- It is best not to drive for at least three to four weeks as it might be difficult to perform an emergency stop. It is best to check with your insurance company.

When can I return to work?

This depends on your job. Most women return to work after four to six weeks. If however your job is strenuous and involves heavy lifting, it may take longer.

Further information

If you have further questions or concerns about your operation, please contact:
Gynaecology Outpatients Department
The Royal London Hospital
Tel: 0203 594 1585

Patient Advice and Liaison Service

If you need general information or advice about Trust services, please contact the Patient Advice and Liaison Service (PALS) on 020 3594 2040 or visit www.bartshealth.nhs.uk/pals**.** Alternatively please contact staff who are providing your care if you require clinical advice.

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For this leaflet in large print, please speak to your clinical team.

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Patient information

Utero-vaginal prolapse and vaginal hysterectomy

Introduction

A utero-vaginal prolapse is when the womb or uterus is protruding into the vagina, and sometimes outside the vagina, causing discomfort and various urinary and bowel symptoms. It is often accompanied with descent of the front wall of the vagina, called a cystocele (movement of the position of the bladder), and/or the back wall of the vagina, called a rectocele.

What treatment options do I have?

Depending on your symptoms and the clinical findings, several treatment options are available:

- Physiotherapy
- Ring or shelf vaginal support pessaries (made of different types of plastic)
- Surgery

At what stage am I eligible for surgery?

Surgery is an option if your symptoms have not improved with physiotherapy and/or with a pessary. Surgery is best for women who no longer wish to have more children, as further pregnancies may increase the risk of prolapse returning.

Do I need to have any special tests prior to the surgery?

You may need investigations on your bladder particularly if you have bladder problems such as leakage of urine. It is important that we do this before we correct any prolapse as sometimes the bladder can be affected.

Will the operation relieve all my symptoms?

The operation will help to relieve the discomfort felt when walking and sitting with a prolapse. It may also improve your urinary and bowel symptoms.

What happen after the surgery?

- You will probably stay in hospital for about two – five days.
- The day after the operation the doctors will come to see and if all is well, you may start drinking water and gradually progress to a light diet later in the day.
- It is important that you try and eat vegetables and fruit to avoid constipation. Sometimes, you may be given a liquid medicine to help prevent this and to avoid straining.
- Vaginal packs, if present, are usually removed within the first 24 hours.
- Urethral catheters are usually removed within two to five days and suprapubic catheters are usually removed within five to ten days.
- Stiches will be internal and dissolvable so do not need to be removed
- We will encourage you to start walking around as soon as possible to minimise the risk of deep vein thrombosis.
- Before you are discharged the nurse will give a general advice regarding how to care for yourself at home. You will be given an outpatient appointment for six to eight weeks.

Recovery when you are discharged

- It is advisable for someone to look after you for at least to two weeks. If you have no-one at home please discuss the situation with us before the operation. Ensure that family and friends understand that you will only be able to resume your normal activities over time.
- It is important to keep the vaginal area clean. Frequent warm baths will also help ease the discomfort.
- **Avoid heavy lifting**, including heavy housework and carrying children for at least two to three months
- We usually recommend that you do not resume sexual intercourse for six weeks.

After about an hour and/or you are fully awake, the recovery staff will move you back to the ward. A nurse will record your temperature, pulse and blood pressure as we as checking your sanitary towel to monitor bleeding (observations will be repeated frequently in the first few hours). You may also have the following.

- A gauze vaginal pack (like a tampon) will help to stop any bleeding. This is usually in place for 24 hours along with a sanitary towel.
- A catheter in the bladder which helps drain urine directly into the bag by your bedside. The catheter may be placed through the abdomen or through the urethra (the tube connecting the bladder to the outside)
- An intravenous infusion or 'drip' to prevent you from becoming dehydrated whilst you are unable to eat or drink (fluid is inserted into the arm through a tube connected to a bag by your bed). The drip will be kept in place until you are drinking well to avoid dehydration and you can use mouthwashes.
- Painkillers may be administered through a tube by pressing a button (you will have been shown how to use this prior to admission)

What pain relief will I be given?

- A self-operated pain control pump (PCA- patient controlled analgesia) may be used to relieve pain with the hand set within easy reach for your use.
- If you do not have a PCA, your nurse will give you an injection for pain relief until you are well enough to drink and have painkillers.
- If your feel sick, an injection will be given to help stop the nausea.

What type of surgery will I be offered?

There are various options available depending on the type of prolapse and these can be done alone or together. Options include:

- Vaginal hysterectomy- for prolapse of the uterus.
- Anterior repair- for prolapse of the anterior vaginal wall
- Posterior repair- for prolapse of the posterior vaginal wall
- Sacro-hysteropexy

Your doctor will discuss which procedure will be the most appropriate for you. Sometimes it is better to repair the prolapse in stages. In this case we would recommend a reassessment and a second procedure will be booked at a later date once the firs operation has healed.

What does a vaginal hysterectomy involve?

This involves removing the uterus through the vagina. A small cut is made around the vagina and the uterus is brought down through this in stages. We will your varies in place. The top of the vagina is then closed off with stiches that dissolve by themselves.

If your uterus is bigger than average or you need your ovaries taken out, we may use keyhole surgery (laparoscopy) at the same time to remove your ovaries and/or start the hysterectomy. This involves inserting a small telescope with a camera and additional small instrument into the abdomen through small cuts.

What does the anterior repair involves?

This involves making a cut in the middle of the anterior (front) vaginal wall. The bladder is pushed back to the normal position and held in place with a number of stiches. The excess vaginal skin is trimmed and then sewn together.

What does a posterior repair involves?

This involves making a cut in the middle of the back of the vagina. The bowel is then pushed back to the normal position and the muscles over it brought together with stiches. The excess vaginal skin is then trimmed and the healthy tissue sewn together.

In some cases when the prolapse has recurred after previous surgery, your doctor may use a mesh (tissue graft) to place over the bladder or the rectum to give additional support before the vagina is sewn back together.

What is a sacro-hysteropexy?

A sacro-hysteropexy is performed when there has been prolapse of the uterus in women who do not want a hysterectomy. The standard method is through keyhole surgery, though occasionally an abdominal incision may be made.

A strong mesh is attached to the utero-sacral ligaments (ligaments holding the uterus in place), the back of the vagina and cervix and the lower body of the uterus. It is pulled gently and attached to the ligaments in front of the sacrum (your lower spine area). This mimics the original attachments of the womb to the lower back. It therefore provides strong support for the uterus.

What type of anaesthesia will be used?

You will see the anaesthetic doctor before your operation to discuss this. These operations are usually done under general anaesthetic where you will be put to sleep. If you have medical problems we may decide to give you an epidural/spinal(an injection in the back to numb the pelvic area) where you will be awake but pain free through the operation.

What are the risks of the operations?

These are all simple procedures and usually patients recover very well. However there are a few specific complications:

- **Vaginal bleeding** – you may notice some vaginal bleeding after the operation but this should stop before you are discharged. Only use sanitary towels for this and not tampons. If the bleeding becomes heavy or smells offensive please let your GP know.
- **Bowel and bladder/ureter injury** – very occasionally the bowel or the bladder/ureters can be damaged during the operation especially if you have previous operations. This will be repaired at the time. If the bladder is injured you may be asked to wear a catheter (soft tube used to get rid of urine) for up to two weeks.
- **Difficulty emptying your bladder after surgery**- a small number of women may have difficulty emptying their bladders and may need a catheter inserted for longer or even reinserted. In some cases we may teach you how to catheterise yourself..
- **Incontinence** – a small number of women may also develop a new leakage of urine after the operation. If this occurs then we will need to do some bladder tests to decide the most suitable treatment.
- **Mesh complications** – if a mesh has been used there is a small risk that it can become infected and erode (or come through) the vagina. This may result in excessive bleeding and discharge. This part of the mesh would then need to be removed.
- **Wound infection** – can occur and antibiotics treatment may be needed.
- **Thromboembolism**- a small risk of developing a clot in your lungs or legs.

Recovery from surgery

The operation usually takes one to two hours. You will wake up in the recovery room with a light mask over your face allowing you to breathe oxygen and dispel the anaesthetic more quickly.