Prolapse, vaginal hysterectomy and pelvic floor repair

Gynaecology department

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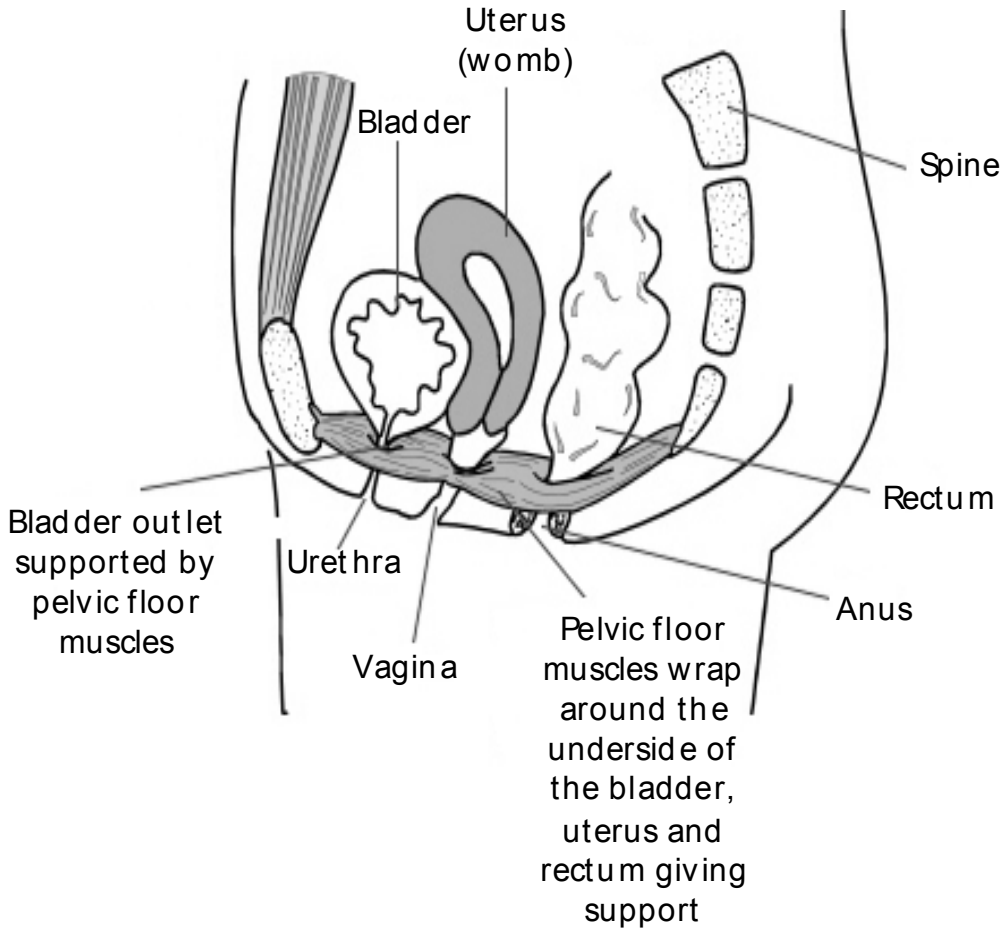
Yeovil Hospital Healthcare

The pelvic floor



What is it?

A vaginal prolapse is caused by a weakness of the supporting tissues of the pelvic floor in a similar way that a hernia is formed. The pelvic floor is made of muscles, collagen, connective tissue and fascia (outer covering of the muscle). A weakness in any of these allows the tissues and organs surrounding the vagina to bulge into the vagina resulting in prolapse.

The diagram opposite shows the position of the pelvic floor and the organs it supports in the body.

Most women who complain of prolapse will either have a cystocele (a prolapse of the front wall of the vagina) a rectocele (a prolapse of the back wall of the vagina), a prolapse of the top of the vagina, or any combination of these.

Approximately one in ten women have pelvic floor surgery to try and cure a prolapse, but up to one in three of these women will need to have repeat surgery at a later date if the repair fails.

The cervix (neck of the womb) and uterus (womb) may also prolapse, or need to be removed for another reason. This is usually carried out at the same time as a repair operation and is called a vaginal hysterectomy.

A vaginal hysterectomy is an operation to remove the uterus through the vagina. One or both ovaries and fallopian tubes can sometimes be removed during the procedure, as well as the uterus and cervix, but your surgeon will discuss this at the time.

Studies have shown that a vaginal hysterectomy has fewer complications, a shorter stay in hospital and faster recovery than removal of the uterus through an abdominal incision (abdominal hysterectomy).

How does a pelvic floor repair work?

A pelvic floor repair is carried out when a part of the vagina is prolapsing and causing bothersome symptoms. A cut is made in the front and/or back wall of the vagina to allow the underlying supporting tissue to be identified.

This tissue is then stitched to strengthen the support and prevent the prolapse from recurring. Sometimes a patch of tissue is sewn in to strengthen the repair to try improve the chances of success and reduce the risk of problems with intercourse after the operation. Your surgeon will discuss this with you if it is needed.

Before the operation

Prior to your admission for surgery you will be asked to attend a pre-assessment clinic to ensure that you are fit and well for your forthcoming surgery.

A pre-assessment nurse will see you. You will be asked about your general health, past medical history and any medication that you are taking. Any necessary investigations (for example, blood tests, ECG, chest x-ray) will be organised. You will also receive information about your admission, hospital stay, operation, pre and post operative care.

You will also be given the opportunity to ask any further questions that you may have.

When you are in hospital you will be seen by the anaesthetist and the surgeon (or a senior member of the team) who will explain what will happen during the operation. You will receive an explanation of the purpose of the operation and the risks associated with it and you be asked to sign a consent form if you have not already done so.

You will also have the opportunity to ask any outstanding questions not covered during the pre-assessment clinic.

After the operation

When you wake up from the anaesthetic, you will have a drip in your hand to give you fluids and a catheter (tube) in your bladder to allow urine to drain. Sometimes the surgeon will leave a pack inside the vagina to stop any bleeding into the tissues. Both the pack and the catheter are usually removed on the day after the operation.

What are the chances of success?

This operation is thought to be the best approach to repair your type of prolapse. However, there is always a chance that the prolapse might come back in the future, or another part of the vagina may prolapse for which you would need further surgery. Most women, however, have no further problems.

Is there a chance that I might need to have an abdominal hysterectomy instead?

After your surgery has begun, your surgeon very occasionally finds conditions, such as extensive scar tissue, that make abdominal hysterectomy the better choice.

Sometimes these conditions are not apparent before surgery. When this happens, the surgeon stops the vaginal procedure and changes to an abdominal approach. The reasons for this change will be explained to you when you are back on the ward.

Are there likely to be complications?

With any operation there is always a risk of complications. The following general complications can happen after any surgery:

- **Anaesthetic problems** - with modern anaesthetics and monitoring equipment these are rare
- **Bleeding** - Sometimes, it is difficult to control bleeding and very rarely you might need a blood transfusion
- **Thrombosis** - any period of inactivity will increase your chance of developing a blood clot (Venous Thromboembolism or VTE). This is a potentially dangerous condition but preventable and as an inpatient at Yeovil Hospital you will be assessed for your risk and preventative treatment given where appropriate such as medication to 'thin your blood' whilst you are in hospital.
- **Infection** - we will give you antibiotics during the operation and keep everything sterile to reduce the risks of infection. Despite this, some people may still develop an infection. This will usually clear with a full course of antibiotics, but you may need to be in hospital for longer than expected.
- **Cystitis** - Sometimes you can get some burning on passing urine from a bladder infection. This may occur while you are in hospital or after you have gone home. If the doctor thinks you have a bladder infection you will be advised to take a course of antibiotics to clear it.

The following complications may occur and are particular to this type of surgery:

- **Bladder problems** - Some women who have an operation for prolapse get problems with their bladder afterwards. If the doctor thinks that this is particularly likely, they will have discussed the possibility of an operation to treat this at the same time. Initially, having to pass water frequently is not unusual but normally settles over a few weeks. If there is a urine infection it may require antibiotics. Unfortunately, a small percentage of women develop stress incontinence (leaking with coughing, sneezing etc) after this operation even when it is not expected. You may find that you need further surgery for this at a later time.

- **Urinary retention** - or the inability to pass urine, is the only complication that is higher in women undergoing vaginal hysterectomy compared to those undergoing the abdominal procedure. If this occurs, the urine can be drained using a catheter until the woman is able to void, usually within 24 to 48 hours.

- **Intercourse** - Some women have problems with sexual intercourse after vaginal surgery because the vagina can become very tight. Whilst every effort is made to prevent this happening, it is sometimes unavoidable.

When can I return to my usual routine?

You should be able to drive and be fit enough for light activities within a month of surgery. We advise you to avoid very heavy lifting and sport for at least six weeks to allow the wounds to heal. Most people need six to eight weeks off work.

You should wait six weeks before attempting sexual intercourse and then to use a vaginal lubricant such as K-Y Jelly, Replens or Sylk. These are non-prescription and available from chemists.

‘My prolapse isn’t too bad at the moment, but should I have an operation now to prevent it getting worse in the future?’

It is difficult to predict what will happen to your prolapse. You should have an operation only if you feel it is right for you and your prolapse is affecting your quality of life.

Is there anything else I can do to avoid an operation?

Conservative treatment of vaginal prolapse is available and your doctor may suggest this to you.

Once a large prolapse is present, pelvic floor exercises are unlikely to cure it, but if the prolapse is not too severe then doing pelvic floor exercises may lessen the chances of it getting worse. Your doctor may refer you to see a physiotherapist to teach you these if needed.

Pessaries (rings) can be used to hold a prolapse in position. These come in a variety of sizes and can be inserted by your gynaecologist. Sometimes a pessary will fall out, either straight away or when you have a bowel movement. If you wash the pessary in warm soapy water, rinse well and use a lubricant jelly, there is no reason why you should not try to put it back yourself if you wish.

If it does not go in easily, your GP or practice nurse may be able to help. If it keeps falling out, you may need a different size or type of pessary. Your gynaecologist would normally advise you if this is the case. The pessary is normally left in position and changed every six to eight months by your gynaecologist or GP. Having a pessary in place should not cause a problem with intercourse, but some women prefer to remove the pessary before and replace it after intercourse. Some types of pessary prevent sexual intercourse and this should be mentioned if it is a problem.

Your gynaecologist will often recommend using vaginal oestrogen in the vagina while using the pessary. This helps prevent discharge and keeps the vaginal skin healthy. If you develop an offensive discharge you should contact your GP.

Pelvic floor exercises and pessaries very rarely cause significant side-effects and can be an appropriate and safe way of managing your prolapse without need for an operation.

Other areas that can affect your prolapse

- Trying to avoid things that may put too much stress on the vagina can help to stop the prolapse getting worse, and might even improve your symptoms
- If you are very overweight you should try and lose weight
- You should make sure your bowels are regular and not become constipated.
- If you are a smoker you should stop, as it will make you prone to chest infections, which put a lot of stress on the pelvic floor and vagina.

Is there any other operation I could have instead?

Sometimes a different operation is needed to correct the prolapse. Your surgeon will discuss this with you.

Sources of further information

Royal college of Obstetricians & Gynaecologists

Website: rcog.org.uk/womens-health

Bladder & Bowel Foundation

SATRA Innovation Park
Rockingham Road
Kettering, Northants, NN16 9JH

Nurse Helpline: 0845 345 0165
Email: info@bladderandbowelfoundation.org
Website: bladderandbowelfoundation.org

Please use this space for any notes or questions you may have:

If you would like this leaflet in another format or in a different language, please ask a member of staff.

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