Surgical Information Sheet for Women having Surgery for Uterine Prolapse

1. Proposed operations:

Removal of uterus (hysterectomy)

Preservation of uterus (suspension)

Pelvic floor repair

Urinary incontinence operation

2. Why am I having this operation?

You and your gynaecologist have agreed that you need an operation to cure or improve symptoms you have been experiencing. These may include a feeling of a bulge in your vagina or something coming down from it, a dragging or heavy sensation or problems with bladder, your bowel or intercourse. Your medical team think your symptoms are caused by a prolapse of your womb (uterine prolapse, see Figure 1) which can be helped by surgery.

3. What will the operation involve?

There are two different ways of treating this kind of prolapse: **vaginal hysterectomy** and **uterine suspension.**

1. Vaginal Hysterectomy

This is the most common operation. It involves completely removing the womb through your vagina. You will not have any cuts on your abdomen. Once your womb is gone, you cannot have children. If you are hoping to have children in the future, talk to your gynaecologist about other treatments.

2. Uterine Suspension

In this operation, the womb is not removed. Instead, it is put back into its correct position and is secured (suspended) in one of two ways:

1. Through your vagina with strong stitches or a special plastic mesh used to attach the neck of the womb (cervix) to ligaments in the pelvis; or
2. Through your tummy or by using a laparoscope (keyhole surgery). In these cases, mesh is stitched to both the neck of the womb (cervix) and to part of your back bone (the sacrum) to hold up (suspend) the womb (see Figure 2).

If special mesh is used, it will be made of a man-made (plastic) netting-like material which is not absorbable, i.e. it will not dissolve.

Although you will still have your womb after this operation, you are strongly advised not to have any more children. This is because pregnancy may undo the repair and make it more difficult to repeat the operation in the future. If you are hoping to have children in the future, talk to your gynaecologist about other treatments.

4. How safe are these operations?

All of these operations have been used by gynaecologists for many years. They have been approved by NICE (National Institute for Health and Clinical Excellence), and are usually successful.

5. What type of anaesthetic will I have?

You will either have a general anaesthetic (be fully asleep) or a spinal anaesthetic (an epidural) which will completely numb the lower half of your body. In this case you will feel drowsy but remain awake. Your anaesthetist will discuss the options with you.

6. What extra operations may be carried out at the same time?

Surgery for a prolapsed womb can also include a repair for a bladder or bowel prolapse. Both are done by replacing the organs in their correct positions and then repairing the weak vaginal walls. The walls can be repaired using stitches, mesh or graft materials. Mesh includes man-made (plastic) materials, some of which dissolve over time and others which don't. Graft materials are made of natural fibres and eventually dissolve. Your gynaecologist will explain which of these materials he or she normally uses.

If you have stress urinary incontinence, your gynaecologist may recommend having a sling placed under the urethra via the vagina, or an operation to lift your bladder (colposuspension) which is carried out through your tummy.

Any such extra operations will be discussed and agreed with you beforehand.

7. Will everything in the operating theatre be as agreed?

No matter what has been planned, your operation might need to be altered when you are examined under anaesthetic. Sometimes it becomes clear that the prolapse is more severe than was first thought. It may then be necessary to perform a different or extra procedure.

8. What will I notice immediately after the operation?

Your gynaecologist may have placed a catheter in your bladder (from below or via your abdomen) to help you pass urine. You may find your vagina has been 'packed' with absorbent material to help reduce bleeding. This will be removed a day or two after the operation. You may be advised to use vaginal oestrogen cream or tablets for some time before and/or after surgery.

Even if the surgery is done through the vagina, it is still a major operation and you should be just as careful as after an abdominal or laparoscopic operation. You should not do any lifting or strenuous exercise for at least 3 months.

9. What might go wrong during the operation?

All operations carry a risk of complications such as bleeding, damage to other organs, or infection**.** Such events are rare and unlikely to happen.

If you lose a lot of blood, you may require a blood transfusion. Around 1 in 50 women who have a vaginal hysterectomy will need a blood transfusion, but it is less likely for other types of prolapse surgery.

If your blood vessels, bladder or bowel are damaged, they will need to be repaired immediately. This sometimes means having an abdominal operation (laparotomy) to correct the problem, prevent serious harm to your future health or save your life.

10. What problems might occur after the operation?

Some problems occur frequently but are **not usually serious**. Normally, they can be treated easily. They include:

- Difficulty passing urine
- Vaginal bleeding or discharge
- Infections in the vagina or abdomen.
- Urinary tract infection or passing urine more often than normal
- Pain in the abdomen, back or vagina.
- Minor mesh exposure

Some more serious problems can occur. They are less common and are treated as and when they arise. They include:

- Damage to blood vessels or excessive bleeding requiring a return to theatre or a blood transfusion
- Bleeding leading to severe internal bruising
- Damage to the bladder or urinary tract
- Damage to the bowel
- Blood clots in the legs or lungs
- Serious infections or pelvic abscess
- Serious mesh problems such as infection or extrusion into bladder or bowel

11. What may I expect in the long term?

Your surgery is designed to improve your prolapse symptoms. Sometimes, symptoms can come back at a lesser level which may be treated without the need for another operation. However, one in three women who has had prolapse surgery will need another prolapse operation at some time in the future: the average time is 12 years later. One in four women whose wombs have been removed will need a new repair to correct a prolapse of the top of the vagina (vault prolapse). Even if you keep your womb, you may still need a further repair in the future. Around 1 in 10 women may start leaking urine after surgery, although only a few will need another operation for it.

Long term effects include:

- Problems with the way your bladder works, such as leakage of urine, urgency, or being unable to pass urine
- Problems with the way your bowel works, such as leakage of stool, urgency or constipation
- Difficulty or pain with intercourse
- Buttock pain
- Menopausal symptoms
- The need to remove mesh or graft materials

In general terms, it is not possible to predict how much you personally will benefit from surgery or whether you will develop any new problems or need further treatment for them.

12. What other prolapse treatments are available?

Women with prolapse may also practise pelvic floor muscle exercises, use oestrogen cream, or use a ring or other type of plastic pessary. These treatments may also be used after prolapse surgery for women who still have symptoms.

Pictures of Pelvic Organ Prolapse

Figure 1. Diagram of side view showing the uterus collapsing down the vaginal canal

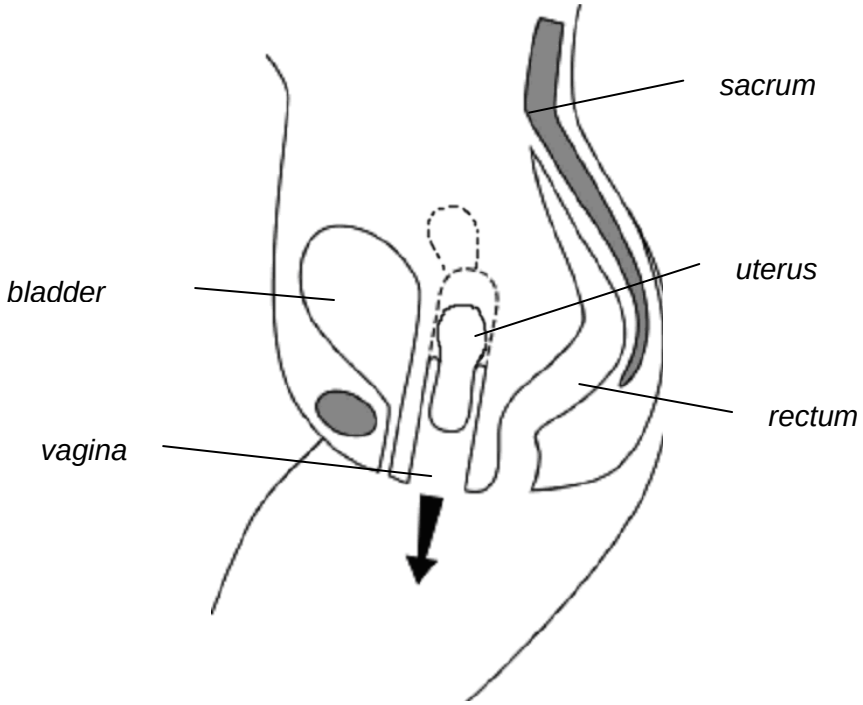

Figure 2. Diagram showing uterus (top of vagina) and posterior vaginal wall supported by mesh.