Healthier Communities, Outstanding Care

Sherwood Forest Hospitals NHS Foundation Trust

INFORMATION FOR PATIENTS

Colposuspension for stress incontinence

We advise you to take your time to read this leaflet, any questions you have please write them down on the sheet provided (towards the back) and we can discuss them with you at our next meeting. It is your right to know about the operations being proposed, why they are being proposed, what alternatives there are and what the risks are. These should be covered in this leaflet.

This leaflet details what stress incontinence is, what alternatives are available within our Trust, the risks involved in surgery and what operation we can offer.

What is stress incontinence?

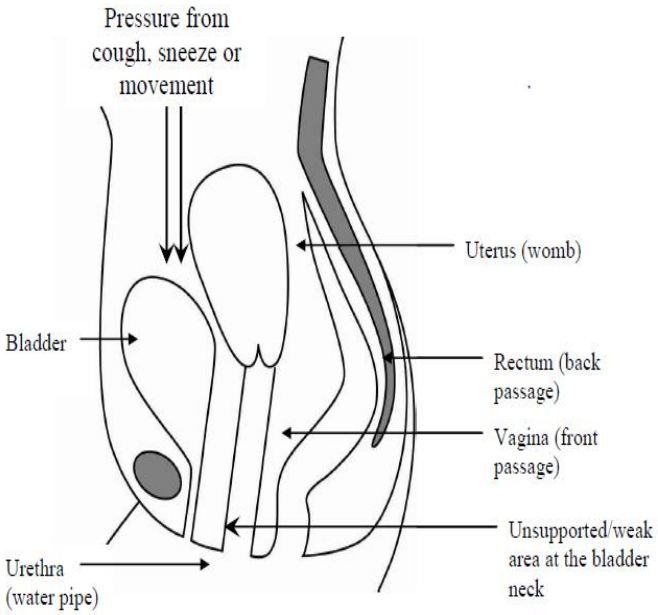
Stress incontinence is the leakage of urine usually caused by an increase in pressure in the abdomen (tummy), e.g. coughing or sneezing (see figure 1) due to weakness in the support of the urethra (urine pipe) and bladder neck.

This weakness is usually caused by childbirth, heavy lifting and constipation, when the pelvic floor muscles are damaged. Further weakening occurs during the menopause because the quality of the supporting tissues deteriorates.

The pressure in the abdomen rises during coughing, sneezing, bending down, etc., and results in urine leakage.

This can cause distress and can limit quality of life. It must be understood that these operations will not cure all urinary symptoms. They will only cure urinary symptoms caused by a weakness in the bladder neck. Many urinary symptoms seen in clinic are not caused by a weakness in the bladder neck.

Figure 1 shows the side view of a woman standing up. You can see the pressure above the bladder and an unsupported (weak) area at bladder neck.



Alternatives to surgery

Pelvic floor exercises (PFE)
The pelvic floor muscle runs from the coccyx at the back to the pubic bone at the front and off to the sides. This muscle supports your pelvic organs (uterus, vagina, bladder and rectum).

Any muscle in the body needs exercise to keep it strong so that it functions properly. This is more important if that muscle has been damaged. PFE can strengthen the pelvic floor and therefore give more support to the pelvic organs. These exercises may not get rid of the prolapse but they make you more comfortable. PFE are best taught by an expert who is usually a physiotherapist. These exercises have little or no risk and even if surgery is required at a later date**,** they will help your overall chance of being more comfortable.

Devices
There are numerous devices (none on the NHS) which essentially aim to support the urethra. The devices are inserted into either the vagina or the urethra. They are not a cure but their aim is to keep you dry whilst in use, e.g. during keeping fit, etc. A booklet is available if you require further information.

Injections into the bladder neck
This involves injecting a substance into the neck of the bladder to make it tighter.

Different substances can be used and can be performed whilst you are awake, under local anaesthetic and sedation. The results of the injections are variable and the chance of curing your leaks is less than an operation. About half of the women who have an injection will have been cured of their leaks straight after their injection. However, the effects can wear off over time.

General risks of surgery

Anaesthetic risk
This is very small unless you have specific medical problems. This will be discussed with you.

Haemorrhage
There is a risk of bleeding with any operation. The risk from blood loss is reduced by knowing your blood group beforehand and then having blood available to give you if needed.

It is rare that we have to transfuse patients after their operation. Please let your doctor know if you are taking an anti-clotting drug such as warfarin or aspirin.

Infection
There is a risk of infection at any of the wound sites. A significant infection is rare. The risk of infection is reduced by our policy of routinely giving antibiotics with major surgery.

Deep vein thrombosis (DVT)
This is a clot in the deep veins of the leg. The overall risk is at most 4-5%, although the majority of these are without symptoms. Occasionally, this clot can migrate to the lungs which can be very serious and in rare circumstances it can be fatal (less than 1% of those who get a clot).

DVT can occur more often with major operations around the pelvis and the risk increases with obesity, gross varicose veins, infection, immobility and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood (heparin).

Specific risks of a colposuspension

Some risks are specific to operations for stress incontinence and some risks are specific to just the colposuspension operation. You should have the chance to discuss these with your doctor.

Failure to work
No operation for stress leakage works for everyone.

Overactive bladder
The bladder becomes irritable or overactive in up to 17% of women. This gives symptoms like needing to rush to the toilet or needing to pass urine more often. Sometimes an overactive bladder can make you leak because you can't get to the toilet in time.

Prolapse
A prolapse is a bulge in the vagina caused by the vaginal walls sagging. It is very common and often doesn't cause you bother or need any treatment. About 14% of women (1 in 7) who have had a colposuspension operation are more likely to get a prolapse to the back wall of the vagina. It might be small and not need any treatment. Sometimes it needs treating with a pessary (a device inserted into the vagina) or an operation if it is causing symptoms.

Difficulty passing urine
You might notice that the flow of urine is different after the operation. Sometimes it is slower and sometimes women notice that they have to change position on the toilet (such as leaning forward to empty the bladder completely) to get the last of the urine out. About 1 in 10 women who have colposuspension have problems emptying their bladder after the operation. The next section of the leaflet explains what your doctor can do when this happens.

Pain during sexual intercourse
Pain during sex can occur after any operation where there are stitches near the vagina. About 1 in 20 women find sex uncomfortable or painful after a colposuspension. Sometimes the sensation during intercourse may be less and occasionally the orgasm may be less intense.

Problems with the stitches
In a very small number of women, the stitches holding the neck of the bladder in place cause problems. Over time they can wear through to the inside of the bladder. This is rare.

Problems passing urine after the operation
Some women have difficulty in emptying their bladder after their operation. This may get better, but in a small number of women it lasts forever.

It is normal to leave a small bit of urine behind after going to the toilet. We call this the 'residual volume'. However, if too much is left behind it can lead to problems such as having to go to the toilet too often and infections of the bladder.

If the residual volume is too high, you may want to learn to empty your bladder using clean intermittent self-catheterisation (CISC).

CISC involves emptying out the urine that has been left behind using a fine catheter tube. This is passed along the urethra (water pipe) into the bladder so the urine can drain into the toilet. Once the urine is out, the catheter is removed and thrown away. A new catheter is used each time and they are available on prescription, like tablets, from your doctor.

Most women pass the catheter tube twice a day, but the number of times it is needed will depend on each woman and how her bladder is behaving.

Although passing the catheter sounds unpleasant, most women find it is easy to do and gives more control and freedom than using a permanent catheter. The normal feeling of wanting to pass urine is not altered so you know when to empty your bladder. The catheters are very small and can easily be hidden in a handbag.

Sometimes the tests on your bladder give a clue that you may have problems passing urine after an operation for stress incontinence. If your doctor thinks you may be more likely to have problems, they may suggest you learn CISC before having the operation. If you then do find you have trouble passing urine after colposuspension, it would not stop you going home and you would be prepared.

Operations available for stress incontinence

Many operations can be done for stress incontinence. Often your doctor will think one of these would be especially good for you. They will have thought about your test results, any medical problems you might have and any treatments you might have tried before. It is important that you have time in clinic to talk about this with your doctor.

We hope that this leaflet gives you an idea of the types of operations available to help you when you talk to your doctor.

Colposuspension
This uses stitches to support the neck of the bladder so that it can't move about and cause stress incontinence.

It has been used to treat stress incontinence for over 40 years so we have a lot of information about how well it works and whether it lasts. It is usually done through a bikini-line cut but can sometimes be done with keyhole surgery.

More than 80% of women, who have not had an operation for bladder leakage before, are cured by a colposuspension. This means that if 100 women had a colposuspension, 80 of them would feel that they had been cured, and 20 would not feel they had been cured. However, 20 years after the operation has been done, 60 out of 100 would feel they had been cured. This may be because our tissues weaken as we get older.

Tension free vaginal tape (TVT)
This operation involves inserting a 1cm synthetic tape through a small cut in the vagina. The tape is looped around the outside of the mid-urethra and the 2 ends come out through 2 very small cuts low down on your tummy. The tape is trimmed so that it lies under the skin and you will not be able to feel it is there. The tape is not stitched in but stays in position by itself. The tape does not dissolve and stays inside the body forever.

About 80% of women, who have not had an operation for bladder leakage before, are cured after a TVT. This means that if 100 women had a TVT operation, 80 of them would feel that they had been cured.

Other types of tape
Since the TVT operation was developed, many similar operations have been developed using slightly different types of tape or different ways of putting the tape in. Some tapes can be put in so that the tape comes out through tiny cuts on your inner thigh (along the underwear line) rather than coming out low down on the tummy wall (transobturator tape or TOT).

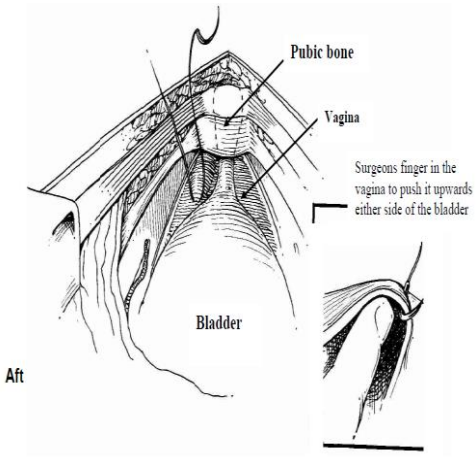
Studies of this type of tape show that it is safe and effective at stopping leakage, with a cure rate similar to the TVT.

A sling operation
This operation uses a piece of your own tissue instead of a strip of artificial tape. The tissue comes from your tummy wall. Studies of this operation show a cure rate similar to colposuspension. However, they have also shown that the risk of having a complication during the operation is higher than colposuspension.

What happens during colposuspension?

- The operation is done under a general anaesthetic (so you are asleep) or a spinal anaesthetic.
- A bikini-line cut is made on your abdomen (tummy) which is about 10cm (4inches) long.
- The abdomen is opened to reach the bladder which lies just behind it.
- Stitches are put into the vaginal wall on either side of the bladder neck and sometimes the bladder base. The stitches are tied to some strong fibrous tissue just behind the pubic bone.
- A fine plastic tube, called a drain, is left in to draw-off any spilled blood.
- The abdomen is repaired and a catheter tube may be put through the abdominal wall into the bladder to rest the bladder for 48 hours.
- You usually stay in hospital for up to 5 days after the operation.

Figure 2 shows a cut in the abdomen to show the bladder. A stitch is then put in the vaginal wall either side of the bladder neck and these are used to lift the bladder neck.



On return from the operating theatre you will have a fine tube (drip) in one of your arm veins with fluid running through to stop you getting dehydrated.

You may have a bandage in the vagina, called a ‘pack’ and a sanitary pad in place. This is to apply pressure to the wound to stop it oozing.

You may have a tube (catheter) draining the bladder overnight. The catheter may give you the sensation as though you need to pass urine but this is not the case.

Usually the drip, pack and catheter come out the morning after surgery or sometimes later the same day. This is not generally painful.

The day after the operation you will be encouraged to get out of bed and take short walks around the ward. This improves general wellbeing and reduces the risk of clots on the legs.

It is important that the amount of urine is measured the first couple of times you pass urine after the removal of the catheter. An ultrasound scan for your bladder may be done on the ward to make sure that you are emptying your bladder properly.

If you are leaving a significant amount of urine in your bladder, you may have to have the catheter re-inserted back into your bladder for a couple of days more.

You may be given injections to keep your blood thin and reduce the risk of blood clots normally once a day until you go home or longer in some cases.

The wound is not normally very painful but you may require tablets or injections for pain relief.

There will be slight vaginal bleeding like the end of a period after the operation. This may last for a few weeks.

The nurses will advise you about sick notes, certificates etc. You are usually in hospital for up to 4 days.

At home after the operation

Mobilisation is very important; using your leg muscles will reduce the risk of clots in the back of the legs (DVT), which can be very dangerous.

You are likely to feel tired and may need to rest in the daytime from time to time for a month or more; this will gradually improve.

It is important to avoid stretching the repair particularly in the first weeks after surgery. Therefore, avoid constipation and heavy lifting. The deep stitches dissolve during the first three months and the body will gradually lay down strong scar tissue over a few months.

Avoid constipation by:

- Drinking plenty of water / juice.
- Eating fruit and green vegetables especially broccoli.
- Eating plenty of roughage e.g. bran / oats.

Do not use tampons for 6 weeks.

At 6 weeks gradually build up your level of activity. After 3 months, you should be able to return completely to your usual level of activity.

You should be able to return to a light job after 6 weeks, and a heavy or busy job in 12 weeks. Always avoid unnecessary heavy lifting, such as luggage and furniture, to protect your pelvic floor.

You can drive as soon as you can make an emergency stop without discomfort, generally after 3 weeks, but you must check this with your insurance company, as some of them insist that you should wait for 6 weeks.

You can start sexual relations whenever you feel comfortable enough after 6 weeks, so long as you have no blood loss. You will need to be gentle and may wish to use lubrication (KY jelly).

Follow up after the operation is usually 6 weeks to 6 months. This may be at the hospital (doctor or nurse), with your GP or by telephone. Sometimes a follow up is not required.

More information about stress incontinence and the operations to treat it

If you would like to know more about stress incontinence and its treatments, you may try the following sources of information:

- Ask your GP.
- Ask the doctor or nurse at the hospital.
- Speak to your local continence nurse advisor (the receptionist at your GP surgery should know who this is).

- Visit the Bladder & Bowel UK website: http://www.bladderandboweluk.co.uk/ or telephone 0161 607 8219

Things I need to know before I have my operation

Please list below any questions you may have, having read this leaflet.

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Please describe what your expectations are from surgery

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Important

Please do not use recording equipment in our hospitals – including cameras, videos or audio recordings on mobile phones. Smart home devices such as Alexa, Echo, Google Home and Siri, record conversations and do not support privacy and dignity for other patients, colleagues or visitors, so please don't bring them to hospital.

Respect for people during your visit

We are an inclusive employer and we are proud of our highly skilled colleagues, who have a range of diverse backgrounds. We also care for a diverse group of patients. We do not tolerate physical or verbal abuse or any form of discrimination towards our staff or patients. This includes, but is not limited to, racism, homophobia, anti-religion and sexism. We will robustly manage any such incidents and, where appropriate, will involve the police.

Further sources of information

NHS Choices: www.nhs.uk/conditions
Our website: www.sfh-tr.nhs.uk

Patient Experience Team (PET)
PET is available to help with any of your compliments, concerns or complaints, and will ensure a prompt and efficient service.
King's Mill Hospital: 01623 672222
Newark Hospital: 01636 685692
Email: sfh-tr.PET@nhs.net

If you would like this information in an alternative format, for example large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know. You can call the Patient Experience Team on 01623 672222 or email sfh-tr.PET@nhs.net.

To be completed by the Communications office
Leaflet code: PIL202202-04-CSI
Created: January 2017 / Revised: February 2022 /
Review Date: February 2024