

Surgery for uterine prolapse

Patient decision aid





What is uterine prolapse?

Uterine prolapse happens when the uterus (womb) slips from its normal position and bulges or hangs down into the vagina. This can cause discomfort and problems with urination.

There are some treatment options that don't involve surgery that NICE says you might like to try. These are:

- **Lifestyle changes**, including losing weight if you are overweight, minimising heavy lifting and preventing or treating constipation.
- **Pelvic floor muscle training**, usually given by a physiotherapist.
- **Vaginal oestrogens**, if you have menopausal symptoms such as vaginal dryness.
- **A vaginal pessary**. This is a device made of PVC or silicone inserted into the vagina and left in place to support the vaginal walls and pelvic organs.

If you have tried to manage your condition without surgery but this hasn't worked, or you don't want to try other treatments, you might like to think about surgery. This decision aid can help you and your surgeon decide together which type of surgery is best for you. **You might also decide that you don't want to have any surgery.**

It is important to make the choice that you feel is right for you. This will depend on your individual circumstances and how you feel about each type of surgery.

Every woman is different so this decision aid is only a guide.

Information about how this decision aid was produced and the evidence on which it is based is available on the NICE website.



What types of surgery does NICE recommend?

NICE recommends four types of surgery as **options** for uterine prolapse. They have technical names but there isn't a short name for any of them. They are:

- Vaginal hysterectomy, with or without sacrospinous fixation with sutures. **Note: this option involves removing your uterus (womb).**
- Vaginal sacrospinous hysteropexy with sutures.
- Manchester repair (also called the Fothergill operation).
- Sacro-hysteropexy with mesh.

The rest of this decision aid talks about each type of treatment: what it involves, the risks and benefits, and how they compare to each other.

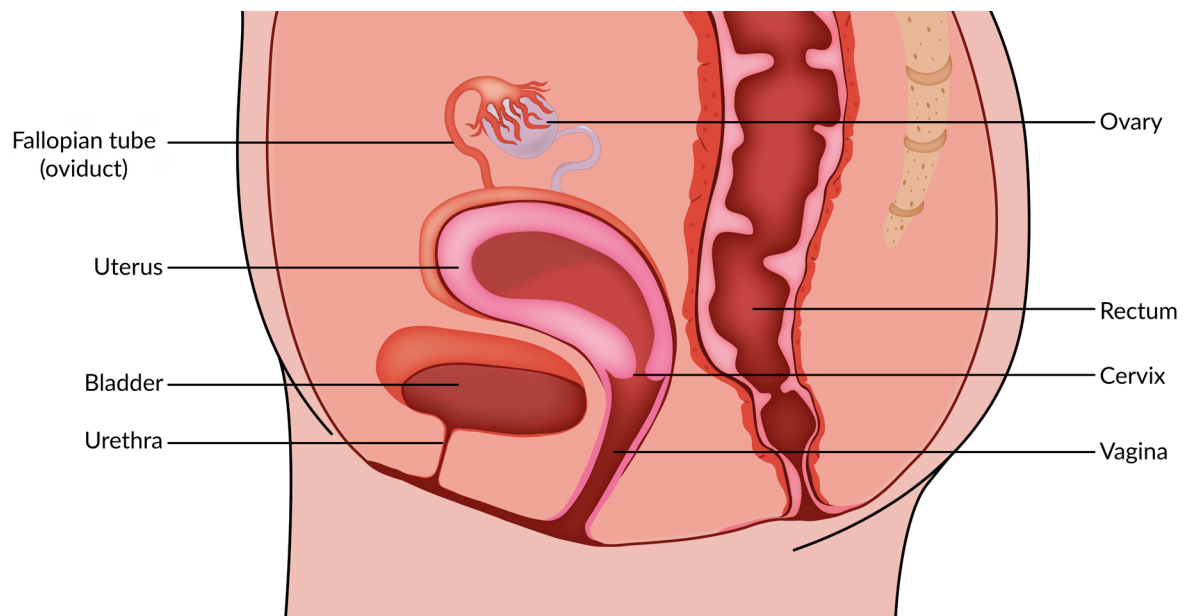
To help you understand the explanations, the normal arrangement of organs in a woman's pelvis is shown in the diagram below.

If the type of surgery you would prefer is not available in your local hospital, you can be referred to a different hospital.

(Note that Manchester repair is not widely available in the UK.)

There is another operation called a **colpocleisis**, which involves closing the vagina completely and permanently. If you have this you would no longer be able to have vaginal sex. It is not included in this decision aid, but your surgeon can discuss this option with you if you wish.

Normal arrangement of organs in a woman's pelvis





Which type of surgery works best, and which has the most complications?

There's limited evidence to answer these questions. These operations can help some women with uterine prolapse, but not everyone. The choice of surgery will also be affected by whether you have had your menopause or not, any previous surgery you may have had, and the type and extent of your prolapse. These might not become clear until after the operation has started.

Some women develop problems, known as complications, after they've had surgery. Some complications only develop several years later, and it's not known for certain what all of them might be. If they do develop they might not trouble you very much, or they could harm your quality of life a great deal. It is not always possible to treat complications successfully.

How do the options compare?

NICE looked at the best studies available that compared the types of surgery when it published its guideline and found that:

- It isn't possible to say for sure that one type of surgery NICE recommends as an option is better than any of the others for treating uterine prolapse, especially in the longer term. Prolapse seems to be more likely to come back after vaginal hysterectomy than after vaginal sacrospinous hysteropexy with sutures, but the evidence is very limited. The chance of prolapse coming back after either of the other two operations wasn't recorded.
- It's also not possible to say for sure whether most kinds of long-term complications are more likely happen with one type of operation than either of the others, **except** for possible complications after mesh surgery. **There is more information about possible complications from mesh surgery on page 12 of this decision aid.**

It is not possible to know for sure what will happen to any individual woman

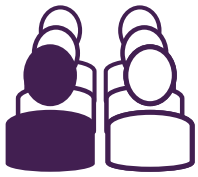


More information about the types of surgery

The tables on the following pages have information about the different types of operation. They cover the things most women may want to know about and that NICE has found evidence about. On page 15 you can write down how you feel about them.

There may also be other things that are important to you.

Talk to your surgeon about all your concerns so that you can make an informed choice.

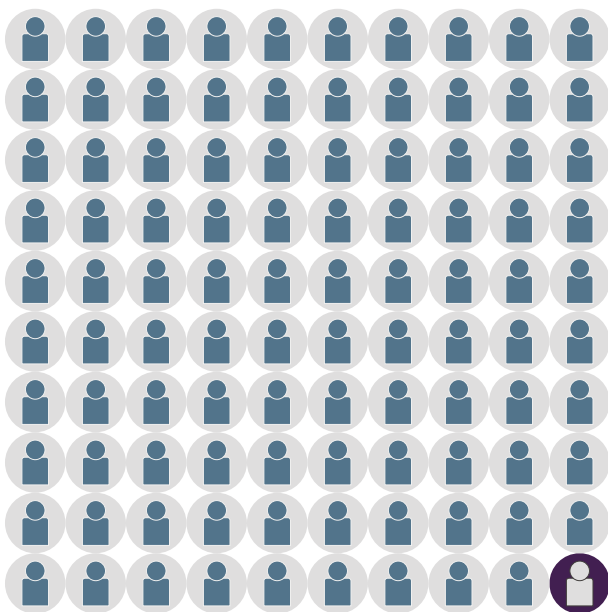


Your chance of getting complications

Sometimes it isn't possible to give very precise figures for the chances of different complications happening, so this decision aid gives a general idea. For example, "1 to 10 women in 100 get this complication (which means 90 to 99 don't)".

Some people find the type of diagram below makes it easier to picture the chances of something happening to them. People who have **experienced an effect** are shown in **purple**.

1 in 100



10 in 100 (or 1 in 10)



It is not possible to know in advance what will happen to any individual woman

	Vaginal hysterectomy	Vaginal sacrospinous hysteropexy with sutures	Manchester repair	Sacro-hysteropexy with mesh
<p>What happens in this type of surgery?</p> <p>The diagram on page 2 may be helpful to understand these descriptions.</p>	<p>This involves removing the uterus (womb).</p> <p>If necessary, the top of the vagina can then be attached to a ligament in the pelvis using synthetic stitches (sutures) to support it in its natural position.</p> <p>Surgeons may use stitches that eventually dissolve or stitches that remain in the body permanently.</p> <p>If you choose this option and you haven't already had your menopause:</p> <ul style="list-style-type: none"> ● you will no longer be able to get pregnant ● you will no longer have periods. 	<p>The pelvic organs are supported in their natural position by attaching cervix (the neck between the vagina and the uterus) to a ligament in the pelvis using synthetic stitches (sutures).</p> <p>Surgeons may use stitches that eventually dissolve or stitches that remain in the body permanently.</p>	<p>The uterus (womb) is supported in its natural position by shortening the cervix (the neck between the vagina and the uterus) using synthetic stitches (sutures).</p> <p>The stitches that are used eventually dissolve but the cervix remains shortened.</p>	<p>The pelvic organs are supported in their natural position by attaching a piece of mesh from the uterus (womb) to a bone at the base of the spine.</p> <p>Synthetic mesh is a plastic product that looks like a net.</p> <p>The mesh stays in the body permanently.</p>

	Vaginal hysterectomy	Vaginal sacrospinous hysteropexy with sutures	Manchester repair	Sacro-hysteropexy with mesh
What does the operation involve?	<p>An incision (cut) is made inside the vagina – there are no cuts in the abdomen.</p> <p>It can be done under:</p> <ul style="list-style-type: none"> • general anaesthetic – you’ll be asleep for the whole operation • spinal anaesthetic – you’ll be awake but numb from the waist down and won’t feel pain. <p>You will usually need to stay in hospital for 1 or 2 days after the operation.</p>	<p>An incision (cut) is made inside the vagina – there are no cuts in the abdomen.</p> <p>It can be done under:</p> <ul style="list-style-type: none"> • general anaesthetic – you’ll be asleep for the whole operation • spinal anaesthetic – you’ll be awake but numb from the waist down and won’t feel pain. <p>Most women can go home the day after their operation.</p>	<p>An incision (cut) is made inside the vagina – there are no cuts in the abdomen.</p> <p>It can be done under:</p> <ul style="list-style-type: none"> • general anaesthetic – you’ll be asleep for the whole operation • spinal anaesthetic – you’ll be awake but numb from the waist down and won’t feel pain. <p>Most women can go home the day after their operation.</p>	<p>This can be done in two different ways:</p> <ul style="list-style-type: none"> • keyhole (laparoscopic) surgery – the operation is carried out through small incisions (cuts) in your lower abdomen • open surgery – a larger incision is made in your lower abdomen. <p>It is done using general anaesthetic – you’ll be asleep for the whole operation.</p> <p>You will usually need to stay in hospital for 1 or 2 days after keyhole surgery or 2 to 3 days after open surgery.</p>

	Vaginal hysterectomy	Vaginal sacrospinous hysteropexy with sutures	Manchester repair	Sacro-hysteropexy with mesh
<p>How do these types of surgery compare for treating uterine prolapse?</p> <p>The diagrams on page 16 may help make sense of the numbers.</p>	<p>In the studies NICE looked at, on average 1 year after vaginal hysterectomy about 65 women in 100 said they no longer had symptoms, and 35 still had symptoms.</p> <p>The evidence is very limited, and it's not possible to say for sure whether vaginal hysterectomy or vaginal sacrospinous hysteropexy with sutures is better at treating uterine prolapse.</p> <p>NICE didn't find any studies that compared vaginal hysterectomy with Manchester repair or sacro-hysteropexy with mesh.</p>	<p>In the studies NICE looked at, on average 1 year after vaginal sacrospinous hysteropexy with sutures about 55 women in 100 said they no longer had symptoms, and 45 still had symptoms.</p> <p>The evidence is very limited, and it's not possible to say for sure whether vaginal hysterectomy or vaginal sacrospinous hysteropexy with sutures is better at treating uterine prolapse.</p> <p>NICE didn't find any studies that compared compared vaginal sacrospinous hysteropexy and Manchester repair or sacro-hysteropexy with mesh.</p>	<p>NICE didn't find any studies that looked at how well Manchester repair works at treating uterine prolapse compared with the other three operations.</p> <p>The evidence is very limited, and it's not possible to say how Manchester repair compares with the other types of surgery for treating uterine prolapse.</p>	<p>NICE didn't find any studies that looked at how well sacro-hysteropexy with mesh works at treating uterine prolapse compared with the other three operations.</p> <p>The evidence is very limited, and it's not possible to say how sacro-hysteropexy with mesh compares with the other types of surgery for treating uterine prolapse.</p>

	Vaginal hysterectomy	Vaginal sacrospinous hysteropexy with sutures	Manchester repair	Sacro-hysteropexy with mesh
<p>How do these types of surgery compare for the chance of prolapse coming back?</p> <p>The diagrams on page 4 may help make sense of the numbers.</p>	<p>In the studies NICE looked at, 1 to 10 women in 100 who had vaginal hysterectomy found that their prolapse came back within 1 year of surgery (so it didn't come back in 90 to 99 women).</p> <p>Prolapse seems more likely to come back after vaginal hysterectomy than after vaginal sacrospinous hysteropexy with sutures, but the evidence is very limited.</p>	<p>In the studies NICE looked at, 1 to 10 women in 100 who had vaginal sacrospinous hysteropexy with sutures found that their prolapse came back within 1 year of surgery (so it didn't come back in 90 to 99 women).</p> <p>Prolapse seems less likely to come back after vaginal sacrospinous hysteropexy with sutures than after vaginal hysterectomy, but the evidence is very limited.</p>	<p>NICE didn't find any studies that looked at how likely prolapse is to come back after Manchester repair compared with the other types of surgery.</p>	<p>NICE didn't find any studies that looked at how likely prolapse is to come back after sacro-hysteropexy with mesh compared with the other types of surgery.</p> <p>NICE's expert advisers have said that, if you have a larger uterus, sacro-hysteropexy with mesh may hold it in place more securely than vaginal sacrospinous hysteropexy with sutures.</p>

For all four types of surgery

What are the possible problems during the operation?

The diagrams on page 4 may help make sense of the numbers.

- **Needing a blood transfusion.** In the studies NICE looked at, 1 to 10 women in 100 needed a blood transfusion after vaginal hysterectomy or sacro-hysteropexy with mesh (so 90 to 99 women did not). The number of women who needed blood transfusions after the other kinds of surgery wasn't recorded in the studies NICE looked at.
- **Bowel injury.** In the study NICE looked at, 1 to 10 women in 100 who had sacro-hysteropexy with mesh had injury to their bowel (so 90 to 99 did not). This seems more likely to happen with this type of surgery than with vaginal hysterectomy. The number of women who had injury to their bowel after the other types of surgery wasn't recorded in the studies NICE looked at.

There are other possible problems that can happen during the operation, but the number of women who had these problems wasn't recorded in the studies NICE looked at. They include:

- **Damage to the bladder or urethra** (the urethra is the tube that carries urine out of your body).
- **Damage to nerves.** This could potentially lead to loss of sensation or persistent pain.

For all four types of surgery

What are the other possible complications?

(Continued on the next page.)

The diagrams on page 4 may help make sense of the numbers.

- **Mesh exposure (if you have sacro-hysteropexy with mesh).** See the next page of this decision aid.

There are other possible complications, but the number of women who had these problems wasn't recorded in the studies NICE looked at. They include:

- **Infections**, including vaginal infections and urinary tract infections.
- **Wound complications**, including wound infections and pain.
- **Persistent pain in the abdomen or pelvis.** Painkiller medicines can help, but not always. The pain might not trouble you very much, but it might be severe. Women who have sacrospinous hysteropexy with sutures may also get pain in their buttocks.
- **Pain or other problems having sex.** NICE thinks these problems may be less likely after sacro-hysteropexy with mesh than after sacrospinous hysteropexy with sutures. This is based on expert advice and studies of similar operations for women who had prolapse after an earlier hysterectomy, but the evidence is very limited.
- **Problems emptying the bladder fully.** If you get these problems you may need a catheter for a few days or weeks, or possibly longer.
- **Stress urinary incontinence.** This is leaking urine, especially during exercise or when you cough, laugh or sneeze. NICE thinks these problems may be less likely after sacro-hysteropexy with mesh than after sacrospinous hysteropexy with sutures. This is based on expert advice and studies of similar operations for women who had prolapse after an earlier hysterectomy, but the evidence is very limited.

For all four types of surgery

What are the other possible complications?

(Continued from the previous page.)

The diagrams on page 4 may help make sense of the numbers.

- **Having to get to the toilet quickly to urinate, or not getting to the toilet in time.** These problems can usually be treated with bladder retraining, physiotherapy or drug treatment, although these don't always work.
- **Pain or difficulty opening the bowels, not getting to the toilet in time, bleeding from the back passage (anus) or passing mucus.** NICE thinks that constipation is more likely after sacro-hysteropexy with mesh than after sacrospinous hysteropexy with sutures. This is based on expert advice and studies of similar operations for women who had prolapse after an earlier hysterectomy, but the evidence is very limited.



Possible complications after sacro-hysteropexy with mesh

There are particular complications that can sometimes happen after mesh surgery for uterine prolapse. Some but not all of these are similar to problems that can also happen after surgery that doesn't include mesh.

It is not possible to say in advance whether these complications will happen at all, or know how bad they will be if they do happen (although if they do happen, they might harm your quality of life a great deal). They can happen soon after surgery or many years later. **It is not always possible to treat mesh-related complications successfully.** Surgery might be needed to try to treat the complications, but it may not be possible to remove the mesh completely.

What complications can happen?

The mesh can sometimes come through into the vagina. This is called vaginal **mesh exposure** or **extrusion**. This can cause some or all of the following symptoms:

- **Pain**, in the vagina, groin, pelvis, abdomen or lower back.
- **Vaginal problems**, including vaginal discharge or bleeding and vaginal infections.
- **Problems having vaginal sex**. These might include painful sex for you and your partner.

The mesh can also come through into the bladder or bowel. This can cause some or all of the following symptoms:

- **Bladder problems**. These might include frequent urinary tract infections, blood in the urine, difficulty emptying the bladder, pain when passing urine, leaking urine or having to get to the toilet quickly.
- **Bowel problems**. These might include pain or difficulty opening the bowels, not getting to the toilet in time, bleeding from the back passage (anus) or passing mucus.

Some women who have had mesh surgery experience **pain** or **changes in sensation** in the back, abdomen, pelvis, leg, vagina, groin or the area between the front and back passages (the perineum). These problems can be severe and persistent, and can be difficult to treat, although there may not be an obvious cause such as mesh exposure.

Continued over the page...

How likely are these complications to happen?

The studies that NICE looked at didn't report how many women had mesh exposure after sacro-hysteropexy with mesh. But in studies of a similar operation for women who had prolapse after an earlier hysterectomy, 1 to 10 women in 100 had vaginal mesh exposure (so 90 to 99 women in 100 did not).

The diagrams on page 4 might help make sense of these numbers.

The evidence is very limited, and it's possible that more women than this might get mesh exposure or other mesh-related complications.



Other things to think about

If you might become pregnant

If you have a hysterectomy you will no longer be able to get pregnant. Women who may wish to get pregnant in the future are usually not recommended to have a Manchester repair.

The other types of surgery (vaginal sacrospinous hysteropexy with sutures or sacro-hysteropexy with mesh) won't affect your ability to get pregnant. **If it's possible that you might become pregnant, it's usually recommended that you don't have surgery until later.** This is because being pregnant and giving birth can cause prolapse to come back, even if you have had successful surgery for it. If you get pregnant after either of these types of surgery you will probably be advised to have a caesarean section.

Risks of surgery

There are some possible problems that come with any kind of surgery. These depend on your medical history, how long the operation lasts and what it involves. Your surgeon will discuss these with you, but in general these are:

- **Infection.** All surgery carries the risk of infection, although you will be given antibiotics to reduce this risk.
- **Blood clots.** Surgery can lead to blood clots forming in the veins of the legs (called deep vein thrombosis, or DVT), or in the lungs (called pulmonary embolus or PE) so to help stop this happening you will be given surgical stockings to wear during the operation and for a short time afterwards, and/or given medicines. On average, 1 person in 100 or fewer may get problems from blood clots, so more than 99 people in 100 or more will not. More rarely, if blood clots occur they can cause serious problems and may even be fatal.
- **Back pain.** You may be lying on your back with your legs raised during the operation. This might lead to back pain for a short while afterwards, especially if you already have back pain problems. Talk to your surgeon and anaesthetist if this is a concern for you.

There is also a risk of problems from the anaesthetic. These are unlikely to happen unless you have particular medical problems, for example problems with your heart or breathing. Your anaesthetist will discuss these risks with you separately.

How do you feel about the options?

Issue	How important is this to me?			
	Very important	Important	Not that important	Not at all important
How troublesome my symptoms are now				
How effective the surgery might be at improving my symptoms				
Keeping my uterus (womb)				
My plans for pregnancy in the future				
The length of time I would have to spend in hospital				
Risks from any kind of surgery				
The possibility of problems from having mesh inserted				
The possibility of damage to other organs				
The possibility of constipation or other bowel problems				
The possibility of leaking urine, problems emptying my bladder properly or other problems urinating				
The possibility of pain or other problems having sex				
The possibility of pain in the pelvis or buttocks				

Other things I want to talk about:

My current choice is (please circle your choice)

Vaginal hysterectomy • Vaginal sacrospinous hysteropexy with sutures
 Manchester repair • Sacro-hysteropexy with mesh • No surgery • Not sure

This is because:

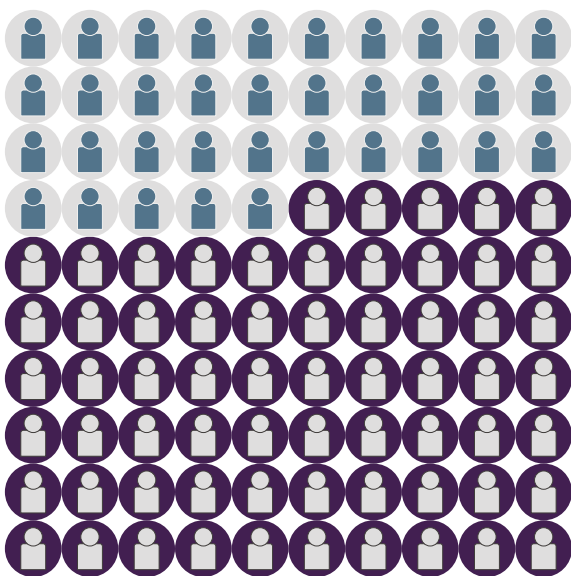
I realise I can change my mind.

Improvement in uterine prolapse symptoms 1 year after surgery



NICE looked at studies that compared the different types of surgery. These diagrams show how many women who took part in the studies that compared vaginal hysterectomy and vaginal sacrospinous hysteropexy with sutures found that their prolapse symptoms had improved around a year after their surgery. **The evidence is very limited and it's not possible to say for sure whether one of these types of operation is better than the other at treating uterine prolapse.**

NICE didn't find any studies that compared how well the other types of surgery worked.

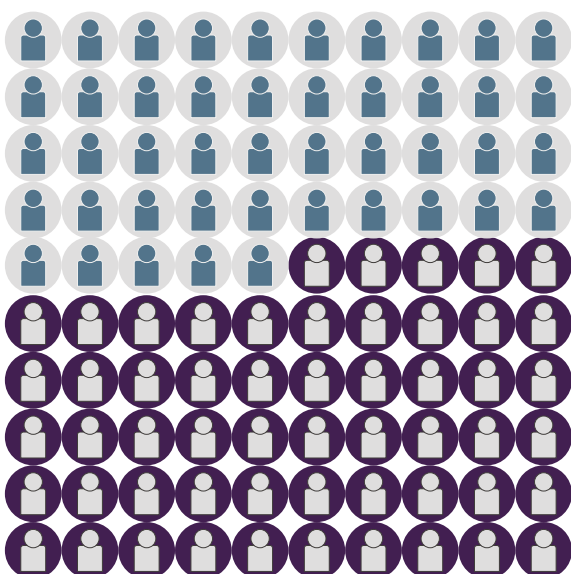
Vaginal hysterectomy





In every 100 women who had vaginal hysterectomy, about 1 year after surgery **on average**:

-  65 women said they had **no symptoms**
-  35 women still had **some symptoms**

Vaginal sacrospinous hysteropexy with sutures



In every 100 women who had a vaginal sacrospinous hysteropexy with sutures, about 1 year after surgery **on average**:

-  55 women said they had **no symptoms**
-  45 women still had **some symptoms**

It is not possible to know in advance what will happen to any individual woman