

# Surgery for Vaginal Prolapse

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**This leaflet is not meant to replace the information discussed between you and your doctor, but can act as a starting point for such a discussion or as a useful reminder of the key points.**

## What is vaginal prolapse?

Vaginal (or pelvic organ) prolapse is a very common condition, particularly among older women. A prolapse is a sinking down of an organ from its normal position. Usually, the pelvic organs are held in place by the pelvic floor muscles and supporting ligaments but they may become too slack to hold the organs in place. This may be due to:

- **Pregnancy** - The weight of the baby and the physical trauma of labour and birth stress and strain the pelvic muscles and ligaments. Some of the tissues that become damaged during pregnancy never fully regain their strength and elasticity
- **Ageing and the menopause** - Our muscles weaken as we grow older and the pelvic muscles are no exception. Although tissue damage is likely to have been caused much earlier, the ageing process further weakens the pelvic muscles, and the natural reduction in oestrogen at the menopause also causes the tissues to become less elastic.

## Other factors that can make prolapse conditions worse are:

- Being overweight
- Coughing (for example from smoking, asthma or bronchitis)
- Straining e.g. when constipated
- Previous pelvic surgery

## Types of prolapse

1. **Cystocele** - This is when the urinary bladder falls towards the vagina and creates a bulge in the front vaginal wall. It is common for both the bladder and urethra to prolapse together. This is called a cystourethrocele.

## What are the symptoms of cystocele?

Symptoms of a cystocele can include:

- Vaginal discomfort and a feeling of a lump
- Incontinence (leaking urine)
- Frequent, urgent need to or difficulty passing urine
- Lower back pain

## Nature of the procedure

- An operation to repair a cystocele is called an Anterior Repair (colporrhaphy). The operation is carried out through the vagina. It involves making a cut in the front of the vagina so the bladder and/or urethra can be pushed back into place.

- Once this is completed, the surgeon stitches together the existing tissues to provide a new support for the bladder and urethra. A small portion of the vaginal wall is removed to give the vagina more strength. If you have associated stress incontinence an additional operation to correct this may be required. If you have had recurrent prolapse, and this is not your first repair operation, mesh may be used to help support the vaginal wall and keep the prolapsed organ(s) in place. This may provide better long-term support.

## Complications

The main complications of Anterior Repair are:

- Vaginal discomfort
  - Discomfort with intercourse - due to possible scarring/narrowing to the vaginal wall
  - Incontinence
  - Recurrent prolapse
  - Small possibility of erosion if mesh is used
2. **Rectocele** - A rectocele occurs when the end of the large bowel (rectum) loses support and bulges into the back wall of the vagina.

## What are the symptoms of a rectocele?

Many women have rectoceles but only a small percentage of women have symptoms related to the rectocele.

### Vaginal symptoms may include:

- The sensation of a lump in the vagina
- Pain during intercourse
- Difficulty with emptying your bladder

### Rectal symptoms may include:

- Constipation
- Difficulty opening bowels - some women may need to insert a finger in their vagina and push the bowel back into place in order to empty their bowels.

## Nature of the procedure

The surgery treatment for a rectocele is called a Posterior Repair. The rectocele is repaired through the vagina. The procedure is similar to an Anterior Repair (see previous page) but the surgeon may first make a small cut at the base of the vagina. A cut is then made in the back wall of the vagina and the rectum is pushed back into place.

The surgeon stitches together the existing tissues to create a new support for the prolapsed organ and then removes some of the skin from the vaginal wall to make it stronger. If a cut was made at the base of the vagina, it will also be stitched back together. Your surgeon may use a mesh to help strengthen the vaginal wall.

## Complications

Following a posterior repair, there is a risk of painful sex. This is due to the possibility of scarring to the vaginal wall which may lead to a narrowing of the vagina, resulting in difficulties with sexual intercourse.

3. **Utero Vaginal** - Prolapse of the womb, when the womb drops down into the vagina and is classified into three grades depending on how far the womb has fallen.
  - **First degree** - the uterus has dropped slightly, the cervix (neck of the womb) remains within the vagina
  - **Second degree** - the uterus has dropped further into the vagina and the cervix can be seen at the vaginal opening
  - **Third degree** - (prolapsed) the most severe form of uterine prolapse. Most of the uterus lies entirely outside the vagina.

### What are the symptoms of a utero vaginal prolapse?

- A sensation of heaviness or dragging down below, often described as feeling “like my insides are falling out”. This feeling can increase with prolonged standing and can be relieved by lying down
- Some patients complain of a feeling as if sitting on a small ball
- Lower backache
- Difficult or painful intercourse can also occur
- With severe prolapse, the skin may become irritated, raw and infected
- Problems with bladder or bowel emptying

### Nature of the procedure

There are two surgical approaches to treating a uterine prolapse:

- Lifting the uterus and holding it in place
- A hysterectomy. This is an operation to remove the womb which will result in the inability to become pregnant. There are a number of different types of procedures, but vaginal hysterectomy is the most commonly used form of surgery for uterine prolapse.

The procedure involves cutting the ligaments that hold the uterus in place, removing the uterus and cervix and closing off the top of the vagina and then shortening and re-attaching the ligaments to hold the vagina up. Extra vaginal support is often required.

## Complications

Hysterectomy is a major operation. A specific complication of vaginal hysterectomy is an increased risk of developing other types of prolapse, particularly vaginal vault prolapse.

4. **Enterocele** - This is a prolapse of the small bowel that lies just behind the uterus. It may slip down between the rectum and the back wall of the vagina.

### What are the symptoms of enterocele?

- Pelvic pain or pressure

- Lower back pain
- A lump protruding vaginally

### Nature of the procedure

Vaginal surgery to correct an enterocele is similar to that of a posterior repair, but also requires additional support to the top of the vagina. This can be carried out in various ways.

**Complications** - same as Anterior/Posterior Repair (see above).

5. **Vaginal Vault Prolapse** - The vaginal vault is the top of the vagina. It can only fall in on itself after a woman's womb has been removed (hysterectomy). Vault prolapse occurs in about 15% of women who have had a hysterectomy for uterine prolapse. Surgery for vault prolapse is often performed with other procedures.

Please see leaflet on Sacrocolpopexy or Sacrospinous fixation available in the clinic.

### Benefits of the procedures

Vaginal prolapse operations are designed to restore the vaginal passage to its normal position. These operations are generally performed through the vagina; therefore, there are no abdominal wounds. The stitches used will dissolve within three to four weeks after the operation.

### Consequences of not having the procedure

If there are no symptoms, no treatment is required. In general, you should avoid constipation and straining by eating a high fibre diet and drinking plenty of fluids. You should also avoid heavy lifting and if you have asthma make sure that it is well controlled.

### What alternatives do I have?

#### Conservative therapy includes:

- Pelvic floor physiotherapy - this can be helpful and may take a few months before you notice any improvement. Its effects are limited if the prolapse is large
- For patients who are:
  - Pregnant
  - Unfit for/waiting for surgery
  - Declined surgery

a vaginal pessary can be used. Patients may also choose to use a vaginal pessary instead of surgery. This is a removable device placed in the vagina, which can be effective in retaining the prolapse. Pessaries are made of silicone or latex and come in many different shapes and sizes. Ring pessaries are most commonly used but, for some women who cannot retain a ring pessary, a shelf pessary may be helpful. Once in place, pessaries are usually comfortable.

If the pessary is relieving your symptoms, you will have a follow up visit **usually every six months**. The doctor will remove the pessary, check whether it is causing any internal problems and whether your prolapse is getting worse. He/she will then insert a new pessary to reduce the risk of vaginal discharge and ulceration to the vaginal skin.

Your own GP or Practice Nurse can carry out these check-ups. Your Gynaecologist will be able to advise you as to whether it is a suitable treatment for you.

- Hormone Replacement Therapy (HRT) - Women with prolapse who are experiencing the menopause may benefit from HRT. This may strengthen the vaginal walls and pelvic floor muscles by increasing the oestrogen levels in your body. Local oestrogen may be helpful to postmenopausal women where mild prolapse symptoms can be made worse by vaginal soreness, irritation and dryness.

### **Risks of the procedures:**

As with all surgery, there can sometimes be complications:

- There is a small risk of damage to organs. The rectum and bladder are at risk of damage during prolapse repairs, especially in repeat surgery
- There is a small risk of bleeding and the possibility of having to return to theatre
- Infection developing in the bladder or vagina can also occur. You will therefore be given antibiotics at the time of surgery to help prevent this
- After the operation there may be a formation of a clot in the veins of the leg. This can become serious if it becomes dislodged and travels to the lung. The risk of this is minimised by the use of compression stockings and Heparin injections which thin the blood.

The specific risks of different procedures have been listed earlier in the leaflet.

### **What should I do before I come into hospital?**

Details of your admission will be sent to you by letter. You will be asked to attend a Pre-assessment Clinic where investigations, such as blood tests, will be carried out. You will be assessed to ensure you are fit for surgery and you will have the opportunity to ask any questions you may have.

### **What will happen when I arrive at the hospital?**

On admission you will be greeted by a member of the ward team and introduced to your named nurse, who will discuss with you the care that you will receive while you are in hospital. You will also be seen by your consultant or one of his/her team.

### **Will I have an anaesthetic?**

Vaginal prolapse can be performed with either a general anaesthetic (which means you will be asleep) or a spinal anaesthetic (in this instance you are awake but have no sensation from the waist down).

### **What can I expect and how will I feel afterwards?**

There will be a certain amount of pain and discomfort following the procedure. To keep you pain free and comfortable, regular pain relief will be given to you by the nursing staff.

### **Pain relief can be given in many different ways:**

- In the form of tablets that can be swallowed or given as an injection

- Sometimes in the form of suppositories which can be given via the rectum (the back passage)
- You may be offered patient controlled analgesia (PCA), which will allow you to control your own pain relief; this option will be discussed with you after you have been admitted to hospital.
- If you are feeling sick, tell the nursing staff and they will give you an injection to treat this
- You will also have a drip in your arm to give you fluids
- The nursing staff will take your blood pressure and pulse regularly and check that you are comfortable.
- You may also be aware of a catheter inside the bladder. This will usually be removed **24 to 48 hours** after surgery
- You may also have a pack in your vagina to minimise oozing of blood after surgery. It is usually removed the day after surgery.

### How long will I be in hospital?

This will vary greatly on the type of surgery you have had but, normally, you will be in hospital for about **two to three days** after the procedure. This will allow your medical team to ensure that your wounds are healing and also to check that your bladder and bowel function have returned to normal.

### What should I do when I go home?

For the **first two weeks** at home, you should ensure that you have someone with you and you should **avoid all work**.

You should not be in bed for the whole of this period, but you will feel the benefit of resting for a couple of hours in the middle of the day.

It is possible that you will be aware of a vaginal discharge which may last **up to six weeks** after you go home. This may be pinkish or slightly blood-stained at times.

**If this vaginal loss approaches a period-type loss or greater, or becomes smelly, then contact your GP as this may indicate possible infection and your GP may want to assess you, take a swab and/or prescribe antibiotics**

You can gradually resume your normal household routine, but **do not** over-tire yourself. Gradually increase the exercise you take beginning with short walks and, most importantly, **avoid heavy lifting**. The reason for this is that the operation takes time to heal; the prolapse repair will only remain in its new position if your tissues unite firmly and if they are given a chance to do so. Heavy lifting or exertion may weaken them despite the stitching.

### What do I do if I feel unwell at home?

Your GP will have been informed of the procedure that you have had, and will be able to help you with any questions or problems. You can contact the hospital if you

have any urgent problems **within the first week** by telephoning the gynaecology ward you were discharged from on **0151 430 1522**

### **Will I have to come back to hospital?**

You may have an outpatient appointment in about **six to eight weeks** after the operation. This will provide the opportunity to let the doctor know about any symptoms which concern you and to ask any questions about your further care. This appointment is not always necessary.

### **When can I resume sexual intercourse?**

Sexual intercourse should be **avoided for six weeks after your operation**. This is because surgery may have slightly altered the shape of your vagina and intercourse in the first six weeks may be uncomfortable. This may also cause some bleeding.

### **When can I go back to work?**

This depends to some extent on your job and the type of operation performed. Most women return to work **after six to eight weeks**. However, if your job is strenuous and involves heavy lifting, it may take **up to eight to ten weeks**.

### **When can I drive?**

We would like you to **avoid driving in the first three to four weeks**. This is because you may still be tender, and it may be difficult to perform an emergency stop. It is important that you check with your own insurance company for clarification before you actually drive.

### **Will the prolapse happen again?**

There is up to a 30% chance that the prolapse will recur. This risk is increased if the surgery has been performed more than once before. It is therefore very important to allow enough time for healing to take place after your operation. Doing pelvic floor exercises once you have recovered may reduce the risk of a recurrent prolapse.

**For further advice please telephone:  
Gynaecology Ward 3E – 0151 430 1522  
(24 hours)**

**Space for your notes**



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