Vaginal Repair of Prolapse with or without the use of a biological graft

Prolapse occurs when the supports to the vagina and/or uterus and cervix have been weakened. Most commonly this is due to childbirth but increased weight, lifting, coughing, constipation and straining also make prolapse more likely. Symptoms may occur shortly after having a baby or after many years.

Prolapse may affect the front wall of the vagina (anterior prolapse), the back wall (posterior prolapse) or the top of the vaginal (apical prolapse) involving the uterus and cervix if there has not been a hysterectomy. Vaginal prolapse surgery may involve repair of only one of these areas or perhaps all three. Sometimes the opening of the vagina needs to be narrowed to support the vagina. It is not always possible to tell exactly which areas need to be repair until during your operation. A hysterectomy will not cure prolapse by itself and prolapse can come back (recurrence) even if a hysterectomy is performed.

Permanent mesh is not routinely used for prolapse repair surgery at the Norfolk and Norwich Hospital.

VAGINAL REPAIR WITHOUT BIOLOGICAL GRAFT

- **Anterior repair -** an incision is made in the front wall of the vagina and the underlying connective tissue is identified and strengthened with stitches.
- **Posterior repair -** an incision is made in the back wall of the vagina and the underlying connective tissue is identified and strengthened with stitches.
- **Perineorrhaphy -** the skin at the back of the opening to the vagina is incised and the muscles stitched together to narrow the entrance to the vagina and support the back wall of the vagina. The stitches for this will be visible on the outside.
- **Vaginal Hysterectomy** - the uterus and cervix are removed through the vagina (from below). There are no stitches on the abdomen, but there will be stitches at the top of the vagina. The ovaries are usually checked at the time of a vaginal hysterectomy but are not usually removed if they are normal.
- **Sacrospinous colpopexy** is sometimes required to lift the top of the vagina. It involves putting in extra stitches through a very strong ligament at the back of the pelvis close to the sacrum/lower part of the spine.

VAGINAL REPAIR WITH BIOLOGICAL GRAFT

This type of repair may be discussed with you if your surgeon feels it is appropriate for you. A hysterectomy is not performed in this type of repair.

- **Anterior repair** - an incision is made in the front wall of the vagina and the damaged connective tissue (fascia) is identified and reattached to the front of the cervix. A biological graft is attached to each side of your pelvis to temporarily support the stitches of the repair at the front. This is a collagen graft (collagen is what most forms of connective tissue are made of) developed from the lining of pig's intestine.

The graft dissolves slowly over six months and the tissue at the site of the graft grows slowly into the graft and replaces it.

- **Posterior repair -** an incision is made in the back wall of the vagina and the damaged connective tissue (fascia) between the vagina and rectum is reattached to the back of the cervix. A biological graft may be used and attached to a muscle in your pelvis; this is called an iliococcygeus fixation and adds support to the back wall and top of the vagina.
- **Apical (top of the vagina) repair** - the ligaments that normally support the cervix are attached to the back of the cervix, shortening them and lifting the cervix up.

You may be asked if you would allow some (anonymous) 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 the operation
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 reduce your weight as this will make the operation easier and reduce the risk of complications.

Before your operation you will have a chance to ask questions of a nurse, your surgeon and your anaesthetist. You may see some of these people either at the pre-operative assessment appointment or when you are admitted to the hospital.

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:
Start taking a stool softening laxative that has been advised to you. This may be purchased over the counter at your local chemist. Take **for 3 days before the operation**, and afterwards until bowel function 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.

2 days before:
Continue taking a laxative

1 day before:

- Trim or shave 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.

If your operation is in the morning: you must have nothing to eat from midnight, you are allowed to drink clear fluids only (water, squash, black tea or coffee but NO milk) until 5.30am the day of surgery.

If your operation is in the afternoon: you must have nothing to eat after a light, early breakfast (no later than 7 am), and then only clear fluids until 11am.

The day of surgery:

- Please arrive promptly at the hospital at the appointed time having starved as instructed (as above).
- 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 within the vagina over the prolapsed area. The bladder is separated from the overlying skin and moved into its correct position; the weaknesses are repaired with stitches to keep the bladder in its new position. A biological graft may be attached to each side of your pelvis to support the repair. The vaginal incision is closed with dissolvable stitches. A similar procedure is done if the prolapse is of the back vaginal wall to reposition the rectum. A cystoscopy (look inside the bladder with a small camera) may be performed to check the ureters (tubes running from the kidneys to the bladder) during your procedure depending on the type of repair performed.

At the end of the operation a bladder catheter will be inserted, and a vaginal pack may be inserted. These will usually be removed the next day.

After the operation

You will be assisted with a bath or shower. Early mobilisation is encouraged with assistance as required. You will start to drink and eat as advised by the nurses and doctors and your appetite will gradually return. You will be given heparin injection to prevent blood clots.
The vaginal pack and bladder catheter will be removed as instructed by your surgeon. After the bladder catheter is removed your bladder emptying will 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).

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

What to expect after the operation and at home
A slight discharge or bleeding is normal and may continue for several weeks and occasionally it may contain threads of dissolving internal stitches. Do not use tampons because of the possibility of introducing infection, only sanitary towels or liners should be worn. If the discharge or bleeding you experience after the operation becomes heavy or there are other symptoms which worry you please contact your GP.

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.

You will probably feel quite tired for the first week, this is normal. It is important to have help at home to allow you to rest and relax, 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.

If you have any doubts or worries please contact your GP.

Hygiene and toileting
A daily bath or shower is advised.
When you go to the toilet to pass urine try to ensure your bladder is completely empty. The flow may be slower than before, and you may have to change position to empty completely. If your urine becomes smelly or painful to pass you may have an infection and it is important that you contact your GP.

Diet
A well balanced diet containing high fibre food is essential for your recovery and will help avoid constipation. Do not overeat.

Activity at home
For the first week at home you should take plenty of rest but can make a cup of tea and do easy household jobs. Sit down when possible to reduce standing. Gradually increase household jobs e.g. cooking, ironing, until by 6 weeks you are almost back to normal with the exception of heavy lifting.

Lifting
With prolapse repairs it is important not to put unnecessary stress on the operation until healing is fully complete. Do not lift heavy weights or move heavy objects for three months. When you do lift anything 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. 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. It is usually after 6 weeks. You will be given sick leave certificate from the hospital for 6 weeks. If you require additional sick leave, please contact your GP. Return to heavy work may need to be delayed until 3 months.

Sports
A gradual return to sport is advised. It should be safe to start at 3 months, although gentle exercise such as swimming can be started about 4 weeks after the operation.

Sex
It is advisable to refrain from penetration for 6-8 weeks after your surgery. Minor problems in resuming sex following repair operations are common. The scar(s) can be tender at first, especially the posterior repair scar and perineorrhaphy scar. The natural vaginal lubrication may be reduced and the vagina feel dry, with gentleness and the use of a liquid-based vaginal lubricant these problems are usually soon overcome.

Report any persistent problem to your doctor, as with proper care all women should be able to resume full sexual activity following repair operations if they wish.

Follow up appointment
Will be arranged. You will be examined to ensure that the vagina has healed well.

Complications
Complications do occur, but not very commonly. They can include

- Heavy bleeding at the time of surgery (2%). After the operation when you are at home the loss will be light, like the end of a period for the first day, getting less and less each day. If it becomes heavier please contact either us at the hospital or your own GP.
- 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; barley water can help, as can a teaspoon of bicarbonate of soda dissolved in a glass of water each day.
- Difficulty emptying your bladder. The stream will be slower than before, and you may have to alter position to completely empty your bladder, but it is important that you do. Be patient and take your time. Sometimes we may have to keep the bladder catheter in for a longer period of time for a few weeks to allow the bladder to recover after the operation. If you are at all worried please contact as above.
- After a large prolapse is repaired urinary leakage that was not present may develop before the surgery in 5% of the patients.
- Difficulty emptying your bowel. The laxative is given to keep the bowel motion soft so that it passes easily, without straining. Keep taking the laxative until your bowel function is back to normal. Eat a balanced diet, and drink plenty of fluid (2 litres daily). If you are at all worried please contact as above.

- Thrombosis (blood clots) in veins and lungs can occur in about 2% of cases, although specific steps are taken to minimize this risk. The overall risk of death due to thromboembolism within six weeks is 37 women in every 100 000 (rare).
- Damage to other structures during surgery is uncommon. This includes damage to bowel (5 women in every 1000) and to bladder/urinary tract (2 women in every 1000). However such injury may make a further operation necessary.
- Biological graft erosion/infection occurs in 5-10%. This may cause ongoing vaginal discharge but will heal as the graft will be gone after 6 months.
- Ongoing vaginal pain and/or persistent pain during intercourse (1-5%) that may require further surgery.
- Buttock pain after a sacrospinous colpopexy which usually resolves by 6 weeks.
- Recurrence of prolapse occurs in 30% of women. This may be in the same place or a different part of the vagina. This only needs attention if it causes symptoms.

Videos about coming into hospital that are available on Youtube - https://www.youtube.com/watch?v=2nW8khbB8gA

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communication for all