Vaginal Repair Sacrocolpopexy/Hysteropexy Transobturator Mid Urethral Slings

What Happens?

There are many different techniques for performing vaginal repairs. My usual technique is "fascial plication", which uses a delayed absorbable suture (stitch) to reinforce the fibrous layers supporting the vagina in order to correct the prolapse. The excess overlying skin (epithelium) is then excised and repaired with a six-week dissolving suture. The procedure is generally performed on women who have a prolapse (a soft lump protruding from the vagina). Sometimes the lump may protrude all the time. This may involve the bladder, the rectum or the upper part of the vagina and cervix. Sometimes the top of the vagina may need to be attached to a ligament inside the pelvis (sacrospinous ligament) in order to prevent the top of the vagina falling down. This is called a *sacrospinous vault suspension or colpopexy*. This may be done in order to make the repair more sound by supporting the upper vagina, or to avoid the need for a hysterectomy. Sometimes prolapse is associated with urinary incontinence. This can be treated with a trans-obturator sling (e.g. Monarc), which supports the neck of the bladder. This has been found to be highly successful in treating urinary incontinence.

The repair is usually combined with a cystoscopy (internal examination of the bladder)

Monarc Slings

Please see separate document on www.philipthomas.com.au

Purpose Of The Procedure

The purpose of the procedure is to normalize anatomy, increase patient comfort, increase confidence with sexual intercourse and to treat urinary incontinence. If you have a prolapse the uterus can drop down into the vagina or even protrude to the outside where it can develop ulcers and cause considerable pain and discomfort.

Preparation

You will require a general (sleeping) or regional (spinal) anaesthetic. You will be required to fast for around six hours. Please check with my secretarial staff if you are unsure from when to fast. Some patients, depending on their medical condition and associated conditions, may need blood tests, imaging studies or other investigations to be performed. The operation can be performed during a patient's period. It is very important to give a full list of your medications prior to the procedure. This also includes natural therapies, herbal preparations and fish oil tablets, which may have an unpredictable effect on the blood's ability to clot.

Anaesthetic

Usually carried out under general anaesthetic however the anaesthetist will decide the most appropriate mode of anaesthetic for you based on a detailed pre-operative discussion of your requirements.

Duration of Procedure

From forty-five minutes to three hours depending on the extent of surgery.

Post-Procedure Care

After leaving the operating theatre you will usually have a drip or intravenous line in-situ. This is to maintain your hydration as you will have been fasting prior to the procedure. You will be cared for in the Recovery Area of the Operating Theatre which involves one on one care by a specialist member of the nursing staff. After around one to two hours you will be able to return to the ward, generally eating and drinking after four hours. You will also have an indwelling urinary catheter which will be removed on the first post-operative day. You may/not have a gauze pack in-situ within the vagina. There may be a small amount of bleeding. Post-operative ward stay is from one to about three days depending on your age, condition and extent of the procedure performed. If a vaginal hysterectomy is performed, recovery is often a little longer.

Post-Discharge Care

I would anticipate that most patients will be up and about, out of bed and out of the house within a week post-procedure. **It is however most important that you refrain from any lifting for six weeks post-procedure.** Gym memberships etc should be suspended. **No heavy lifting for three months.** There may be mild discomfort, which can be treated with non-steroidal anti-inflammatories such as Naprogesic or Nurofen in combination with Panadol, Panadeine 8/15 or Panadeine Forte. There may be a small amount of bleeding and whilst bleeding it is wise to avoid tampons and refrain from intercourse until after your six week check. Bathing is allowed but swimming in public pools should be avoided for six weeks. There may be a red to pink discharge for around six weeks. You should notify me if you develop a fever (temperature greater than 37.5 degrees), pain or cramping that does not respond to regular doses of simple analgesics or bleeding involving clots or foul smelling vaginal discharge. The dissolving stitches used in the repair will create a watery discharge, which will disappear as the sutures dissolve. **Post-operative review will be at around six weeks.** Note that if a **sacrospinous colpopexy/hysteropexy** is performed, a small amount of buttock pain may be expected which generally resolves within a short period of time. You may drive after one week but exercise caution if you are still taking pain relief.

Do not drive an automatic car for	1 week
Do not drive a manual car for	2 weeks
Do not make a bed for	2 weeks
Do not hang out washing for	4 weeks
Do not use your vaginal estrogen for	4 weeks
Do not stretch upward for	4 weeks
Do not do any lifting (>4kg) for	6 weeks
Do not use tampons for	6 weeks
Do not have sexual intercourse for	6 weeks or until after your post op check
Do not do heavy lifting for	3 months

Complications

Complications of any surgery may include the following. All complications are more frequent in smokers.

- Small areas of the base of the lung may collapse requiring post-operative antibiotics or chest physiotherapy.
- Clots in the legs (deep venous thrombosis) may cause pain and swelling and rarely may break off and travel to the lungs (pulmonary embolus), which can be fatal. Thromboembolic deterrent (TED) stockings, dynamic calf compression and Clexane are all used.

- A heart attack may occur because of strain on the heart or a stroke.
- Death under anaesthetic (less than 1:100,000). Compared to dying in a car accident every year in Victoria, about 6:100,000.

Complications Specific to Vaginal Repair and Sacrospinous Colpopexy: The following have been described

- Temporary difficulty in passing urine immediately following the surgery. This certainly may occur if you have had a trans-obturator sling inserted. Around 1:20 women may need to be discharged with a temporary catheter in-situ, which is generally removed after a trial of void in one week. If this does not succeed, intermittent self-catheterization may be required (rare).
- Rarely (less than 1:200) the dissection carried out to affect the vaginal repair may create a small hole in either bowel or bladder, which lie adjacent to the vagina. This will be repaired at the time of the surgery although several days catheterisation may be required.
- A connection (fistula) may develop between the vagina and the bladder or rectum as the operation site heals. This is extremely uncommon but may require further surgery.
- Pain during intercourse.
- Long-term recurrence of prolapse. Recurrence of prolapse is related to the age of the patient, condition of the skin pre-operatively, physical activity after the repair (especially heavy lifting) and most importantly, patient genetics. There is no doubt that some people are more prone to developing vaginal prolapse or hernias due to the way their connective tissues are formed.
- Unmasking of a previous tendency to stress incontinence. Sometimes vaginal prolapse hides the patient's tendency to leak from the bladder when coughing or sneezing. This may require further surgery.
- Infection in the operating site or urinary tract (around 5%). Generally easily treated with antibiotics.
- Having a cystoscopy may cause temporary irritation when voiding