Brighton and Sussex University Hospitals NHS Trust

GP015 Management of Patients Admitted for Vaginal Wall Repair

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Protocol Title:	GP015 Management of Patients Admitted for Vaginal Wall Repair
Cross reference:	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:	GP015
Version number:	1.0
Approving Committee:	Womens' Safety & Quality Committee
Date agreed:	31st October 2014
Review Date:	31st October 2017

GP015 Management of Patients Admitted for Vaginal Wall Repair

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 vaginal wall repair.

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 VAGINAL WALL 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 USA 40 % of the participants had some degree of prolapse, 14 % of them had uterine prolapse.

1.0.3 In UK, it accounts for 20% of women waiting for gynaecology surgery.

1.0.4 Vaginal wall repairs can be done for the anterior and/ or posterior vaginal wall. It is also known as Pelvic Floor Repair. It involves fascial support of the prolapsed organ (Perivesical or pub cervical fascia in case of prolapsed urinary bladder or perirectal fascia in case of prolapsed rectum).

1.0.5 The surgical repair can be done under general anaesthesia (GA), spinal anaesthesia or local anaesthetic infiltration (LA) either with or without sedation.

1.0.6 The patient can go home on the same day of the procedure unless there is a medical or social reason to keep her in over night, which should be identified before the procedure in the urogynaecology clinic, during the booking process.

1.0.7 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.

1.0.8 These guidelines are applicable to patients who are admitted to gynaecology ward or those who are fulfilling the criteria for day surgery unit (DSU) admission.

1.0.9 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***

1.0.10 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 vaginal wall repair require rectal enema or perineal shaving.

1.1.2 All cases admitted for vaginal wall repair need to be fasted for six hours.

1.1.3 The patient will have the routine observation, routine checks and the routine enhanced recovery programme (ERP) whether she is on gynaecology ward or on the day surgery unit.

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 for preoperative counselling and consenting

1.1.6 **Cases admitted for repair under Local Anaesthesia**

- Ibuprofen 400mg PO

- If Ibuprofen is contraindicated then, Cocodamol 30/500 two tablets PO

- To facilitate the administration of the medications on time, the prescriptions should be written in clinic.

- If no prescriptions available at the time of admission then the consultant or one of his team will prescribe it during the preoperative ward round, otherwise the SHO on-call for Gynaecology is to be called no later than 8:00am to prescribe it.

1.2 POST-OPERATIVE BLADDER CARE

1.2.1 Insertion of a catheter should be at the discretion of the surgeon.

1.2.2 That applies regardless of the type of anaesthesia, unless it is stated clearly in the post operative care plan.

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

1.2.4 If the patient does not pass urine but feels an urge to do so, then a Foley's catheter is to be inserted with flip flow valve.

1.2.5 Record the amount of urine drained and allow home on the same day unless there is another indication to keep her over night.

1.2.6 The patient who goes home on the same day with a catheter in, should be reassured that this is a rare complication and is self limiting in most of the cases.

1.2.7 These patients should be seen either on gynaecology ward or at VLH according to the patient's preference, to try passing urine without a catheter (TWC) 48 hours later.

1.2.8 If the voiding difficulty continues after 48 hours, then the catheter with valve should be left in for another week. Alternatively, the patient could be taught 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.

1.2.9 Please keep the surgeon informed.

1.3 POST-OPERATIVE PRESCRIPTION AND FOLLOW-UP

1.3.1 Patients who had the repair under LA infiltration or spinal can eat & drink once they are on gynaecology ward or the DSU recovery.

1.3.2 Patients who had repair under GA can eat & drink once they are fully conscious and after assessment by the nursing staff.

1.3.3 It is acceptable for the patients to have a mild blood loss following the repair (similar to what would be expected at the end of a period) especially if vaginal pack was not used. The patient would have been informed about this loss preoperatively and should be reassured.

1.3.4 The patient can go home once she passes urine and feels well enough to go home.

1.3.5 Regular analgesia for 48 hours then PRN for 5 days:
Ibuprofen 400mg PO tds
And
Paracetamol 1 gm tds

1.3.6 Lactulose 10mls bd for 3 weeks

1.3.7 Follow up in GOPD in 3 months

1.3.8 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. Annette Kuhn, Wolf Gellman, Suzanne O'sullivan, Ash Monga, (2006) "The feasibility, efficacy and functional outcome of local anaesthetic repair of anterior and posterior vaginal wall prolapse", European Journal of Obstetrics & Gynaecology and Reproductive Biology124, 88-92.

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3. John R Miklos and Mickey M Karram (1995), "vaginal Correction of Pelvic Organ Relaxation Using Local Anaesthesia", Obstetric & Gynaecology, 1995, 922- 924.

4. Hendrix et al. (2002), "pelvic organ prolapse inn the women's health intiative: gravity & gravidity", Am J Obstet Gynecol 2002; 186:1160-6

5. Olugbenga A, Adekanmi and Robert M Freeman (2008), "Diagnosis and management Of genitourinary prolapse", Trend in Urology Gynaecology & Sexual Health, March/April 2008, pp16-22.