

INFORMATION FOR PATIENTS

Posterior vaginal wall prolapse repair and repair of the perineum

We advise you to take your time to read this leaflet. If you have any questions 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 a posterior vaginal wall prolapse is, what alternatives are available within our Trust, the risks involved in surgery and what operation we can offer.

What is a posterior vaginal wall prolapse?

Posterior means towards the back, so a posterior vaginal wall prolapse is a prolapse of the back wall of the vagina.

Posterior vaginal wall prolapse is called a rectocele, which describes the structure bulging into the vagina - the rectum.

The pelvic floor muscles form a 'sling' or 'hammock' across the opening of the pelvis.

These muscles, together with their surrounding tissue, are responsible for keeping all of the pelvic organs (bladder, uterus, vagina, and rectum) in place and functioning correctly.

Prolapse occurs when the pelvic floor muscles, their attachments or the vagina have become weak. This usually occurs because of the damage of childbirth but is most noticeable after the menopause when the quality of supporting tissue deteriorates.

With straining, for example on passing a motion, the weakness described above allows the rectum (back passage) to bulge into the vagina and sometimes bulge out of the vagina (rectocele).

A large rectocele may make it very hard to have a bowel movement, especially if you have constipation.

Some women have to push the bulge back into the vagina or support the perineal area (the area between the anus and the vagina) with their fingers in order to complete a bowel movement.

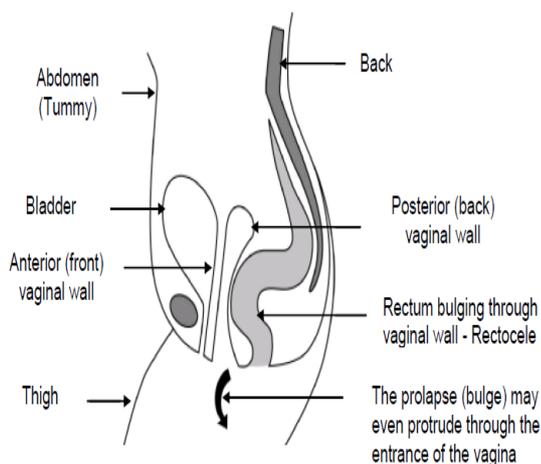
Some women have to insert a finger in the back passage to facilitate evacuation of their bowel, this is called digitation.

If a woman has difficulty in emptying the back passage or has to use her fingers to achieve bowel emptying, a special x-ray test to assess bowel emptying may be needed in planning the surgical approach.

The x-ray will involve inserting a special paste in the back passage and taking x-rays while trying to evacuate the paste from the back passage.

Some women find that the bulge causes a dragging or aching sensation.

The diagram bellows shows the rectum bulging through the posterior (back) vaginal wall (in standing women).



Alternatives to surgery

Do nothing

If the prolapse (bulge) is not distressing then treatment is not necessarily needed.

If however, the prolapse permanently protrudes through the opening to the vagina and is exposed to the air, it may become dried out and eventually ulcerate. Even if it is not causing symptoms in this situation it is probably best to push it back with a ring pessary (see below) or have an operation to repair it.

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 no risk and even if surgery is required at a later date, they will help your overall chance of being more comfortable.

Types of pessary

Ring pessary

This is a soft plastic ring or device which is inserted into the vagina and pushes the prolapse back up. This usually gets rid of the dragging sensation and can improve urinary and bowel symptoms. It needs to be changed every 6-9 months and can be very popular - we can show you an example in clinic. Other pessaries may be used if the ring pessary is not suitable.

Some couples feel that the pessary gets in the way during sexual intercourse, but many couples are not bothered by it.

Shelf pessary or gellhorn

If you are not sexually active this is a stronger pessary which can be inserted into the vagina and again needs changing every 6 months.

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.

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 this surgery

Damage to local organs

This can include bowel and blood vessels. This is a rare complication but requires that the damaged organ is repaired and this can result in a delay in recovery. It is sometimes not detected at the time of surgery and therefore may require a return to theatre. If the rectum (back passage) is inadvertently damaged at the time of surgery, a temporary colostomy (bag) may be required but this is exceptionally rare.

Prolapse recurrence

If you have one prolapse, the risk of having another prolapse sometime during your life is 30%. This is because the vaginal tissue is weak.

Pain

You may have general pelvic discomfort. This usually settles with time but occasionally pain on intercourse may occur and can sometimes be permanent.

Reduced sensation during intercourse

Sometimes the sensation during intercourse may be less and occasionally the orgasm may be less intense.

Change in bowel function

Occasionally, patients can become constipated after the operation but often bowel function is improved.

Posterior vaginal wall prolapse repair

Following the operation you are likely to feel more comfortable. Intercourse may be more satisfactory. Opening your bowels may be easier, but this cannot be guaranteed.

Before the operation

It is recommended that you take a medication to soften your motions for at least three days before the operation. This will help to reduce the risk of you getting constipated after the operation and could mean you get home earlier. Magnesium sulphate, Lactulose or Movicol would be suitable and you can obtain these from your GP or local pharmacist. If you are post-menopausal your gynaecologist may recommend oestrogen cream.

How the operation is performed

The operation can be done with a spinal or general anaesthetic. You may have a choice of which anaesthetic is used. A spinal anaesthetic involves an injection in the lower back, similar to what we use when women are in labour or for a Caesarean Section. The spinal anaesthetic numbs you from the waist down; this removes any sharp sensation but a pressure sensation will still be felt. A general anaesthetic will mean you will be asleep (unconscious) during the entire procedure.

During the operation:

- The legs are placed in stirrups (supported in the air).
- The back vaginal wall is infiltrated with local anaesthetic.
- A horizontal cut is made where the back wall of the vagina meets the skin just outside the vagina.
- A vertical cut is then made in the back wall of the vagina, over the area of the bulge – see figures 1 and 2.
- The vaginal skin is then separated from the rectum (lower bowel).
- Stitches (2 or 3) are placed in tissue at either side of the rectum.
- These stitches are then tied in the centre thus bringing the tissue into the middle so that the rectum is held behind them and thus supported. This then stops the rectum bulging into the back vaginal wall – see figure 3.
- Sometimes a perineorrhaphy, which is a surgical repair of the perineum (the skin and muscle between the front and back passage), will be performed. This can improve the prolapse repair but can result in tightening of the vaginal entrance and pain during sexual intercourse.
- Any excess vaginal skin is trimmed and then the vaginal skin closed with stitches – see figure 4.
- A vaginal pack (ribbon gauze to apply pressure) may then be inserted into the vagina which is removed the following morning. A catheter may also left in the bladder overnight.

Figure 1: Diagram showing back (posterior) vaginal wall protruding through vagina.

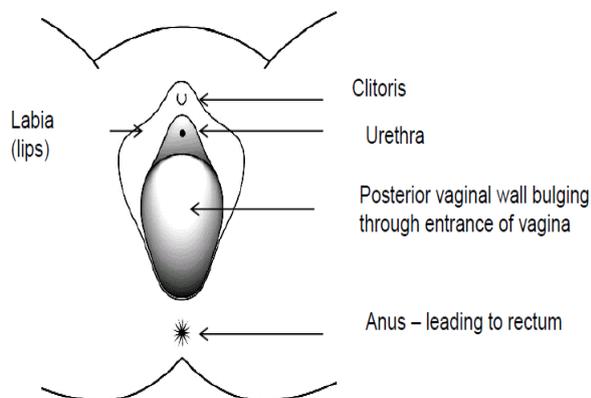


Figure 2: Diagram showing vertical and horizontal incisions in posterior vaginal wall.

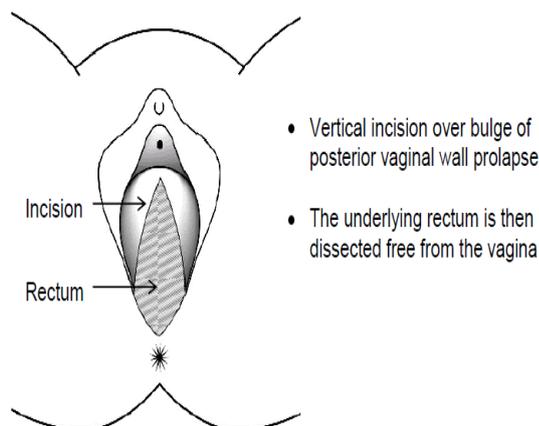


Figure 3: Diagram showing stitches in fibrous tissue under the vaginal skin.

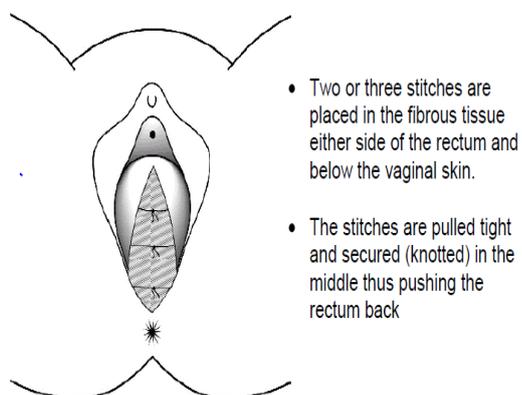
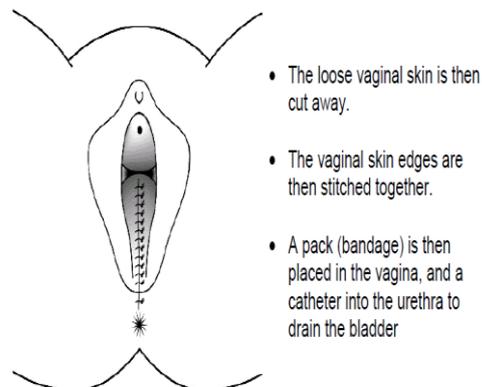


Figure 4: Diagram showing the excess vaginal skin cut away and the vaginal skin closed with stitches.



After the operation - in hospital

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 of 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 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 sometimes 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.

After the operation - at home

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.

There are stitches in the skin wound in the vagina. The stitches under the skin will dissolve by themselves. The surface knots of the stitches may appear on your underwear or pads after about two weeks; this is quite normal.

There may be little bleeding again after about 2 weeks when the surface knots fall off, this is nothing to worry about.

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 about 6 weeks. Leave a very heavy or busy job until 12 weeks.

You can drive as soon as you can make an emergency stop without discomfort, generally after 3 weeks.

You must, however 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, as long as you have no blood loss. You will need to be gentle and may wish to use lubrication (such as KY jelly) as some of the internal knots could cause your partner discomfort. You may, otherwise, wish to defer sexual intercourse until all the stitches have dissolved, typically 3 months.

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.

Further information

Bladder & Bowel UK
<http://www.bladderandboweluk.co.uk/>
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.

This document is intended for information purposes only and should not replace advice that your relevant health professional would give you. External websites may be referred to in specific cases. Any external websites are provided for your information and convenience. We cannot accept responsibility for the information found on them. If you require a full list of references for this leaflet, please email sfh-tr.patientinformation@nhs.net or telephone 01623 622515, extension 6927.

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