Posterior vaginal wall and perineal body repair (without the use of mesh)

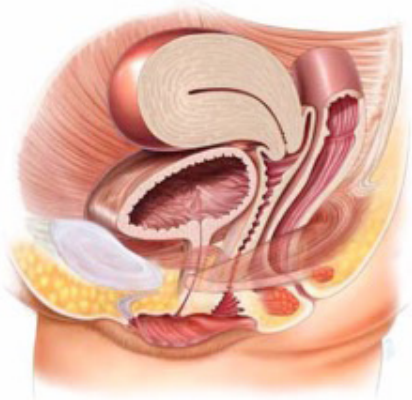
Gynaecology

Introduction

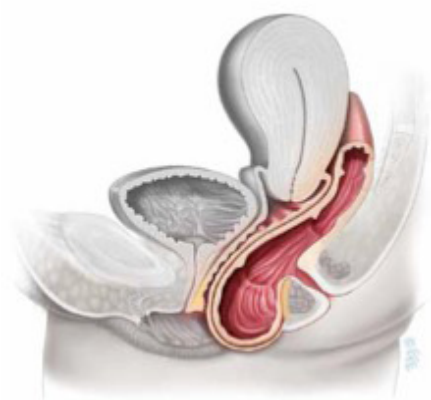
This leaflet has been designed to provide information for ladies who are considering having a posterior vaginal and/or perineal body repair operation to treat their prolapse and the likely plan of care after the operation. It will also include the benefits, risks and alternatives of the procedure. Please feel free to ask a member of the team if there is anything you do not understand.

What is a posterior vaginal wall prolapse?

About 1 in 10 women who have had children require surgery for vaginal prolapse. A prolapse of the back (posterior) wall of the vagina is usually due to a weakness in the strong tissue layer (fascia) that divides the vagina from the lower part of the bowel (rectum). This weakness may cause difficulty when passing a bowel motion, a feeling of fullness or dragging in the vagina or an uncomfortable bulge that extends beyond the vaginal opening. Other names for the weakness of the back wall of the vagina include rectocele and enterocele. The perineal body (the supporting tissue between vaginal and anal openings) also helps to support the back wall of the vagina. The perineum is the area that is often damaged when tears or episiotomies occur during childbirth. This area may need to be repaired along with the back wall of the vagina to give perineal support and, in some cases, narrow the vaginal opening.



Normal anatomy



Posterior vaginal wall prolapse

The prevention of infection is a major priority in all healthcare and everyone has a part to play.

- **Please decontaminate your hands frequently for 20 seconds using soap and water or alcohol gel if available**
- **If you have symptoms of diarrhoea and/or vomiting, cough or other respiratory symptoms, a temperature or any loss of taste or smell please do not visit the hospital or any other care facility and seek advice from 111**
- **Keep the environment clean and tidy**
- **Let's work together to keep infections out of our hospitals and care homes.**

What is a posterior repair?

A posterior repair, also known as a posterior colporrhaphy, is a surgical procedure to repair or reinforce the fascial support layer between the rectum and the vagina. A perineorrhaphy is the term used for the operation that repairs the perineal body.

Why is a posterior repair performed?

The aim of surgery is to relieve the symptoms of vagina bulge and/or laxity and to improve or maintain bowel function without interfering with sexual function.

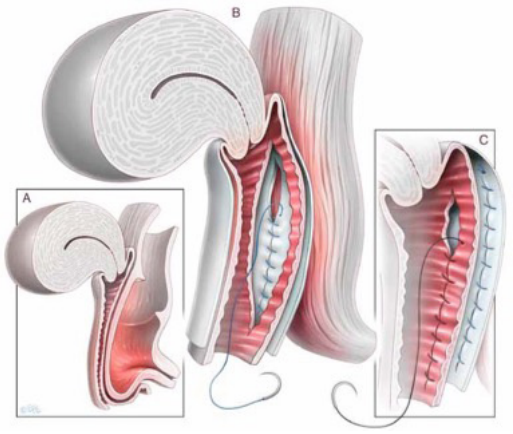
How is a posterior repair performed?

The operation is usually performed under general anaesthetic. This means that you will be asleep during the entire procedure. Occasionally, it is done using a spinal anaesthetic which numbs you from the waist downwards following an injection in your back.

There are many ways to perform an posterior repair. Below is a general description of a common repair method.

An incision is made along the centre of the back wall of the vagina starting at the entrance and finishing near the top of the vagina. The vaginal skin is separated from the underlying supportive fascial layer. The weakened fascia is repaired using absorbable stitches, these will absorb over 4 weeks to 5 months depending on the type of stitch (suture) material used. The perineal body may then be repaired by placing deep sutures into the underlying perineal muscles to build up the perineal body. The overlying skin is closed with absorbable sutures; these dissolve after 4 to 6 weeks and do not need to be removed. Sometimes, reinforcement material in the form of biological (absorbable) graft is used to repair the posterior vaginal wall. Your doctor will explain this to you if it is necessary. This is usually reserved for cases of repeat surgery or severe prolapse. A pack may be placed into the vagina and a catheter into the bladder at the end of surgery; if so, this is usually removed after 3 to 48 hours. The pack acts like a compression bandage to reduce vaginal bleeding and bruising after surgery.

Commonly, posterior vaginal repair surgery may also be combined with other surgery such as vaginal hysterectomy, anterior vaginal wall repair or incontinence surgery. These procedures are covered in detail in other leaflets which will be supplied as necessary.



A) posterior vaginal wall prolapse

B) repairing the fascial layer

C) repairing vaginal skin layer

How long will the operation / surgery take?

You could be in the operating theatre for up to three hours to include the anaesthetic, surgery and recovery period.

What are the benefits of posterior repair surgery?

The symptoms of vagina bulge and / or laxity are improved.

What are the risks of posterior repair surgery?

With any surgery, there is always a small risk of complications.

General risks of surgery:

Anaesthetic risk. This is very small unless you have specific medical conditions, such as a problem with your heart, or breathing. Smoking and being overweight also increase any risks.

Bleeding. There is a risk of bleeding with any operation. It is rare that we have to transfuse patients after their operation. Please let your doctor know if you are taking an anticlotting drug such as warfarin or aspirin. The risk of excessive bleeding during the operation is about 1 in 100 women

Infection. There is a small risk of infection with any operation (about 5 to 13 cases in 100 operations). If it occurs, an infection can be a wound infection, vaginal infection or a urinary infection, and is usually treated with antibiotics. The risk of infection is reduced by routinely giving you a dose of antibiotic during your operation. Chest infection may also occur as a result of a general anaesthetic.

Deep Vein Thrombosis (DVT). This is a clot in the deep veins of the leg. Occasionally, this clot can travel to the lungs (pulmonary embolism) which can be very serious and in rare circumstances it can be fatal (less than 1 in 100 of those who get a clot). The risk increases with obesity, severe varicose veins, infection, immobility and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood.

Bladder infections (cystitis) occur in about 6% of women after surgery and are more common if a catheter has been used. Symptoms include burning or stinging when passing urine, urinary frequency and, sometimes, blood in the urine.

The following complications are more specifically related to posterior vaginal wall repair:

Damage to local organs. This can include bowel and blood vessels. This is a rare complication but requires that the damaged organ is repaired and this can result in a delay in recovery. It is sometimes not detected at the time of surgery and, therefore, may require a return to theatre. If the rectum (back passage) is inadvertently damaged at the time of surgery, temporary colostomy (bag) may be required, but this is exceptionally rare.

Prolapse recurrence: If you have one prolapse, the risk of having another prolapse sometime during your life is 30%. This is because the vaginal tissue is weak.

Pain: General pelvic discomfort, this usually settles with time but occasionally pain on intercourse may occur and can sometimes be permanent. Reduced sensation during intercourse: Sometimes, the sensation during intercourse may be less and occasionally the orgasm may be less intense.

Change in bowel function: Occasionally, patients can become constipated after the operation, but often, bowel function is improved.

How successful is posterior repair surgery?

Quoted success rates for posterior vaginal wall repair is 80-90%. There is a chance that the prolapse might come back in the future, or another part of the vagina may prolapse, for which you would need further surgery. About 50% of women who have symptoms such as incomplete bowel emptying or constipation will have improvement in their symptoms following surgery.

What happens if I do not have the operation?

Your problem may remain the same, get worse or improve over time. There is no sure way of predicting this.

Are there any alternatives to surgery?

Do nothing

If the prolapse (bulge) is not distressing then treatment is not necessarily needed. If, however, the prolapse permanently protrudes through the opening to the vagina and is exposed to the air, it may become dried out and eventually ulcerate. Even if it is not causing symptoms in this situation, it is probably best to push it back with a ring pessary (see below) or have an operation to repair it.

Pelvic floor exercises (PFE):

The pelvic floor muscle runs from the coccyx at the back to the pubic bone at the front and off to the sides. This muscle supports your pelvic organs (uterus, vagina, bladder and rectum). Any muscle in the body needs exercise to keep it strong so that it functions properly. This is more important if that muscle has been damaged. PFE can strengthen the pelvic floor and, therefore, give more support to the pelvic organs. These exercises may not get rid of the prolapse but they make you more comfortable.

PFE are best taught by an expert who is usually a Continence Nurse Advisor or Women's Health Physiotherapist. These exercises have no risk and even if surgery is required at a later date, they will help your overall chance of being more comfortable.

Ring pessary:

This is a soft plastic ring or device which is inserted into the vagina and pushes the prolapse back up. This usually gets rid of the dragging sensation and can improve urinary and bowel symptoms. It needs to be changed every 6-9 months, or earlier if there is any bleeding or discharge, and can be very popular; we can show you an example in clinic. Other pessaries may be used if the ring pessary is not suitable. Some couples feel that the pessary gets in the way during sexual intercourse, but many couples are not bothered by it. Shelf Pessary or Gellhorn - If you are not sexually active, this is a stronger pessary which can be inserted into the vagina and again needs changing every 4-6 months.

The choice about which treatment is best for you will be made together with your doctor. This will be based on the risks and benefits of the treatment and individual circumstances.

What should I expect before the operation?

Before admission for surgery, you will be asked to attend a pre-admission clinic to ensure that you are fit and well for your surgery. A nurse practitioner or a doctor will ask about your general health, past medical history and any medication that you are taking. Any necessary investigations will be organised, such as blood tests, ECG (heart trace) and chest X-rays.

You will receive information about your admission, hospital stay, operation and pre and post-operative care. You will also be given the opportunity to ask any further questions that you may have.

You are advised that you should not go on a long haul flight (more than four hours) in the six weeks prior to your surgery due to increased risk of clots in your legs.

Plan ahead - when you come out of hospital you are going to need extra help at home for the first two weeks. Make sure your family knows this.

If you smoke, try to stop completely. This will make your anaesthetic safer, reduce the risk of complications after operation, and speed up the recovery time. If you are unable to stop completely, even doing so for few days will be helpful.

Some medicines need to be stopped or altered before the operation. You should check with your GP and bring your list of medications with you when you come to the pre-admission clinic. If you are on a contraceptive pill, you should stop it at least four weeks before the operation and you should use another method of contraception.

What will happen on the day of my surgery?

On the day of your operation, you must have nothing to eat or drink for a specified time prior to your operation. You will be advised as to what time you need to stop eating and drinking.

Before your operation can take place, a doctor will see you to reconfirm your written consent, which will have already been obtained at a previous appointment. We must seek your consent for any procedure or treatment beforehand. Your doctor will explain the risks, benefits and alternatives, where relevant before they ask for your consent. If you are unsure about any aspect of the proposed procedure or treatment, please do not hesitate to ask for more information. You will have the opportunity to ask any questions not covered during your pre-admission clinic appointment.

You are requested to have a bath or shower before you come into hospital. Prior to your surgery, you will be asked to put on a theatre gown. You will be asked to remove all items of clothing including underwear, jewellery (except wedding rings) including all piercings, nail varnish, false nails, make up, contact lenses, hearing aids, dentures, wigs and any false limbs.

You will be requested to wear a pair of elasticated stockings (TEDS). The stockings help to prevent clots (thrombosis) in your legs. You will need to keep these on until you are discharged from hospital. The nurses will advise you how long you will need to continue to wear the stockings following your discharge from hospital.

You will be escorted to theatre by a member of the team. If a premedication (pre-med) has not been given, you may have the option of walking to theatre, otherwise a theatre trolley will be arranged to collect you from the ward.

You will be taken to the anaesthetic room where you will be asked few questions. If you are having general anaesthesia, you will be given an injection into a vein usually in the back of your hand. Once you are asleep, you will be taken into theatre.

You will wake up in the recovery area once your operation is finished. A nurse will then escort you back to your bed on the ward.

What will happen to me after the operation?

When you wake up from the anaesthetic, you will have a drip in your hand to give you fluids. The surgeon may place a vaginal pack (swabs inside the vagina) to stop any bleeding into the tissues. There will also be a tube in the bladder (catheter) to avoid urinary retention. The pack and catheter, is usually removed within 48 hours of the surgery. Patients are usually in hospital 2-7 days depending on individual circumstances.

Will I have any pain following surgery?

Most people experience some pain or discomfort for the first few days and you will be offered pain relief to help ease it. Initially, you may need to have pain relief by injection to keep you comfortable. After this, you will have the choice of tablets or suppositories. You will be encouraged to take regular pain relief, as being pain-free will speed up your recovery. The anaesthetist will discuss pain relief with you before your operation.

Having an anaesthetic, being in pain, and having strong pain relief can sometimes make you feel nauseous or sick. This can be relieved by injections or tablets.

Many women get wind pains a few days after the operation, which can be uncomfortable and make the tummy look distended (swollen). This should not last long and can be relieved by medicines, eating and walking about.

You should avoid constipation. Once you are eating and drinking again you can do this by:-

- Drinking plenty of water or juice
- Eating fruit and green vegetables, especially broccoli
- Eating plenty of roughage, such as bran or oats.

Will there be bleeding?

It is normal to get a creamy discharge for 4 to 6 weeks after surgery. This is due to the presence of stitches in the vagina; as the stitches absorb, the discharge will gradually reduce. After the operation, you may have some slight vaginal bleeding and you may need to wear a sanitary pad. We advise that you do not use tampons for six weeks and avoid douching the vagina. Your vaginal loss should settle after about a week. (If you have any new pain, fresh bleeding or bad smelling discharge after you go home, you should contact your GP).

Will I have stitches?

You will have vaginal stitches, which are dissolvable. Threads may come away for up to three months, which is quite normal.

How will I cough?

If you need to cough, your stitches will not come undone. You will be wearing a sanitary towel, and coughing will hurt less if you press on your pad firmly to give support between your legs. Any persistent cough following discharge should be treated promptly. Please see your GP as soon as possible.

When can I return to my usual routine?

Recovery is a time-consuming process, which can leave you feeling tired, emotionally low or tearful. The body needs time and help to build new cells and repair itself. You will need to take 4 to 6 weeks off work to recover. This also depends on the nature of your work. After a posterior repair, most women stay in hospital for approximately 2-3 days, but it could be longer if necessary. Your date of discharge depends on the reasons for your operation, your general health and how smoothly things go after surgery.

It is important to remember that everyone's experience is different; recovery time varies from woman to woman and it is, therefore, best not to compare your own recovery with that of others on the ward.

When can I drive again?

You can drive as soon as you can operate the pedals and look over your shoulder without discomfort, generally after three weeks, but you must check this with your insurance company, as some of them insist that you should wait for six weeks.

When can I exercise again?

It is important to continue to exercise and walking is recommended. To help prevent DVT (deep vein thrombosis), the same or the day after your operation, you will be encouraged to get out of bed and take short walks around the ward. This improves general wellbeing and reduces the risk of clots in the legs. You may be given a daily injection to keep your blood thin and reduce the risk of blood clots until you go home or longer in some cases, along with the anti-embolism stockings previously mentioned.

Once home, gradually increase the length of your walks, but remember to only walk the distance you can achieve comfortably. Cycling and swimming are equally good once discharge has settled.

You are encouraged to do pelvic floor exercises within 1-2 weeks of the operation.

Will I have a follow-up appointment?

You usually have a follow-up appointment anything between six weeks and six months after the operation. This may be at the hospital with a doctor or nurse, with your GP, by telephone or a postal survey. Sometimes, follow-up is not required.

When can I have sex after the operation?

For many women, following recovery, this aspect of their life is improved because there is no longer any discomfort. We advise that you avoid penetrative intercourse for about six weeks.

Take your time, feel comfortable, do not be rushed and for the first few times you might find a lubricating gel is helpful. You can buy this from the chemist. Talk to your partner about this, as you will need them to be extra gentle and understanding.

Is there any advice with regards to childbirth post-surgery?

If you are planning to have children after the procedure, a pregnancy may damage the repair and cause the prolapse to recur. To help prevent this, you may be advised to have a scheduled caesarean section rather than a vaginal birth.

What happens if I feel unwell after I go home?

You may expect some minor bleeding, especially some old, brownish blood for two weeks.

You should contact your GP or Ward D7
(01902 694034 24 hours a day, 7 days a week) if you notice any of the following:

Increased temperature

Wound swelling

Worsening pain

Bad smelling discharge either from the wounds on your tummy or the front passage

Blood in your urine or bowel motions

Abdominal distension (swelling)

Failure to open your bowels.

You can also contact The Emergency Gynae Assessment Unit (EGAU) Monday - Friday 08.30am - 4.30pm and 08.00am - 13.00pm on Saturday on 01902 307999 ext 84606.

Finally, prior to your admission if you have any questions or worries you may contact your GP for advice or contact the urogynaecology nurse specialist on 01902 307999 ext 85186 Monday to Friday 08:30am – 16:30pm.

Useful support advice and literature is available:

PALS (Patient Advice Liaison Service) - 01902 695362

HNSDirect - 08454647

Gynaecology Ward D7 on extension (01902 694034)

Bladder & Bowel Foundation SATRA Innovation Park,
Rockingham Road Kettering, Northants, NN16 9JH

Nurse Helpline for medical advice: 0845 345 0165

Counsellor Helpline: 0870 770 3246

General enquiries: 01536 533255
Fax: 01536 533240
mailto:info@bladderandbowelfoundation.org

http://www.bladderandbowelfoundation.org

Also: http://www.nice.org.uk/nicemedia/pdf/IPG267PublicInfo.doc

http://www.easyhealth.org.uk/

English

If you need information in another way like easy read or a different language please let us know.

If you need an interpreter or assistance please let us know.

Lithuanian

Jeigu norėtumėte, kad informacija jums būtų pateikta kitu būdu, pavyzdžiui, supaprastinta forma ar kita kalba, prašome mums apie tai pranešti.

Jeigu jums reikia vertėjo ar kitos pagalbos, prašome mums apie tai pranešti.

Polish

Jeżeli chcieliby Państwo otrzymać te informacje w innej postaci, na przykład w wersji łatwej do czytania lub w innym języku, prosimy powiedzieć nam o tym.

Prosimy poinformować nas również, jeżeli potrzebowaliby Państwo usługi tłumaczenia ustnego lub innej pomocy.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਪੜ੍ਹਨ ਵਿਚ ਆਸਾਨ ਰੂਪ ਜਾਂ ਕਿਸੇ ਦੂਜੀ ਭਾਸ਼ਾ ਵਿਚ, ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

ਜੇ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ ਦੀ ਜਾਂ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

Romanian

Dacă aveți nevoie de informații în alt format, ca de exemplu caractere ușor de citit sau altă limbă, vă rugăm să ne informați.

Dacă aveți nevoie de un interpret sau de asistență, vă rugăm să ne informați.

Traditional Chinese

如果您需要以其他方式了解信息，如易读或其他语种，请告诉我们。

如果您需要口译人员或帮助，请告诉我们。

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