Healthier Communities, Outstanding Care

Sherwood Forest Hospitals NHS Foundation Trust

INFORMATION FOR PATIENTS

An operation for anterior vaginal wall prolapse

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.

In this leaflet we cover your right to know about the operations being proposed, why they are being proposed, what alternatives there are and what the risks are.

This leaflet details what an anterior vaginal wall prolapse is, what alternatives are available within our Trust, the risks involved in surgery and what operation we can offer.

What is an anterior vaginal wall prolapse?

Anterior means towards the front, so an anterior vaginal wall prolapse is a prolapse of the front wall of the vagina.

Another name for an anterior vaginal wall prolapse is a cystocele, which describes the structure bulging into the vagina- the bladder (see diagram at the end of this section).

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, and rectum) in place and functioning correctly.

A prolapse occurs when the pelvic floor muscles, their attachments or the vagina have become weak. This usually occurs because of damage at the time of childbirth, but is most noticeable after the menopause when the quality of supporting tissue deteriorates. It is also related to chronic strain caused by heavy lifting and constipation.

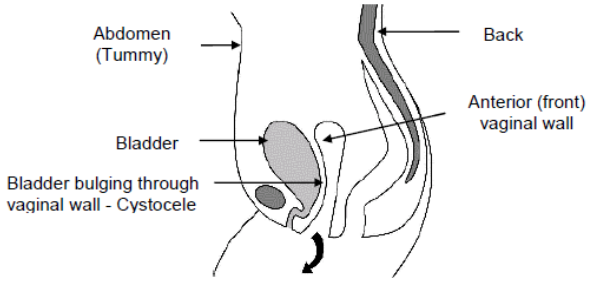
When the anterior vaginal wall is weak the bladder pushes down into the vagina causing a bulge. This sometimes can be large and push out of the vagina especially on straining e.g. exercise or passing a motion.

A large cystocele can often cause, or be associated with urinary symptoms, such as urinary leakage, urinary urgency (strong and sudden desire to pass urine), having to go frequently, difficulty passing urine or a sensation of incomplete emptying.

Some women have to push the bulge back into the vagina or lean forward in order to completely empty the bladder. Incomplete bladder emptying may make you prone to bladder infections (urinary tract infection).

Some women find that the bulge causes a dragging or aching sensation, or is uncomfortable when having sexual intercourse.

The diagram below (sideward view) shows the bladder bulging through the anterior (front) 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 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 continence nurse advisor or women's health 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 or earlier if there is any bleeding or discharge. 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 4-6 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 bladder, ureters (pipes from kidneys to the bladder) 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 bladder is inadvertently opened during surgery, it will need catheter drainage for 7-14 days following surgery.

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. The operation may not work and it may fail to alleviate your symptoms.

Pain
General pelvic discomfort, this usually settles with time, and tenderness on intercourse due to vaginal tethering or mesh erosion. Occasionally, pain on intercourse can be permanent.

Overactive bladder symptoms
Urinary urgency and frequency usually get better after the operation, but occasionally can start or worsen after the operation. If you experience this please make us aware so that we can treat you for it. Stress incontinence may develop in up to 5%.

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

The operation for anterior vaginal wall prolapse (anterior colporrhaphy)

This operation has been performed for a long time. There is a high recurrence rate (symptoms returning) but the operation can be repeated.

Because this prolapse involves the bladder, a test of bladder function (urodynamics) is sometimes required prior to the operation, especially if the prolapse is large or if you already have urinary symptoms (frequency, urgency or incontinence).

The benefits are that you are likely to feel more comfortable, intercourse may be more satisfactory and you may empty your bladder more effectively.

Before the operation

It is recommended that you take a medication to soften your motions for at least 3 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. Your gynaecologist may recommend local oestrogen if you are post-menopausal.

How the operation is performed

The operation can be done with a spinal or general anaesthetic and you may have a choice in this.

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.

After anaesthetic:

- The legs are placed in stirrups (supported in the air).
- The front vaginal wall is injected (infiltrated) with local anaesthetic.
- A vertical cut is made in the front wall of the vagina over the area of the bulge (see figure 2).
- The vaginal skin is then separated from the bladder.
- Two or three repair sutures are placed in the tissues at either side of the bladder (see figure 3).
- These stitches are then tied in the centre, thus bringing the fibrous tissue into the middle so that the bladder is elevated behind them and thus supported. This stops the bladder bulging into the front vaginal wall. Any excess vaginal skin is trimmed and then the vaginal skin closed with dissolvable stitches (see figure 4).

Figure 1 The prolapse bulge from the front vaginal wall protruding through the vaginal entrance – anterior wall prolapse or cystocele.

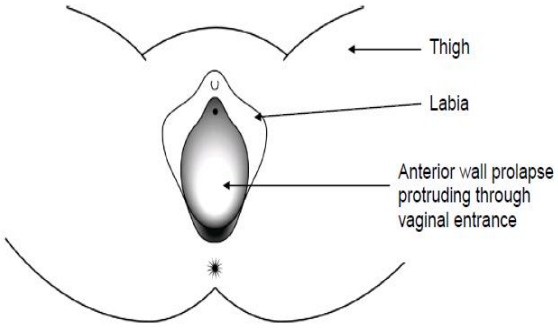
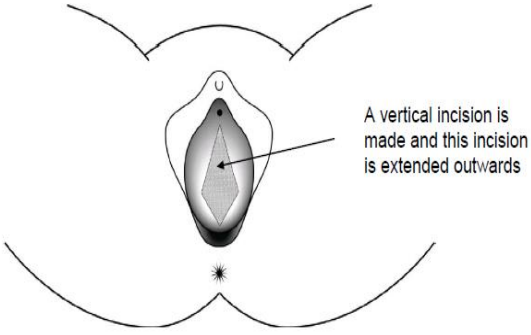


Figure 2 A vertical incision is made over the prolapse and the vaginal skin dissected free from the bladder.



A vertical incision is made and this incision is extended outwards.

Figure 3 Stitches (sutures) are then placed in fibrous tissue at the edge of the bladder and underneath it.

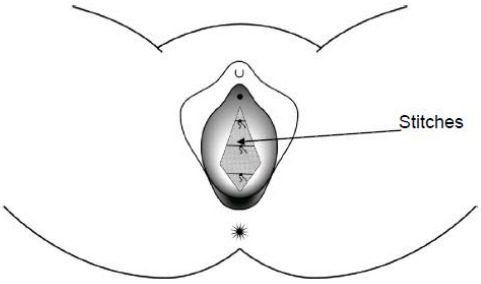
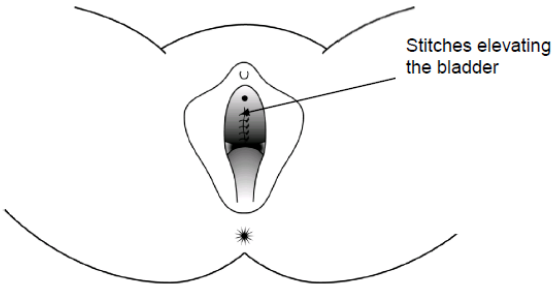


Figure 4 These stitches are then pulled tight and this has the effect of elevating the bladder. The vaginal skin is then trimmed and closed.



Stitches elevating the bladder.

After the operation - in hospital

When you 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 into your bladder for a couple more days.

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 but 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/fruit juice, eating fruit and green vegetables (especially broccoli) and eating plenty of roughage (bran/oats).

Do not use tampons for six weeks.

There are stitches in the skin wound in the vagina. Any stitches under the skin will dissolve by themselves. The surface knots of the stitches may appear on your underwear or pads after about 2 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, 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 (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 maybe at the hospital (doctor or nurse), with your GP or by telephone. Sometimes follow up is not required.

Useful contacts

Bladder & Bowel UK
http://www.bladderandboweluk.co.uk/adults/
Telephone: 0161 607 8219

Things I need to know before my operation

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

……

……

……

……

……

……

Please describe what your expectations are from surgery

……

……

……

……

……

……

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.

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