Laparoscopic Paravaginal Repair

An operation for anterior vaginal wall prolapse

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1 Introduction

An anterior vaginal wall prolapse is a weakness of the front wall of the vagina. This is the area which the bladder and urethra sit behind and therefore is often referred to as a cystocele or cysto-urethrocele.

This leaflet provides information about an operation called a laparoscopic paravaginal wall repair. It is one of the operations that we offer to treat front wall prolapse. This leaflet has been made to help you understand why this operation has been recommended and what surgery might involve.

2 What does laparoscopic paravaginal repair mean?

Laparoscopic paravaginal repair is an operation to help with anterior vaginal wall prolapse. Using keyhole surgery, internal stitches are placed to lift up the front wall of the vagina either side of the bladder.

3 How can a laparoscopic paravaginal repair help?

If you have symptoms of a front wall prolapse, this operation is likely to help you. Although the operation is effective, no operation will work for everybody. Some women will find that the prolapse can recur. Sometimes, the operation works well initially but the problems start again some-time later.

4 What are the risks of laparoscopic paravaginal repair?

All treatments and procedures have risks and we will talk to you about the risks of laparoscopic paravaginal repair. Problems that occur during or after surgery are called complications. These are undesirable or unwanted effects that happen as a result of surgery. If a complication affects you, it does not mean that something must have gone wrong during the surgery. If you have a complication, you can expect us to explain what has happened, and whether any further treatment is required.

We always provide additional care and support for patients who experience problems after an operation.

We will use numbers to explain how often we might expect problems to happen after laparoscopic colposuspension. For example, a '10 in 100' chance of a problem means that if we performed 100 operations, the problem would happen 10 times. This is the same as a 10 per cent chance.

Problems that may happen straight away Bleeding during surgery

Bleeding that might need a blood transfusion: 1 in 100.

Infections after surgery

- Urine infection immediately after surgery: 30 in 100.
- Urine infections that might be a recurrent problem: 5 in 100.
- An infection of the small 'keyhole surgery' wounds: 1 in 100.
- Infection inside the pelvis: This has been reported but we do not know how often this happens. It is likely to be very uncommon.

How are infections treated? Most infections are easily treated with antibiotics. A serious infection might rarely need a second operation. Life-threatening infection after laparoscopic paravaginal repair is extremely rare.

Damage to other organs during surgery

Damage to bladder: 5 in 100.

Damage to the urethra: The urethra is the tube that you pass urine out of. Damage to the urethra has not been reported in research studies so it is likely to be rare. It could still happen, but we are not sure what the chance of it happening is.

If you are affected, the damaged organs will be repaired during the operation. Sometimes a cut on your abdomen called a laparotomy is needed in order to fix things. If you have had previous abdominal or pelvic surgery the risk of damage may be higher.

Rarely, damage might occur that is not recognised during the operation. If this happened, you might experience no symptoms, or you could become ill after your

surgery. You would need extra tests to find out if this was the case. You might need another operation to repair the damage.

How is bladder or urethral damage repaired? We use stitches to repair the bladder. A catheter tube is left in the bladder for around two weeks afterwards whilst the bladder heals. If the urethra is damaged, it is also repaired with stitches. You may need a catheter tube to be left in place for longer if the urethra is damaged.

Bladder symptoms after surgery

Paravaginal repair may improve bladder symptoms after surgery however some women will experience new or worsening bladder symptoms.

These problems might include:

- New or worsening urinary urgency: 5-10 in 100.
- Difficulty emptying your bladder:
    - Short term catheter use for a few days: 10 in 100. - Catheter use for six weeks or more: 3 in 100.
- Being unable to pass urine at all after surgery: We are not sure how often this happens but it is likely to be rare.
- Occasionally treating the prolapse can reveal underlying stress incontinence which may require additional surgery.

How is urinary urgency treated? Problems with urinary urgency after surgery often settle down on their own. If treatment is needed, medication or other non-surgical treatments are usually effective.

How are problems with bladder emptying dealt with?

Sometimes women can pass urine after surgery but the bladder does not empty very well. If this happens you might have to go home with a catheter tube in the bladder. It is removed after a few days and things usually go back to normal. If the bladder is still not emptying fully, you may have to use intermittent self-catheterisation up to four times a day. This means that you would pass a small catheter tube through the urethra yourself to empty the bladder. You would still pass urine normally and self-catheterisation would drain off any urine left behind. We would teach you how to do this. Things usually settle down in a few weeks although it can take longer. Permanent problems are uncommon.

What if I cannot pass urine at all? If this happens we will initially leave a catheter in place and send you home. We usually try to remove the catheter after a week. If you still cannot pass any urine we may allow a further week with a catheter tube in place. We might also teach you how to self- catheterise. If there is no improvement at all we sometimes recommend removing the internal stitches. Things may go back to normal afterwards, although your stress incontinence would come back. Sometimes the internal stitches are removed but problems with bladder emptying continue long term.

Pelvic pain or problems with painful sexual intercourse

If you do not have problems with pelvic pain or painful sexual intercourse before surgery, it is unlikely that you will have problems afterwards. The risk of developing problems is low:

New or worsening pain in the pelvis or groins: 5 in 100.

New or worsening painful sexual intercourse: 1-5 in 100.

If you already experience chronic pain in other areas of the body, the risk of pain after surgery is higher. Sometimes, pain can be a long-term problem.

What if I have persistent pain after surgery? If you have problems, you will be checked to see if there is a problem with the operation, or another cause. If no problem is found the pain could be coming from nerves that have been damaged by surgery. If this happens, you will be referred to a specialist in pain medicine and you may be prescribed medication.

What causes painful sex? After surgery, the position of the vaginal walls can be slightly different. This is because the stitches we put in to lift up the bladder can pull on the vagina. Although this does not usually cause problems, it can make sex uncomfortable for some women. This normally settles down in time. Painful sex can also be caused by a lack of hormones in the vagina. This can be treated with a hormone cream or tablet.

Can the internal stitches be removed if I have problems?

Severe pain after surgery is rare. If this happened, we might offer removal of the internal stitches. This would require another operation. This might help to improve your pain but in some cases the pain carries on. If the stitches were removed your stress incontinence would probably come back. This might need further treatment.

Problems that may happen later

Stress urinary incontinence might develop

This can occur even if the operation went well. It is due to unkinking of the urethra by correcting the prolapse.

You could develop a different prolapse

Prolapse is a condition where the womb or vaginal walls drop down from their normal position. You may feel that ‘something is coming down’ in the pelvis or have symptoms of a lump or bulge in the vagina. Having a laparoscopic paravaginal repair can sometimes make it more likely that you will develop other areas of vaginal prolapse. The risk depends on what other surgery is carried out at the same time.

The internal stitches used lift up the front wall of the vagina. This can weaken the tissues that support the womb and the back wall of the vagina, causing other prolapse. Most of the time, the back wall of the vagina is affected. This is the lower vagina covering the bowel. Occasionally, the womb can be affected. Sometimes we put some extra stitches in during your operation to try and prevent this happening or perform an operation to support the womb fully as part of the procedure. Five years after surgery, around 10-15 in 100 women might have problems with prolapse. Sometimes this requires extra treatment that might include surgery. The risk depends on whether or not the surgery is carried out together with an operation to support the womb or the top of the vagina.

You could develop a suture erosion

Normally we use permanent sutures to hold up the vagina to give a better long-term result. The decision on whether or not to use permanent sutures is based on the degree of prolapse and what other additional procedures are performed. Rarely after several months to years these sutures can migrate into the vagina or bladder and need a small operation to remove them.

Problems that are rare, but serious

- Damage to major blood vessels and life-threatening bleeding: 1 in 1000.
- Blood clots in the legs that can travel to the lungs: 5 in 1000.
- Damage to the ureters: 5 in 1000.
- Damage to bowel: 1 in 100.
- Internal stitches migrating into the bladder: 1-10 in 1000.

The ureters are the tiny tubes that carry urine from the kidneys to the bladder.

If any organs are damaged during surgery, they will be repaired whilst you are asleep. Sometimes a cut on your abdomen called a laparotomy is needed in order to fix things. If you have had previous abdominal or pelvic surgery the risk of damage may be higher.

Rarely, damage might occur that is not recognised during the operation. If this happened, you might experience no
symptoms, or you could become ill after your surgery. You would need to extra tests to find out if this was the case and you might need another operation.

How is serious bleeding dealt with during surgery?

Damage to major blood vessels is rare but can cause life- threatening bleeding. If this happens, a large cut on the abdomen is needed to repair the damage. You would require a major blood transfusion that would be life saving. **Please ensure to tell you doctor if you would not accept a blood transfusion on religious or other grounds. This is extremely important.**

What happens if I develop a blood clot? After surgery, blood becomes stickier, and clots more easily. Blood clots can form in the legs, break off, and travel through the bloodstream to the lungs. These blood clots stop the lungs working properly, causing breathing difficulties. This condition is known as 'venous thromboembolism'. If this happens, your hospital stay will be prolonged, and you will be given blood thinning medication for a few months. Thankfully, the condition is only life-threatening for very small number of affected patients. To reduce the risk of this problem, you will wear special stockings on your legs, and receive a small, daily injection of blood thinning medication in hospital.

What happens if my ureters are damaged? Damage to the ureters is repaired with stitches. Tiny plastic tubes, known as stents, are placed inside the ureters whilst they heal. Rarely, it may be necessary to perform a bigger operation to change how the ureters and the bladder are connected to fix things. This is known as a 'ureteric re-implantation'. If this happens, you may need to see a specialist for a regular check up after your surgery. This is to make sure you do not develop any problems after the repair.

How is bowel damage repaired? Bowel is usually repaired using stitches. Rarely, a small piece of bowel has to be removed. We would not expect this to cause any long-term problems. If the damage is serious, a stoma might be required. This is an opening on the front of your abdomen that diverts your faeces into a bag whilst the bowel heals. The stoma would be a temporary measure whilst the bowel heals. The stoma is usually reversed within a few months.

Problems with the anaesthetic

You will be given a general anaesthetic for your operation. This means that you will be unconscious and will not feel anything during your surgery. Anaesthetists are doctors who specialise in anaesthetics. Your anaesthetist will give you your anaesthetic medication and gently place a tube through your mouth into your throat. This is to keep your windpipe open so oxygen can get to your lungs.

Some problems are very common after an anaesthetic. They normally settle down very quickly after surgery or are easy to treat. Sore throat or throat pain, feeling sick and vomiting, or shivering after surgery, can affect up to half of patients.

Some problems are more likely to affect certain groups of patients. If you are older, overweight, a smoker, or have other medical problems, you are more likely to be affected:

Chest infection after surgery: 1-10 in 100.
Permanent nerve damage: 1 in 1000.
Permanent loss of sight: 1 in 100,000.
Death as a result of anaesthesia: 1 in 100,000.

Older patients, especially those with dementia, poor eyesight or hearing, can become confused after an operation. It is not known how often this happens.

Damage to the lips and tongue may occur but this is usually minor. Tooth damage is more likely to happen if you have diseased teeth and gums, or have had extensive dental work:

Damage to the lips and tongue: 5 in 100. Damage to teeth: 5 in 10,000.

Some problems can happen to anyone as a result of an anaesthetic:

The eyeball getting grazed or damaged: 4 in 10,000.
Being aware of what is happening during surgery despite the

anaesthetic: 5 in 100,000.
Life-threatening allergic reaction: 1 in 10,000.

5 What will happen if I choose not to have laparoscopic paravaginal repair?

If you decide not to have this operation you could simply carry on as you are. You will continue to have symptoms of front wall prolapse. Whilst these symptoms can be distressing, you are unlikely to come to any harm.

6 What alternatives are available?

After reading this leaflet, you may decide that you want to look at other options. A vaginal repair is an alternative and this will have been discussed as an option and the reason why this was not the recommended approach for your situation.

The non-surgical alternatives to laparoscopic paravaginal repair include:

- Pelvic floor physiotherapy.
- Weight loss.
- A pessary.

Will physiotherapy work? You will be taught how to strengthen your pelvic floor muscles with an expert physiotherapist. If you keep doing the exercises, they seem to keep working. If you stop, your problems will come back. Success rates depend on the amount of prolapse present.

Can weight loss help? If you are overweight, weight loss may reduce prolapse symptoms. If you need advice or guidance to help you lose weight, please speak to your GP.

What is a pessary? These are flexible plastic or silicone rings that are inserted into the vagina. They gently press on the walls of the vagina. If you use a pessary, you will need a check up every six months so that your vagina can be examined. Pessaries can sometimes rub on the vaginal walls, or cause a little bleeding or

discharge. This affects around 5 in 100 women. Rarely a minor infection can develop. Pessaries can be safely used long term. You can learn to remove and replace the pessary yourself. This is helpful if you only use it at certain times when your symptoms are worse. Some women use pessaries only when they are exercising. Some women remove their pessary overnight. Pessaries can make sex difficult as they might get in the way.

7 How should I prepare for laparoscopic paravaginal repair?

The Preoperative Assessment Clinic (PAC)

Before your operation, you will be seen in the PAC to make sure that you are fit for your surgery. Specialist nurses and anaesthetists run the clinic. When you have your appointment, you should bring the following:

- A list of your medical conditions and previous operations.
- A list of your current medications and allergies.

Sometimes, certain types of medication need to be stopped before your operation. The team in PAC will tell you if any of your medication needs to be stopped and which ones you should take on the day of your operation. **Please do not stop any medication before your operation unless you are asked to do so. Stopping important medication before your surgery may mean that your operation is cancelled or you come to harm.**

Most patients may need to take additional medication the day before their surgery to clear their bowels. This is called 'bowel preparation'. If you require bowel preparation, we will discuss it with you before your operation.

What if the PAC finds a problem? Occasionally, a new health problem is found. Sometimes, an existing problem may need further treatment before surgery. If this happens, your surgery will need to be delayed. Your GP will be asked to arrange any extra tests, treatment, or consultations with other specialists. Whilst we understand how disappointing this might be, the PAC team are there to make sure your surgery is conducted safely. If your operation is delayed, we will arrange another date for you as quickly as possible when you are cleared for surgery.

The day of your surgery

On the day of surgery, after admission, your operating surgeons will see you for final checks. The nurses will then prepare you for your surgery.

You may be given an enema to clear out the lower bowel before your operation. You will not need this if you took bowel preparation.

On the day of surgery, you should follow the instructions given to you at the PAC appointment about the following:

- Which medications to take on the morning of surgery.
- When to stop eating and drinking before your surgery.

If you are confused about any of the instructions, you must contact us before your surgery.

Please be aware that your surgeon will be operating on several patients normally until 21.00. They are often unable to leave the operating theatre between patients. For this reason, they see all patients before the list starts, even if surgery is planned for later in the day.

If your surgery is late in the afternoon, you may be allowed to drink some water. Drinking at the wrong time may mean that your operation is cancelled.

There is a very small chance that your surgery may be cancelled on the day you come in to hospital. This might happen because the hospital is full and there is no bed for you. This is uncommon but obviously very distressing if it occurs.

Making plans for after your surgery

Please make plans well in advance:

- You will be in hospital for one or two nights.
- Please ensure that your travel plans are flexible. Remember that your stay might also be extended on medical grounds.
- You will need an escort to help you get home and you will not be able to use public transport to get home alone.
- You will need at least two to three weeks off work. If you have a strenuous job you may need longer to recover.
- You should avoid carrying anything heavier than 5kg for the first four weeks after surgery.
- You will need friends and family to help with groceries and household chores, particularly in the first two weeks.
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8 Asking for your consent

We want to involve you in all the decisions about your care and treatment. If you decide to go ahead with treatment, by law we must ask for your consent and will ask you to sign a consent form. This confirms that you agree to have the procedure and understand what it involves. Staff will explain all the risks, benefits and alternatives before they ask you to sign a consent form. If you are unsure about any aspect of your proposed treatment, please ask to speak with a senior member of staff again.

9 What happens during a laparoscopic paravaginal repair?

The operation takes around two hours and is performed using ‘keyhole surgery’.

- A camera, known as a cystoscope, is passed into the bladder through the urethra. Two thin tubes may then be passed through the ureters to protect them during your surgery. These tubes are called ‘ureteric catheters’.
- Four or five small cuts are made on the abdomen and special tubes, known as ‘ports’, are placed through these cuts.
- A tiny camera and special operating instruments are inserted through the ports.
- Pictures of the inside of the abdomen are sent from the camera to television screens that the surgeons watch.
- Your surgeon will place internal stitches to support the front wall of the vagina either side of the bladder. These stitches are not placed into the bladder itself. They are inserted into strong tissue, known as fascia, which is between the front wall of the vagina and the bladder. Two stitches are placed in the fascia on each side.
- The other ends of the stiches are pulled up and tied up to the back of the pubic bone.
- We normally use stitches that do not dissolve and are permanent.
- Once this part of the operation is finished, we check inside the bladder using a cystoscope inserted through the urethra. This is to make sure that none of the internal stitches passed through the bladder by accident. If all is well, we then remove the ureteric catheters.
- You will have a drip in your hand and a catheter tube in the bladder.

  The drip will be removed the day after surgery. The catheter might be removed whilst you are in hospital, depending how long you stay. Sometimes we will send you home with a catheter draining into a bag on your leg for a few days. This is to let the bladder rest after surgery. If you go home with a catheter tube still in the bladder, it will need to be removed by a few days later. The nurses usually do this in the outpatient clinic a few days after you are sent home. You will be given an appointment for this if it is needed.

  We explained earlier that laparoscopic paravaginal repair might make it more likely that you develop prolapse in the future. This can happen many months or even years after the operation. If it does, the back wall of the vagina is usually affected. This is the lower vagina covering the bowel.

  Occasionally, womb prolapse can be a problem after laparoscopic paravaginal repair. Whilst we are operating, we can sometimes see that the womb is being pulled down by the internal stitches we are putting in. This might lead to womb prolapse in the future, which can cause symptoms.

  If this happens, we might do an additional procedure to help lift the womb up. This procedure is called a laparoscopic sacrohysteropexy.

  We will have discussed potential additional surgery.

10 What should I expect after laparoscopic paravaginal repair?

The first two weeks after surgery

- You will need to rest and take regular painkillers.
- You should take regular medicine, known as a laxative, to keep your bowels opening every day.
- You will spend some of your time at home but should take short walks. You should avoid anything strenuous and lifting anything heavier than 5kg.
- You should try to shower, rather than have a bath, to allow the keyhole stitches to heal. If you do take a bath, do so in shallow water for a maximum of ten minutes.
- You can remove the plasters from the keyhole scars after three days and then keep the areas clean and dry.
- If you have any urgent worries please contact the hospital
- For any non-urgent worries pleade contact the consultant PA.
- We will give you a supply of painkillers, laxative medication, and any other drugs you will need at home. If you need further supplies after you have gone home, you will need to contact your GP.

Weeks two to four after surgery

- You will be able to reduce your regular painkillers, start taking them only if needed, and eventually stop using them.
- You will continue to use your laxatives to keep your bowels opening daily. If you can do this by eating plenty of fruit and fibre, and drinking enough water, you can stop the laxatives.
- You can increase your activity, go out for longer walks, and visit friends and family, provided you take things easy.
- You will continue to avoid lifting anything heavier than 5kg.
- You can start driving again but you should inform your insurance company that you have had surgery. They must be happy for you to drive again. You should only start driving again if you feel safe to do so. You must be able to perform an emergency stop if needed.

Four weeks onwards

- You can get back into your normal routine and return to work. If you have a strenuous job, you may need slightly longer to recover.
- If you exercised regularly before your surgery, please discuss this with us before you go home. We might suggest some changes to your usual exercise programme.
- You can start having sexual intercourse after six weeks.

We will need to make a clinic appointment normally three months after surgery.

What serious problems should I look out for? Serious problems after surgery are rare but they need to be checked urgently. If you develop the following symptoms, you should go to your nearest Accident and Emergency department or contact the hospital.

- High fever.
- Repeated vomiting.
- Pain in the abdomen that is getting worse.
- Swelling of the abdomen that is getting worse.
- You are unable to pass urine or pass very little.
- Swelling, redness, or tenderness in the lower legs. - Difficulty breathing, or chest pain.

If you have to go to hospital, please contact the consultant afterwards to let them know.

What I have other less urgent problems? You should discuss these problems with your consultant or your GP within 24 hours. Such problems might include:

- Burning when you are passing urine.
- Difficulty passing urine.
- Not opening your bowels for three days.
- Redness around your abdominal wounds. - A smelly vaginal discharge.