Colpocleisis (Closure of the vagina to treat prolapse)

About this leaflet

The information provided in this leaflet should be used as a guide. There may be some variation in how each gynaecologist performs the procedure, the care procedures on the ward immediately after your operation and the advice given to you when you get home. You should ask your gynaecologist about any concerns that you may have.

You should take your time to read this leaflet. A page is provided at the end of the leaflet for you to write down any questions you may have. It is your right to know about your planned operation/procedure, why it has been recommended, what the alternatives are and what the risks and benefits are. These should be covered in this leaflet. You may also wish to ask about your gynaecologist's personal experience and results of treating your condition.

Benefits and risks

The success and the risks of most operations carried out to treat prolapse and incontinence have been poorly studied and so it is often not possible to define them clearly. In this leaflet risks may be referred to as common, rare etc. or an approximate level of risk may be given.

Further information about risk is explained in a leaflet published by the Royal College of Obstetricians and Gynaecologists "Understanding how risk is discussed in healthcare". https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pi-understanding-risk.pdf

The following table is taken from that leaflet:

	Risk	Unit in which one adverse event would be expected
Very common	1 in 1 to 1 in 10	A person in family
Common	1 in 10 to 1 in 100	A person in street
Uncommon	1 in 100 to 1 in 1000	A person in village
Rare	1 in 1000 to 1 in 10,000	A person in small town
Very rare	less than 1 in 10,000	A person in large town

What is colpocleisis?

Colpocleisis is an operation to close the vagina using stitches. This operation is usually offered to women who have a prolapse and are not planning to be sexually active in future.

What condition does a colpocleisis treat?

This treats advanced prolapse of the vagina and / or uterus (womb).

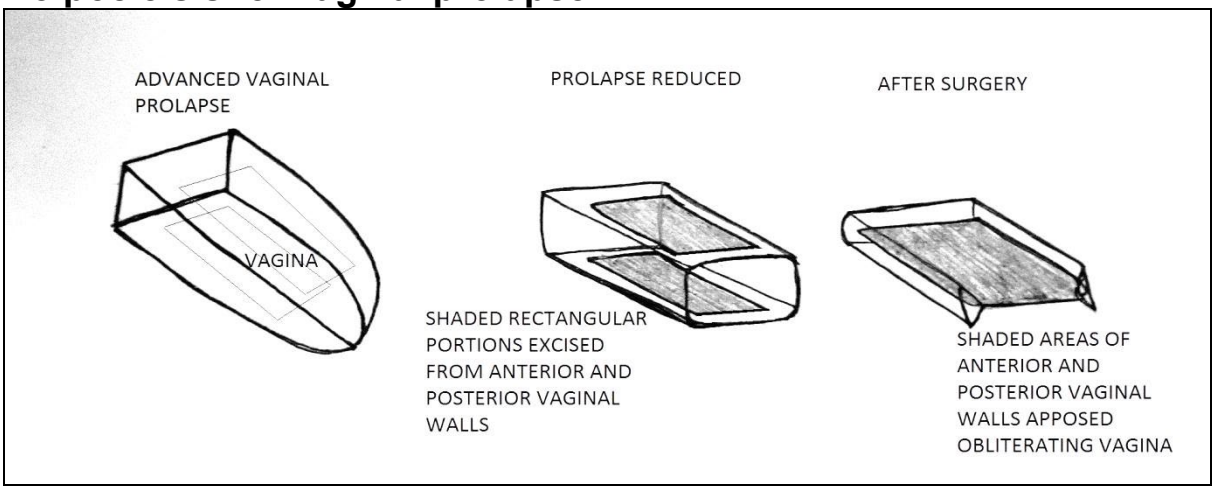
How is a colpocleisis done?

This operation can be done under general or regional anaesthesia and rarely is offered under local anaesthetic, if the patient is not fit for any other form of anaesthetic.

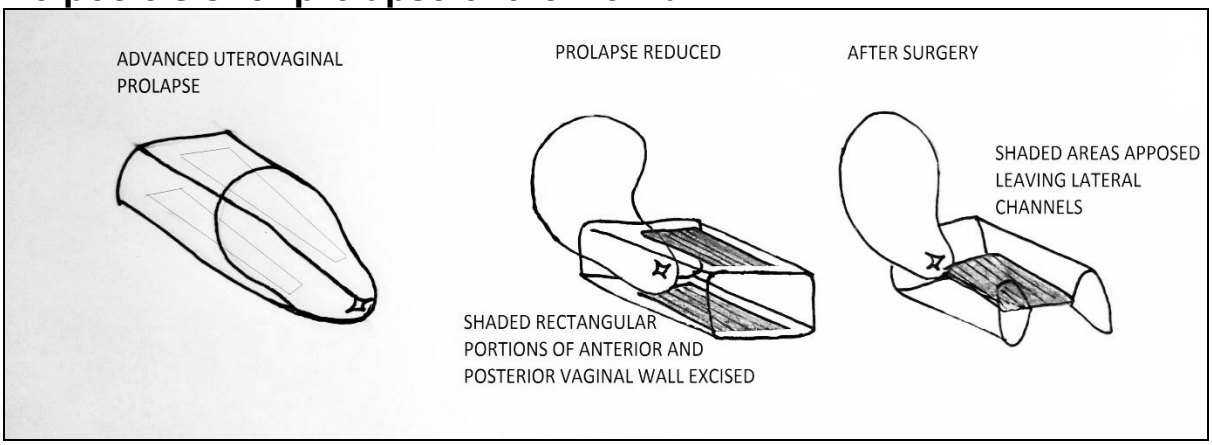
Information for Patients

A rectangular area of skin is removed from the front and back walls of vagina which are then stitched together, closing the vagina. The entrance to the vagina is often made narrower by removing skin over the perineum (skin between front and back passage). The underlying muscles and skin are pulled together using dissolvable sutures. This part of the operation is called perineorrhaphy (repair of perineum).

Colpocleisis for vaginal prolapse



Colpocleisis for prolapse of the womb



Other operations which can be performed at the same time.

A hysterectomy can be done at the same time.

Mesh tape operations for stress urinary incontinence can also be done at the same time as a colpocleisis.

Benefits of Surgery

Colpocleisis is associated with high rates of patient satisfaction with respect to prolapse symptoms. The satisfaction rates are similar other prolapse repair procedures, with lower rate of recurrent prolapse.

It is less invasive than other prolapse repair procedures and hence better tolerated by frail or elderly women.

Risks of Surgery

- **Anaesthetic risk.** This is very small unless you have specific medical conditions, such as a problem with your heart, or breathing. Smoking and being overweight also increase any risks. An anterior repair can be performed with you asleep (a general anaesthetic) or awake (a spinal anaesthetic) whereby you are awake but numb from the waist down. This will be discussed with you. Make the anaesthetist aware of medical conditions such as problems with your heart or breathing. Bring a list of your medications. Try to stop smoking before your operation. Lose weight if you are overweight and increase your activity.

- **Bleeding**
  There is a risk of bleeding with any operation but it would be very rare for this to be a large amount. There is a risk of bleeding with any operation, but it would be very rare for this to be a large amount. Please let your doctor know if you are taking a blood-thinning tablet such as warfarin, aspirin, clopidogrel, apixaban, rivaroxaban, dabigatran, etc, as you may be asked to stop them before your operation.

- **Infection**
  There is a small risk of infection with any operation (about 5 to 13 cases in 100 operations). If it occurs, an infection can be in the vagina or a urinary infection, and is usually treated with antibiotics. The risk of infection is reduced by routinely giving you a dose of antibiotic during your operation. Chest infection may also occur because of the anaesthetic. Treat any infections you are aware of before surgery. After surgery, regular deep breathing exercises can help prevent chest infections; the nurses will guide you how to do this.

- **Deep Vein Thrombosis (DVT)**
  This is a clot in the deep veins of the leg. Occasionally this clot can travel to the lungs (pulmonary embolism) which can be very serious and in rare circumstances it can be fatal (less than 1 in 100 of those who get a clot). The risk increases with obesity, severe varicose veins, infection, immobility and other medical problems.

  The risk is significantly reduced by wearing compression stockings and injections to thin the blood. Stop taking any hormones such as hormone replacement therapy (HRT) and some types of birth-control pills 4 weeks before surgery. These can usually be restarted 4 weeks following surgery when the risk of blood clots has reduced.

  Do not arrange surgery the day after a long car journey or flight. As soon as you are awake start moving your legs around. Keep mobile once you are at home and continue to wear your compression stockings during times when you are less mobile.

- **Wound complications**
  The wound within the vagina can become infected or occasionally stitches can become loose allowing the wound to open up.

- **Failure to cure** symptoms. Even if the operation cures your prolapse it may fail to improve your symptoms.

- **Damage to bladder**

This means accidentally making a hole in the bladder. It is an uncommon complication but usually straightforward to repair with stitches if detected at the time of surgery. It can result in a delay in recovery, but usually does not cause any long-term problems. A catheter is usually kept in the

bladder for 7-14 days following surgery to allow the bladder to heal.

Damage to the bladder is sometimes not detected at the time of surgery and may not be diagnosed for days or weeks after surgery. In this situation, the bladder can take weeks to heal.

- **Overactive bladder symptoms**
  (urinary urgency and frequency with or without incontinence) usually improve after the operation, but occasionally can start or worsen after the operation.

- **Stress incontinence**
  A prolapse of the anterior vaginal wall sometimes causes some kinking of the tube through which you pass urine (urethra). This can be enough to stop urine leaks on coughing, sneezing or exercise. By correcting the prolapse, this kink gets straightened out, and if there is an underlying weakness in the tissues, leakage of urine can occur. It is difficult to define an exact risk but it is reported to be in the order of 10% (1 in 10). Doing pelvic floor exercises regularly can help to prevent stress incontinence.

- **Damage to bowel**
  This is a rare complication which means accidentally making a hole in the bowel (rectum). Minor damage can be repaired with stitches if detected at the time of surgery without any long-term consequences. Sometimes the injury is not detected at the time of surgery and may require another operation and temporary colostomy (bag) but this is rare.

- **A change in the way your bowel works**
  Some patients experience worsening constipation following surgery. This may resolve with time. It is important to try to avoid being constipated following surgery to reduce prolapse recurrence. If you are struggling with constipation after simple changes in diet and fluid intake, your doctor/GP may prescribe a laxative.

- **Regret**
  due to inability to have penetrative sexual intercourse. Both patient and partner should be completely comfortable with the prospect of losing vaginal sexual function before this operation can be considered. Up to 1 in 10 women have reported regret for losing vaginal sexual function.

- **Inability to reach the cervix or uterus through the vagina**
  This may be required if there is bleeding or abnormal vaginal discharge. An abdominal ultrasound scan can still be performed and so also other imaging modalities like MRI or CT scan. If a tissue sample is required for further diagnosis, a hysterectomy might have to be considered.

After the operation - in hospital

- **Pain relief**
  An anterior repair is not a particularly painful operation, but sometimes you may require tablets or injections for pain relief. Some women describe the pain as similar to a period. It is often best to take the painkillers supplied to you on a regular basis aiming to take a painkiller before the pain becomes a problem.

Information for Patients

- **Drip**
  You may have a drip after the operation; this is to keep you hydrated until you are drinking normally. The drip is usually removed within 24 hours.

- **Catheter**
  You may have a tube (catheter) draining the bladder. The catheter may give you the sensation as though you need to pass urine but this is not the case. It is usually removed the morning after surgery or sometimes later the same day.

- **Pack**
  Some gynaecologists insert a length of gauze into the vagina at the end of the operation. It acts as pressure bandage and is usually removed the following day.

- **Vaginal bleeding**
  There may be slight vaginal bleeding like the end of a period after the operation.

- **Eating and drinking**
  You should be able to drink and eat within a few hours of returning to the ward.

- **Preventing deep vein thrombosis (DVT)**
  You will be encouraged to get out of bed soon after our operation and take short walks around the ward. This improves general wellbeing and reduces the risk of DVT. You may be given a daily injection to keep your blood thin and reduce the risk of blood clots until you go home or longer in some cases.

- **Going home**
  You are not usually in hospital for more than one or two days and may go home the same day. If you require a sick note or certificate please ask.

After the operation – at home

- Mobilisation is very important; using your leg muscles will reduce the risk of DVT.
- Bath or shower as normal.
- Avoid douching the vagina.
- 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, which is normal. There may be little bleeding again after about two weeks when the surface knots fall off, this is nothing to worry about.
- 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.
- Avoiding constipation:
  Drink plenty of water / juice
  Eat fruit and green vegetables especially broccoli
  Plenty of roughage e.g. bran / oats
- Any constant cough is to be treated promptly. Please see your GP as soon as possible.
- At six 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 six weeks, a busy job in 12 weeks. Avoiding unnecessary heavy lifting will possibly reduce the risk of the prolapse recurring.

- You can drive as soon as you can operate the pedals and look over your shoulder 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 usually have a follow up appointment anything between 6 weeks and six months after the operation.
- See link: https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/recovering-well/pelvic-floor-repair-operation.pdf

What to report to your doctor after surgery

- Heavy vaginal bleeding
- Smelly vaginal discharge
- Severe pain
- High fever
- Pain or discomfort passing urine or blood in the urine
- Leakage of urine which you did not have before the operation
- Difficulty opening your bowels
- Warm, painful, swollen leg
- Chest pain or difficulty breathing

ALTERNATIVE TREATMENTS

Non-surgical

- **Do nothing.** If the prolapse is not too bothersome then treatment may not be 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.

  Weight reduction in overweight women and avoiding risk factors such as smoking (leading to chronic cough), heavy weight lifting jobs and constipation may help with symptom control. The prolapse may become worse with time but it can then be treated.

- **Pelvic floor exercises (PFE).** The pelvic floor muscles support the pelvic organs. Strong muscles can help to prevent a prolapse dropping further. PFE are unlikely to provide improvement for a severe prolapse which is protruding outside the vagina.

  A women's health physiotherapist can explain how to perform these exercises with the correct technique. It is important that you try the above to help to manage the symptoms of your prolapse and to prevent it becoming worse. It is also very important to continue with your pelvic floor exercises even if you have opted for other treatment options.

- **Pessary.** A pessary (see image below) is a plastic device which may be placed in the vagina to support the vaginal walls and uterus. A pessary is usually used continuously and changed by a doctor or nurse every four to twelve months depending upon the type used and how well it suits you. Alternatively, if you prefer, you may be taught to replace the pessary yourself.

  It is possible to lead a normal life with continuation of activities such as bathing, cycling, swimming and, in some cases, sexual intercourse. Ongoing care is often at the GP practice but some women will need to be kept under review in the hospital clinic.

Information for Patients

Pessaries are very safe and many women to choose to use one long term rather than have an operation. On occasions their use has to be discontinued due to bleeding, discharge, sexual difficulties or change in bladder function but these all stop quickly after removal. Sometimes it will take several visits to the clinic to determine the best size for you but a pessary is not suitable for all women.

Surgical options

The following table lists the different operations in addition to colpocleisis that can be considered to treat **uterine prolapse**. Further information on the operations is available in separate leaflets. Not all operations are available in all hospitals. Your consultant may recommend a particular operation depending on his or her preference and expertise, or your individual needs.

Surgical Treatment	Advantages	Disadvantages
Colpocleisis – closure of vagina using stitches described in this leaflet	No abdominal incision Can be done with you awake or asleep May also treat a co-existing vaginal prolapse.	Sexual intercourse will never be possible after this operation. Not possible to take a smear Difficult to investigate abnormal bleeding from womb Urinary incontinence in the future may be more difficult to treat
Vaginal Sacrospinous Hysteropexy - stitches inserted through vagina to support womb	No abdominal incision May also treat a co-existing vaginal prolapse. Pregnancy still possible although prolapse can recur during or after pregnancy Can be done with you awake or asleep	Not possible with a short vagina Can cause temporary buttock pain
Sacrohysteropexy - open abdominal operation	May also treat a co-existing vaginal prolapse. No cuts or stitches in vagina. Vaginal length maintained. Pregnancy still possible although prolapse can recur during or after pregnancy	Requires a general anaesthetic (asleep) As mesh is used there is a small risk that the mesh will work its way into surrounding tissues.
Vaginal Hysterectomy - removal of uterus via the vagina)	No abdominal incision Can be done with you awake or asleep	Not effective for very advanced prolapse Risk of prolapse of the vault (top) of the vagina in the future

Manchester repair - removal of only the cervix via the vagina	No abdominal incision Can be done with you awake or asleep	Not effective for advanced prolapse

The following table lists the different operations in addition to colpocleisis that can be considered to treat **vaginal vault prolapse** (after a previous hysterectomy). Further information on the operations is available in separate leaflets. All operations are not available in all hospitals. Your consultant may recommend a particular operation depending on his or her preference and expertise, or your individual needs.

Surgical Treatment	Advantages	Disadvantages
Colpocleisis - closure of vagina using stitches (described in this leaflet)	No abdominal incision May also treat a co-existing vaginal prolapse. Can be done with you awake or asleep	Sexual intercourse will never be possible after this operation. Urinary incontinence in the future may be more difficult to treat
Vaginal Sacrospinous Fixation -stitches to support top of the vagina inserted through vagina	No abdominal incision May also treat a co-existing vaginal prolapse. Can be done with you awake or asleep	Not possible with a short vagina Can cause temporary buttock pain
Sacrocolpopexy – open abdominal operation	May also treat a co-existing vaginal prolapse. No cuts or stitches in vagina. Vaginal length maintained.	Requires a general anaesthetic (asleep) As mesh is used there is a small risk that the mesh will work its way into surrounding tissues.

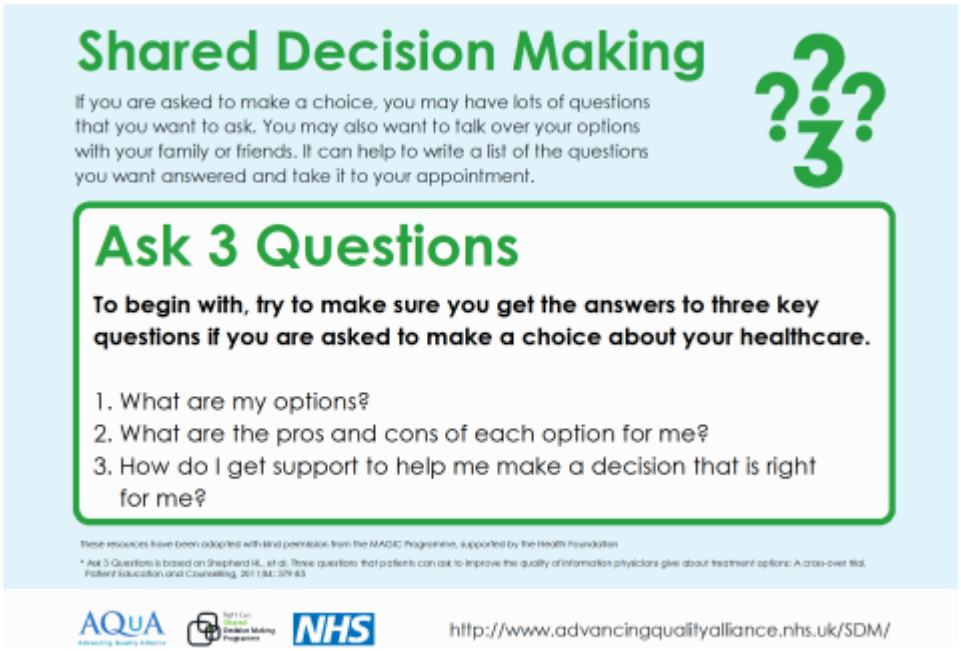
More information

If you would like to know more about uterine prolapse and the treatments available for it, you may try the following sources of information.

- Ask your GP.
- Ask the Doctor or Nurse at the hospital.
- Look at a website such as:
  - NHS choices at http://www.nhs.uk/pages/home.aspx
  - Patient UK at http://patient.info/health
  - Royal College of Obstetricians and Gynaecologists Recovering Well leaflet at https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/recovering-well/pelvic-floor-repair-operation.pdf
  - Royal College of Obstetricians and Gynaecologists patient information leaflet – Pelvic organ prolapse at https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/gynaecology/pi-pelvic-organ-prolapse.pdf
  - International Urogynaecology Association (IUGA) patient information leaflet – Colpocleisis at http://c.ymcdn.com/sites/www.iuga.org/resource/resmgr/leaflet/Colpocleisis.pdf

Information for Patients

Making a decision - things I need to know before I have my operation.



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

1)……

2)……

3)……

Please describe what your expectations are from surgery.

1)……

2)……

3)……

If you require this information in another format, such as a different language, large print, braille or audio version please ask a member of staff or email patientexperience@uhb.nhs.uk.