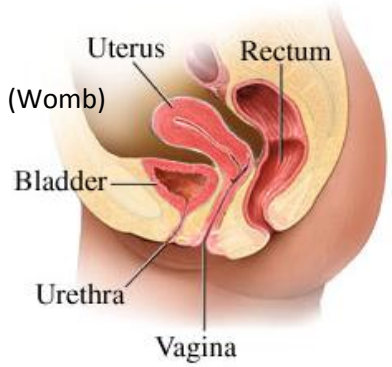
Sacrospinus Fixation

Proposed Operation:_____

What is a prolapse?

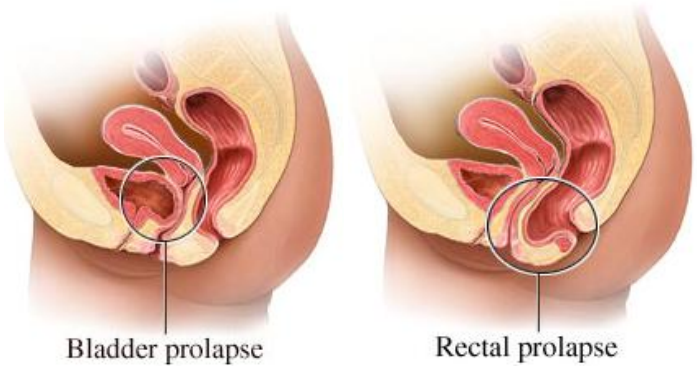
A prolapse is a bulge in the wall of the vagina. It is caused by weakness of the supports around the vagina. There are different types of prolapse.

Normal
female pelvic anatomy



An **Anterior** prolapse occurs when the supporting tissue between the vagina and bladder become weakened. This is when bladder drops into the vagina.
A **Posterior** prolapse occurs when the supporting tissue between the vagina and the bowels become weakened.
A **uterine** prolapse occurs when the womb (the uterus) moves down from its normal place into the vagina.
If you have had a hysterectomy (operation to remove your womb) in the past, there is also risk of developing a **vault** prolapsed. This is where the top of the vaginal wall also begins to drop downwards.

You may have one, or a combination of these prolapse.



Bladder prolapse Rectal prolapse

What causes prolapse?

A prolapse is usually caused by childbirth. However it can occur in women who have never been pregnant. This is usually noticed after the menopause (50-52), when oestrogen levels are low. Other related issues like long term constipation, doing a job which involves strenuous activity; being overweight and having a long term cough can make the problem more noticeable earlier.

Why do I need a prolapse repair?

A prolapse can cause the following problems:

- A 'sensation of something coming down'.
- The feeling of having not fully emptied your bladder or bowel.
- The need to press on the back wall of the vagina to empty bowel completely.
- A bulge in the vagina, which can cause discomfort when having sex and difficulty keeping a tampon in.

What are the other options?

There are other nonsurgical options available to treat prolapse. You may choose to try pelvic floor exercise under supervision of a specialist physiotherapist or a nurse specialist. This may control your symptoms. You may choose to have a vaginal pessary fitted. Pessaries can lift the prolapse up. You are required to get the pessary checked every 4to 6 months. If you

are interested in any of these options you can talk to your doctor or nurse about it to know whether it is an appropriate option for you.

What are the benefits of having a prolapse repair?

The aim of the surgery is to restore the supports for the vagina, bladder and bowel. The surgery is primarily aimed to improve your symptoms.

What type of surgery will I have?

The management of prolapse may involve one or a combination of the following procedures:

1. Anterior Repair (Repair of the front wall of the vagina)
2. Posterior Repair (Repair of the back wall of the vagina)
3. Vaginal Hysterectomy (Removal of womb through the vagina)
4. Sacrospinus Fixation (Suspension of the vagina)

How is the operation done?

Anterior & Posterior Repair

A cut is made through the lining at the front (anterior) and/ or back (posterior) of the vagina. The fascia supporting the bladder and/ or rectum are shortened with stitches. This repairs the weakness returning the bladder and rectum to their original position. The bulging part of the vagina is cut off and closed with dissolvable stitches.

Vaginal Hysterectomy

A cut is made at the top of the vagina, and the uterus and cervix is removed leaving the fallopian tubes and ovaries behind. This allows you to have a natural menopause if you are still having periods. There is no abdominal scar. The top of the vagina is the sewn up with dissolvable stitches where the incision was made.

Sacrospinous Fixation

The procedure involves making a cut through the lining at the back wall of the vagina. The top of vagina or the cervix is pulled up and fixed to a strong ligament at the back of the pelvis called the Sacrospinous ligament.

Prolapse repair is performed either under spinal or general anaesthetic. The Anaesthetist will advise on the best type of anaesthetic for you. You will see the anaesthetist on the day of the surgery. If you have any specific questions you can contact your surgeon and ask further questions.

Preoperative assessment

You will be seen in this clinic to prepare you for the operation. At the preoperative assessment your medical history will be taken. Blood tests and an ECG (tracing of your heart) may be done. You will be given an explanation about your operation and about what to expect between coming in and going out of hospital. Your questions will be answered and we aim to reduce your anxieties as much as possible.

You will usually be admitted to hospital on the day of the operation. You will be asked to sign a consent form before the operation. Please ask any questions that you wish. A nurse will carry out a safety checklist ensuring we have the correct details about you.

What are the risks with the procedure?

We will do our best to make your surgery as safe as possible, but with all operations there are some risks.

- Excessive bleeding. Occasionally you may require blood transfusion.
- Infection
- Allergic reaction to drugs or anaesthetic
- Buttock pain that may last for a few weeks and occasionally longer
- Recurrence of prolpase

Serious complications such as damage to the bowel or bladder are fortunately rare. Another rare but serious complication is thrombosis (blood clots) in the veins.

You will be given antibiotics to help reduce the risk of an infection also injections and stockings to reduce the risk of thrombosis.

Common but minor complications are raised temperature and temporary difficulty emptying the bladder. If you are unable to pass urine, you may be discharged with a catheter with a valve attached to it. You may be taught

how to empty your bladder by introducing a small catheter in the bladder by yourself (Intermittent self catheterisation). In either of these cases we will support you with regular phone calls. If you go home with the catheter, you will be asked to come back to the hospital to have a catheter removed in few days time.

At the end of the operation

When you wake up from the anaesthetic you will be in the recovery area. You will be given pain relief in the form of strong painkillers or injections. Anti-sickness injections will be given if needed. The following equipment may be attached to you:

- **Oxygen mask:** You will usually be given oxygen for about four hours.
- **Drip or intravenous line** This is a fine tube coming from a vein in your hand or arm, to give you fluids so that you do not become dehydrated.
- **Catheter** You will have a tube in your bladder to drain urine. It will usually be removed after 24 hours.
- **Vaginal pack** You may have gauze dressing in the vagina. This is usually removed on the following day.

Postoperative Recovery

Recovery exercises: For the first few days after your operation it is important to perform 'deep breathing exercises'. This is to try to help prevent a chest infection and involves taking deep breaths slowly in and out, to improve the flow of oxygen. Try to do these five times every hour. To help prevent circulatory problems try not to cross your legs in bed and move your feet up and down at the ankles, also circle them round and round. Try to do these exercises up to 10 times every hour until you are mobile.

Fluids and diet: You will be offered small drinks of water after your operation. Further fluids and diet will be offered as you recover.

Hygiene: On the day after your operation you should be able to have a wash in the bathroom. Following this a shower can be taken daily.

Bowels: You may not have a bowel action for the first few days, this is quite normal. You will be given some suppositories to help if needed. A diet rich in fibers may help. You will be advised to take appropriate laxatives for few weeks to help you with bowels.

Prevention of blood clot: During your stay in the hospital you will be less mobile. You will be given an injection of heparin to prevent complications with blood clot formation in your calf.

Going Home

You will usually be discharged approximately two days following your operation.

Housework and exercise: At first rest when you feel tired, but it is important to walk around the house to try to prevent complications with blood clotting. Gradually increase the distance that you walk outside as you improve. For the first two weeks you should not lift anything heavier than a kettle half full of water. Avoid vacuuming and ironing for four to six weeks. You are at risk of developing further prolapse if you do any heavy lifting. Swimming is possible six to eight weeks after surgery. More strenuous exercise such as gym work should be avoided for three months.

Vaginal bleeding/discharge: It is possible to have some bleeding or discharge for up to six weeks following surgery. The discharge may contain threads as the stitches dissolve. If the discharge becomes offensive or smelly, see your GP as you may have an infection. It is best to avoid tampons and to use pads to reduce the risk of infection.

Intercourse: We advise you to wait five to six weeks before having sex. This is to allow the wound inside the vagina to heal. If you feel any discomfort a lubricant gel may be helpful.

Bowels: Try to avoid constipation by eating plenty of fruit, vegetables and wholemeal bread.

Smears: If the operation involved removal of the womb it is unlikely that you will need any further smears.

Driving You should not drive for approximately five weeks, to avoid any problems with your recovery. Also you may be unable to perform an emergency stop.

Time off work: Take a minimum of four to six weeks off work, if you have a heavy job you may need eight to twelve weeks off. We would encourage you to get back to normal activity as soon as you are able. Discuss this with your consultant/GP.

When to seek medical advice

- If you develop a temperature
- Burning or stinging when passing urine
- Heavy or smelly vaginal discharge or bleeding which restarts

Follow up

You will have a follow up appointment in three months when you will be seen by a nurse specialist. In some cases you may have an early appointment if it is clinically required. This will be discussed with you prior to your discharge after your surgery. If you develop problems or require advice following discharge you should initially contact your GP.

Useful Contacts

Helen Barker: 01536 411241

If you have any Questions please write them down here. We will be happy to answer all your questions when you are admitted for your operation.