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Gynaecology, Uro-gynaecology and Urodynamic Specialist Services

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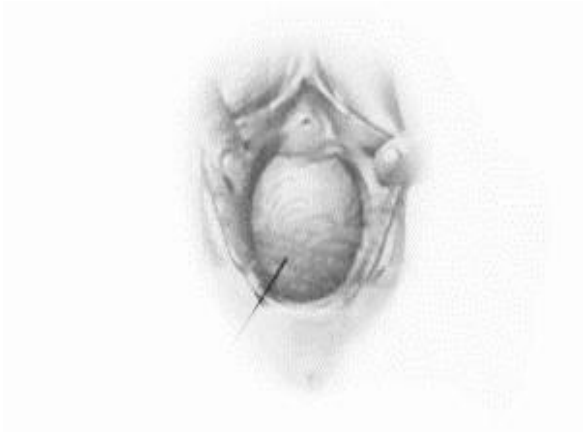
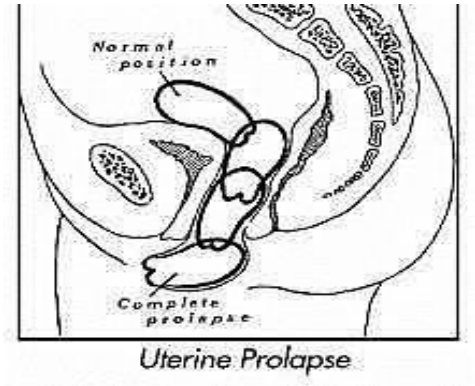
Patient information leaflet

Surgery for pelvic organ prolapse

What is pelvic organ prolapse?

Prolapse occurs when the muscles and supporting tissues of the pelvic floor becomes weak and no longer able to support the pelvic organs. This typically follows childbirth especially in women with naturally weaker supporting tissues and also with advancing age. The prolapse that can result include Cystocele (bladder), recto-enterocele (small and large bowel), vault (vaginal apex after hysterectomy), uterine prolapse (womb).





Uterine Prolapse

Why is surgery required?

Surgery is usually indicated in cases of bothersome prolapse when conservative treatments have failed or when Patient requests surgery. Conservative treatment includes pelvic floor exercise, vaginal pessary insertion and watchful waiting.

What are the benefits of surgery?

Surgery for prolapse is generally safe and has the advantage of immediate resolution of the prolapse and restoration of the vaginal anatomy in most cases.

How are prolapse operations performed?

These operations are usually carried out through the vagina. Sometimes however the abdominal route will be used and this needs to be discussed before the operation. The use of mesh is generally discouraged as it often increases complication without additional benefit.

What are the risks of surgery?

These depends on factors such as types and combinations of surgery performed, the route of the surgery, the age of the patient, the severity of the prolapse, previous prolapse/vaginal surgery, the state of the patients pelvic floor and the associated symptoms before surgery.

Complications such as bleeding, infection and blood clot disorder like deep vein thrombosis and pulmonary embolism are generic risks associated with most operations. Specific risk includes painful sex, vaginal scarring, smaller vaginal capacity, and injury to bowel, bladder, ureters, recurrence of prolapse, constipation, urinary incontinence or other bladder symptoms including difficulty with voiding. Some

have reported reduced sensation during intercourse following prolapse repair. Buttocks and thigh pain are associated with sacrospinous ligament fixation to fix the vaginal apex but these usually resolve in the long term. Major complications occurring at time of surgery are usually uncommon and can be fixed at the time of surgery when identified. To some extent the likelihood of some of these complications also depends on each individual patient's risk, the complexity of surgery, the materials employed during surgery and the expertise of the operating surgeon.

The table below based on the Royal College of Obstetricians and Gynaecologist (RCOG, UK) Clinical Governance Advice helps in understanding how risk is discussed in healthcare.

Term	Equivalent numerical ratio	Colloquial equivalent
Very common	1/1 to 1 in 10	A person in family
Common	1/10 to 1/100	A person in street
uncommon	1/100 to 1/1000	A person in village
Rare	1/1000 to 1/10 000	A person in small town
Very rare	Less than 1/10 000	A person in large town

What type(s) of surgery would I need?
This would depend on the type of prolapse in question and sometimes the degree and complexity of the prolapse only becomes fully evident following anaesthetic just before surgery. This should be discussed with your surgeon beforehand. Here are the various types of surgery for prolapse:

- Anterior repair – to fix bladder prolapse (cystocele)
- Posterior repair – to fix bowel prolapse (Rectocele/enterocele)
- Sacrospinous ligament fixation - to fix vaginal apex prolapse from the vagina
- Sacro-colpopexy – to fix vaginal apex prolapse to the sacrum from the abdomen
- Vaginal hysterectomy – to remove the uterus from the vagina
- Perineal repair – to fix a prolapsed perineum and tighten the vagina
- Sacro-hysteropexy – to fix the uterus or cervix to the sacrum from the abdomen
- Sacro-spinous hysteropexy – to fix the uterus to the sacrospinous ligament through the vagina.

What type of anaesthetic will I need?

These operations can be done with a spinal or general anaesthetic and you may have a choice in this. A spinal anaesthetic involves an injection in the lower back. The spinal anaesthetic numbs you from the waist down and a general anaesthetic will mean you will be asleep (unconscious) during the entire procedure. Your anaesthetist will discuss these options with you.

When can I return to work, normal activities, drive, swim and resume sexual intercourse

These take few weeks but varies widely depending on the operation/combination of operations performed as well as each individual's circumstance. Your doctor will usually advise you further.

This leaflet is written by:

Mr Ben Onyeka
MBBS; DFFP (UK); Cert Urodynamics (UK); CCST (UK); FRCOG; FRANZCOG
Obstetrician and Gynaecologist and Director Eden medics