

Vaginal Hysterectomy Anterior/Posterior Repair

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Reasons for the procedure

Prolapse is a very common condition, particularly among older women. It is estimated that half of the women who have children will experience some form of prolapse in later life. A prolapse is a sinking down of an organ from its normal position. Normally the pelvic organs are held in place by the pelvic floor muscles and supporting ligaments but when the pelvic floor becomes stretched or weakened, they become too slack to hold the organs in place.

Common types of prolapse

- Cystocele (front wall of the vagina with the bladder behind)
- Rectocele (back wall of the vagina with the back passage or rectum)
- Uterine Prolapse (the womb sinks down into the vagina)
- Vaginal Vault Prolapse (roof of the vagina sinks down)
- Enterocele (back of the vaginal vault sinks down the vagina with loops of small bowel above it)

The nature of the procedure

The type of procedure you have will be determined by the type of prolapse identified. It will also depend on age, symptoms, desire for more children and intercourse. The aim is to restore your body to normality, relieve your symptoms and improve your quality of life.

Vaginal hysterectomy

A vaginal hysterectomy involves removal of the womb and cervix. The tubes and ovaries are not normally removed with this procedure. The top of the vagina is then over-sewn. A pelvic floor repair may also be necessary as part of the procedure.

Pelvic floor repairs

- **Cystocele:** An operation to repair a cystocele is called an anterior repair (colporrhaphy). The operation is done through the vagina. It involves making a cut in the front of the vagina so that the bladder and/or urethra can be pushed back into place. Once this is done the surgeon stitches together the existing tissue with stitches which dissolve inside the vagina. Some excess vaginal tissue may need to be removed. If you have associated stress urinary incontinence, an additional operation may be required to correct this.
- **Rectocele:** Surgical repair of a rectocele is called a posterior repair or posterior colpoperineorrhaphy. The rectocele is repaired through the vagina.

The procedure is similar to an anterior repair. The cut is made on the back wall of the vagina and the rectum is pushed back into place. The doctor 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. This type of repair is associated with potential narrowing and shortening of the vagina and you will be informed of this.

- **Vaginal vault prolapse:** The vaginal vault is the top of the vagina. The treatment for this is more complicated and may involve a sacrospinous fixation (stitching the vault to a ligament in the pelvis) or you may have been informed that you require an abdominal procedure in which case a sacrocolpopexy has been recommended to you. (Information is available regarding these procedures).
- **Enterocele:** This is a prolapse of the top of the vagina and the small bowel that lies just behind the top of the vaginal vault. Surgery to correct an enterocele is similar to that of a posterior repair but will require additional support to the top of the vagina. We do not normally use mesh for this surgery.

The benefits of the procedure

The benefits of the procedure are to restore the vaginal passage to its normal position. These operations are generally performed through the vagina so there are no abdominal wounds. The stitches (sutures) will dissolve within about **6 weeks** after your operation.

The risks of the procedure

As with all surgery sometimes there can be complications. There is a small risk of damage to organs.

- The rectum and bladder are at risk of damage i.e. perforation during prolapse repairs especially in repeat surgery.
- Your bladder may be opened during the procedure. This will require closing and a catheter (tube in the bladder) left in for approximately **5-7 days**.
- 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.
- Risk of a further prolapse developing in the future

After your operation there is the possibility of a blood clot forming in the veins of the leg. This can become serious if dislodged and travels to the lung. The risk of this is

minimised by the use of anti-embolism stockings and blood thinning injections given in your stomach.

An extra procedure which may become necessary during the procedure

At your outpatient appointment it is possible that your prolapse was thought to involve the vaginal walls only. However, during the operation it may become apparent that the womb is coming down also. This may mean that a vaginal hysterectomy is necessary during the repair.

The discomforts of the procedure

You may have a catheter in your bladder – this is usually removed within 24 hours of surgery.

You may have a pack inserted into the vagina to reduce the risk of bleeding – this is usually removed within the first 24 hours.

You may have lower abdominal discomfort and this may even seem like period cramps. This should settle with painkillers. You may also need to urinate more frequently due to a catheter having been in the bladder and you may also have some constipation.

You will usually stay in hospital for 2 – 3 days and should avoid any heavy lifting or constipation for at least 6 weeks.

You may have some vaginal bleeding for 2 – 3 weeks; you should use sanitary towels and **not** tampons to avoid infection. The bleeding is not normally heavier than a period or smelly. If the bleeding is heavy and/or smelly, you need to be checked by your doctor.

The alternatives to the procedure

In the absence of symptoms no treatment is required. In general you should avoid constipation and straining by eating a high fibre diet and drinking plenty of fluids. Conservative therapy includes:-

- **Lifestyle changes:** prolapse symptoms can be eased by
 - Losing weight if you are overweight
 - Managing a chronic cough if you have one (eg. by stopping smoking)
 - Avoiding constipation
 - Avoiding heavy lifting and high impact exercise

- **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.
- **A vaginal pessary** can be used for patients who are currently unfit for surgery, waiting for or have declined surgery, or by choice. 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 different shapes and sizes. Ring pessaries are commonly used but for some women who cannot retain a ring pessary, a shelf pessary may be helpful. Once in place pessaries should be comfortable. You will be given a follow up appointment and the pessary will be changed **every 6 months**. Part of the change will involve an examination of the vaginal tissues to make sure that there are no internal problems such as ulceration to the vaginal skin. It is possible that your own GP or Practice Nurse can carry out these pessary changes.

The consequences of not having the procedure

Whilst a prolapse is not life threatening, it may get worse over time and there may be more symptoms. You could feel something coming down between your legs in the form of a lump, which may or may not be compressible. The swelling may protrude outside the vaginal opening, you may have difficulty passing urine or needing to urinate frequently, including at night time. In addition, you may have constipation and require regular laxatives. The prolapse may also interfere with sexual intercourse.

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



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