British Society of Urogynaecology
Registered charity No 1143157

Anterior Vaginal Wall Repair without the use of mesh

Patient information leaflet

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 an anterior repair?

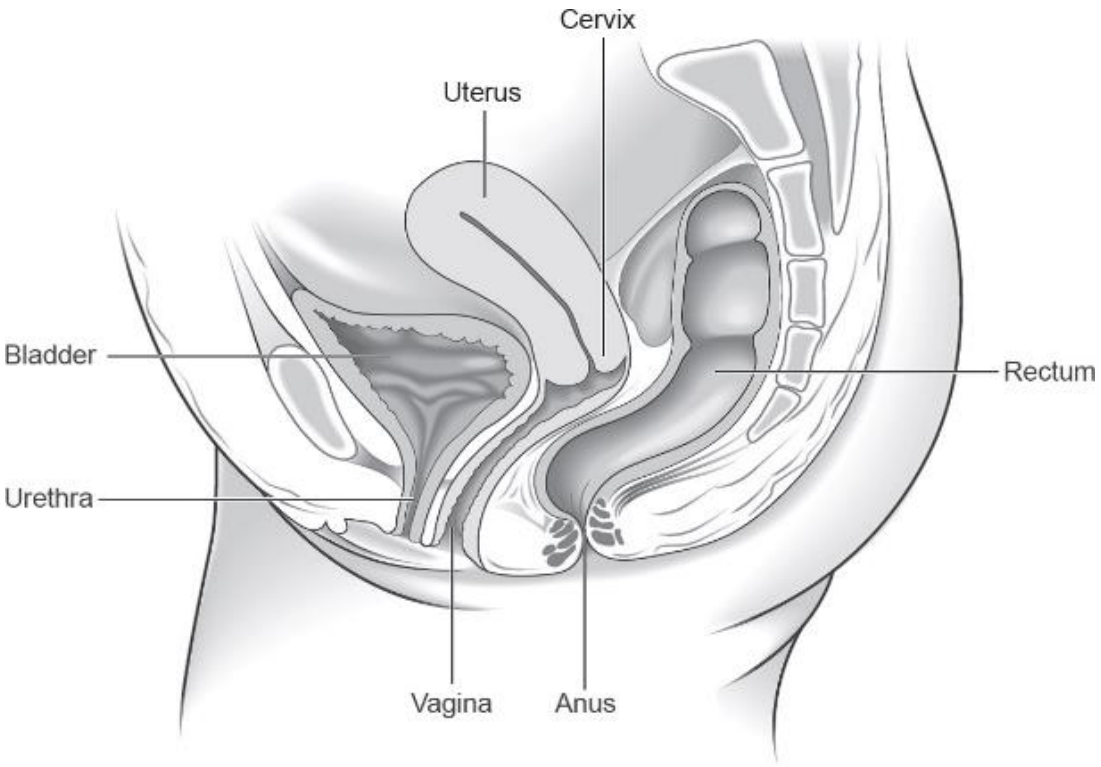
An anterior vaginal repair (anterior colporrhaphy) is an operation performed within the vagina (front passage) to treat an anterior (front) vaginal wall prolapse also called a cystocoele.

This leaflet describes an anterior vaginal repair using your own tissues (native tissue repair) and without the use of mesh.

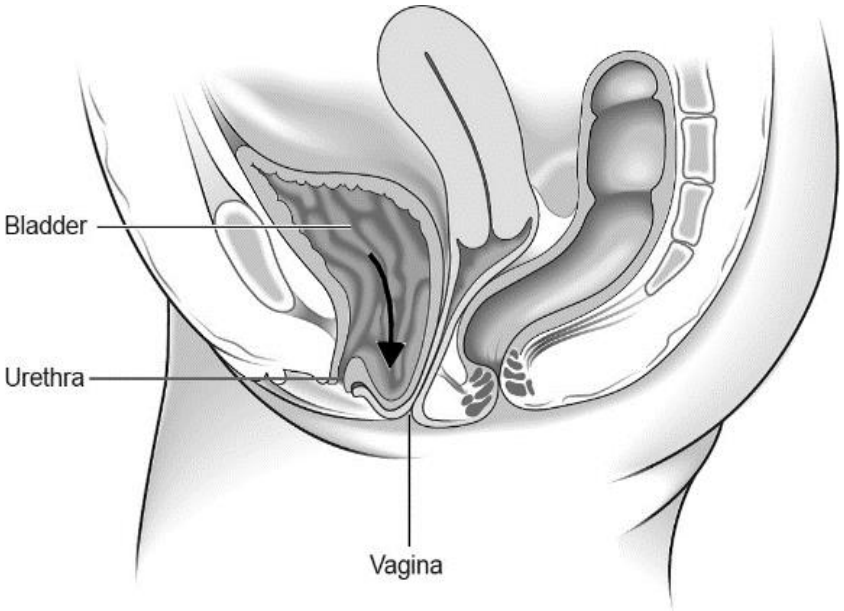
What is anterior vaginal wall prolapse?

- 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 (front passage). 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 with the bladder bulging into the vagina (Figure 1). This sometimes can be large and push out of the vagina especially on straining e.g. exercise or passing a motion.
- The pelvic floor muscles form a hammock across the opening of the pelvis. This hammock, together with the surrounding tissue holds the pelvic organs (bladder, uterus, and rectum) in place.
- Prolapse occurs when the pelvic floor muscles, their attachments or the vaginal tissue become weak. This usually occurs because of damage at the time of childbirth but is most noticeable after the menopause when the quality of supporting tissue deteriorates. It is also related to long term straining caused by heavy lifting, repeated coughing and constipation.
- A large cystocoele 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 have to push the bulge back into the vagina or lean forward in order to completely empty the bladder. Incomplete bladder emptying may make you prone to bladder infections (Urinary Tract Infection)
- Some women find that the bulge causes dragging or aching or is uncomfortable when having sexual intercourse.

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



Normal pelvis without prolapse



Anterior vaginal wall prolapse (cystocoele) with bladder bulging into the vagina due to weakness of the anterior (front) vaginal wall

How is an anterior vaginal wall repair done?

- The operation is usually done under general or spinal anaesthetic. A general anaesthetic will mean you will be asleep during the entire procedure. A spinal anaesthetic involves an injection in your back to numb you from the waist downwards. In rare circumstances, the operation is done using local anaesthetic but the results don't tend to be as good.
- The operation is all done vaginally and involves repairing the supportive tissues using dissolvable stitches. These stitches usually take 4 to 6 weeks to dissolve although some surgeons use sutures that take about 3-6 months to dissolve completely. This should not affect your recovery time.
- A catheter and a vaginal pack (strip of gauze) may be inserted after the operation but this is not essential and depends on your 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; to treat a prolapse of the uterus (womb) or the top of the vagina.
- Surgery to treat incontinence.

You should also refer to an information leaflet about any planned additional procedure.

Benefits

The primary aim of the operation is to reduce the bulge within your vagina.

Following the procedure:

- you are likely to feel more comfortable;
- intercourse may be more satisfactory;
- your bladder 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 conditions, such as a problem with your heart, or breathing. If you smoke or are overweight, this also increases risk. An anterior repair can be done with you asleep (a general anaesthetic) or awake (a spinal or local anaesthetic) whereby you are awake but numb from the waist down or just the vaginal area numbed to most pain. This will be discussed with you.

- **What can I do?** Make the anaesthetist aware 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 uncommon for this to be a large amount. It is uncommon that we have to give a blood transfusion after this operation. 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 tablet 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, 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. 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) 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. This is referred to as thromboprophylaxis which means doing something to reduce or prevent thrombosis.
  - **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 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.** The wound within the vagina can become infected. Occasionally stitches can become loose allowing the wound to open up or on the other hand, tighten up causing discomfort.

  - **What can I do?** Keep the surrounding area clean and dry carefully after washing using a clean towel or a hairdryer on a cool setting. Do not douche your vagina or use tampons.

General risks of prolapse surgery

- **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 for you to require further treatment.

  - **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 your symptoms.

- **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/GP may prescribe some laxatives.

- **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.

Specific risks of an anterior vaginal wall repair

- **Damage to bladder**. This is a rare complication but the damage needs to be repaired and this can delay your recovery. It is sometimes not recognised at the time of surgery and therefore you might need further surgery. A bladder injury will need a catheter to drain your bladder for 7-14 days following surgery but usually there are no long term problems.

- **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.
    - **What can I do?** If you experience this, please let your doctor know so that treatment can be arranged.
- **Stress incontinence** Having 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, 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 in the order of 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 experience difficulty 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.
- **Painful sexual intercourse**. The healing usually takes about 6 weeks and after this time it is safe to have intercourse. Some women find sex is uncomfortable at first, but it gets better with time. Occasionally pain with intercourse can be long-term or permanent.

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.

After your operation - in hospital

- **Pain relief**. An anterior repair is not a particularly painful operation and even when you are under a general or spinal anaesthetic often includes injection of local anaesthetic into your vaginal tissues during the operation but sometimes you require tablets or injections for pain relief. Some women describe the pain as like period pain. 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.
- **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.
- **Pack**. 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 should be able to drink and eat within a few hours of returning to the ward.
- **Preventing DVT (deep vein thrombosis).** 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 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 not usually in hospital for more than one or two days and may go home the same day. If you require a sick note or certificate please ask.

After your operation – at home

- Mobilisation is very important; using your leg muscles will reduce the risk of clots in the back of the legs (DVT).
- Bath or shower as normal.
- Do not use tampons for 6 weeks and avoid douching the vagina
- Any of the stitches under the skin will melt away by themselves. The surface knots of the stitches may appear on your underwear or pads after about two weeks, this is quite 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. The deep stitches dissolve during the first three 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.
- 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, perform an emergency stop 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 longer.

- The healing usually takes about 6 weeks and after this time 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. Occasionally pain on intercourse can be long-term or permanent.
- You usually have a follow up appointment anything between six weeks and six months after the operation. This maybe at the hospital (doctor or nurse), with your GP or by telephone. Sometimes follow up is not required.
- 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
- Difficulty opening your bowels.
- Warm, painful, swollen leg
- Chest pain or difficulty breathing

Treatment Alternatives

Non-surgical

- **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 ring pessary (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 exercises (PFE).** 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 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 vaginal device, a pessary (see image below), may be placed in the vagina to support your 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 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.

Surgical

The following table lists different operations that can be considered to treat prolapse of the anterior vaginal wall (cystocoele). Further information on the operations is available in separate leaflets. All operations are not available in all hospitals. Your consultant may recommend a particular operation depending on his or her preference and expertise, or your individual needs.

Treatment	Advantages	Disadvantages
Anterior vaginal repair (described in this leaflet)	No cuts on abdomen (tummy) Can be done with you awake or asleep Can be performed as a day case.	Recurrence rate of prolapse of up to 30%
Colpocleisis Closing of vagina	No cuts on abdomen (tummy) High success rates (90-95%) Can be done with you awake or asleep Can be performed as a day case.	Sexual intercourse will never be possible after this operation. Urinary incontinence in the future may be more difficult to treat If you have not already had a hysterectomy • Not possible to take a smear • Difficult to investigate inside the uterus if abnormal bleeding occurs
Paravaginal repair Laparoscopic (keyhole) or open abdominal	Decreased risk of pain on sexual intercourse as there is less scarring in the vagina	Usually requires an overnight stay in hospital Recurrence rate of prolapse of up to 30% Cuts on the abdomen (tummy) Not offered in all units

More information

If you would like to know more about uterine prolapse and the treatments available for it, you could do the following:

- Ask your GP.
- Ask the Urogynaecology 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 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
    - Patient information leaflets for you own hospital and others (usually available on-line)

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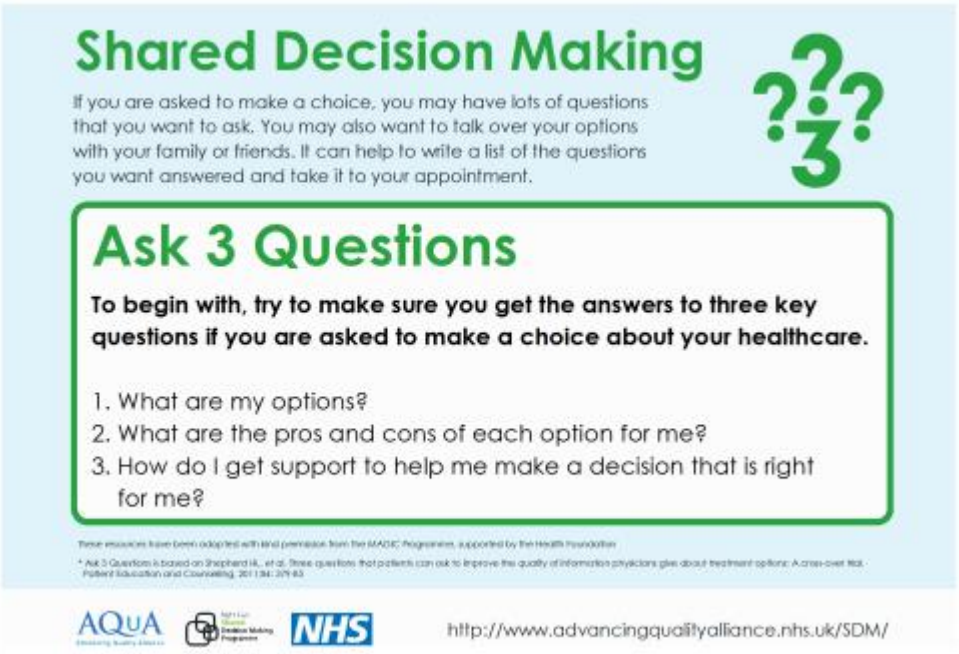
Making a decision - things I need to know before I have my operation.



Please list below any questions you may have, having read this leaflet.

1)……

2)……

3)……

Please describe what your expectations are from surgery.

1)……

2)……

3)……