Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Vaginal Hysterectomy for Prolapse

Version number: **4**
Last modified date: **12th November 2026**

Vaginal Hysterectomy for Prolapse

Patient Information

Gynaecology Services

- Author ID: JD/MC
- Leaflet Ref: Gyn 012
- Version: 4
- Leaflet title: Vaginal Hysterectomy for Prolapse
- Date Produced: November 2024
- Expiry Date: November 2026

Introduction

This leaflet has been written to try and answer questions you might have about vaginal hysterectomy for prolapse; however, it is not intended to replace the personal contact between you and the doctors and nurses.

It should be read together with the leaflet Gyn 058 about prolapse, available on this link: https://www.wwl.nhs.uk/leaflets/download/wwl-5ff723901af9c6.37706261

or scan the QR code:

Also, the NICE (The National Institute for Health and Care Excellence) Patient Decision Aid on Surgery for Uterine Prolapse which is available in our clinics or on the internet https://www.nice.org.uk/guidance/ng123/resources/surgery-for-stress-urinary-incontinence-patient-decision-aid-pdf-6725286110

If at any time you have any worries or questions not covered by the leaflet, please feel free to discuss them with a member of staff.

What is a vaginal hysterectomy?

It is the removal of the uterus (womb) and cervix (neck of womb) through the vagina. It is

one of a number of operations to treat a prolapsed uterus (dropped womb).

Alternative treatments for prolapse

These are described in their own information sheets and are compared in the information sheet about the treatment of prolapse. These leaflets give more information about other treatments which are available, and they are described and compared.

How is a vaginal hysterectomy done?

The surgery is all carried out within the vagina. The hysterectomy is done in the same way as an operation through your abdomen by cutting and stitching along the edges of the uterus and cervix to remove them. Although people sometimes refer to the operation as a suction hysterectomy, in fact hysterectomies have never been performed using suction.

The ligaments (uterosacral ligaments) which should support your uterus (womb) are attached to the top of the vagina at the end of the procedure, to keep it in place. If the ligaments are very stretched, they need to be shortened by stitching the top of the vagina to a point high up the ligament using dissolving stitches. This is called a high uterosacral ligament suspension. When doing this procedure there is a small risk that the ureter (tube draining urine from the kidney to the bladder) becomes kinked and blocked. At the end of the operation a camera examination of the bladder (cystoscopy) is done to check that urine can still drain freely.

If there is also prolapse of the vaginal wall this will be repaired at the same time. The skin of the wall of the vagina is cut and the tough, supporting tissues (fascia) underneath are found. These will have a gap within them through which the prolapse is bulging.

Once this gap is identified it can be repaired by stitching the edges together using dissolving stitches. The skin is then closed over the repair. **Mesh is not used.**

There are two types of vaginal wall repair for vaginal prolapse:

Anterior repair: is a repair of the anterior (front) vaginal wall, usually because of a cystocoele.

- A cystocoele is a bulge caused by the bladder, due to weakness of the anterior (front) vaginal wall.

Posterior repair: is a repair of the posterior (back) vaginal wall, usually because of a rectocele.

- A rectocele is a bulge caused by the rectum, due to weakness of the posterior (back) vaginal wall or an enterocoele.

- An enterocoele is a bulge caused by bowel pressing through a weakness high on the posterior (back) vaginal wall

Both repairs are described in the leaflet about vaginal repair.

How successful is the operation?

As with all operations for prolapse, it is not guaranteed to be completely successful, as the reason for the prolapse occurring in the first place is that the tissues in that area are weak. Although the uterus will be removed, the top of the vagina can come down and also the walls of the vagina. Overall, 7 out of 10 ladies having a prolapse operation are cured permanently but 3 out of 10 will develop a further prolapse.

Benefits of treating prolapse

The main benefit of treating a prolapse is to make things feel more comfortable. Occasionally it can improve bowel or bladder function, but this is not always the case. Generally, if a prolapse is not treated it will not result in any harm except for the feeling of discomfort.

Risks

- The biggest risk following a prolapse operation is that it will not cure all your symptoms, even if the prolapse is effectively repaired, and also there is a risk that over time a prolapse will return (as described above).

- Immediately after the operation you may have difficulty passing urine. This usually settles over a few days but may require a catheter in the bladder.

- There is a very small risk that your bowel or bladder or ureter (tube from the kidney to the bladder) could be damaged but any damage would usually be repaired at the time of the operation. Occasionally this will need an open operation if the repair cannot be done through the vagina.

- There is a small risk of infection either in the pelvis at the site of the operation or a water (urinary) infection. Antibiotics are given during the procedure to reduce this.

- There is a small risk of thrombosis (blood clot in the leg or lung). Stockings are worn and injections are given following the operation to reduce this risk.

- Your vagina may become narrower after the operation and this can make sexual intercourse difficult, especially if a vaginal wall repair is performed at the same time. Scar tissue may also cause discomfort with intercourse which is usually temporary but may persist. Your doctor will enquire before the procedure about your wishes for sexual activity and discuss this further.

- Heavy bleeding may occur occasionally either during the operation or afterwards. Rarely, a second operation may be necessary to stop the bleeding. This may require an incision (cut) in the abdomen (tummy). Bleeding can occur even after you have returned to the ward and this means you may need to return to the theatre.

- You may also rarely require a blood transfusion (1-2 in 100).

- Sometimes when a prolapse comes down it makes a kink in the urethra (tube from the bladder through which urine passes). This can make it difficult to pass urine (wee) but it can also stop urine leaking out. When the prolapse is repaired the urethra is straightened out and you become aware of urine leaking with coughing and exercise which was not happening before surgery. This happens in up to 10% (1 in 10) women who have surgery and unfortunately there is no good test to predict who will get this. It can usually be treated effectively.

- In about 1 in 10 women, there can be irritation of the bladder causing frequent visits to the toilet or occasionally leakage, especially if a very large prolapse has been corrected. This usually gets better gradually.

What should I expect after my operation?

- Immediately after your operation, you may have a drip in your arm to give you fluid until you are able to eat and drink properly. This may include a system where you can press a button to administer pain relief to yourself as required (Patient Controlled

Analgesia or PCA)

- You may have a catheter into your bladder to drain urine, which is likely to be removed the following morning.

- You may have a gauze pack (like a tampon) inside the vagina to help stop any bleeding. This will be removed before you go home. This is usually only used if you have had a repair of the front and the back walls of the vagina at the same time.

- You will be given an injection to thin your blood and help prevent thrombosis (blood clots) until you are fully mobile.

- You will be encouraged to move about after the operation which may be the same day as your surgery. Moving around will reduce the chance of you developing any post-operative complications, such as clots in your legs and lungs and should also help prevent you getting a chest infection.

After your operation, you will be seen by a doctor or a nurse who will explain to you how your operation went and if there were any changes to the previously planned operation. You should be informed of your progress at all times. Don’t be afraid to ask the nurses or doctors if you have any questions.

After a hysterectomy you may be in hospital for one night or you may be able to go home the same day.

For other information about recovery after the operation see the leaflet “Prolapse” and the leaflet “Following major Gynaecological surgery”

How long will it take for me to recover?

It takes between six and twelve weeks to get back to normal. It is important for you to be as active as possible, as being bed-ridden can mean there is an increased risk of thrombosis (blood clots) occurring in the veins and lungs. Although you need to be active, you should be sensible and make sure you have periods of rest when you begin to feel tired.

You are advised to gradually start doing a little more each day without tiring yourself. Do whatever you feel able to do without too much effort, however, avoid lifting and straining until you are seen again in the out-patients clinic.

It is recommended that you avoid the following until at least 12 weeks after surgery:

- Sit up exercises.
- Lifting children or heavy objects.
- Gardening.
- Heavy housework.
- Aerobic exercises.

Follow-up

You will be sent an appointment for a follow up consultation in clinic 8-12 weeks after your operation. This is usually face-to-face but may be by telephone

Contact information

If you have any problems after you have gone home or if you have any questions about the information in this leaflet, please feel free to speak to one of the nurse's, telephone:

Swinley Ward 01942 822568



Version number: **4**
Last modified date: **12th November 2026**

All rights reserved © 2026
WWL Teaching Hospitals NHS Foundation Trust