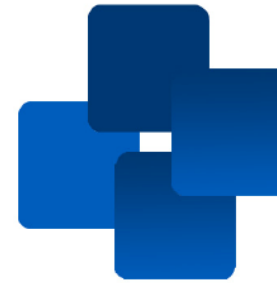
East and North Hertfordshire
NHS Trust

Patient Information

Sacrospinous fixation of the vaginal vault or of the uterus

Operations for Prolapse of the Vaginal Apex

Urogynaecology

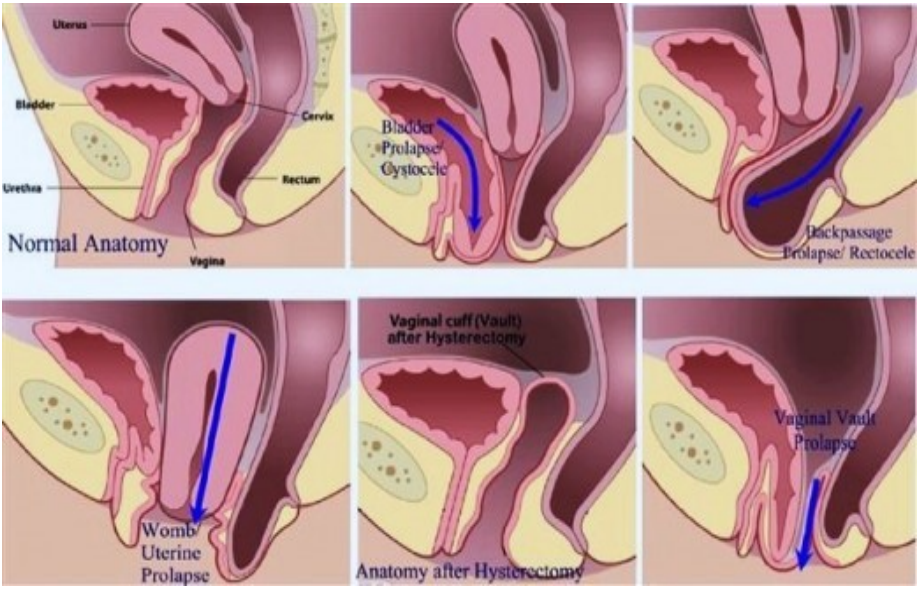


What is prolapse of vaginal apex?

A prolapse is where the vaginal tissue is weak and bulges downwards into the vagina itself. In severe cases it can even protrude outside the vagina.

The apex is the deepest part of the vagina (top of it) where the uterus (womb) is usually located. If you have had a hysterectomy then the term (vault) is used to describe the area where your womb would have been attached to the top of the vagina (front passage).

A vaginal vault prolapse is a prolapse arising from the vaginal vault.

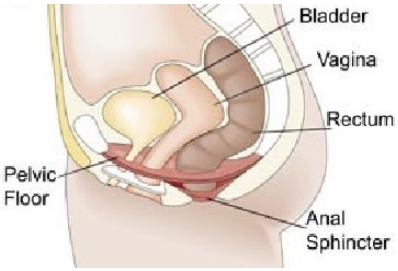


Alternatives to surgery

Do nothing - If the prolapse (bulge) 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 the next page) 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 get rid of the prolapse but they make you more comfortable.

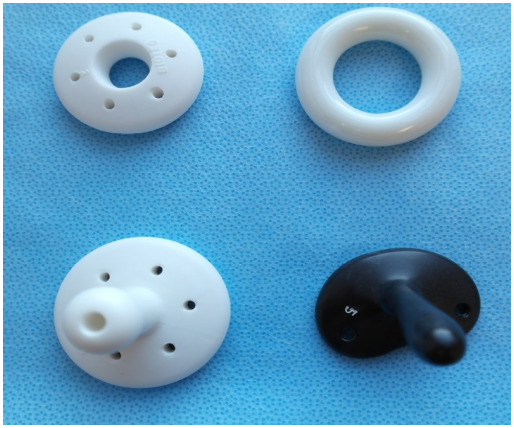
Pelvic floor exercises are best taught by an expert who is usually a physiotherapist. These exercises have no risk and even if surgery is required at a later date, these might help you to have less chance of recurrence.

Types of pessaries

There are several types of pessaries to be considered in the management of prolapse. The choice will depend on the type of prolapse and the individual herself. The two most commonly used are:

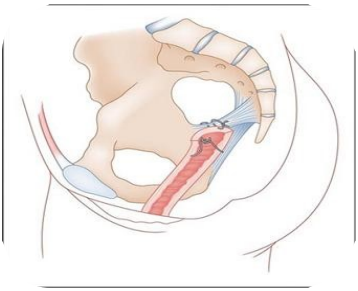
Ring pessary - This is a soft plastic ring or device which is inserted into the vagina and pushes the prolapse back up. This usually gets rid of the dragging sensation and can improve urinary and bowel symptoms. It needs to be changed every 4-6 months and can be very popular; we can show you an example 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.

Shelf pessary or Gellhorn - If you are not sexually active this is a stronger pessary which can be inserted into the vagina. It needs changing every 4-6 months.



General risks of surgery

Are there any complications?



With any operation there is always a risk of complications. The following general complications can happen after any type of surgery:

Bleeding - Serious bleeding requiring blood transfusion can occur rarely following vaginal surgery.

Wound infection - Although antibiotics are often given just before surgery and all attempts are made to keep surgery sterile, there is a small chance of developing an infection in the vagina or pelvis. Symptoms include an unpleasant smelling vaginal discharge, fever and pelvic pain or abdominal discomfort. If you become unwell contact your doctor as you may require antibiotics.

Bladder infections (cystitis) - This occurs in about 6% of women after surgery and is more common if a catheter has been used. Symptoms include burning or stinging when passing urine, a frequent need to urinate and sometimes blood in the urine. Cystitis is usually easily treated by a course of antibiotics.

Damage to nearby organs (rectum, ureter, bladder, blood vessels or nerve) occurs rarely. The resulting injury may require further surgery.

DVT/ Thrombosis - Blood clots forming in the legs or lungs.

Specific complications related to sacrospinous fixation suspension include:

Pain - Approximately one in ten women who have a sacrospinous fixation will get pain in their buttocks for the first few weeks after surgery. This will get better by itself and you will be given painkillers to help. It usually settles by six weeks. It is also quite common to get some stabbing or burning rectal pain that settles within a short time.

Constipation is a common short term problem and your doctor may prescribe laxatives for this. Try to maintain a high fibre diet and drink plenty of fluids to help as well.

Pain/discomfort with intercourse - this can occur in 1-5% of women. Whilst every effort is made to prevent this happening, it is sometimes unavoidable. Some women feel confident and find intercourse is more comfortable after their prolapse is repaired.

Failure of the operation to achieve its aim, or formation of a prolapse in another part of the vagina which could require further surgery to correct the problem in the future

After the operation - In hospital

- On return from the operating theatre you will have a drip (a fine tube) 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 oozing.

- You may have a catheter (tube) 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 or sometimes later the same day. This is generally not painful.

- The day after the 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 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 back 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. This is 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 (like the end of a period) after the operation. This may last for a few weeks.

- The nurses will advise you about fit notes (a Statement of Fitness for Work), also known as a medical statement, sick note etc.

- You are usually in hospital for one or two nights.

After the operation - At home

- Mobilisation is very important; using your leg muscles will reduce the risk of clots in the back of the legs (DVT), which can be very dangerous.

- 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 the body will gradually lay down strong scar tissue over a few months.

- **Avoid constipation**
    - Drink plenty of water/juice
    - Eat fruit and green vegetables, especially broccoli
    - Plenty of fibre (roughage), e.g. bran and oats

- **Do not use tampons for six weeks.**

- There are stitches in the skin wound in the vagina. The parts 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 a little bleeding again after about two weeks when the surface knots fall off, this is nothing to worry about.

- At six weeks gradually build up your level of activity.

- After three 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.

- 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 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, 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 3-4 months.

Follow-up appointment

Follow-up after the operation is usually six weeks to six months. This may be at the hospital (doctor or nurse), with your GP or by telephone. Sometimes a follow-up is not required.

Please use this space to write down any questions you may like to ask:

Contact details

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Further Information

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www.enherts-tr.nhs.uk

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