Brighton and Sussex University Hospitals NHS Trust

GP014 Management of Patients Admitted for Major Vaginal Surgery for Pelvic Organ Prolapse (POP)

Urogynaecology lead:	Ayman Fouad
Author:	Ayman Fouad, VuiVun Wong, Anirrudha Gayen
Protocol Title:	Management of Patients Admitted for Major Vaginal Surgery for Pelvic Organ Prolapse (POP)
Cross reference:	**GP015** Management of Patients Admitted for Vaginal Wall Repair Enhanced Recovery Programme (ERP) (***http://nww.bsuh.nhs.uk/clinical/teams-and-departments/enhanced-recovery-programme-erp/gynaecology-pathway/***) RCOG guideline 46 NICE guideline IPG 267
Protocol Number:	GP014
Version number:	1.0
Approving Committee:	Womens' Safety & Quality Committee
Date agreed:	31st October 2014
Review Date:	31st October 2017

GP014 Management of Patients Admitted for Major Vaginal Surgery for Pelvic Organ Prolapse (POP)

Consultation committee:	Protocol and Guideline Group
Date:	21st October 2014
Ratification committee:	Womens' Safety & Quality Committee
Date:	31st October 2014

KEY PRINCIPLES

A protocol is a set of measurable, objective standards to determine a course of action. Professional judgement may be used in the application of a protocol.

SCOPE

This guideline applies to: All women attending for major vaginal surgery for pelvic organ prolapse (POP).

RESPONSIBILITES

Nursing staff & Gynaecologists

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this protocol

Management:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations
- To ensure the protocol is accessible to all relevant staff
- To ensure the protocol is available to service users on request

OBJECTIVE STANDARDS

1.0 PELVIC ORGAN PROLAPSE

1.0.1 Vaginal wall prolapse or pelvic organ prolapse (POP) is the herniation of the bladder, rectum or uterus due to a failure of ligamentous & fascial support of these organs.

1.0.2 It is a common problem. In the women's health initiative (WHI) trial in the USA 40% of the participants had some degree of prolapse, 14 % of them had uterine prolapse. In UK, it accounts for 20% of women waiting for gynaecology surgery.

1.0.3 Major vaginal surgery for POP includes vaginal hysterectomy (VH) +/- anterior or posterior vaginal wall repair or both. It also includes surgical treatment for vault prolapse in the form of vaginal sacrospinous fixation (VSSF) or vaginal mesh.

1.0.4 This guideline should be read in conjunction with other guidelines relating to the management of patients admitted for operative procedures, such as thromboprophylaxis and consent guidelines.

1.0.5 RCOG Vaginal vault prolapse Green top guidelines No. 46. ***http://www.rcog.org.uk/womens-health/clinical-guidance/management-post-hysterectomy-vaginal-vault-prolapse-green-top-46***

1.1.6 NICE guidelines on surgical repair of vaginal prolapse using mesh IPG267. ***http://www.nice.org.uk/guidance/IPG267***

1.1 PRE-OPERATIVE MANAGEMENT

1.1.1 Not all cases admitted for major vaginal surgery (VH, VSSF, vaginal mesh) will require rectal enema or perineal shaving.

1.1.2 These patients need to be fasted for 6 hours before the operation.

1.1.3 The patient will have the routine observations, routine checks and the routine enhanced recovery programme (ERP).

1.1.4 Enhanced Recovery Programme. http://nww.bsuh.nhs.uk/the-trust/safety-and-quality/safety/initiatives/enhanced-recovery-programme/

1.1.5 The patient will be seen by the consultant gynaecologist and anaesthetist for preoperative counselling and consenting.

1.2 POST-OPERATIVE BLADDER CARE

1.2.1 Some of the major vaginal surgery (VH, VSSF or vaginal mesh) will have Foley's catheter and vaginal pack inserted unless it is stated clearly in the post-operative care plan.

1.2.2 The vaginal pack and Foley's catheter are to be removed the early morning after the operation according to the ERP, unless otherwise is stated clearly in the post-operative care plan.

1.2.3 Ensure that the patient passes urine 6 hours after catheter removal of the catheter. If the patient is comfortable but is not able to pass urine then give her another 2 hours and try again.

1.2.4 If this is not successful then insert a Foley's catheter with a flip flow valve and leave it in for 48 hours then try without a catheter (TWC).

1.2.5 If the patient is still unable to pass urine she could go home with the catheter in and should be reassured that this is a rare complication and is self-limiting in most cases and TCI to try without catheter (TWC) a week later.

1.2.6 No need for bladder scan, especially if the patient passes more than 200- 250mls of urine.

1.2.7 If there is still voiding difficulty after a week, then leave the catheter with valve for another week or teach the patient intermittent clean self-catheterisation (ICSC) under the care community continence nurses or urology nurse specialist at BSUH and review the nurse weekly until the problem resolves.

1.2.8 Please keep the surgeon informed.

1.3 POST-OPERATIVE PRESCRIPTION AND FOLLOW-UP

1.3.1 The patient can have sips of fluid once she is fully conscious and has been assessed by the nursing staff.

1.3.2 Ensure that the patient gets adequate thromboprophylaxis (usually below knee elastic stocking and Tinzaparin according to the local protocol) and adequate analgesia

1.3.3 Routine post-operative observations.

1.3.4 The intravenous fluids and patient controlled analgesia pump may be removed the following day once the patient has been reviewed in the

ward round, unless otherwise been decided in the consultant ward round.

1.3.5 Regular oral analgesia

1.351 Ibuprofen mgs PO tds
1.352 Paracetamol 1 gm PO tds
1.353 PRN morphine

1.3.6 Laxatives: Lactulose 10mls bd for 3 weeks

1.3.7 The patient should be ready to go home day 2 post operatively, unless otherwise stated clearly in the post-operative care plan.

1.3.8 Follow up in GOPD in 3 months

1.3.9 Leaflet for pelvic floor exercise.

2.0 MONITORING COMPLIANCE

Please refer to the ***Monitoring and Auditing*** document for details on monitoring compliance for this protocol.

3.0 REFERENCES

1- RCOG guidelines, October 2007,The Management of Post Hysterectomy Vaginal Vault Prolapse

2- Carey M (2001) Iliococcygeaus or sacrospinous fixation for vault prolapse: perispinous Vs. sacrospinous. Obstetrics and Gynaecology, 98: 40-44.

3- Cardozo L (1995), management of genital prolapse, Dewhurst text book of Obstetrics & gynaecology for postgraduates. Oxford: Blackwell Science, 642-652

4- Geoff R Mc Cracken and Guylaine Lefebvre (2007), Review Mesh- free anterior vaginal wall repair: history or best practice? The obstetrician & Gynaecologist, 9, 233- 242

5- Hendrix SL (2002), pelvic Organ Prolapse in the women's health Initiative, Am J Obstet Gynecol; 186:1160-6.

6- Marchioni E (1999), True incidence of Vaginal vault prolapse, Journal of reproductive medicine, 44:679-684.

7- Olugbenga A, Adekanmi and Robert M Freeman (2008), Diagnosis and management of genitourinary prolapse, Trend in Urology Gynaecology & Sexual Health, March/April, p16-22.

8- NICE Guidelines, IPG 267, June 2008, Surgical repair of vaginal wall prolapse using mesh