Operations to treat Prolapse of the Vaginal Vault (top of the vaigna)

Patient information leaflet

BSUG

British Society of Urogynaecology

About this leaflet

You should use the information provided in this leaflet as a guide. The way each gynaecologist does this procedure may vary slightly as will care in the hospital after your procedure 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 or 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 want to ask about your gynaecologist's experience and results of treating your condition.

Benefits and risks

There are not many studies about the success and the risks of most of the procedures carried out to treat prolapse and incontinence, so it is often difficult to state them clearly. In this leaflet, we may refer to risks as common, rare and so on, or we may give an approximate level of risk. You can find more information about risk in a leaflet 'Understanding how risk is discussed in healthcare' published by the Royal College of Obstetricians and Gynaecologists.

https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pi-understanding-risk.pdf

The following table is taken from that leaflet

Risk table

Verbal description[a]	Risk	Risk description[b]
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 10000	A person in small town
Very rare	Less than 1 in 10000	A person in large town

[a] EU-assigned frequency
[b] Unit in which one adverse event would be expected

British Society of Urogynaecology (BSUG) database

To understand the success and risks of surgery for prolapse and incontinence the British Society of Urogynaecology has set up a national database. We ask all members of the society to enter onto the database all procedures they carry out and how the patients fare after surgery. They may ask you before your operation if you agree to them entering the details of your procedure on this database. We then use this anonymised information to develop a picture of what procedures are being performed throughout the UK, as well as complications and patient satisfaction. Individual surgeons can also use it to see how they compare with others.

What is vaginal vault prolapse?

A vaginal vault prolapse is a bulge within the vagina (front passage) caused by the top of the vagina dropping downwards.

Prolapse occurs when the pelvic floor muscles, their attachments or the vaginal tissue become weak. This weakness allows one or more pelvic organ to bulge downwards into or out of the vagina. Pelvic organs include the uterus (womb), bladder and bowel.

A prolapse may arise because of weakness in the walls of the vagina (vaginal wall prolapse) or weakness in the ligaments that support the top of the vagina (apical prolapse).

There are different words used to describe these.

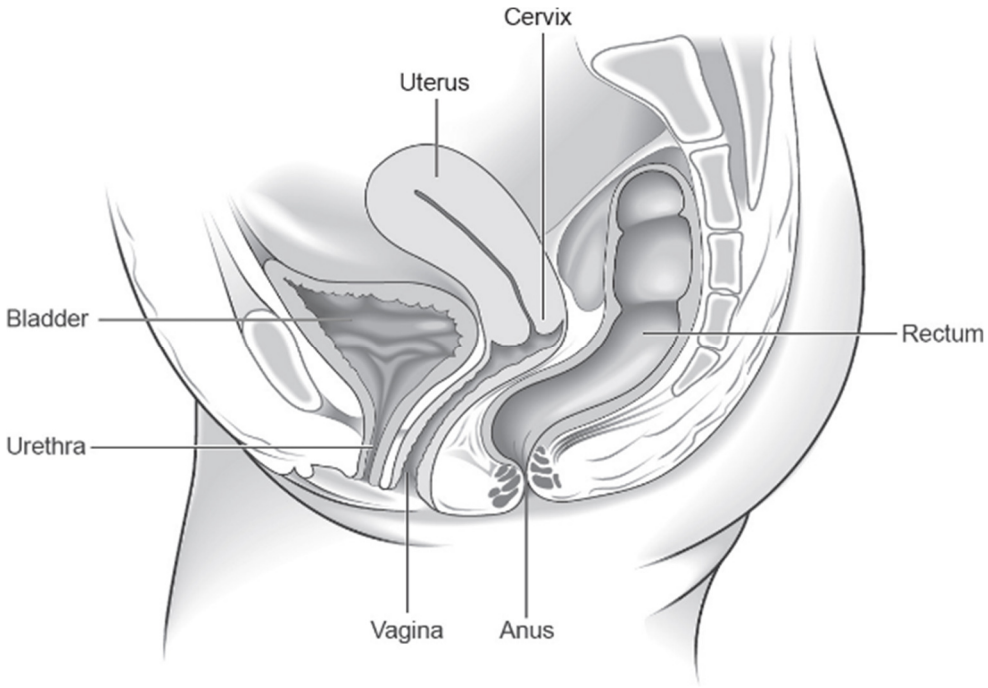
- A bulge because of weakness in the front wall of the vagina may be called an anterior compartment prolapse or a cystocoele. Sometimes it is described as a bladder prolapse because the bladder drops down into the bulge.
- A bulge because of weakness in the back wall of the vagina may be called a posterior compartment prolapse or a rectoenterocoele/rectocoele. Sometimes it is described as a bowel prolapse because the bowel drops down into the bulge. This must not be confused with a rectal prolapse when the bowel drops down through the back passage.
- A bulge because of weakness in the ligaments at the top of the vagina allows the vault (top) of the vagina to drop down. This may be called a vault prolapse or also an apical compartment prolapse. If you have not had a hysterectomy (removal of your womb), the weakness in the ligaments at the top of the vagina allows the uterus (womb) to drop down causing a uterine prolapse which may also be called an apical compartment prolapse.

Many women have a prolapse in more than one part of the vagina at the same time. This leaflet is about operations to treat vaginal vault prolapse

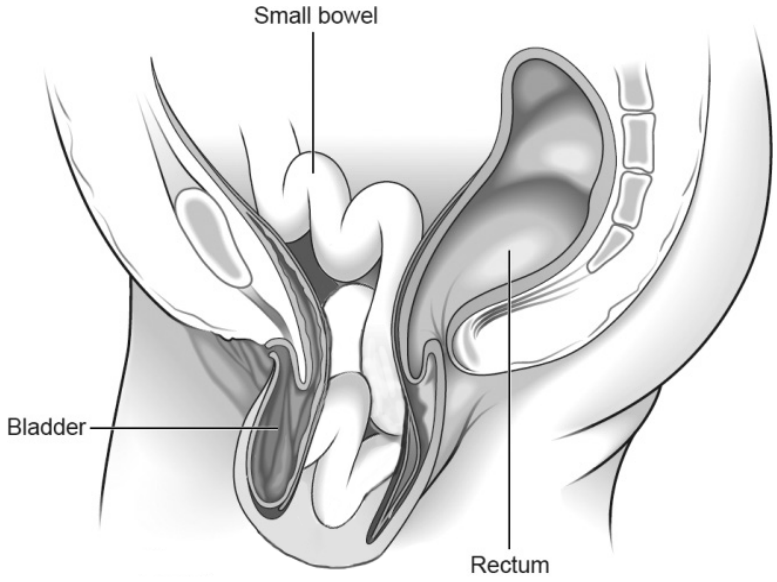
You should keep in mind that even if an operation cures your prolapse, it may or may not relieve all your symptoms. You should consider alternative options before considering surgery (see Page 13) and may wish to try these before making a final decision about having surgery.

You will only be offered an operation when you have had a thorough discussion with your doctor about the type of prolapse you have, the extent (grade or stage) of your prolapse and how much your prolapse bothers you as well as your personal preferences.

Figure 1. Diagrams (courtesy of the RCOG) - side view of a standing woman



Normal pelvis without prolapse



Vaginal vault prolapse with the top of the vagina coming out of the vagina (often the top of the vagina is not as low as shown here and only comes partly out of the vagina)

Operations to treat vaginal vault prolapse

Operation	Advantages	Disadvantages
Sacrocolpopexy - laparoscopic (keyhole) or open (usually through a bikini line cut). **(Page 16)** The prolapsed vaginal vault's position is restored by attaching it to the inside of the sacrum with a permanent mesh	Abdominal mesh provides strong and continuing support to the vault of the vagina reducing the chance of the prolapse re-occurring. No cuts or stitches in vagina. Vaginal length maintained. Likely to be a quicker recovery following an uncomplicated laparoscopic approach but possibly a longer procedure time.	Requires a general anaesthetic (asleep). As mesh is used there is a small risk that the mesh will work its way into surrounding tissues. **If performed as an open operation** • More painful than the other procedures • Slower return to normal activities Longer hospital stay
Vaginal Sacrospinous Fixation (Page 14) Stitches to support the top of the vaginal inserted through the vagina	No abdominal cut(s) Can be done with you awake or asleep	Can cause temporary buttock pain Variable long-term success with recurrence of vaginal vault prolapse 14-30%.
Colpocleisis (Page 19) Closing of vagina	High success rates both for prolapse of the top of the vagina and the walls of the vagina. No abdominal cut(s) Can be done with you awake or asleep	Sexual intercourse will **not** be possible after this operation. Urinary incontinence in the future may be more difficult to treat

Further information for each operation is given later in this leaflet. All operations are not available in all hospitals. Your consultant may recommend a particular operation depending on your individual needs.

Benefits

The primary aim of these operations is to reduce the bulge within your vagina due to vaginal vault (top of the vagina) prolapse.

Following the procedure:

- you are likely to feel more comfortable;
- intercourse may be more satisfactory;
- your bladder and bowel may empty more effectively; and
- urinary frequency and urgency may be reduced.

Risks

General Risks of Surgery

- **Anaesthetic risk.** This is very small unless you have specific medical problems, such as with your heart, or breathing. If you smoke or are overweight, this also increases risk. All the operations for vaginal vault prolapse except for sacrocolpopexy can be done with you asleep (a general anaesthetic) or awake but numb from the waist down (a spinal anaesthetic). This will be discussed with you.
    - **What can I do?** Make the anaesthetist aware of all 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. It is uncommon that we have to give a blood transfusion after these operations. Rarely bleeding can occur some hours or even days after the operation meaning that you need to be taken back to the operating theatre for further surgery.
    - **What can I do?** Please let your doctor know if you are taking a blood-thinning medicine such as warfarin, aspirin, clopidogrel or rivaroxaban 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, 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. You might also get a chest infection because of the anaesthetic.
    - **What can I do?** 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 (thrombus) in the deep veins of your leg. Occasionally the clot can travel to the lungs (pulmonary embolism - PE) 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 if you are overweight, have severe varicose veins, infection, are not very mobile, are taking hormones and if you have other medical problems. The risk is significantly reduced by wearing special compression stockings and having injections to thin your blood for a period of time following your surgery (you will be advised of the duration before the surgery).

- **What can I do?** You should consider stopping taking any hormone tablets such as hormone replacement therapy (HRT) and some types of birth-control pills 4 weeks before surgery. Stopping these hormones will not be a threat to your life and the risk of continuing to take them may be greater than the benefit you will get from taking them. You can usually restart these 4 weeks after surgery when the risk of thrombosis (blood clots) has reduced. The risk is greatest for hormones taken as tablets. The risk from hormone replacement given through the skin using patches, gels and pessaries is very low but not completely absent. If you decide to continue taking hormone medication you will need thromboprophylaxis (measures to prevent thrombosis) during and after the operation.
- 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.** Wounds can become infected or occasionally stitches can become loose allowing the wound to open up or stitches can tighten causing discomfort.
  - **What can I do?** Keep any wounds clean and dry external wounds carefully after washing using a clean towel or a hairdryer on a cool setting. If there are vaginal wounds from a vaginal repair do not douche your vagina or use tampons. It is also better not to sit in a bath but to have showers instead.

General risks of prolapse surgery

- **Getting another prolapse**. Although these operations are usually successful in treating vaginal vault prolapse, they do not always stop you from getting a prolapse of the vaginal walls in the future or a further prolapse of your vaginal vault. There is very little published evidence of exactly how often prolapse recurs. Recurrence of the same prolapse probably occurs in about 1 in 10 cases and 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 tissues are weak. Sometimes even though another prolapse develops it is not bothersome enough for you to require further treatment. Sometimes it is possible to treat it without surgery (Page 13)
  - **What can I do?** Doing your pelvic floor exercises, keeping your weight normal for your height (normal BMI), avoiding unnecessary heavy lifting, and not

straining on the toilet or during exercise, 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 all your symptoms.
- **Overactive bladder symptoms** (urgency to pass urine and frequency of passing urine with or without leakage of urine) usually improve after the operation, but occasionally can start or worsen after the operation.
    - **What can I do?** If you experience this, please let your doctor know so that treatment can be arranged.
- **Stress incontinence.** Having a prolapse sometimes causes some kinking of the tube through which you pass urine (urethra). This can be enough to stop urine leaks on coughing, laughing or sneezing (stress incontinence). By correcting the prolapse this kink gets straightened out and the leaks are no longer stopped. It is difficult to define an exact risk but it is thought to be about 10% (1 in 10). You may be offered a special bladder test called a urodynamic test before surgery which may give an idea of how likely you are to develop stress incontinence after the operation.
    - **What can I do?** Doing pelvic floor exercises regularly can help to prevent stress incontinence.
- **Bladder emptying or voiding problems** generally improve after surgery for prolapse but as is the case for any surgery in the pelvic area there may be problems with voiding (emptying your bladder) after the operation. There can be persistence of voiding problems for many months in 1 in 10 women but very few women will have ongoing difficulty or be unable to void long term.
    - **What can I do?**
        - If you have trouble passing urine, you may wish to lean forwards or even stand slightly to allow better emptying of your bladder. Make sure that you have your legs apart rather than having your knees together when sitting on the toilet. Waiting for a few minutes after the initial void and trying again may help. This is known as the ‘double voiding’ technique.
        - Learn clean intermittent self-catheterisation (CISC). CISC involves emptying out the urine using a fine catheter tube. You pass this along the urethra (water pipe) into the bladder so the urine can drain into the toilet. Once the urine is out, you remove the catheter and throw it away. You use a new catheter each time and they are available on prescription, like tablets, from your doctor. Although passing a catheter might sound unpleasant, most women find it is easy to do and it gives you more control and freedom than using a permanent catheter. The normal feeling of wanting to pass urine is not altered so you know when to empty your bladder. The catheters are very small and can easily be hidden in a handbag.

- **A change in the way your bowel works**. Some women experience worsening constipation following surgery. This may resolve with time. It is important to try to avoid being constipated following your surgery as this may reduce your risk of developing another prolapse.
    - **What can I do?** If you are struggling with constipation after simple changes in diet and fluid intake, your doctor may prescribe some laxatives.
- **Painful sexual intercourse.** If your operation only involves cuts on your abdomen, once any abdominal wounds are comfortable, there is nothing to stop you from having sex. If any of your operation involved cuts in the vagina, you need to wait at least 6 weeks (sometimes longer) to allow the vaginal wounds to heal. Some women find sex is uncomfortable at first, but it gets better with time. Occasionally, pain with intercourse can be long-term or permanent. Pain on intercourse is more common if your operation includes vaginal surgery.
- **Altered sensation during intercourse:** Sometimes the sensation during intercourse may be less. On the other hand, repair of your prolapse may improve it.

Other operations which may be performed at the same time.

Your doctor may suggest that an operation to treat your vaginal vault prolapse is all that is required. Sometimes, additional operations (see below) are done at the same time and your doctor will advise you about this before your operation.

- **Removal of the ovaries and fallopian tubes**. The tubes and ovaries are not involved in prolapse and do not need to be taken out to treat a prolapse. They are not always removed at the time of hysterectomy and if they are still present, these can be removed at the same time as a sacrocolpopexy and this will be discussed with you before the operation. There is a 2% risk of developing fallopian tube or ovarian cancer in a woman's lifetime so they can be removed if you wish.
- **Vaginal wall repair.** Sometimes there is also a prolapse of the front (anterior) or back (posterior) walls of the vagina and your doctor may suggest repairing them at the same time as your operation for vaginal vault prolapse. This is quite common. This may alter the risks of the operation, for example, painful intercourse (sex) is more likely if a repair is done, although it is still uncommon. You should, therefore, discuss this with your doctor who may have an extra information leaflet for you about vaginal wall repairs.
- **Continence Surgery.** Sometimes an operation to treat urinary leakage can be done at the same time as your operation for vaginal vault prolapse. Some gynaecologists prefer to do this later as a separate procedure. You should also refer to an information leaflet about the planned additional procedure.

Before your operation - Pre-op assessment

Usually, you are seen in a preoperative clinic some weeks before your planned operation. At that visit you will be seen by a nurse and possibly also a doctor. You will be asked about your general health and any medications you take. Your blood pressure will be checked and you may have tests to assess your heart and breathing. Blood tests will be taken to check you for anaemia and other things according to your medical condition.

Swabs may be taken from your nose and groin to make sure that you do not carry MRSA (bacteria that are very resistant to antibiotics and may cause problems after your operation).

You may be asked to sign a consent form if this has not been done already.

You may be given some medication to take the day before surgery to help clear your bowels, this is called 'Bowel Prep'.

After your operation - in hospital

- **Pain relief**. Pain can be controlled in a number of ways depending on the preference of your anaesthetist and/or gynaecologist. Options are an epidural, injection of local anaesthetic into the tissues during the operation, self-administration of pain relief (patient controlled analgesia - PCA), drugs in a drip, tablets or suppositories. The wounds following laparoscopic (keyhole) surgery are not normally very painful but sometimes you may require tablets or injections for pain relief. It is often best to take the pain killers supplied to you on a regular basis aiming to take a pain killer before the pain becomes a problem. If you have had an open operation you may need more pain relief.
- **Drip.** You may have a fluid drip into a vein in your arm or leg 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.
- **Drain.** If there has been more than average bleeding during the operation a drain (tube) from inside your tummy to outside may be placed beside a wound to let out any blood which has collected. This is usually taken out the next day.
- **Pack**. If surgery includes wounds in your vagina you may have a length of gauze in your 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 can drink fluids soon after the operation and will be encouraged to start eating as soon as tolerated.
- **Preventing DVT (deep vein thrombosis).** The same day or the day after your operation, you will be encouraged to get out of bed and take short walks around the ward. This improves general wellbeing and reduces the risk of blood clots in your 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 usually in hospital for one or two days. 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 blood clots in the back of the legs (DVT).
- Shower as normal.
- If you have had vaginal surgery avoid douching the vagina
- 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 tissues around the operation particularly in the first weeks after surgery. Therefore, avoid constipation and heavy lifting. The deep stitches dissolve during the first 3 months and your body will gradually lay down strong scar tissue over a few months.
- 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.
- After 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 all unnecessary heavy lifting will possibly reduce the risk of the prolapse recurring.

- You can drive as soon as you can operate the pedals, perform an emergency stop and look over your shoulder without discomfort, generally after 3 weeks, but you must check this with your insurance company, as some of them insist that you wait longer.
- You can start having sex whenever you feel comfortable enough after about 6 weeks. Stitches which have not dissolved after vaginal surgery may cause you or your partner some discomfort until they fully dissolve. You will need to be gentle and may wish to use lubrication.
- You usually have a follow up appointment anywhere between 6 weeks and 6 months after the operation. This varies between hospitals and may be at the hospital (doctor or nurse), with your GP or by telephone. Sometimes follow up is not required.
- See links: https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/recovering-well/pelvic-floor-repair-operation.pdf and https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/recovering-well/vaginal-hysterectomy.pdf

What to seek advice about 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 Non-Surgical Treatments

- **Do nothing.** If your prolapse is not too bothersome then you may not necessarily need treatment. If, however, your prolapse permanently protrudes through the opening of your vagina and is exposed to the air, the skin on the prolapse may become dry and eventually crack and bleed or get infected. This is why even if a prolapse which is coming outside the opening of the vagina is not causing symptoms it is probably best to push it back with a vaginal pessary designed to support prolapse (see below) or have an operation to repair it. Losing weight if you are overweight and avoiding risk factors such as smoking (leading to long term cough), jobs or exercise involving lifting heavy weights or high impact and constipation may help control your symptoms. Your prolapse may become worse with time but it can then be treated.
- **Pelvic floor muscle exercises (PFME).** The pelvic floor muscles support your pelvic organs. Strong muscles can help to prevent your prolapse dropping further. PFEs are unlikely however to provide significant improvement for a severe prolapse which is protruding outside the vagina. A pelvic floor specialist 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 vaginal device, a pessary (see image below), may be placed in the vagina to support your vaginal walls. 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 Gynaecology clinic. Pessaries are very safe and many women to choose to use one long term rather than have an operation. On occasions you have to stop using a pessary due to bleeding, discharge, sexual difficulties or a change in bladder function but these all stop quickly after it is removed. Sometimes it will take several visits to the clinic to determine the best size for you and a pessary is not suitable for everyone.

Vaginal sacrospinous fixation

What is a vaginal sacrospinous fixation?

A sacrospinous fixation is an operation to attach the top of the to a pelvic ligament (sacrospinous ligament) with a stitch. There are no cuts in the abdomen (tummy).

How is a sacrospinous fixation done?

The operation is done under general anaesthetic (asleep during the entire procedure) or a spinal anaesthetic (awake but numb from the waist down).

The top of the vagina is stitched to some strong tissue (sacrospinous ligament) at the back of the pelvis, so there are no cuts in your tummy. In most cases the stitch is placed through the ligament on the right side. Occasionally, if extra support is required, a stitch is placed through the left ligament as well. Some surgeons use dissolving stitches and others use permanent stitches.

Benefits

- Relief of prolapse symptoms.
- Some women report an improvement in passing urine especially if this was a problem before surgery.
- Some women report an improvement in overactive bladder symptoms, e.g. less urgency, passing urine less frequently.

Specific risks of sacrospinous fixation

These risks are in addition to the general risks mentioned above.

- **Damage to the bladder or bowel** can occur because these are immediately next to the vagina. The risk is greater if you have had pelvic infection in the past. It is usually possible to repair the damage straight away, but it may slow down your recovery. A bladder injury may need a catheter to drain the bladder for 7-14 days following surgery. A bowel injury may require a temporary colostomy (bag to collect faeces).
- **Buttock pain** – approximately 1 in 10 women will get pain in the right buttock (as the stitch is usually put through the right sacrospinous ligament). Occasionally, a stitch may be placed through both ligaments, in which case the pain may occur in either or both buttocks. You may need to take painkillers, but the pain usually lasts for no more than a few weeks although occasionally it can last a few months. In a few cases, the pain may be severe, in which case removal of the stitch(es) may have to be considered.

- **Stitch complications** – if permanent stitches are used these can work their way through the walls of the vagina causing vaginal discharge or bleeding and discomfort during intercourse.

Sacrocolpopexy

What is a Sacrocolpopexy?

A sacrocolpopexy is an operation to treat a prolapse of the vaginal vault (top of the vagina/front passage) in women who have had a hysterectomy (removal of womb) using a strip of synthetic mesh to lift the top of the vagina and hold it in place.

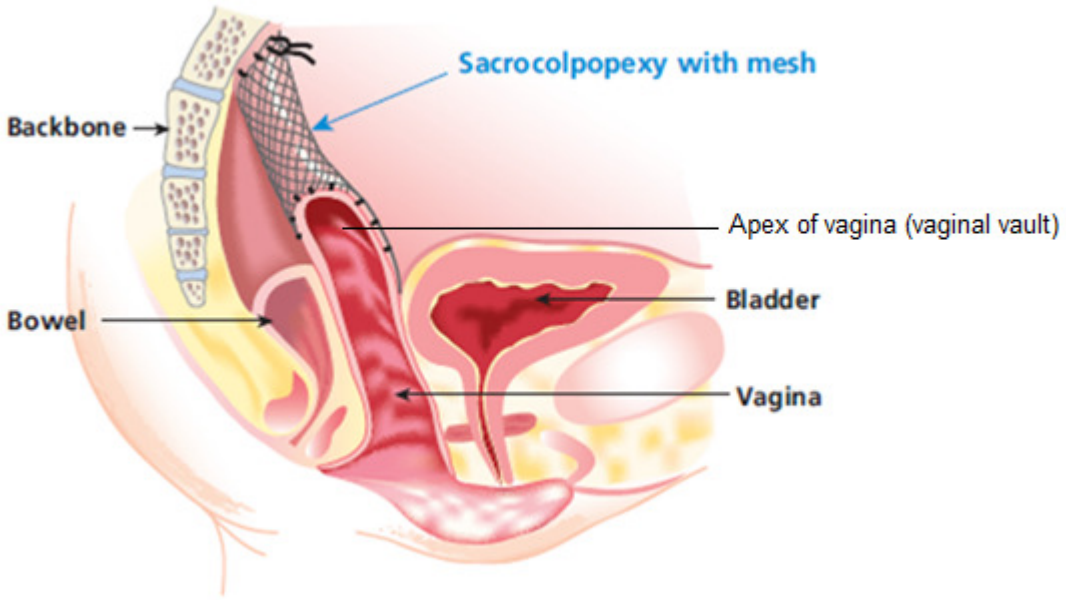


Diagram showing suspension of the vaginal vault (top of the vagina) using mesh following sacrocolpopexy

The operation is primarily intended to treat prolapse of the vault (top) of the vagina. It can also help correct a prolapse of the bladder or bowel to some extent if they are also present along with prolapse of the vaginal vault.

How is a sacrocolpopexy done?

- The operation is done under general anaesthetic. A general anaesthetic will mean you will be asleep during the entire procedure.
- The operation of sacrocolpopexy can be done through an open operation or laparoscopically (keyhole). The open operation is done through a horizontal or bikini-line incision in your lower abdomen (tummy) and for a laparoscopic operation there are 3-4 small incisions on your abdomen (tummy). So far, studies have not shown any difference for successful repair of the prolapse between the two techniques. However, there is evidence that the laparoscopic (keyhole) operation may results in less blood loss, fewer wound infections and a shorter hospital stay. The decision about the way in which the surgery is performed depends on a number of factors that your surgeon will discuss with you.

- The vagina is suspended by stitching one end of a strip of synthetic mesh to the top of the vagina with the other end being stitched or stapled (titanium staples) to a prominent part of the sacrum (the sacral promontory).
- The mesh remains permanently in the body.
- A urinary catheter is often left in place, usually overnight.

Benefits

A sacrocolpopexy helps to restore the normal position of the vagina, thereby relieving the symptoms of prolapse without shortening the vagina. Common symptoms that are relieved are a lump/bulge within or protruding out of the vagina and a dragging sensation.

85% (85 in 100) women had no symptoms of prolapse 2 years after the operation. No success rates are yet available for longer than this. The degree of success of a sacrocolpopexy depends on many factors.

If a sacrocolpopexy is done laparoscopically (keyhole surgery) there are advantages such as minimal blood loss and shorter length of hospital stay.

Specific risks of Sacrocolpopexy

These risks are in addition to the general risks mentioned above.

- **Damage to local organs.** This can include bowel, bladder, ureters (tubes from kidneys to the bladder) and blood vessels. The risk of bladder injury is about 1 in 200 procedures and bowel injury about 1 in 1000. Damage to the ureters is even less common. The damaged organ is usually repaired at the same time and this may delay your recovery. Sometimes, it is not detected at the time of surgery and therefore may occasionally require a return to theatre. A bladder injury may need a catheter to drain the bladder for 7-14 days following surgery. Injury to the rectum (back passage) may require a temporary colostomy (bag to collect faeces) in rare circumstances and inserting the mesh may be delayed till a later date.
- **Mesh exposure/erosion**: There has been a lot in the news about meshes. The meshes in the news are those used in the vaginal wall to treat prolapse or around the bladder to treat urinary incontinence whereas the mesh used in this operation, although it is the same mesh, is placed within the abdomen and is considered safer. There is still a small risk of mesh erosion (2-3 in 100) into near-by organs such as bladder and bowel or the top of the vagina. Although this is uncommon this may require a repeat operation to trim the mesh and in severe cases may reduce the effectiveness of the operation. It may also cause pain with sexual intercourse but this is less common than for the alternative surgery performed through the vagina.

- **Infection of mesh**: The mesh and/or the tissues attached to it may get infected but this is uncommon. This is usually treated by antibiotics and in rare cases, by removing the mesh.
- **Inflammation of sacral bone** (osteomyelitis) is serious, but rare.
- Sometimes even if that is what is planned, a laparoscopic approach is not possible and conversion to a laparotomy (open surgery) may be required or you may be advised to have open surgery from the outset. Occasionally it is not possible to perform the operation at all due to scar tissue from previous surgery or infection.

Colpocleisis

What is colpocleisis?

Colpocleisis is an operation which closes the vagina (front passage) partly or completely but allows space for you to still be able to pass urine. This operation is offered to women who have prolapse symptoms and who do not want to have sexual intercourse in future.

What condition does colpocleisis treat?

This treats advanced prolapse of the top and walls of the vagina. Closing the vagina holds the prolapse up.

How is colpocleisis done?

The operation is done under general anaesthetic (asleep during the entire procedure) or a spinal anaesthetic (awake but numb from the waist down).

The front and back walls of vagina are stitched together.

Extra support can be provided by making the entrance to the vagina narrower by using dissolvable stitches to provide support around the perineum (skin between front and back passage). This part of the operation is called perineorrhaphy (repair of perineum).

Benefits

- **Usually a shorter operating duration** than most of the other options. This means a shorter anaesthetic and quicker recovery
- **Less risk of damage to other organs** such as bladder or bowel
- Recurrence of prolapse is probably less likely after colpoclesis than after other prolapse operations.

Disadvantages

- You will no longer be able to have sexual intercourse

Specific risks of colpocleisis

These risks are in addition to the general risks mentioned above.

- **Regret** due to inability to have penetrative sexual intercourse. Both patient and partner should be completely comfortable with the prospect of losing vaginal sexual function before this operation can be considered. Up to 1 in 10 women have reported regret for losing vaginal sexual function.
- **Damage to local organs**. The local organs include bowel, bladder, urethra (water pipe) and ureters (tubes from kidneys to the bladder). The overall risk of organ damage is considered low in comparison with other prolapse repair procedures. The estimated chance of organ damage is thought to be less than 1 in 1000 cases

(uncommon). The damaged organ is repaired at the same time and this may delay your recovery. Sometimes, it is not detected at the time of surgery and therefore may occasionally require a return to theatre. A bladder injury may need a catheter to drain the bladder for 7-14 days following surgery.

More information

If you would like to know more about vaginal vault prolapse and the treatments available for it, you could do the following.

- Ask your GP.
- Ask the doctor or nurse at the hospital.
- Look at these websites.
    - 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 leaflets at https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/recovering-well/pelvic-floor-repair-operation.pdf

      and https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/recovering-well/vaginal-hysterectomy.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 leaflets: Sacrocolpopexy https://www.yourpelvicfloor.org/media/sacrocolpopexy-RV2-1.pdf
      Sacrospinous fixation / iliococcygeus suspension https://www.yourpelvicfloor.org/media/Sacrospinous_Fixation_RV1.pdf
      Colpocleisis https://www.yourpelvicfloor.org/media/Colpocleisis_RV1-2.pdf
    - National Institute for Health and Clinical Excellence (NICE). Information for the public. Sacrocolpopexy with hysterectomy using mesh to repair uterine prolapse at https://www.nice.org.uk/guidance/ipg577/ifp/chapter/What-has-NICE-said
    - National Institute for Health and Clinical Excellence (NICE). Patient Decision Aid (PDA) for vaginal vault prolapse at

      https://www.nice.org.uk/guidance/ng123/resources/surgery-for-vaginal-vault-prolapse-patient-decision-aid-pdf-6725286114
    - Pelvic obstetric and gynaecological physiotherapy website at www.thepogp.co.uk
    - Patient information leaflets for you own hospital and others (usually available online)

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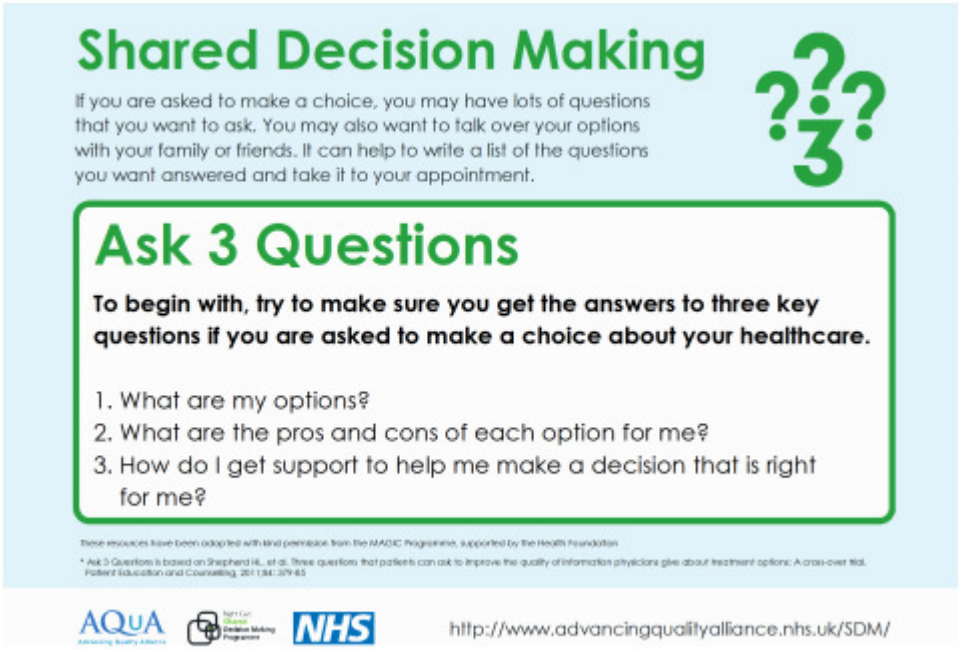
Making a decision - things I need to know before I have my operation.



Please list below any questions you may have, after reading this leaflet.

1)……

2)……

3)……

Please describe what you expect from the surgery.

1)……

2)……

3)……