



Vaginal Prolapse and Repair

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INTRODUCTION

Vaginal repair is performed to correct a prolapse, which is a situation where the ligaments supporting the vagina and uterus have weakened and are stretched and loose due to childbirth and age. Although one type of prolapse may predominate, all the ligaments and muscles of the pelvic floor are interconnected and usually it is necessary to strengthen the whole pelvic support structure, as the extra pressure may cause prolapse in another site. Prolapse may occur in four main sites:

- ? Uterus - the uterus may descend to and through the vaginal entrance.
- ? Bladder (cystocele) - felt as a soft balloon protruding from the front wall of the vagina through the vaginal entrance. This may lead to frequency and urgency of urine.
- ? Rectum (rectocele) - felt as a bulge on the back wall of the vagina. This may lead to difficulty in emptying the bowels.
- ? Bowel (enterocele) - this usually occurs after hysterectomy if the corner stone of the pelvic support structure, the cervix, is removed. There is a bulge from the vaginal vault down to and through the vaginal entrance. Repair usually requires sacropexy .

The above may occur alone or more commonly in combination and it may not always be apparent what has to be repaired until the patient is asleep on the operating table. Thus it may not be possible to decide on the appropriate procedure until then. The uterus is not usually removed unless there are also specific problems with the uterus itself. If future pregnancy is desired, caesarean section is recommended.

PROCEDURE

The operation involves minimally invasive surgery with careful dissection and strengthening of the ligaments of the pelvis, avoiding the areas most likely to cause pain. Repair of prolapse of the uterus involves removing a wedge of the cervix from behind and tightening the ligaments that support it from an incision below the cervix. The front and back walls of the vagina are supported by incising a 'bridge' of vaginal skin and using this as the supporting tissue, over which the skin edges are brought together. Local anaesthesia is injected at the time of the operation and post-operative pain is usually minimal, although this can vary. No vaginal pack or catheter is normally required.

ADMISSION TO HOSPITAL

This normally occurs the morning of the operation. You should have nothing to eat or drink from midnight the night before. If the operation is to be in the afternoon, you can have a light breakfast before 6am, eg: toast, tea or coffee. If you develop a cough, cold or fever before the operation, it may need to be postponed. The appropriate anaesthesia will be decided by the anaesthetist and should be discussed with him or her. The anaesthetist will arrange the appropriate premedication if required. If there are major medical problems, the operation can be performed under local or epidural anaesthesia.

If you are currently taking Aspirin, Indocid, Naprosyn or other anti-inflammatory drugs, these should be discontinued ten days before the operation, as these can cause bleeding. Please bring a packet of sanitary pads with you to hospital with your own night attire and toiletries.

RECOVERY

You will wake up in the post-operative recovery room within the theatre complex. You may have an oxygen mask fitted comfortably over your mouth and nose. There may be an intravenous 'drip' needle in your arm. Analgesic medication will be prescribed to prevent any postoperative pain. The pain is usually minimal, as local anaesthetic is injected into the operative area. In rare cases catheterisation may be necessary.

There may be some nausea and vomiting, although medication to counteract this is routinely given during the operation. If you continue to feel nauseated, notify the nursing staff so that further medication may be administered. The nursing staff will measure the volume of urine passed each time to make sure that there is no retention of urine. In this case, a small "in-out" catheter will be passed to empty the bladder. This is not normally left in the bladder.

The amount of vaginal bleeding will be checked on a regular basis. Once fluids are tolerated, the intravenous 'drip' will be removed. You will normally be discharged home the afternoon of the operation or the next morning. A longer hospital stay may be necessary depending on your medical condition or personal circumstances. You should not drive yourself home.

DISCHARGE HOME

These operations were designed to enable patients to return to work and normal activities as soon as possible ie: you can usually drive your car, cook, shop, look after your children within 10-14 days. However, in some patients, recovery may take longer. Please remember to be sensible. Most operations that fail, do so because sutures tear out of the vagina due to excessive strain and lifting before the tissues have knitted together. Vaginal intercourse should be avoided for six weeks. Avoid tampons during this time and prevent constipation with orange juice, bran and other fibre products. It is important to exercise extreme care when getting in and out of a car or getting up from a chair. In particular, the knees should be kept together as much as possible during activity, especially lifting and squatting.

FOLLOW-UP

An initial appointment may be made 1 - 2 weeks after the operation, or earlier if there is a problem. There is a further follow-up at six weeks. There may be some vaginal bleeding in the first few days after the operation. You should be able to pass urine normally. For the first few days, you may experience some urgency ie: a desire to pass urine frequently. This could be a result of the catheter used at the operation, swelling around the sutures or infection. Any problems should be notified.

You should expect a vaginal discharge for 2-3 weeks, sometimes longer. This is due to the irritation caused by the vaginal sutures and will settle once they have dissolved. It does not indicate infection. Some patients will experience discomfort sitting down and again this is due to the vaginal sutures and will eventually settle.

RESULTS OF THE OPERATION

The results of any operation cannot be guaranteed and it is possible for the prolapse to recur. This can happen if the sutures tear out before the tissues have knitted together, but if you are careful the results are normally excellent. It is important to realise that the principal reason for your problem is that the ligaments and muscles around the vagina have been damaged and stretched and can no longer function normally. As the tissues are damaged, the absolute success rate for surgery cannot be higher than 85-90%. It is also possible that strengthening the pelvic ligaments in one area may cause extra pressure in other areas, leading to other types of prolapse, requiring further surgery.

COMPLICATIONS

Complications are rare, but it must be understood and accepted that these can occur. Although major complications are not common, they may be disabling and even life threatening and may require further surgery to correct. This can lead to prolonged recovery time and even permanent disability. It is your responsibility to make sure that you understand the proposed surgery and to ask any questions if you are unsure.

The complications that can occur include, but are not limited to the following, as it is not possible to list all rare or unexpected complications that may occur:

- ? Retention of Urine - this is rare but if it did occur a catheter would need to be inserted.
- ? Injury to Bladder - during dissection, an incision may be made in the bladder. This would have to be repaired and a catheter inserted.
- ? Injury to Ureter - the ureter which brings urine from the kidney to the bladder may be kinked or tied. This could cause pain in the kidney and possible fistula formation and would require a further abdominal operation to correct and reimplant it into the bladder.
- ? Injury to Bowel - if there is an enterocoele, the bowel could be caught by a suture. This could lead to bowel obstruction and/or peritonitis and require further abdominal surgery.
- ? Deep Venous Thrombosis - a possible complication of any surgery, but much less likely with this type of operation where you are mobilised almost immediately.
- ? Granulation Tissue - this is the formation of fleshy polyps at the site of the sutures. This is caused by poor healing and may need to be removed or cauterised.
- ? Vaginal Narrowing - there is a possible risk that the vagina may be shortened and/or narrowed. This may require further surgery to correct, but could be permanent causing pain with intercourse.

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