

Abdominal Colposuspension for Stress Urinary Incontinence

Stress urinary incontinence (SUI) is a common form of incontinence defined as: “an involuntary loss of urine on physical effort”. There are many causes of stress incontinence all of which result in lack of pelvic floor support of the bladder neck or urethra.

There are several treatment options for stress incontinence.

Conservative treatment options are:

- Doing nothing if symptoms are not troublesome.
- Pelvic floor exercises supported by a physiotherapist to improve pelvic floor strength.
- Intravaginal support devices – such as large sanitary tampons. These can be used during exercise to support the urethra but should not be kept in for too long.
- Medication – duloxetine. This medication increases the pressure in the urethra and reduces the amount of leakage. It needs to be taken daily and is associated with side effects such as nausea.

Pelvic floor physiotherapy is helpful for most women with a cure rate of 70%. If it fails or is inappropriate surgical treatment options are considered. Surgery is generally recommended once a woman’s family is complete. Prior to having surgery for stress urinary incontinence bladder function tests called urodynamics are recommended.

Surgical treatment options are:

- Stress incontinence sling – permanent mesh sling inserted to support the urethra – currently not available
- Abdominal colposuspension – supporting the bladder neck by elevating the anterior vaginal wall towards the pubic bone
- Urethral bulking agent (Bulkamid) – synthetic filling agent injected into the bladder neck

No permanent mesh is used in abdominal colposuspension.

Abdominal Colposuspension

This operation is performed usually under a general anaesthetic, through a small bikini line cut in the abdomen. Stitches are placed in the vagina either side of the bladder neck and are attached to a strong ligament on the back of the pubic bone to elevate the front wall of the vagina. This gives the bladder neck additional support to reduce leakage with exercise, coughing, sneezing etc. The stitches may be permanent or slowly dissolving depending on your surgeon.

This operation can also be used (with modifications) to correct an anterior vaginal wall prolapse.

This operation is successful in improving or curing SUI in 80-90% of women. If you have had a previous procedure for SUI the success rate is slightly lower.

You may be asked if you would allow some data about your operation to be put onto a national database of the British Society of Urogynaecology (BSUG) for the purposes of giving the best care possible.

Preparation for operation

Colposuspension is a major operation and it is important that you are as fit as possible. If you smoke, try to give up as soon as possible as smokers are much more likely to develop chest infections, and coughing after the operation will affect the healing.

If you are overweight, lose weight as this will make the operation easier and reduce the risk of many complications.

Before your operation you will have a chance to ask questions of a nurse, a doctor and an anaesthetist. You will see all of these people either at the pre-operative assessment clinic or when you are admitted to the ward.

You should ensure that you have sanitary protection after the operation and a supply of pain killers such as paracetamol at home.

Count down to the operation

3 days before:

We recommend taking a stool softener from 3 days before surgery, and afterwards until bowel function after the operation is normal. A laxative will keep the bowel motion soft, so that there should be no need to strain to open your bowels in the postoperative recovery period.

Laxative such as lactulose 15 mL twice daily is appropriate and can be bought from your local pharmacy.

2 days before:

Continue taking a laxative

1 day before:

Trim or shave the top of your pubic hair

Bath or shower in the evening

Remove all nail polish

Remove all jewellery and leave at home, please do not bring jewellery or valuables in with you. You may leave your wedding ring on.

Check you have packed everything as instructed by the hospital, and have read all the information given to you, and that you know where to attend and at what time.

The day of surgery:

Please arrive promptly at the hospital at the appointed time having starved as instructed. You will be welcomed by the ward nurse and your details will be checked.

You will see your consultant (or deputy) and may see your anaesthetist.

If not already done so, you will be asked to give formal written consent to the operation and anaesthetic.

Please feel free to ask questions at any time.

The operation

Your anaesthetist will have discussed the anaesthetic with you. When you are anaesthetised you will be transferred to the operating theatre where you will be positioned on the operating theatre table with your legs lifted and separated in supports.

An incision is made on your abdomen (tummy) just above the pubic bone. The muscles of your abdominal wall are separated and the area behind your pubic bone, the ligament at the back of your pubic bone (Cooper's ligament), your bladder neck and front vaginal wall are exposed. Two or three strong stitches are placed in the vaginal wall at the level of the bladder neck and then passed through Cooper's ligament and tied to elevate the vagina.

A camera may be passed into the bladder (cystoscopy) to check the stitches have not gone into the bladder. If the stitches are seen they can be removed and replaced, this it will not affect the result of your surgery or your bladder function.

A urethral catheter will be left in to drain your bladder. Occasionally a catheter may be placed through your abdomen into the bladder (suprapubic catheter); this will usually have been discussed with you prior to your operation.

After your operation

On return from the operating room you will have a drip with fluids and you may have a drainage tube coming from the wound.

You will be helped to have a wash on the first day and a daily bath/shower is then advised. Early mobilisation is encouraged with assistance as required. You will start to drink and then eat as advised by the nurses and doctors and your appetite will gradually return. You will be given heparin injections to prevent blood clots.

It is normal not to have a bowel movement for the first two days. If necessary suppositories are given.

Most women are ready to go home after 1-2 days.

Bladder care

The operation makes it difficult to pass urine at first. This is why you have a urethral or suprapubic catheter.

After the urethral catheter is removed your bladder emptying will be checked by measuring how much urine you pass and a bladder scan (involves a small probe placed above the pubic bone and is not painful).

The suprapubic catheter (if you have one) will be closed with a valve on the second day after the operation to see if you can pass urine normally and that you are able to empty your bladder adequately. When the bladder does empty normally and completely, the catheter will be removed and you can go home.

On occasion the bladder does not empty properly to begin with and you may be sent home with the catheter still in. If this is the case, you will be reviewed in the department and the catheter removed when the bladder is working properly.

Some women will experience urgency to pass urine after the operation— where the bladder feels irritated. This is usually a temporary problem and prolonged urgency is unusual.

What to expect after the operation and at home

For the first few days you will probably feel quite tired and it is important to have help at home to allow you to rest and relax for this time however progressive exercise is important to speed your recovery. It is safe for you to climb stairs slowly when you go home. Start with short daily walks, gradually increasing the distance and speed until by 6 weeks you should be taking brisk walks of 20-30 minutes. In addition continue with exercises taught by the physiotherapist.

Continue to take the laxative, but eat as normally as possible. It is important to drink plenty. You should aim to take 4 pints (2 litres) each day. It is normal not to have a bowel movement for the first two days. Do not strain, the laxative should keep the motion soft.

You may be prescribed some painkillers to take home. You should however ensure that you have a supply of paracetamol of your own. Take them when needed if you have discomfort. Don't wait for pain and do not exceed the stated dose.

**If you have any concerns after your operation please contact either:
Cley Ward (anytime) 01609 289953 or
Gynaecology outpatients (0800 to 1800 Monday to Friday) 01603 286734**

Hygiene

A daily bath or shower is advised.

When you go to the toilet try to ensure your bladder is completely empty. If your urine smells offensive or if you have pain on passing urine contact your GP.

Diet

A well balanced diet containing high fibre food is essential and will help avoid constipation. Drink plenty of fluids. If you do have a problem with constipation take a laxative as necessary. Do not overeat.

Activity at home

For the first week at home you should take plenty of rest but are able to make a cup of tea, do dusting and easy household jobs. Sit on a chair when possible to reduce standing. Gradually increase household jobs e.g. cooking, ironing, and using a vacuum cleaner until by 4 weeks you are back to normal with the exception of heavy lifting.

Lifting

Do not lift heavy weights like toddlers, shopping bags or move furniture for 6 weeks. When you do lift anything again remember to bend your knees, keep a straight back and hold the object close to you and lift by straightening your knees.

Driving

You should be able to drive again when you feel able to concentrate fully and can stop in an emergency without worrying - usually about 3 weeks after the operation. If you can walk comfortably up steep stairs you should be able to drive comfortably, however it is important that you contact your insurance company before you start driving.

Work

Your doctor will advise you when you are ready to return to work. Most women who have a colposuspension are able to return to work at about 4-6 weeks. A medical certificate will be issued on request.

Sports

A gradual return to sport is advised. It should be safe to start after the post-operative check, although gentle swimming can be started 2-3 weeks after the operation.

Sex

Sex can be resumed when you feel comfortable, say about 4 weeks after the operation.

Follow up visit

You will have a follow up appointment at the hospital after your operation. You will be examined to ensure that everything is healing satisfactorily and the bladder is well supported.

What about complications?

Like any other operation there are some risks involved and although minor problems are common after elective operations, serious complications are rare.

Complications include:

- Bleeding – at the time of surgery is rare, blood loss is usually less than 150mls.
- Urinary tract infection – surgery is covered by antibiotics, but urinary infection may occur in 10% of patients. If your urine is smelly, cloudy or hurts to pass, take a urine sample and contact your GP. Drink plenty, cranberry juice (or tablets) and barley water can help, as can a teaspoon of bicarbonate of soda dissolved in a glass of water each day.
- Damage to other structures – bowel or bladder.
- Failure to work in 10 to 20% of women
- Pain – has usually eased by ten days, and rarely felt after 2 months. Take your painkillers as directed
- Discharge – there should be almost none. If you are worried contact the ward on the number above.
- Difficulty emptying your bladder in up to 10% of women. The stream will be slower than before, and you may have to alter position (often rocking forwards) to completely empty your bladder, but it is important that you do. Be patient and take your time. Sometimes this can persist in the long term and there is a need to empty your bladder intermittently with a catheter (clean intermittent self catheterisation)
- New or worsening urinary urgency in 17% of women. Sometimes the bladder will be irritated by the operation so that you feel you need to pass urine more frequently and urgently. Damage to other structures during surgery is a very rare complication which may make a further operation necessary. Sometimes this can persist in the long term and require further management.
- Ongoing vaginal pain and/or persistent pain during intercourse (1-5%)

- Vaginal prolapse as this operation lifts the anterior vaginal compartment forwards. This can allow prolapse of the upper vagina, uterus and posterior vaginal wall to develop. This may occur in up to 20% of women.
- Stitch erosion – occasionally when permanent stitches are used these may erode into the bladder or vagina and need removal.
- Wound complications:
 - Wound infection – antibiotics are given at the time of surgery to reduce this risk
 - Wound dehiscence – this occurs when the wound edges separate and may involve only the skin or deep layers of the wound. This occurs in 0.3-3% of women having pelvic surgery and may require further surgery.
 - Incisional hernia – this occurs when the skin of the wound heals but the deep layers do not. This occurs in 1% of women having surgery and usually requires an operation to repair it at a later date.
- Thrombosis (blood clots) in leg veins and lungs can occur after any surgery. Specific steps are taken to minimize this risk including pressure stockings, mini heparin injections and early mobilisation.

If you are particularly concerned about any of these risks, please speak to a doctor.

Videos about coming into hospital that are available on Youtube -

<https://www.youtube.com/watch?v=2nW8khhB8gA>

