Suspended Mesh Kit Posterior / Vault Prolapse Repair

Patient Information Leaflet

Please note – this is a relatively new operation and long term information is not available.

BSUG Patient Information Sheet Disclaimer

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We will endeavour to update the information sheets at least every two years.

Suspended Mesh Kit Posterior / Vault Prolapse Repair

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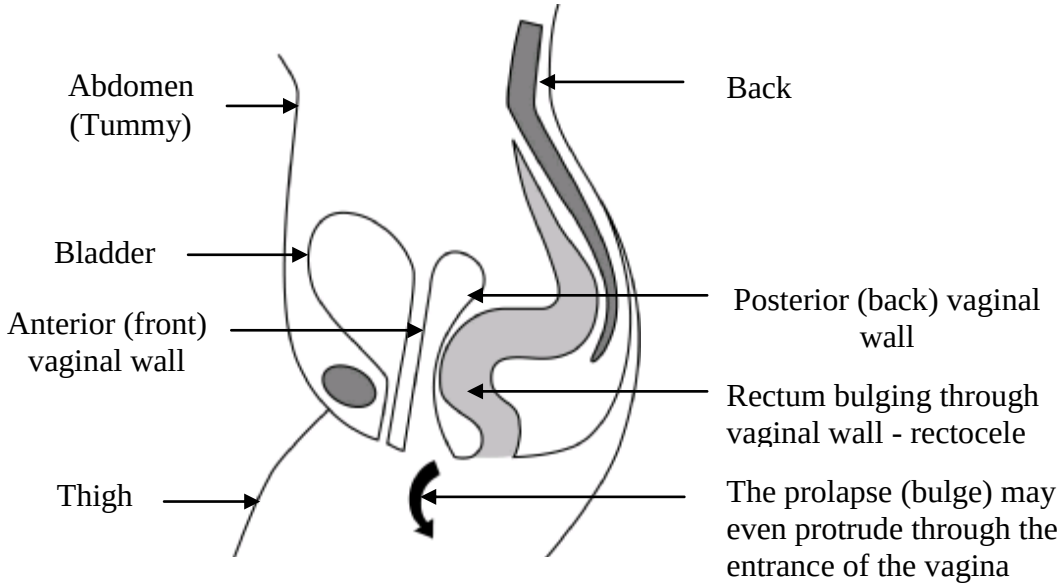
What is a Posterior Vaginal Wall / Vault Prolapse

- Posterior means towards the back, so a Posterior Vaginal Wall Prolapse is a prolapse of the back wall of the vagina. Vault means the top of the vagina.
- The pelvic floor muscles are a series of muscles that form a sling or hammock across the opening of the pelvis. These muscles, together with their surrounding tissue, are responsible for keeping all of the pelvic organs (bladder, uterus, and rectum) in place and functioning correctly.
- Prolapse occurs when the pelvic floor muscles or the vagina have become weak. This usually occurs because of the damage of childbirth but is most noticeable after the menopause when the quality of supporting tissue deteriorates.
- With straining, for e.g. on passing a motion, the weakness described above allows the rectum (back passage) to bulge into the vagina and sometimes bulge out of the vagina. This is called a Posterior Vaginal Wall Prolapse or a Rectocele.
- A large Rectocele may make it very hard to have a bowel movement, especially if you have constipation.
- Some women have to push the bulge back into the vagina or support the perineal area, the area between the anus and the vagina with their fingers in order to complete a bowel movement - this is called digitation.
- Some women find that the bulge causes a dragging or aching sensation and interferes with sexual intercourse.

Diagram showing rectum bulging through the posterior (back) vaginal wall (in standing women)



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 Physiotherapist. These exercises have little or no risk and even if surgery is required at a later date**,** they will help your overall chance of being more comfortable.

Types of Pessary

- **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 4-6 months 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.

General Risks of Surgery

- **Anaesthetic risk.** This is very small unless you have specific medical problems. This will be discussed with you.
- **Haemorrhage.** There is a risk of bleeding with any operation. The risk from blood loss is reduced by knowing your blood group beforehand and then having blood available to give you if needed. It is rare that we have to transfuse patients after their operation.
- **Infection.** There is a risk of infection at any of the wound sites. A significant infection is rare. The risk of infection is reduced by our policy of routinely giving antibiotics with major surgery.
- **Deep Vein Thrombosis (DVT).** This is a clot in the deep veins of the leg. The overall risk is at most 4-5% although the majority of these are without symptoms. Occasionally this clot can migrate to the lungs which can be very serious and in rare circumstances it can be fatal (less than 1% of those who get a clot). DVT can occur more often with major operations around the pelvis and the risk increases with obesity, gross varicose veins, infection, immobility and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood (heparin).

Specific risks of this surgery

It is generally successful, however, 5-15% of women will develop recurrent prolapse. Some patients develop relapse in other parts of the vagina, which may require further surgery, other risks are below:

- **Bladder symptoms** (urinary urgency and frequency) usually get better after the operation, but occasionally can start or worsen after the operation. If you experience urinary symptoms, please make us aware so that we can treat you for it. Stress incontinence may develop in up to 5%. Difficulties passing urine necessitating prolonged self catheterization postoperatively may occur in 1% of women. Urinary tract infection: affects 1-5% of women.

- **Mesh exposure / extrusion**: affects up to 20% of women and presents as vaginal discharge, bleeding, and pain during sexual intercourse. Its treatment may include an operation to trim the eroded mesh. This can develop some years after the initial prolapse operation.

- **Mesh infection** - although uncommon, can be serious, requires antibiotic treatment. Rarely the mesh will need to be removed.

- **Damage to local organs**. This can include bowel, bladder, ureters (pipes from kidneys to the bladder) 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 bladder is inadvertently opened during surgery, it will need catheter drainage for 7-14 days following surgery. If the rectum (back passage) is inadvertently damaged at the time of surgery, this will be repaired, however, inserting the mesh may be delayed till a later date. This will require another operation, and in rare circumstances, a temporary colostomy (bag) may be required. Very rarely further surgery can be required to close a fistula (false tract between vagina and bladder or bowel) - affects 1 to 2 per 1000 cases.

- **Excessive bleeding** requiring blood transfusion is uncommon (<1%) but may require admission to ITU.

- **Pain on intercourse** (approx 20%).1-5% of women experience ongoing vaginal pain and/or persistent pain during sexual intercourse that may require further surgery due to scarring.

This is a relatively new procedure and long term outcome data are not available yet.

The Operation: Suspended Mesh Posterior / Vault Prolapse Repair

About the operation

- The operation was devised for those with severe or recurrent prolapse.
- The long-term risks, complications and prolapse recurrence rate are uncertain.
- You are likely to feel more comfortable from a prolapse point of view
- Intercourse may be more satisfactory.
- Opening your bowels may be easier.

How the operation is performed

- The operation can be done with a spinal or general anaesthetic. You may have a choice in which anaesthetic is used.
  - A spinal anaesthetic involves an injection low in the back, similar to what we use when women are in labour or for a caesarean section. The spinal anaesthetic numbs you from the waist down. This removes any sharp sensation but a pressure sensation will still be felt.
  - A general anaesthetic will mean you will be asleep (unconscious) during the entire procedure.
- The legs are placed in stirrups (supported in the air)
- A vertical cut is made in the back wall of the vagina, over the area of the bulge – Figures 1 & 2.
- The vaginal skin is then separated from the rectum (lower bowel).
- The tissue is then further dissected each side of the rectum to find a bony landmark deep in the pelvis.
- A special needle with a surrounding plastic tube (cannula) is then passed through the buttock after making two small cuts either side (1 cm each) and comes out near the bony landmark in the pelvis. This is done on each side. Figure 3.
- The needle is removed and the plastic tube is left in place.
- The arms of the mesh graft are then fed into the deep end of the tube and are brought out of the tube as the tube enters the buttock.

- The plastic tube on each side is then removed leaving the central mesh graft in place and the mesh tails protruding through the buttocks, where they will be trimmed.
- The vagina is the stitched back together – Figure 4 & 5.
- A vaginal pack (surgical material to apply pressure) is then inserted into the vagina which is removed after approximately 24 hours. A catheter in the bladder is also left in place for 24 hours.

Figure 4. The final position of the mesh between the vaginal skin and rectum. (Image courtesy CR Bard)

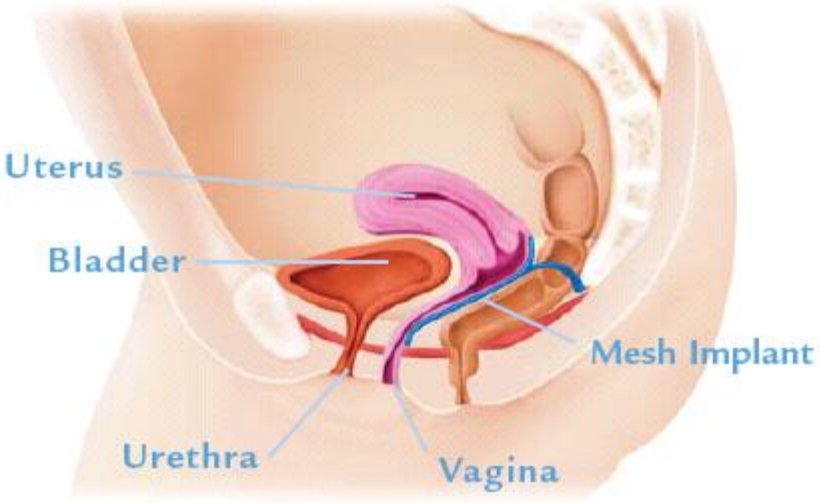
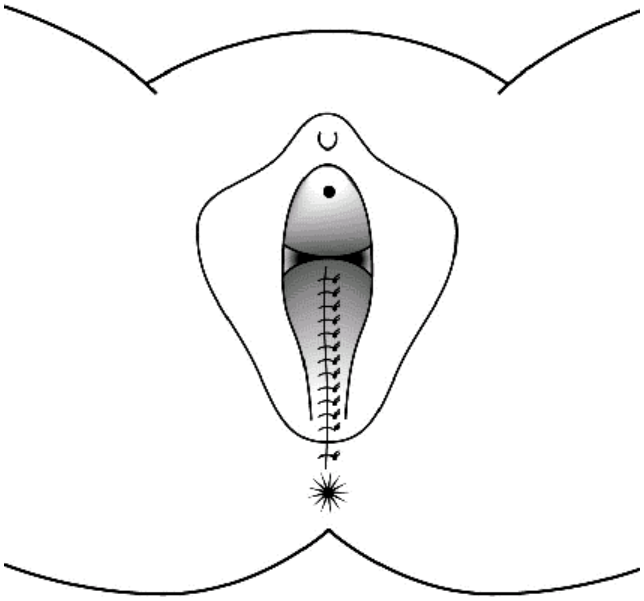


Figure 5. Diagram showing the vaginal skin closed over the mesh.



- The vaginal skin edges are then stitched together.
- A pack (bandage) is then placed in the vagina, and a catheter into the urethra to drain the bladder

After the operation - in hospital

- On return from the operating theatre you will have a fine tube (drip) in one of your arm veins with fluid running through to stop you getting dehydrated.
- You may have a bandage in the vagina, called a ‘pack’ and a sanitary pad in place. This is to apply pressure to the wound to stop it oozing.
- You may have a tube (catheter) draining the bladder overnight. The catheter may give you the sensation as though you need to pass urine but this is not the case.
- Usually the drip, pack and catheter come out the morning after surgery or sometimes later the same day. This is not generally painful.
- The day after the 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 on the legs.

- It is important that the amount of urine is measured the first couple of times you pass urine after the removal of the catheter. An ultrasound scan for your bladder may be done on the ward to make sure that you are emptying your bladder properly. If you are leaving a significant amount of urine in your bladder, you may have to have the catheter re-inserted back into your bladder for a couple of days more.

- You may be given injections to keep your blood thin and reduce the risk of blood clots normally once a day until you go home or longer in some cases.

- The wound is **not** normally very painful but sometimes you may require tablets or injections for pain relief.

- There will be slight vaginal bleeding like the end of a period after the operation. This may last for a few weeks.

- The nurses will advise you about sick notes, certificates etc. You are usually in hospital up to 4 days.

After the operation - at home:

- Mobilization is very important; using your leg muscles will reduce the risk of clots in the back of the legs (DVT), which can be very dangerous.

- You are likely to feel tired and may need to rest in the daytime from time to time for a month or more, this will gradually improve.

- It is important to avoid stretching the repair particularly in the first weeks after surgery. **Therefore, avoid constipation and heavy lifting.** The deep stitches dissolve during the first three months and the body will gradually lay down strong scar tissue over a few months.

- Avoiding constipation
    - Drink plenty of water / juice
    - Eat fruit and green vegetables esp broccoli

    - Plenty of roughage e.g. bran / oats

- Do not use tampons for 6 weeks.

- There are stitches in the skin wound in the vagina. Any stitches under the skin will melt away by themselves. The surface knots of the stitches may appear on your underwear or pads after about two weeks, this is quite normal. There may be little bleeding again after about two weeks when the surface knots fall off, this is nothing to worry about.

- At six weeks gradually build up your level of activity.

- After 3 months, you should be able to return completely to your usual level of activity.

- You should be able to return to a light job after about six weeks. Leave a very heavy or busy job until 12 weeks.

- You can drive as soon as you can make an emergency stop 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.

- You can start sexual relations whenever you feel comfortable enough after six weeks, so long as you have no blood loss. You will need to be gentle and may wish to use lubrication (KY jelly) as some of the internal knots could cause your partner discomfort. You may, otherwise, wish to defer sexual intercourse until all the stitches have dissolved, typically 3-4 months.

- Follow up after the operation is usually six weeks to six months. This maybe at the hospital **(**doctor or nurse), with your GP or by telephone. Sometimes follow up is not required

Where can I obtain more information?

- The Continence Foundation
- 307 Hatton Square
- 16 Baldwins Gardens
- London EC1N 7RJ

http://www.2womenshealth.co.uk/index.htm

http://www.ucsf.edu/wcc/index.html

British Society of Urogynaecology
27 Sussex Place, Regent's Park, London, NW1 4RG
Telephone: +44 (0) 20 7772 6211
Facsimile: +44 (0) 20 7772 6410
Email: bsug@rcog.org.uk
Website: www.bsug.org.uk

Things I need to know before I have my operation.

Please list below any questions you may have, having read this leaflet.

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Please describe what your expectations are from surgery.

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