Posterior Vaginal Wall Repair

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 a posterior vaginal repair?

A posterior vaginal repair (colporrhaphy) is an operation performed within the vagina to treat a prolapse of the posterior (back) vaginal wall. It is often combined with a perineorrhaphy, which is a repair of the area between the vagina and the back passage called the perineum.

What is a posterior vaginal wall prolapse?

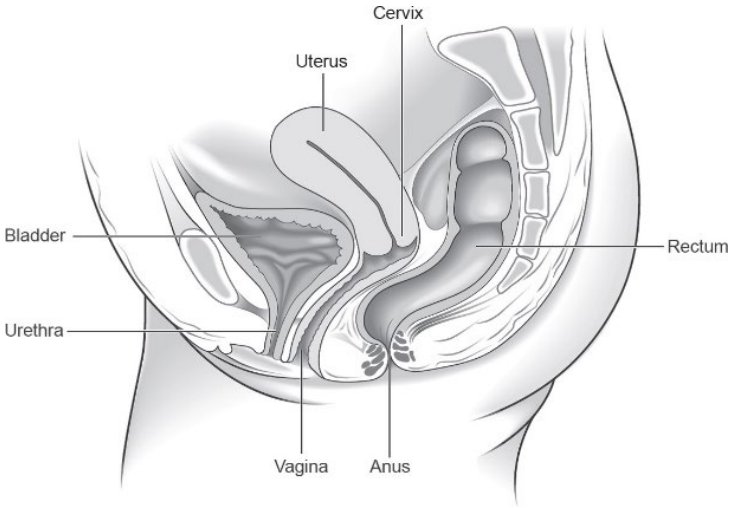
- A prolapse is a bulge within the vagina caused by a weakness in the supporting tissues and muscles around the vagina so that one or more pelvic organs bulge downwards into or out of the vagina. Pelvic organs include the womb, bladder and bowel.

Information for Patients

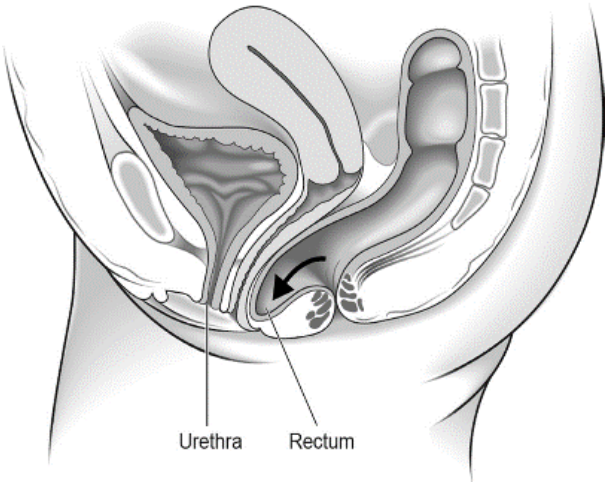
- With a posterior vaginal wall prolapse, it is the rectum (rectocele) or small bowel (enterocele) or both, which are pushing the vagina out (see diagram below).

- 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 with their fingers, support the perineum or insert a finger in the back passage in order to complete a bowel movement.

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



Normal pelvis without prolapse



Posterior vaginal wall prolapse (rectocoele) with bowel bulging into the vagina

How is a posterior vaginal wall repair done?

- The operation is usually done under general anaesthetic. A general anaesthetic will mean you will be asleep during the entire procedure. A spinal anaesthetic can also be used which involves an injection in your back to numb you from the waist downwards.

- The operation is all done vaginally and involves repairing the supportive tissues using dissolvable stitches. If your own tissue is thin or deficient, your surgeon may insert a layer of biological graft made from collagen.

This acts as scaffolding for new tissue to grow and eventually disappears after about three months. Your surgeon will discuss this before your operation it a graft may be required.

The stitches usually take 4 to 6 weeks to dissolve although some surgeons use stitches that take about 3-6 months to dissolve completely. This should not affect your recovery time. If the perineum is repaired you might notice a few stitches on the outside but these will dissolve.

- A catheter and a vaginal pack (gauze tampon) may be inserted in the vagina after the operation, but this is not essential and depends on the surgeon's preference and method of operating. These are usually removed the following day.

Other operations which may be performed at the same time

- Surgery for other types of prolapse; for example, an anterior vaginal repair, a vaginal hysterectomy or a sacrospinous fixation or sacrohysteropexy to treat a prolapse of the womb or the top of the vagina.

- Surgery to treat incontinence.

You should also refer to an information leaflet about any planned additional procedure.

Benefits of Surgery

The main aim of surgery is to get rid of the feeling of a lump or bulge. As a result, you should feel more comfortable. Some women report an improvement in sex. Many women who have difficulty opening their bowel before surgery report an improvement following surgery, but this cannot be guaranteed.

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. 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, it can be a vaginal infection 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. Do not douche the vagina or use tampons. Wait 6 weeks before resuming sexual activity.

- **Getting another prolapse**
  There is little published evidence of exactly how often prolapse recurs, but it can happen. This is because the vaginal tissue is weak. Sometimes, even though another prolapse develops it is not bothersome enough to require further treatment. Keeping your weight normal for your height (normal BMI), avoiding unnecessary heavy lifting, and not straining on the toilet, may help prevent a further prolapse, although even if you are very careful it does not always prevent it.

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

- **Damage to bowel**
  This is a rare complication which means accidentally making a hole or tear 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 very 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 can prescribe a laxative.

- **Altered sensation during intercourse**
  Sometimes the sensation during intercourse may be less and occasionally orgasm may be less intense. On the other hand repair of your prolapse may improve it.

- **Painful sexual intercourse**

The healing usually takes about 6 weeks and after this it is safe to have intercourse.
Some women find sex is uncomfortable at first, but it gets better with time. You will need to be gentle and may wish to use lubrication initially. Occasionally pain on intercourse can be long-term or permanent.

After the operation - in hospital

- **Pain relief**
  A posterior 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.

- **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 a DVT. You may be given a daily injection to keep your blood thin and reduce the risk of DVT until you go home or longer in some cases.

- **Going home**
  You are not usually in hospital for more than one or two days, but some patients will be well enough to 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.
- Do not use tampons for 6 weeks and avoid douching the vagina

Information for Patients

- The stitches under the skin will dissolve. 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.
  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 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, 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 6 weeks.

- The healing usually takes about 6 weeks and after this period it is safe to have intercourse. Some women find sex is uncomfortable at first but it gets better with time.

  Sometimes the internal knots could cause your partner discomfort until they dissolve away. You will need to be gentle and may wish to use lubrication initially. Occasionally pain on intercourse can be long-term or permanent.

- You usually have a follow up appointment anything between 6 weeks and 6 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
- 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 treatment may not be necessary. 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 improve an advanced prolapse 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 4 to 12 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. Pessaries are 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. A pessary is not suitable for all women.

Information for Patients

Surgical

The following table lists the different operations that can be considered to treat prolapse of the posterior vaginal wall. 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.

Treatment	Advantages	Disadvantages
Posterior vaginal repair (described in this leaflet)	Relatively minor operation Can be done with you awake or asleep	Can cause shortening and/or narrowing of the vagina.
Colpocleisis (closure of the vagina with stitches)	Relatively minor operation Can be done with you awake or asleep	Sexual intercourse will never be possible after this operation. Surgery to treat urinary incontinence in the future may be more difficult to do. If you have not already had a hysterectomy • Not possible to take a smear • Difficult to investigate abnormal bleeding from the womb or cervix
Biological graft insertion vaginally	No cuts in abdomen (tummy) May or may not provide better support compared to standard repair with stitches Can be performed as a day case.	Risks vary depending on which graft is used. Some grafts can result in fluid collections which may need draining. Risk of healing problems and graft exposure in the vagina with some grafts.
Synthetic mesh insertion vaginally	May provide better support for repeat surgery Can be done with you awake or asleep	Significant risk of complications: mesh exposure/estrusion, discomfort with intercourse, other pain, infection

More information

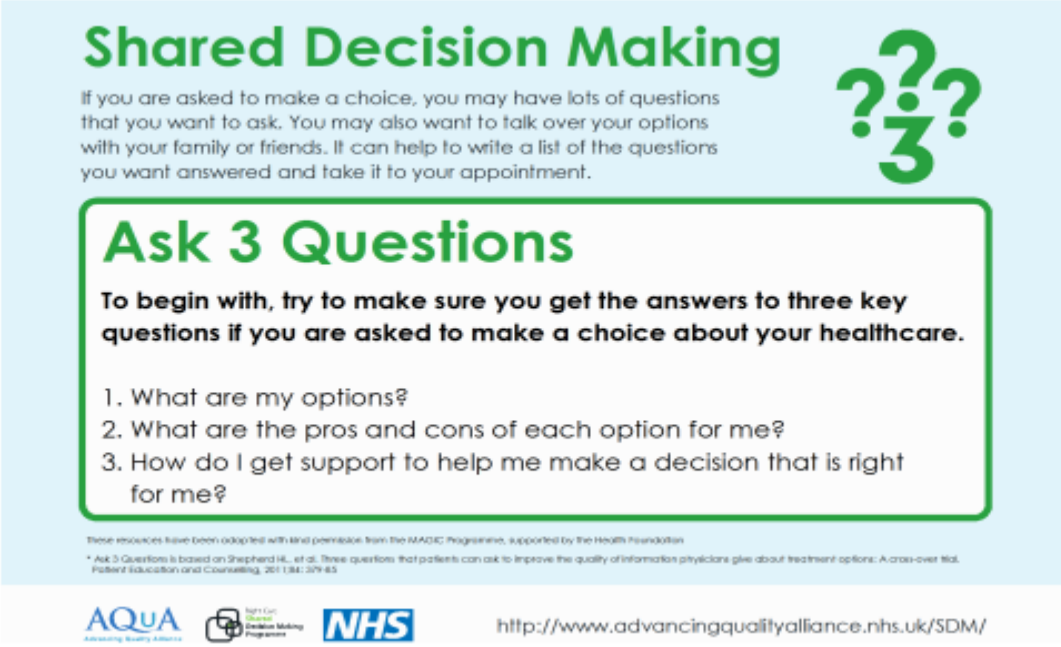
If you would like to know more about uterine prolapse and the treatments available for it, you may try the following sources of information.

- 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

Information for Patients

- 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 – Anterior vaginal repair (bladder repair) at http://c.ymcdn.com/sites/www.iuga.org/resource/resmgr/Brochures/eng_antvwrepair.pdf

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)……

Information for Patients

Our commitment to confidentiality

We keep personal and clinical information about you to ensure you receive appropriate care and treatment. Everyone working in the NHS has a legal duty to keep information about you confidential.

We will share information with other parts of the NHS to support your healthcare needs, and we will inform your GP of your progress unless you ask us not to. If we need to share information that identifies you with other organisations we will ask for your consent. You can help us by pointing out any information in your records which is wrong or needs updating.

Additional Sources of Information:

Go online and view NHS Choices website for more information about a wide range of health topics http://www.nhs.uk/Pages/HomePage.aspx

You may want to visit one of our Health Information Centres located in:

- Main Entrance at Birmingham Heartlands Hospital Tel: 0121 424 2280
- Treatment Centre at Good Hope Hospital Tel: 0121 424 9946
- Clinic Entrance Solihull Hospital Tel: 0121 424 5616
  or contact us by email: healthinfo.centre@heartofengland.nhs.uk.

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.