

Dr Alison De Souza
M.B.B.S., F.R.A.N.Z.C.O.G., C.U.
Urogynaecologist, Obstetrician & Pelvic Floor Surgeon
ABN: 565 785 716 40
Provider No. 216403JA

145 Victoria Parade
FITZROY VIC 3065

www.dralisonsouza.com.au

Ph: 9419 9699
Fax: 9419 8744

Vaginal Prolapse Surgery- Patient Information

The aim of prolapse surgery is to support the vaginal walls, maintain vaginal function and treat incontinence if necessary. Symptoms of prolapse include the feeling of a lump, dragging sensation or “something coming down”.

Surgery involves having a regional or general anaesthetic. A regional anaesthetic numbs part of your body while you remain awake. A general anaesthetic relaxes your muscles, makes you feel as if you are in a deep sleep, and prevents you from feeling pain.

Anterior Repair

Due to a weakness, prolapse has occurred of the front wall of the vagina. This can sometimes be associated with urinary leakage (incontinence) and/or difficulty emptying the bladder. The vagina overlying the bladder and urethra (water pipe) is incised in the midline. The bladder is mobilized and sutures are placed to support the front wall of the vagina and restore normal anatomy. The vaginal skin is closed with an absorbable suture.

Posterior Repair

Due to a weakness, prolapse has occurred of the back wall of the vagina. This can sometimes be associated with difficulties emptying the bowel or difficulty with bowel control. The vagina overlying the rectum is incised and the rectum is mobilized. Sutures are placed to support the back wall of the vagina.

Mesh Reinforcement

If the repair is a repeat procedure, or for very large prolapse the use of mesh may be necessary to allow extra support.

Vaginal Vault Suspension

After a hysterectomy prolapse of the apex or top of the vagina can occur. A number of surgical solutions to the problem may be used.

1) Uterosacral or Sacrospinous Fixation

This surgery offers support to the upper vagina. After incision of the vaginal skin and mobilisation of the back passage (rectum), the uterosacral ligaments or the sacrospinous ligament is identified and exposed. Sutures are placed through these ligaments on one or both sides and attached to the top of the vagina.

2) McCall Culdoplasty

This is usually performed at the time of vaginal hysterectomy to prevent further prolapse. The uterosacral ligaments (strong ligaments in the pelvis) are identified and incorporated into the closure of the peritoneum and upper vagina using 1-2 sutures.

Very commonly, more than one area is affected by prolapse. All these procedures may be performed in combination if necessary, depending on your individual problems.

Possible Side Effects of Prolapse Surgery

There are some risks like heart attack, blood clots in the legs or the lung (< 1%) or stroke, which may occur with any major surgery.

Infection can occur. To minimize this risk you will receive antibiotic cover during the procedure as prevention. Excessive bleeding is very uncommon. A blood transfusion would be rarely required.

Difficulty passing urine can be experienced (1-2%) after the surgery. This is usually temporary, but rarely may require the prolonged use of a urinary catheter or intermittent self catheterisation.

Inadvertent involvement of adjacent structures (urethra, the bladder, the rectum or the ureters) occurs rarely (3-5/1000) and is usually repaired during the surgery. If this is not identified and repaired at the time of the surgery a connection (fistula) between the bladder and vagina or backpassage and vagina can occur (1-2/1000 cases). This would require further repair surgery to be resolved.

A cystoscopy is performed routinely to look inside the bladder to reassure normality of the bladder. The normal function of the ureters is checked at the end of the surgery.

After prolapse is repaired, stress urinary leakage that was not present before the surgery can occur (5-10%).

With sacrospinous fixation buttock pain on the side that the sutures have been placed can occur (5-10%). This can be painful but usually subsides by 6 weeks.

Recurrence of the prolapse is possible (5-30%).

Shortening of the vagina resulting in painful intercourse (5%) can occur following prolapse surgery.

If it is necessary to use mesh to reinforce the repair there is a 5 to 10 % risk of mesh erosion or infection. This may require removal of the part of the mesh at a later time.

Discomfort with intercourse is not uncommon initially but usually improves after a few weeks. Occasionally this can persist for a longer period of time (5%).

There are other rare complications that can occur that have not been discussed here.

If you require further information please discuss this with your surgeon before the surgery.