East Kent Hospitals University NHS Foundation Trust

Operations for prolapse of the vaginal apex

Information for patients from the British Society of Urogynaecologists (BSUG)

- Sacrospinous fixation of the vaginal vault
- Sacrospinous fixation of the uterus

We advise you to take your time to read this leaflet, any questions you have please write them down 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 firstly describes what a vaginal vault prolapse is, it then goes on to describe what alternatives are available within our trust, the risks involved in surgery, and finally what operation we can offer.

This patient information sheet was put together by members of the BSUG Governance Committee paying particular reference to any relevant NICE Guidance.

Where can I find more information?

- **Bladder and Bowel Foundation**
  Nurse helpline for medical advice: 0845 34 50 16 5
  Counsellor helpline: 0870 77 032 46
  General enquiries: 01536 53 32 55
  Email: info@bladderandbowelfoundation.org
  Web: www.bladderandbowelfoundation.org

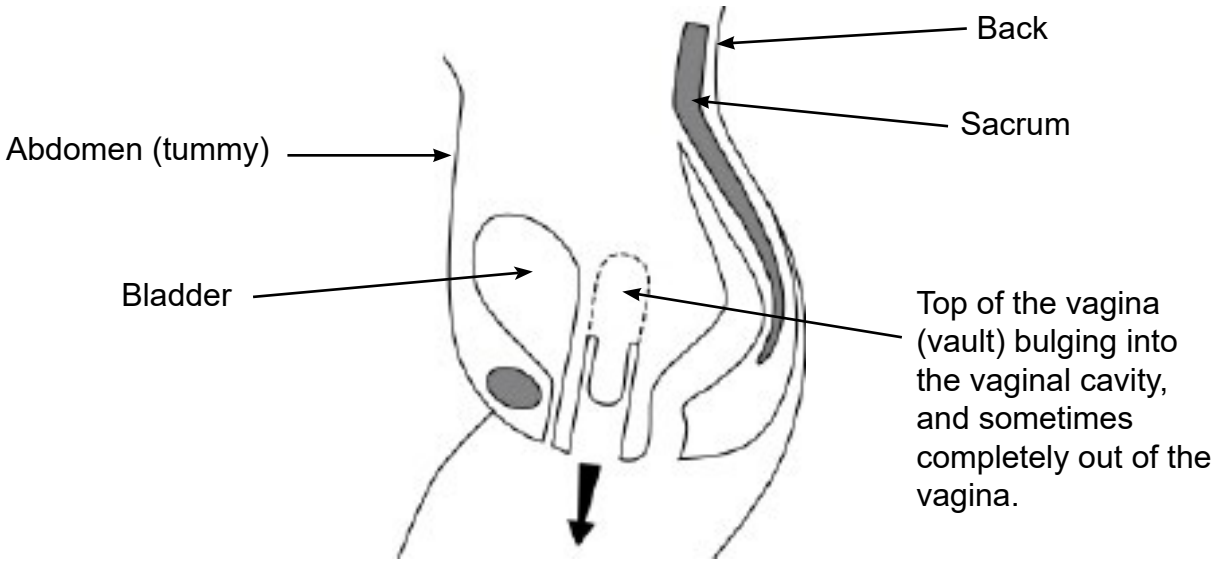
We care

What is a prolapse of the vaginal apex?

- A prolapse is where the vaginal tissue is weak and bulges downwards into the vagina itself. In severe cases it can even protrude outside your vagina.

- The apex is the deepest part of your vagina (top of it) where your uterus (womb) is usually located. If you have had a hysterectomy then the term ‘vault’ is used to describe the area where your womb would have been attached to the top of your vagina (front passage). A vaginal vault prolapse is a prolapse arising from the vaginal vault (see diagram below).

Figure 1 - a sideways diagram showing the normal position of a vagina (dotted line) and a prolapsing vaginal vault (continuous line).



- It is often accompanied by a posterior vaginal wall prolapse, either a high posterior vaginal wall prolapse called a Enterocele, or a low posterior vaginal wall prolapse called a Rectocele, or sometimes both.

- The pelvic floor muscles are a series of muscles that form a sling or hammock across the opening of your pelvis. These muscles, together with their surrounding tissue, are responsible for keeping all of your pelvic organs (bladder, uterus, and rectum) in place and working correctly.

- Prolapse happens when your pelvic floor muscles or vagina have become weak. This is usually after childbirth but is most noticeable after the menopause when the quality of your supporting tissue deteriorates (weakens).

- With straining, for example when going to the toilet, the weakness described above allows the vault of your vagina to bulge downwards and your rectum (back passage) to bulge into your vagina and sometimes bulge out of your vagina.

- Some women have to push the bulge back into their vagina with their fingers in order to go to the toilet.

- Occasionally, you may find that the bulge causes a dragging or aching sensation.

Are there 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 your 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 your coccyx at the back to your 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 works properly. This is more important if that muscle has been damaged. PFE can strengthen your pelvic floor and therefore give more support to your pelvic organs. These exercises may not get rid of your 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 needed at a later date, they will help your overall chance of being more comfortable.

What are the different types of pessary?

- **Ring pessary** 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 four to six 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 your vagina and again needs changing every four to six months.

What are the general risks to having 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 and then having blood available to give you if needed during surgery. It is rare that we have to transfuse patients after their operation.

- 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 to 5% (or four to five in every 100 patients) although the majority of these are without symptoms. Occasionally this clot can move to the lungs which can be very serious and in rare circumstances it can be fatal (less than 1% or one in 100 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 (not being able to move around), and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood (Heparin).

What are the specific risks of this surgery?

- **Pain** - there may be short term buttock pain for approximately one in four patients. Long term buttock pain occurs in around one in every 100 patients.

- **Damage to local organs** - this can include bowel, bladder, ureters (pipes from kidneys to the bladder), and blood vessels. This is a rare complication but the damaged organ will need to be repaired and it can result in a delay to your recovery. It is sometimes not noticed at the time of surgery so you may need to return to theatre. If your bladder is opened during surgery, it will need catheter drainage for seven to 14 days following surgery. If your rectum (back passage) is damaged during surgery, this will be repaired, however, inserting the mesh may be delayed until a later date. This will need another operation, and in rare circumstances, you may need a temporary colostomy (bag).

- **Recurring prolapse**: if you have one prolapse, three in 10 women are at risk of having another prolapse during their lifetime. This is because their vaginal tissue is weak.

- **Painful sexual intercourse**. Once the wound at the top of your vagina has healed, there is nothing to stop you from having sex. The healing usually takes about six weeks. Some women find sex is uncomfortable at first but it gets better with time and sometimes improves using a bit of extra lubrication. Sometimes sex continues to be painful after the healing has finished but this is unusual.

- **Change in sensation with intercourse**. Sometimes the sensation during intercourse may be less and occasionally the orgasm may be less intense.

This operation has been performed for a long time and the success rate of the operation is 70 to 90%, this may go down with time. You should feel more comfortable following your operation and the sensation of the prolapse, or something coming down should have gone.

What happens before my operation?

It is recommended that you take medication to soften your stools for at least three days before your operation. This will help to reduce the risk of you getting constipated after your operation and could mean you get home earlier. You can use Magnesium Sulphate, Lactulose, or Movicol, all of which you can get from your GP.

How is the sacrospinous fixation 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.

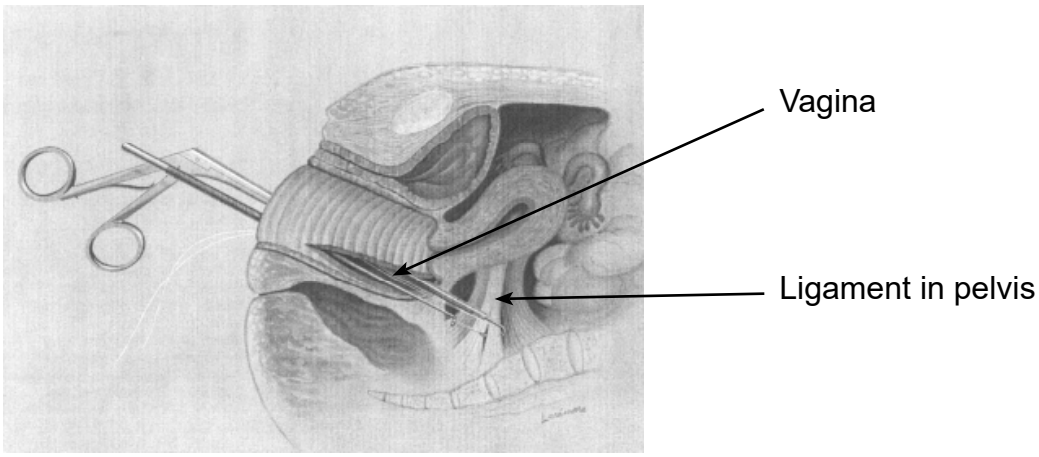
- A general anaesthetic will mean you will be asleep (unconscious) during the entire procedure.

- Your legs are placed in stirrups (supported in the air).

- The operation is done through your vagina with special instruments (see diagram below).
- The top of your vagina (if you have had a hysterectomy) or the neck of your womb (cervix) is suspended to a ligament in your pelvis called the sacrospinous ligament using suture (stitch) material that dissolves slowly (over three months) or permanent sutures.

Posterior repair may be done at the same time. For more information, ask a member of staff for a copy of the Trust leaflet for posterior repair.

Figure 2 - Sacrospinous fixation using special instruments (Miya hook) done through the vagina.



What happens after my operation?

- 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 your 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 your 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 your surgery or sometimes later the same day. This is not generally painful.
- The day after your 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 you developing clots in your 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 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 sometimes you may need tablets or injections for pain relief.
- There will be slight vaginal bleeding, like the end of a period, after your operation. This may last for a few weeks.
- The nurses will advise you about such things as sick notes and certificates. You are usually in hospital for up to two days.

What happens when I return home?

- Moving around is very important; using your leg muscles will reduce the risk of clots in the back of your legs (DVT), which can be very dangerous.
- You are likely to feel tired and may need to rest in the day 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. You avoid constipation by drinking plenty of water / juice, and eating fruit, green vegetables (especially broccoli), and plenty of roughage (such as bran and oats).
- Do not use tampons for six weeks.

When will my stitches be removed?

There are stitches in the skin wound in your vagina. The parts of the stitches under the skin will melt away 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 a little bleeding again after about two weeks when the surface knots fall off, this is nothing to worry about.

When can I resume normal activities?

- At six weeks gradually build up your level of activity.
- After three 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 six 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 three weeks, but you must check this with your insurance company, as some of them insist that you should wait for six weeks.
- You can start having sex whenever you feel comfortable enough after six weeks, so long as you have no blood loss. You will need to be gentle and may wish to use lubrication as some of the internal knots could cause your partner discomfort. You may, otherwise, wish to avoid sexual intercourse until all the stitches have dissolved, typically three to four months.

Will I have a follow-up appointment?

You will be sent a follow-up appointment in the outpatient clinic around six to eight weeks after your operation. This maybe at the hospital (doctor or nurse), with your GP, or by telephone. Sometimes a follow-up is not needed.

What if I have questions or concerns once I return home?

You should contact the medical team or ward if there are any immediate problems after you return home. If you have any concerns in the days and weeks that follow, please contact your GP, who will be able to advise you.

This patient information sheet was put together by members of the BSUG Governance Committee paying particular reference to any relevant NICE Guidance.

This leaflet has been produced with and for patients

If you would like this information in **another language, audio, Braille, Easy Read, or large print** please ask a member of staff. You can ask someone to contact us on your behalf.

Any complaints, comments, concerns, or compliments please speak to your doctor or nurse, or contact the Patient Advice and Liaison Service (PALS) on 01227 78 31 45, or email ekh-tr.pals@nhs.net

Patients should not bring in large sums of money or valuables into hospital. Please note that East Kent Hospitals accepts no responsibility for the loss or damage to personal property, unless the property had been handed in to Trust staff for safe-keeping.

Further patient leaflets are available via the East Kent Hospitals web site www.ekhuft.nhs.uk/patientinformation

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