We continually strive to improve the quality of information given to patients. If you have any comments or suggestions regarding this information booklet, please contact:

Women & Children’s Division
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Clinical Guidelines Subgroup: 3 Mar 2011, V3 Sep 2016
MSLC: Dec 2011, V3 Jun 2016

How can I help to reduce healthcare associated infections?
Infection control is important to the well-being of our patients and for that reason we have infection control procedures in place. Keeping your hands clean is an effective way of preventing the spread of infections. We ask that you, and anyone visiting you, use the hand sanitisers available at the entrance to every ward before coming into and after leaving the ward. In some situations hands may need to be washed at the sink using soap and water rather than using the hand sanitiser. Staff will let you know if this is the case.

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Vaginal and Pelvic Floor Repair
Patient information leaflet
If you require a translation of this leaflet please call Ward 16B on 01296 4418110/8111
What is a vaginal repair and why is it performed?
A vaginal repair (or pelvic floor repair) is an operation carried out to correct vaginal wall prolapse.

A sign of prolapse is usually a bulging of either the front or back wall of the vagina – or both. This may also occur along with a prolapse of the uterus (womb) itself. When the uterus is also prolapsed it is very likely that a vaginal hysterectomy as well as vaginal repair will be carried out. If this applies to you, please also read the patient’s guide to vaginal hysterectomy.

Prolapse can also occur in women who have already had a hysterectomy. When the front wall of the vagina prolapses this is called a cystocoele. This is herniation of bladder into vagina and it can cause bladder symptoms.

When the posterior wall of the vagina prolapses this is called a rectocoele and this can cause bowel symptoms.

Problems
Please do not worry if you have your periods or due to have periods on the day of your operation. Unless you have any particular objection, it is usually still possible to proceed.

Please inform us if you are, or think you could be pregnant as it is essential that the procedure is not carried out. If your period is late or there is a possibility of pregnancy then a pregnancy test will be carried out before your operation. If doubt still remains then the operation will be postponed.

When do I come in and how long do I stay in hospital?
We try to ensure that all patients are seen in the pre-assessment clinic at least a week before the operation takes place. This is an outpatient visit and is an opportunity for us to ensure that you are fit to have the planned operation.

We will carry out routine blood tests and sometimes other investigations such as an ECG (heart trace) or chest X-ray, if you have certain medical problems. It is also an excellent

Useful Contact Numbers
Stoke Mandeville Hospital
Consultant Gynaecologists 01296 316239/6548

Wycombe Hospital
Consultant Gynaecologists 01494 425009/425724

Other sources of information and help
www.bsug.net : patient information leaflet
www.rcog.org.uk/…/patient information leaflet/pelvic organ prolapse

Women’s Health Concern PO Box 2126 Marlow, Bucks. SL7 2RY http://www.womens-health-concern.org.uk
Tel: 01628 488065.
Women’s Health Concern produces information leaflets about hysterectomy, prolapse and associated health conditions.

Hysterectomy Association 60 Redwood House Charlton Down Dorchester, Dorset, DT2 9UH http://www.hysterectomy-association.org.uk
Tel: 08717 811141
Information and support about hysterectomy. The website contains an online discussion area for patients and their families.

NHS Direct Online
http://www.nhsdirect.nhs.uk
Information on prolapse, hysterectomy, other options and an online enquiry service.

Please Note:
This leaflet explains some of the most common side-effects that some people may experience. However, it is not comprehensive. If you experience other side-effects and want to ask anything else related to your treatment please speak to your GP or Consultant Gynaecologist.
Longer term questions:

Work
Returning to work depends on many different factors and your gynaecologist and GP should guide you. However, in general it may be reasonable to plan to return to work 4-6 weeks after surgery if you have a relatively sedentary job. If you have a physically demanding job you should plan to return to work after 8 weeks.

Further prolapse / recurrence
A small number of women (up to 29%) may experience problems with a further prolapse later in life. Hence, you need to be aware of the predisposing factors for the prolapse eg family history, being overweight, smoking, chronic cough, chronic constipation or having a job that entails very heavy lifting or straining. Sometimes there may not be any explanation for the recurrence and further treatment may be required. Allowing sufficient time for convalescence post-operatively, carrying out effective pelvic floor exercises, avoiding excessive weight gain and, if you smoke, stopping may reduce this risk.

Smears
If you still have a uterus then cervical smear tests will continue to be done – as before.

Contact Information
If you have any concerns about the procedure beforehand then please ask.
If you have any problems after discharge then please either contact:
  • Your GP
  • Ward 16B on 01296 418110/418111

opportunity for you to discuss your operation and aftercare with medical and nursing staff. This visit usually takes about one hour.

You will be admitted on the same day as your operation. Your length of stay in hospital could depend on a number of factors but an average stay in the ward after such surgery would be 2-3 days.

What happens when I come into hospital?
You will come to the ward, meet the nursing staff who will be looking after you and introduce you to the ward facilities. Later, you will be seen by your surgeon and an anaesthetist prior to your operation. You will be asked the date of your last menstrual period (if relevant).

Your surgeon will explain the procedure and the risks associated with the procedure in detail. Your formal (written) consent to the procedure will be confirmed. The anaesthetist will discuss the type of anaesthetic as well as about the postoperative pain relief options with you.

Regular treatment with a drug to thin the blood (an anticoagulant - Heparin) is usually used to minimise the risk of deep vein thrombosis (DVT) and pulmonary embolism (PE) post operatively. Heparin is given by injection under the skin, once or twice daily and will be given for about a week.

Day of operation
You will be taken to the operating theatre by a porter and a ward nursing staff. Normally you are taken to a small room next to the operating theatre, the anaesthetic room. This is where the anaesthetist gives your anaesthesia before transferring you into the operating theatre.

After the anaesthetic is given and before starting the operation you will be positioned carefully on the operating table. You will be lying on your back with both legs held up by stirrups to allow the gynaecologist to carry out your surgery from inside the vagina.
A careful examination is then carried out before the operation proceeds.

An antiseptic solution is used to cleanse the vagina and surrounding area, a urinary catheter (a fine plastic tube) is then used to drain the bladder.

**Risks of Vaginal Repair**
Most operations are straightforward and without complications. However, there are risks associated with all operations. You need to be aware of these when deciding the right treatment for you.

The risks are:
- **Excessive bleeding.** This may occur during or after the operation (about 1 in 100 women, requiring a blood transfusion or return to theatre.
- **Infection**—which may affect the wound, bladder or lungs, or develop around the operation site internally. Antibiotics are given during your surgery to reduce the risk of infection complicating your recovery. Most infections are easily treated with a course of antibiotics but others can be more severe.
- **Damage to the bladder or one of the tubes that drain into the kidneys (the ureters):** 1 in 150 women.
- **Deep vein thrombosis (DVT).** This is the formation of a blood clot in a leg vein. This occurs in 1 in 250 women. A clot can then move to the lungs causing a very serious condition called pulmonary embolism. Preventative treatment will be given to reduce the risk of DVT.
- **Abdominal incision (cut).** Although the aim is to do the surgery through the vagina. However, very rarely an emergency cut on the abdomen is given to control the complications such as severe bleeding.
- **Operative risk, in general, tends to be increased by factors such as co-existing medical problems (eg diabetes, high

Looking after yourself in this way really is important during the first 4-6 weeks after your operation. During this time all the healing tissues are held together by the sutures (stitches) placed at the time of your operation – any undue strain could burst these and undo the repair surgery.

However, you should be able to do all the things you need to do to look after yourself, take short walks, do simple exercises and …enjoy your recovery! You can certainly carry on doing your pelvic floor exercises when you feel comfortable doing them. You will be advised about these during your stay.

**Sexual intercourse**
You should avoid sexual intercourse for about 6 weeks while the sutures are healing. Having this type of surgery should not change your sexual feelings (libido) or the enjoyment of sex. You and your partner may well be anxious and apprehensive about sex after your operation. If you feel a bit dry inside it is perfectly fine to use some water-soluble lubricating jelly - the type you can buy from the chemist.

**Follow up**
You will receive a telephone consultation from your surgeon’s team in 6-8 weeks time.

During your recovery you will experience a gradual improvement in your wellbeing but at times you may feel your recovery is going rather more slowly than you would like. Feeling a bit despondent, depressed and, possibly, tearful at these times is very common. It will pass.

If you find these negative feelings are becoming difficult to cope with then we suggest you discuss this with your GP and those closest to you.
However if you do experience severe pain, heavy vaginal bleeding, offensive vaginal discharge, burning and frequency passing urine (cystitis) or a high temperature you should seek your GP’s advice.

You may have some vaginal blood loss to begin with. This usually settles down during the days you are in hospital although some women do experience some bleeding for few days.

Sanitary towels/pads should be used. Please avoid tampons.

You will probably have a routine blood test carried out to check your haemoglobin level (“blood count”) on the day 2 of your surgery. Sometimes a urine test will be taken to investigate whether you have a minor urine infection (cystitis) - this sometimes happens after gynaecological surgery.

At Home
After your discharge from the hospital, you may have some discomfort from time to time so it may be useful to have a supply of painkillers such as paracetamol (eg "Panadol") or ibuprofen (eg "Nurofen") at home to take following the manufacturer’s instructions.

You may also find that after the bleeding stops you may have a brownish or clear discharge which is normal.

What can I do afterwards?
You will be advised during your stay on the important “do’s and don’ts” after your operation. In general you must avoid:

- All vigorous and strenuous activities such as lifting heavy objects
- Straining your abdominal muscles, pushing downwards into your pelvis, prolonged standing (ie standing still)
- You should not drive for the first 4 weeks after your operation. Only when you feel confident and capable to do so and your insurance cover is appropriate can you resume driving.

blood pressure, or certain drug treatment) or previous surgery. Being overweight does make both anaesthetics and surgery more difficult and therefore increases risk.

- Smoking tobacco is also an important risk factor, if you do smoke it would be best to stop for at least 2 weeks preoperatively and during your recovery.

Although vaginal repair is a relatively safe operation and serious complications are not very common, it is still major surgery. You and your doctor must together weigh the benefits and risks of surgery, giving consideration to alternative treatments.

Your surgery may take between 30-60 minutes to carry out. If a vaginal hysterectomy is to be performed then this will usually be 1-2 hours in total.

The operation
The operation is carried out inside the vagina. During the operation the bulge in the wall of the vagina is identified and the weakness in the muscles, fascia, and ligaments is confirmed. A cut is made to allow the tissues to be dissected (opened out) into their separate layers. The excess, stretched, vaginal skin is then removed.

The operation is completed by suturing (stitching) the tissues firmly together again. This tightens the ligaments, fascia and muscles and creates a firm repair which supports the bladder and/or bowel wall as well as the vaginal walls.

The suture materials used are dissolvable. Some of the sutures gradually dissolve over 6 weeks time and can be felt. At the end of the operation a gauze dressing may be inserted into the vagina and left in place for 24 hours afterwards. This is a long gauze ribbon; it is usually lightly soaked in an antiseptic cream (usually a bright yellow colour).
The dressing helps to reduce oozing of blood from the healing tissues after your operation. This reduces bruising and helps wounds to heal. It may cause some pressure in the vagina and make you feel as though you need to empty your bladder or even evacuate the bowel.

A urinary catheter (plastic tube into the bladder) is often inserted at the end of the operation. The catheter usually comes out on the 2nd day of your operation.

**Vaginal repair**

**Cystocele (anterior) repair**

**Posterior (rectocele) repair**

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**After surgery**

After the operation you are taken to the “Recovery Area”, where all patients remain for a time after surgery. You will stay there until you have recovered from your anaesthetic. You will be transferred to the ward once your observations are stable.

**How do I feel afterwards? In Hospital**

After your anaesthetic you will probably feel drowsy. Everyone responds in a slightly different way and some patients feel nauseated. You may have some lower discomfort and soreness in your back and/or bottom.

The nursing staff will ensure that you continue to receive effective pain relief during your recovery. If you need more pain relief, please inform the nursing staff.

You will spend most of the first day after surgery in bed but as soon as possible we would endeavour to have you sitting out of bed then mobilising steadily over the next 24-48 hours.

If you have a urethral catheter in place this will usually be removed after 24-48 hours, although it can sometimes be left in place for a longer period.

Most patients tell us that they find the initial recovery easier than expected. In general, vaginal surgery does not cause too much discomfort and you will probably mobilise quickly. Your appetite should soon return enabling a return to a normal diet.

Passing urine may be a little uncomfortable to begin with and your bladder may seem slightly irritable initially. Your bowel action may be a little upset with some constipation for a day or so. Both of these problems usually return to normal by themselves although some women may need a laxative to aid bowel action.

It is very unlikely that you will have further problems after going home from hospital.