Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Prolapse

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Prolapse

Patient Information

Gynaecology Services

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What is a prolapse?

A prolapse is usually felt as a lump coming down in the vagina. Sometimes it is the uterus (womb) which has dropped. More often it is caused by a weakness in the wall of the vagina. If you have had a hysterectomy the top of the vagina (vaginal vault) can drop causing a vaginal vault prolapse.

The weakness in the wall of the vagina may also allow the bladder (if the weakness is in the front of the vagina) or the bowel (if it is at the back) to bulge into the vagina causing a lump.

What are the common causes of a prolapse?

Childbirth, long term coughing, heavy lifting and straining, constipation and being overweight. In some cases, a prolapse occurs because of naturally weak tissues despite avoiding all of the above.

Treatments for prolapse

Do nothing

It is not essential to treat a prolapse. The condition is not a life threatening one and treatments are designed to improve comfort.

If the prolapse (bulge) is not distressing, then treatment is not necessarily needed unless the prolapse of front wall of the vagina (cystocele) is causing difficulty with passing urine or incomplete emptying of bladder with recurrent water infections. In addition, if 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 supporting 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. These exercises may not cure the prolapse, but they make you more comfortable. PFE are best taught by an expert who is usually a Physiotherapist. These exercises have little or no risk and even if surgery is required at a later date, they will help your overall chance of being more comfortable.

Vaginal Pessary

Ring pessary - this is a soft plastic ring or device 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. If you wish to avoid surgery this can be a very successful treatment; we can show you an example in clinic. Other pessaries may be used if the ring pessary is not suitable. Some couples feel that the pessary gets in the way during sexual intercourse, but many couples are not bothered by it. It needs to be changed every 4-6 months, and this can often be done at your GP's surgery or alternatively in one of the clinics run by nurses in the hospital. An alternative is to learn how to remove it, clean it and replace it yourself, giving you the freedom to use it when you wish and not necessarily all the time.

Certain types of pessaries can be washed and replaced as per manufacturers instructions. This would be undertaken in the event of a shortage of supply.

Shelf Pessary or Gellhorn - If you are not sexually active this is a stronger pessary which can be inserted into the vagina and again needs changing every 4-6 months. Most GPs do not change this type of pessary so you would need to come to the nurse led hospital clinic. Although it can be removed and replaced by you most women find this difficult

Surgery

Vaginal wall prolapse

If your prolapse just involves the walls of the vagina it is usually best treated with a vaginal repair which is a fairly minor procedure often carried out as a day case.

Prolapse of the anterior (front) wall of the vagina especially if it has come back after a previous repair or if it is associated with leakage of urine when coughing and exercising (stress incontinence) can also be treated by an operation through a cut in the abdomen (tummy) or laparoscopic (keyhole) surgery called a colposuspension, sometimes also called a paravaginal repair. This is a bigger operation than a vaginal repair and often requires 1-2 nights in hospital.

Prolapse of the uterus or vaginal vault

If your prolapse includes your uterus (womb) coming down or the top of the vagina (vault) coming down in those who have already had a hysterectomy additional surgery is required to lift the womb or the top of the vagina. You may need to stay in hospital 1-2 days.

There are a number of operations available to treat vault prolapse or a prolapse of the uterus. Operations available that are fully described in their own leaflets are:

- Sacrocolpopexy (vaginal vault) or sacrohysteropexy (uterus)
- Vaginal hysterectomy and vaginal repair with or without high uterosacral ligament suspension
- Sacrospinous fixation with or without vaginal hysterectomy
- Le Forts procedure (colpocleisis)

Your consultant will advise you whether a vaginal hysterectomy alone is a suitable treatment for prolapse of the uterus. If the top of the vagina is not well supported, it may need to be combined with a sacrospinous fixation or high uterosacral ligament suspension.

A sacrocolpopexy/sacrohysteropexy and a sacrospinous fixation have similar success rates initially but the sacrocolpopexy is possibly longer lasting. It is also slightly less likely to cause discomfort with intercourse. It is however a somewhat more major operation.

A Le Fort's procedure is a much more minor procedure, but it is only suitable for those who no longer wish to have intercourse as it almost completely closes the vagina.

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 (unless you are having repeated water infections with cystocele) except for the feeling of discomfort.

Risks

As with any surgical procedure and general anaesthetic, there is a degree of risk involved.

- 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 that over time a prolapse will return. This may not be a prolapse of the same part of the vagina; for instance if you have a repair of the front wall of the vagina it may be that the back wall of the vagina will become weak at a later time. Overall, 7 out of 10 having a prolapse operation are cured permanently but in 3 out of 10 a prolapse recurs. This may be a prolapse from a different area within the vagina.

- 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 could be damaged but any damage would usually be repaired at the time of the operation.

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

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

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

There is always some bleeding during surgery. This is usually minor for repairs of vaginal wall prolapse but operations to treat prolapse of the vaginal vault or the uterus carry a small risk of bleeding enough to need a blood transfusion and very rarely this occurs after the operation is over with a need to return to the operating theatre to stop the bleeding.

Consent

Your consultant will explain the operation to you and discuss all the risks. If you are worried about any of the risks listed here, please speak to your consultant. Once you are happy that you wish to have the operation you will be asked to sign a consent form which will document the operation planned and any risks.

All surgeons in the United Kingdom are asked to report all operations for prolapse to a national database together with any complications and whether it was successful. With your permission we report cases to the British Society of Urogynaecology database and this will be explained in clinic.

Pre-operative clinic

Before your operation, you will be invited to attend the pre-operative clinic at the Thomas Linacre Centre or Leigh Infirmary depending on which is more convenient for you.

You will have some blood taken for routine investigations and you will be asked some general questions regarding your health.

The enhanced recovery nurse

If you are likely to stay in hospital overnight, you may see the enhanced recovery nurse in the pre-operative clinic. The enhanced recovery nurse is a specialist nurse who is able to streamline your admission and can help you towards a quicker discharge. The specialist

nurse will be able to answer any questions you have about your admission, will discuss discharge arrangements and talk you through your admission, length of stay and treatment on the ward.

How long will I have to stay in hospital?

Length of stay varies; some procedures only require a day case admission and for others you need to stay 1-2 days. You may need some help at home after your operation, so please let the staff know if you think this may be a problem.

What type of anaesthetic will I have?

The Anaesthetist will discuss with you the type of anaesthetic available and the risks involved and what will be best for you.

- General anaesthetic - which would send you to sleep so you do not feel, see or hear anything during your operation.

- Spinal anaesthetic - is where you are given an injection of local anaesthetic into your back, which will numb the lower half of your body. You will be awake and able to communicate throughout the procedure. This is especially suitable for those who have other medical problems.

Admission

You will be admitted the morning of the operation onto the Surgical Admissions Lounge at Wigan or Ward 3 at Leigh. You will book in with the admissions clerk and then the nursing staff will prepare you for theatre. All investigations carried out in the outpatient clinic or in the pre-operative clinic are checked and the nurse or doctor will ensure that your consent is

correct and all your questions are answered. Do not be afraid to ask the nursing staff or doctors if you are not sure about anything and need further explanations. The nurse will provide you with a wristband for identification and complete an anaesthetic check list.

- Please have a bath or shower first thing in the morning.
- Please remove makeup, nail polish and jewellery.
- If you wear glasses, dentures or a hearing aid these can be removed either in the surgical admission lounge, or in the anaesthetic room.
- It is necessary to put tape over your wedding ring.
- You will be given a gown to wear, which ties at the back, you can bring a dressing gown to put over the theatre gown whilst you are waiting for your operation.
- You will be fitted with your compression stockings.
- You will either walk or be taken to theatre on a trolley
- At Leigh you will return to the same ward after your operation and in Wigan you will often go to a surgical ward. Your possessions will be taken to your ward from the admissions lounge.

Once in the theatre department, you will be connected to a heart monitor (to check your heart while you are asleep) and an injection will be given to you in the back of your hand to send you to sleep.

Recovery

When you wake up, you will be in the Recovery Room in Theatre. Here you will remain under careful observation for a short while before you are transferred to the ward. You will have a drip in place to ensure you have fluids until you can drink normally, which will usually be some hours after the operation

After the operation

After your operation you will be seen by a nurse or a doctor 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. You may have a gauze pack (like a tampon) in the vagina to help stop any bleeding by applying pressure and if so this will be removed before you go home. If you have a catheter in your bladder this will be removed the morning after the operation. If you have had just a vaginal repair, you will usually go home the same day but if you have had surgery for vault or uterine prolapse you may be in hospital one to two days.

Coping with pain

After the operation you will experience some pain and discomfort, but you will be given painkillers to control it. During the first day following the operation you may have a patient-controlled machine, which allows you to give yourself a dose of painkiller when needed. After that you will be given painkillers in the form of tablets or suppositories. Please ask for painkillers if you need them.

You will be encouraged to get up and about early after the operation.

Eating and drinking

You will be encouraged to drink 1.5 - 2 litres of fluid a day. Once your appetite returns, usually by the second day, you can eat normally.

Wind and bowels

You may feel bloated and have difficulty opening your bowels. Don't worry; this should resolve itself as you become more active. If necessary you will be given medicine to help relieve any discomfort.

Stitches

For most operations all the stitches are in the vagina (front passage). They will take up to three months to dissolve. You may notice bits of them coming away with some vaginal discharge during this period.

If you have a sacrocolpopexy or sacrohysteropexy there will be stitches in your abdomen (tummy). Usually these will be the type that dissolve but if they need removing then a district nurse appointment will be arranged for this to be done.

Bathing

You may bath and shower as normal. Don't be afraid to ask for help if you need it.

Discharge

On discharge from hospital you will be given a letter for your GP and pain killers to take home.

The nurse on the ward will inform you whether or not a District Nurse is needed, if so then the staff will refer you to the district nurse service and they will contact you to make arrangements for you to go to their clinic.

How long will it take for me to recover?

It takes about six to 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 leg 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.

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.

Will I have any problems after the operation?

If you have pain when passing urine, it may mean that you have a mild infection which needs treatment. You should contact your family doctor (GP).

Constipation can be a problem; it is important to drink plenty of fluids and take lots of fibre in your diet, such as fruit, vegetables and wholemeal bread.

When will I be able to go back to work?

You should be able to go back to work after about six to eight weeks, depending on the type of work you do. Those doing manual or physical work will need longer at home than those doing more sedentary (seated) office type work.

When will I be able to drive?

When you can wear a seat belt and stop the car in an emergency without any discomfort. This is usually between four to six weeks after your operation.

- Can you concentrate?
- Can you do an emergency stop?
- Check with your insurance company.

Returning to sexual relations

You can start sexual relations 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 (KY jelly). Some of the internal knots could occasionally cause your partner discomfort so you may wish to defer sexual intercourse until all the stitches have dissolved, typically 3-4 months.

Follow-up

You will be sent an appointment for a follow up consultation in clinic 8-12 weeks after your operation.

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 nurses on:

Swinley Ward 01942 822568

Or

Ward 3, Leigh Infirmary 01942 264260

Patient Decision Aid

Procedure	Advantages	Disadvantages

Uterine prolapse (dropped womb)		
Vaginal hysterectomy with or without High Uterosacral Ligament Suspension	• Vaginal surgery avoiding cut in abdomen • Usually only moderate pain after operation • Stops periods if still having them • Can be done with spinal anaesthetic	• Not always enough support in vagina to get a good result
Sacrospinous fixation (with or without hysterectomy)	• Vaginal surgery avoiding cut in abdomen • Can be done with spinal anaesthetic	• Long term success rates lower than sacrohysteropexy as relies on own tissues • Can give discomfort with intercourse • Buttock pain for a few months (up to 25%)

Procedure	Advantages	Disadvantages
Sacrohysteropexy	• Good success rates as uses artificial mesh for support • Low chance of discomfort with intercourse	• Major abdominal surgery or major laparoscopic (key hole) surgery • Mesh left in abdomen • Higher risk of bleeding • Requires a general anaesthetic
Colpocleisis (Le Fort's procedure)	• Good success rates • Fairly minor procedure • Can be done using spinal anaesthetic	• No longer possible to have intercourse • May be difficult to investigate any abnormal bleeding from the uterus
Vaginal vault prolapse (prolapse of the top of the vagina after a hysterectomy)		
Sacrospinous fixation	• Vaginal surgery avoiding cut in abdomen • Can be done with spinal anaesthetic	• Can give discomfort with intercourse • Buttock pain for a few months (up to 25%)

Sacrocolpopexy	• Good success rates as uses artificial mesh for support • Low chance of discomfort with intercourse	• Major laparoscopic (key hole) surgery or major abdominal surgery • Leaves mesh in abdomen • Higher risk of bleeding • Requires a general anaesthetic
Colpocleisis (Le Fort's procedure)	• Good success rates • Fairly minor procedure • Can be done using spinal anaesthetic	• No longer possible to have intercourse



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