Anterior 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 an anterior repair?

An anterior vaginal repair (colporrhaphy) is an operation performed within the vagina to treat an anterior (front) vaginal wall prolapse, also called a cystocoele.

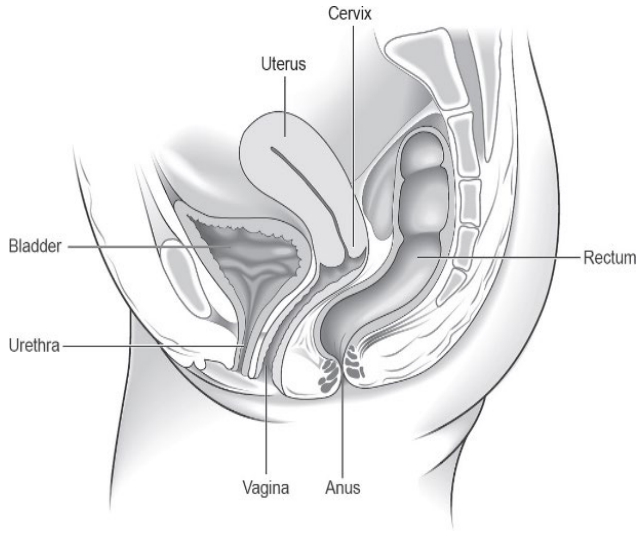
Information for Patients

What is anterior vaginal wall prolapse?

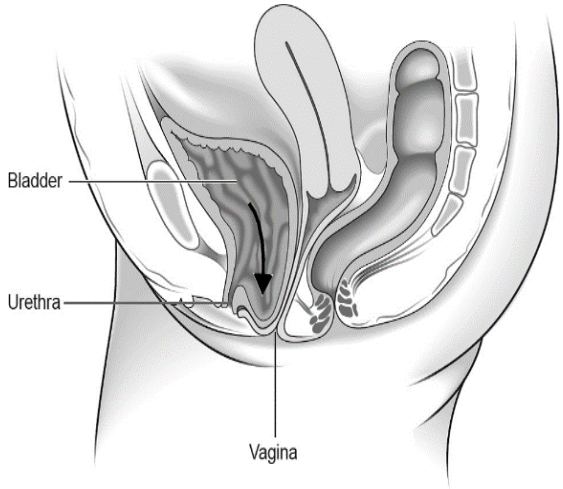
- A prolapse is a bulge within the vagina caused by a weakness in the supporting tissues and muscles around the vagina so that one or more pelvic organs bulges downwards into or out of the vagina. Pelvic organs include the uterus (womb), bladder and bowel.

- Anterior means towards the front, so an anterior vaginal wall prolapse (also called a cystocoele) is a prolapse of the front wall of the vagina, immediately behind which is the bladder (see diagram below).

- A large anterior vaginal wall prolapse may 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 find that the bulge causes a dragging or aching sensation, or is uncomfortable when having sexual intercourse.



Normal pelvis without prolapse



Prolapse of bladder – pushing down on front vaginal wall.

Information for Patients

How is an anterior 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.

- 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, a posterior vaginal wall repair, a vaginal hysterectomy, sacrospinous fixation or sacrohysteropexy to treat a prolapse of the uterus (womb) or the top of the vagina can be done at the same time after discussion with you.

- 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 bulge or lump. As a result, you should feel more comfortable. Some women notice an improvement in the way their bladder works.

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. Inform the anaesthetist 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, an infection can be a wound infection, 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.

Information for Patients

- **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, like any wound, 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. Recurrence of the same prolapse probably occurs in about 1 in 10 cases but it is generally believed that about 3 in 10 women who have an operation for prolapse will eventually require treatment for another prolapse. 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.

- **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.

- **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.

- **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**. 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 any 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 clots in the legs. 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, but some women will be well enough to 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 developing a DVT.

- Bath or shower as normal.

- Do not use tampons for 6 weeks and avoid douching the vagina

- The stitches under the skin will dissolve. 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.

- 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. 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.

- 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 that you did not have before your 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, 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.

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 an advanced 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 is 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.

  Pessaries are safe and many women 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

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

Information for Patients

Treatment	Advantages	Disadvantages
Anterior vaginal repair (described in this leaflet)	No cuts in abdomen (tummy) Relatively minor operation Can be done with you awake or asleep Can be performed as a day case.	Recurrence of prolapse is common
Colpocleisis (closure of the vagina using stitches)	No cuts in abdomen (tummy) Can be done with you awake or asleep Can be performed as a day case	Sexual intercourse will never be possible after this operation Surgery for 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
Synthetic Mesh insertion vaginally	No cuts in abdomen (tummy) May provide better support for repeat surgery Can be performed as a day case.	Significant risk of complications: mesh exposure/extrusion, discomfort with intercourse, other pain, infection
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.
Laparoscopic (key hole) or open abdominal **paravaginal repair**	No cuts in the vagina	Usually requires an overnight stay in hospital Recurrence rate of prolapse of up to 30% Cuts in the abdomen (tummy)

More information

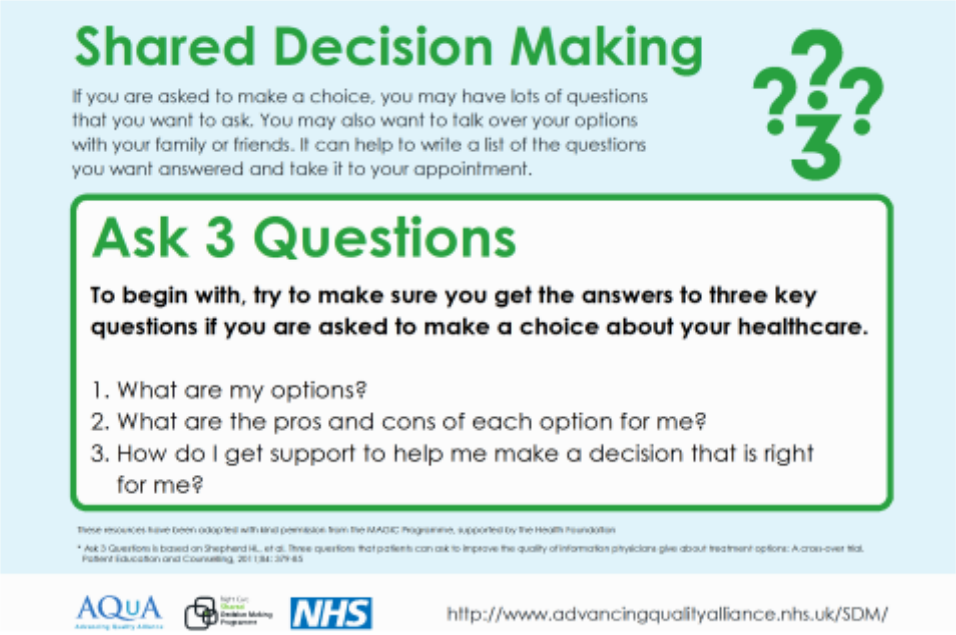
If you would like to know more about uterine prolapse and the treatments available for it, you may try the following sources of information.

- 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 – 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)……

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.