Gynaecology

Vaginal Vault Prolapse and modified uterosacral ligament suspension

Normal Anatomy

Vault prolapse

Uterus

Rectum

Bladder

Perineal Body

Vagina
About this leaflet

We advise you to take your time to read this leaflet. Any questions you have please write them down and we can discuss them at our next meeting. It is your right to know about the operations being proposed, why they are being proposed, what alternatives there are and what the risks are. These are covered in this leaflet.

What is a vaginal vault prolapse?

- Following a hysterectomy, the top of the vagina may collapse downwards, (rather like the toe of a sock turning inside out) falling towards or out of the vaginal opening
- The main cause of prolapse is damage to the nerves, ligaments and muscles which support the pelvic organs and may result from the following:
- Pregnancy and childbirth are considered to be major factors leading to weakening of the vagina and its supports. Prolapse affects about one in three women who have had one or more children. A prolapse may occur during or shortly after a pregnancy or may take many years to develop. However, it is important to emphasise that only 1 out of 9 women (11%) will ever need surgery for prolapse in their lifetime.
- Ageing and menopause may cause further weakening of the pelvic floor structures.
• Conditions that cause excessive pressure on the pelvic floor like obesity, chronic cough, chronic constipation, heavy lifting and straining.
• Some women may have an inherited risk for prolapse, while some diseases affect the strength of connective tissue.
• Some women have to push the bulge back into the vagina with their fingers.
• Some women find that the bulge causes a dragging or aching sensation.

Alternatives to surgery

Do nothing – if the prolapse is not distressing then treatment is not necessarily needed. If, however, the prolapse permanently protrudes through the opening to the vagina and is exposed to the air, it may become dried out and eventually ulcerate. Even if it is not causing symptoms in this situation it is probably best to push it back with a ring pessary (see below) or have an operation to repair it.

Pelvic floor exercises (PFE) - The pelvic floor muscle runs from the coccyx at the back to the pubic bone at the front and off to the sides. This muscle supports your pelvic organs (uterus, vagina, bladder and rectum). Any muscle in the body needs exercise to keep it strong so that it functions properly. This is more important if that muscle has been damaged.
PFE can strengthen the pelvic floor and therefore give more support to the pelvic organs. Evidence suggests that PFE may not get rid of your prolapse but may improve the stage of the prolapse and make you more comfortable. PFE are best taught by an expert who is a Women’s Health Physiotherapist. These exercises have no risk and even if surgery is required at a later date, they will help your overall chance of being more comfortable.

**Pessary** - This is a soft plastic device (see pessary leaflet), which is inserted into the vagina and pushes the prolapse back up. This usually gets rid of the dragging sensation and can improve urinary and bowel symptoms. It needs to be changed every 6 months or earlier if there is any bleeding or discharge. This is a very popular treatment and we can show you an example in clinic. There are different types of pessaries available. Some couples feel that the pessary gets in the way during sexual intercourse, but many couples are not bothered by it.

**How is the operation performed?**

The operation is called a modified uterosacral ligament suspension and is all done vaginally. This is designed to restore support to the vaginal vault (top of the vagina in a woman who has had a hysterectomy).
The uterosacral ligaments are strong supportive structures that attach the cervix (neck of the womb) to the sacrum (bottom of the spine). Weakness and stretching of these ligaments can contribute to pelvic organ prolapse. An uterosacral ligament suspension involves stitching the uterosacral ligaments to the apex or top of the vagina, thereby restoring normal support to the top of the vagina. These stitches usually take 4 to 6 weeks to absorb. A catheter and a vaginal pack may be inserted in the vagina after the operation. The pack puts pressure on the vaginal walls to prevent vaginal bleeding and reduce the chance of a blood collection to form. This operation may be combined with other prolapse or incontinence surgery, which is covered in other leaflets that may be given to you.

**Benefits of surgery**

The benefits are that you are likely to feel more comfortable and intercourse may be more satisfactory. Quoted success rates for uterosacral ligament suspension are between 80 and 90%.
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. A repair can be performed whilst you are asleep, (using a general anaesthetic) or when you are awake, (using a spinal anaesthetic) whereby you are numb from the waist down. This will be discussed with you.

**Bleeding.** There is a risk of bleeding with any operation. Excessive bleeding is unusual during a prolapse repair. It is rare that we have to give patients a blood transfusion after their operation. Please let your doctor know if you are taking a blood-thinning tablet such as warfarin, aspirin or clopidogrel as you may be asked to stop them before your operation.

**Infection.** There is a small risk of infection with any operation. If it occurs, an infection can be a vaginal infection or a urinary infection, both of which are easily treated with antibiotics. A significant infection is rare. The risk of infection is reduced by routinely giving you antibiotics during your operation.

**Deep Vein Thrombosis (DVT).** This is a clot in the deep veins of the leg. The overall risk is at most 4-5% although the majority of these are without symptoms.
Occasionally this clot can travel to the lungs which can be very serious and in rare circumstances it can be fatal (less than 1% of those who get a clot). DVT can occur more often with major operations around the pelvis and the risk increases with obesity, varicose veins, infection, immobility and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood (heparin). These are routinely given to you.

**Specific risks of this surgery**

**Damage to local organs.** This includes the bladder, ureters, bowel, rectum and blood vessels. This is a rare complication but requires that the damaged organ is repaired. This can result in a delay in recovery. It is sometimes not detected at the time of surgery and therefore may require a return to theatre. If the rectum (back passage) is damaged at the time of surgery, a temporary colostomy (bag) may be required but this is exceptionally rare.

**Prolapse recurrence:** If you have one prolapse, the risk of having another prolapse sometime during your life is 30%. This is because the vaginal tissue is weak. The operation may not work and it may fail to improve your symptoms. One-year follow-up data in our unit shows a 10% recurrence.
Pain: General discomfort in your pelvis or vagina which usually settles with time. You may also experience intense buttock pain, which can last for a few days. You may have pain on intercourse due to vaginal scarring. Occasionally pain on intercourse can be permanent.

Reduced sensation during intercourse: Sometimes the sensation during intercourse may be less and occasionally orgasm may be less intense.

After the operation - in hospital

- On return from theatre you will have a fine tube (drip) in one of your arm veins with fluid running through to stop you getting dehydrated.
- You may have a bandage in the vagina, called a ‘pack’ and a sanitary pad in place. This is to apply pressure to the wound to stop it bleeding.
- You may have a tube (catheter) draining the bladder overnight. The catheter may give you the sensation as though you need to pass urine but this is not the case.
- Usually the drip, pack and catheter come out the morning after surgery. This is not generally painful.
- The day after the operation you will be encouraged to get out of bed. This improves general wellbeing and reduces the risk of clots in the legs.
- It is important that the amount of urine is measured the first couple of times you pass urine after the removal of the catheter.
- An ultrasound scan for your bladder may be done on the ward to make sure that you are emptying your bladder properly. If you are leaving a significant amount of urine in your bladder, you may have to have the catheter re-inserted into your bladder for a couple of days more.
- You may be given injections to keep your blood thin and reduce the risk of blood clots normally once a day until you go home or longer in some cases.
- The wound is not normally very painful but sometimes you may require tablets or injections for pain relief.
- There will be slight vaginal bleeding after the operation similar to the end of a period. This may last for a few weeks.
- The nurses will advise you about sick notes, certificates etc. You are usually in hospital up to 24-48 hours.

After the operation - at home

- Mobilization is important; using your leg muscles will reduce the risk of a DVT.
- Avoid constipation and heavy lifting. The deep stitches dissolve during the first three months and the body will gradually lay down strong scar tissue over a few months.
- The surface knots of the stitches may appear on your underwear or pads after about two weeks, this is quite normal.
• There may be a little bleeding again after two weeks when the surface knots fall off, this is nothing to worry about.
• Do not use tampons.
• 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. Leave a very heavy or busy job until 12 weeks. If you are unsure follow the advice of your GP.
• You can drive as soon as you can make an emergency stop without discomfort, generally after three weeks, but you must check this with your insurance company, as some of them insist that you should wait for six weeks.
• You can have sexual intercourse whenever you feel comfortable enough after six weeks, so long as you have no blood loss. You will need to be gentle and may wish to use lubrication (such as KY jelly) as some of the internal knots could cause your partner discomfort. You may, otherwise, wish to defer sexual intercourse until all the stitches have dissolved, typically 3 months.
• Follow up after the operation will be at 3 months and 1 year in the gynaecology clinic at Nene Park. You will be examined and asked to complete a questionnaire at your 1-year follow-up.
Useful references - Where can I obtain more information?

- Bladder & Bowel Foundation ☎ 01536 533255
- Nurse Helpline for medical advice: ☎ 0845 345 0165
- Counsellor Helpline: ☎ 0870 770 3246
- General enquiries: ☎ 01536 533255 Fax: 01536 533240
-mailto:info@bladderandbowelfoundation.org
- http://www.bladderandbowelfoundation.org
- http://www.easyhealth.org.uk/

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

Things I need to know before I have my operation.

1. ...........................................................................................................
2. ...........................................................................................................
3. ...........................................................................................................

Please describe what your expectations are from surgery.

1. ...........................................................................................................
2. ...........................................................................................................
3. ...........................................................................................................
If you need this information in another format or language, please telephone 01536 492510.

Further information about the Trust is available on the following websites:
KGH - www.kgh.nhs.uk  |  NHS Choices - www.nhs.uk