

Women's Services

The prosima pelvic floor repair utilizing mesh and a vaginal support device (VSD)

Description of treatment: Surgical operations to treat prolapse of the vagina or womb, aim to return the tissues and organs to their correct position. A number of operations can be performed to achieve these aims. These include

- Pelvic floor repair with or without mesh, performed through a cut in the vagina.
- Pelvic floor repair with or without mesh and sacrospinous fixation (the prolapsed tissue is fixed with a stitch to a ligament inside the pelvis, all performed through a cut in the vagina).
- Abdominal Sacrocolpopexy with mesh (the vagina or womb is fixed to the inside of the pelvis using a mesh. This operation is performed either through keyhole surgery or through a larger cut in the tummy).
- A combination of vaginal and abdominal operations.

If your womb is contributing to your prolapse we will suggest performing a hysterectomy at the time of your pelvic floor repair surgery. Additional patient information leaflets are available covering abdominal, vaginal and laparoscopic/keyhole hysterectomy. Please ask for this information if you haven't been given it.

Preparing for your operation

You should maintain a sensible diet aimed at reducing your calorie intake. Daily exercise in the run up to the operation will improve your recovery. A 30 minute brisk walk, three to four times a week should be sufficient. Swimming is a good alternative. Avoid alcohol and cigarettes in the month before the operation.

Discuss the operation with your General Practitioner and get him/her to review your medications. Medications such as low dose aspirin, non-steroidal anti-inflammatories (such as ibuprofen, diclofenac) need to be stopped at least seven days before the operation. Blood thinning medications such as Warfarin need to be converted to an alternative drug before the operation. If you are on high blood pressure medication you should arrange to have your blood pressure checked by your General Practitioner.

If you have any symptoms of a cold or flu in the days leading up to the operation you must let your surgeon know as this may necessitate the cancellation of your operation. It is very dangerous to undergo surgery if you have any sort of infection.

In the two days before the operation take plenty of fluids. Ensure that you drink at least 1.5 to 2 litres of fluid in the two days before the operation. It is important to avoid dehydration in the days before the operation.

Before your operation

- You will be seen in the pre-admission out-patients clinic by the pre-admission sisters and usually you will see one of the consultants or a member of their medical team.
- At this clinic, we will ask you for details of your medical history and perform any necessary clinical examinations and investigations. This is a good opportunity for you to ask us any questions about the procedure, but please feel free to discuss any concerns you might have at any time.
- If you are taking any tablets or other forms of medication, you should tell the pre-admission sister and the doctor treating you. Usually, we will ask you to stop hormone-replacement treatment (HRT) or tamoxifen at approximately two weeks prior to surgery, if appropriate. We will also give you advice if you are taking warfarin or aspirin like drugs (such as ibuprofen or diclofenac) that might prevent your blood from clotting.
- Most people who have this type of procedure will stay in hospital for two to four days. However, some women are ready to be discharged the day following surgery. Sometimes we can predict whether you will need to stay for longer than usual. Your doctor will discuss this with you before you decide to have the procedure.
- Before your operation your anaesthetist will visit you on the ward, although occasionally this will happen in a pre-anaesthetic assessment clinic. The anaesthetist who looks after you on the day of your operation is the one who is responsible for making the final decisions about your anaesthetic. They will need to understand about your general health, any medication that you are taking, any past health problems that you have had, whether or not you are a smoker, whether you have had any abnormal reactions to any drugs or if you have any allergies. They will also want to know about your teeth, whether you wear dentures, have caps or a plate. Your anaesthetist needs to know all these things so that he or she can assess how to look after you in this vital period. Your anaesthetist may examine your heart and lungs and may also prescribe medication that you will be given shortly before your operation, the pre-medication or 'pre-med'.
- Pre-medication is the name given to medication (drugs) given to you some hours before your operation. These drugs may be given as tablets, injections or liquids. They relax you and may send you to sleep. They are not always given. Do not worry if you do not have a pre-med, your anaesthetist has to take many factors into account in making this decision and will take account of your views on the topic if possible. Do not be worried about your anaesthetic. When your anaesthetist visits you before your operation, this is the time to ask all the questions that you may have, so that you can forget your fears and worries.

- Before your operation you will usually be changed into a gown and wheeled to the operating suite into an anaesthetic room. This is an ante-room outside the theatre. The anaesthetist, his or her assistant and nurses are likely to be present. An intravenous line (drip) may be inserted. Monitoring devices may be attached to you, such as a blood pressure cuff or a pulse oximeter. A pulse oximeter is usually a little red light in a small box, which is taped to your finger. It shows how much oxygen you have in your blood and is one of the vital monitors that an anaesthetist uses during your operation to ensure that you remain in the best of health. You may be given some oxygen to breathe.

During your operation

- You will be given a general anaesthetic for this operation. Whilst you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you in the correct level of unconsciousness for the period of the surgery. Your anaesthetist is constantly aware of your condition and trained to respond. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. They will also constantly watch your need for fluid or blood replacement. If you have any other medical conditions, your anaesthetist will know of these from your pre-operative assessment and be able to treat them during surgery.
- Occasionally the anaesthetist will decide to do the operation under spinal anaesthetic. In this case you will be awake during the operation but may also be administered a sedative. The anaesthetist will discuss this with you in more detail.

Prosima pelvic floor repair system

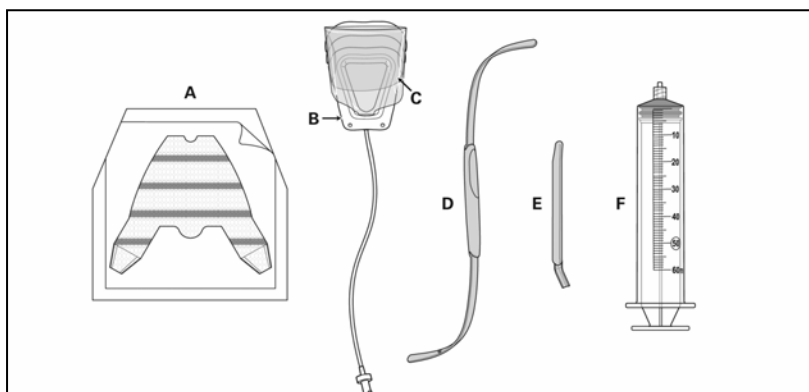
- Operations for pelvic floor repair are associated with a significant failure rate. In order to reduce this surgeons have been using plastic mesh implants to support routine pelvic floor repairs. It is hoped that these plastic prostheses will improve the success rate of the operation both functionally and anatomically.
- The operation will begin as a standard anterior or posterior repair. These are described below.

Anterior vaginal repair

This operation is performed to treat a bulging of the bladder or urethra in to the anterior wall of the vagina. The vagina overlying the bladder and urethra is cut in the midline and the tissues supporting the bladder are repaired using stitches that dissolve.

On completion of the repair a dissection is made into an area in the pelvis alongside the bladder. Using specially designed instruments the arms of a specially prepared Y-shaped mesh (Fig 1: A) are placed into the tunnels with their ends adjacent to the obturator internus muscle. (One of the muscles in the pelvis)

Fig 1



The excess vaginal skin is removed and the skin then closed in two layers with absorbable sutures.

Posterior vaginal and perineal repair

This operation is performed to treat a bulging of the rectum in to the posterior wall of the vagina. At the same time we may also repair the perinium (area separating entrance of the vagina and anus). A cut is made in the posterior wall of the vagina, starting at the entrance and finishing at the top of the vagina. The tissues supporting the posterior wall of the vagina are repaired using stitches that dissolve.

On completion of the repair two tunnels are dissected on either side of the bladder in the direction of a ligament (sacrospinous) in the pelvis. Again using specially designed instruments the arms of the mesh are placed into the tunnels so that the ends lie alongside the sacrospinous ligament.

Sometimes excessive vaginal skin is removed before the vaginal skin is then closed, again with dissolvable stitches. The perineum is repaired by placing deep sutures into the perineal muscles. The overlying vaginal and vulval skin is then repaired with stitches that dissolve.

The mesh provides a scaffold, into which your tissues grow. The mesh is cut into a shape that is considered to be the correct dimension and shape to repair the damaged tissue. To ensure that the mesh stays in the correct place, a flat trapezoid silicone splint is placed and stitched into the vagina. (Fig 1: B) Attached to the splint is a balloon which will be inflated for the first 24 hours to prevent bleeding. (Fig 1 C and Fig 2) This splint will be removed four weeks after your operation. You will be asked to attend the gynaecology ward, where one of the medical team will remove the splint, with you awake on an examination bed.

Fig 2

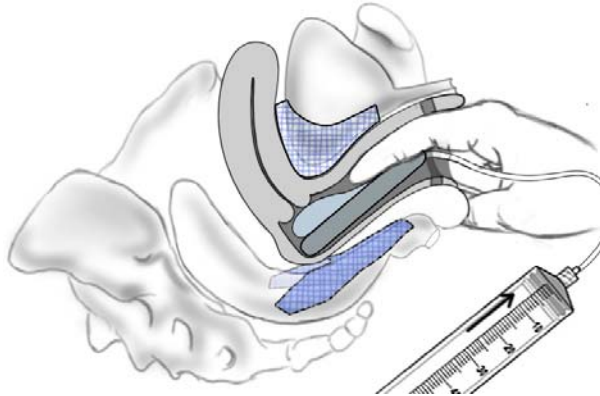
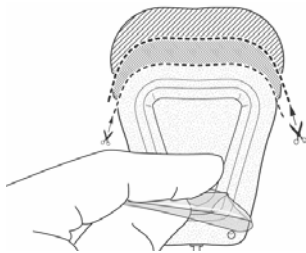


Fig 3



The prosima pelvic floor repair system

This operation is a modification of previously described pelvic floor repair operations using mesh. An audit of a prototype of this operation was published in 2008 with success rates of 85% and minor complications in less than 8%.

In mesh operations there is a risk of the mesh eroding into the vagina. This can cause a discharge and bleeding and may require a return to theatre for removal under anaesthetic.

A further study looking at the outcome of the operation was performed at 10 centres around the world. A total of 134 patients were included. The patients were followed up for one year after surgery.

In this study 78% had complete anatomical resolution of the prolapse. 73% reported themselves to be much better with over 85% reporting themselves as a little better or much better. The majority of the patients reported an improvement in sexual activity with only five reporting the new onset or persistence of pain at one year.

The majority of patients were not troubled by the pessary. Most found it acceptable and tolerable. In 10 patients the pessary fell out or had to be removed before the four week mark.

Complications

A list of complications in this study appears below:-

Bladder perforation	2	1.3 %
Mesh exposure	12	8.1 %
Incision site infection	4	2.7 %
Urinary tract infection	4	2.7 %
DVT	2	1.3 %
OAB/UUI	6	4.4 %
SUI	6	4.0 %

After your operation

- A catheter (tube) will be placed in your bladder during the operation to allow accurate measurements of your urine output, during and after the operation. This will probably be removed on the ward, when you are able to mobilize to the bathroom. In a small percentage of patients this may need to be in place for one or two weeks. If that is the situation for you, you will be discharged home with a urine collection bag that can be strapped to your leg. You will then be readmitted to the ward for a day to remove the catheter and ensure that you are able to empty your bladder completely.
- After your operation your anaesthetist continues to monitor your condition carefully. You will be transferred to a recovery ward where specially trained nurses, under the direction of anaesthetists, will look after you. Your anaesthetist and the recovery nurses will ensure that all the anaesthetic effects are reversed and that you are closely monitored as you return to full consciousness. You may be given some oxygen to breathe in the recovery area and may find that intravenous drips have been inserted whilst you are unconscious in theatre and that these will be replacing fluids that you might require. You will be given medication for any pain that you might feel, and systems, such as patient controlled anaesthesia (PCA) may be set up to continue pain control on the ward. Your intravenous drip will also be attached to a bag of fluid, which feeds your body with fluid until you are well enough to eat and drink by yourself.
- You are likely to feel drowsy and sleepy at this stage. Some patients feel sick, others may have a sore throat related to the insertion of the breathing tube during surgery. During this time it is important that you relax as much as you can, breathe deeply, do not be afraid to cough and do not hesitate to ask the nursing staff for any pain relief or anti-sickness medication. You are likely to have hazy memories of this time and some patients experience vivid dreams. Once you are fully awake you will be returned to the ward.

Balloon

The balloon will be deflated the next morning on the ward and removed. In the study no discomfort was experienced with this procedure.

The splint will be removed after four weeks. Once again the study demonstrated that this is a painless procedure.

- **Eating and drinking:** Usually following surgery you will be able to drink fluids when you are ready. If you feel hungry, you can usually have something light to eat soon after the operation.
- **Getting around and about:** After your operation, we will try to get you mobile (up and about) as soon as we can to help prevent complications from lying in bed.
- **When you can leave hospital?** The actual time that you stay in hospital will depend on how quickly you recover from your operation and the type of operation you have had. Usually, you will be in hospital for at least one to two nights, although the actual time you are an inpatient can range from 24 hours to several days after the operation. If you have problems with the operation or require further treatment you might need to stay in for longer.
- **After you are discharged from hospital:** You may experience a heavy bleed (as much as a period) about 10 days after the operation. This is normal and will usually settle within a few hours. A vaginal discharge can persist for up to four to six weeks. Weight loss and avoidance of smoking can minimize failure of the procedure in the long term.
- You should avoid driving until you are pain free. It is worth checking with your insurers about your safety to drive.
- Sexual activity can usually be safely resumed after six weeks. It is sensible to use a commercial lubricant for the first time (Amielle, Durex).
- In the early postoperative period you should avoid situations where excessive pressure is placed on the repair, such as lifting (more than 15kg), straining, coughing and constipation. The tissues take up to three months to repair fully and care needs to be taken during this time. If you develop urinary burning, frequency or urgency you should see your local doctor. You can return to work at approximately four to six weeks depending on the amount of strain that will be placed on the repair at your work and on how you feel.
- **Check-ups and results:** You will be given information about your operation during your time in hospital. A follow-up clinic appointment will be made when you are discharged from the ward. We aim to see you three to four months after your surgery. However, should you feel the need to talk to the surgeons or other staff, before your follow up please contact us through our secretarial team (01223 245151).

Who will perform my procedure?

This procedure will be performed by a consultant gynaecologist or a qualified doctor undertaking supervised gynaecological training.

Alternative treatments that are available

- Physiotherapy may improve some of your symptoms however the more severe cases are unlikely to be helped. Even if physiotherapy doesn't improve your symptoms it will improve the outcome of surgery.
- A vaginal pessary may help control the symptoms caused by your prolapse. There are many different types of pessary but the most commonly used are ring and shelf pessaries. These are fitted in the out-patients clinic and if placed correctly you will not be able to feel the pessary. It may take more than one visit to fit the correct size pessary for you. Once inserted, they need to be changed every few months. Pessary changes may be performed by your GP or at the outpatient clinic, by a member of our team. Ring pessaries do not prevent intercourse, but they are not suitable for some patients and will fall out. Over time some patients will develop vaginal discharge or bleeding and the pessary will need to be removed.

What might happen if I don't have an operation?

Your problem may remain the same or get worse. There is no sure way of predicting this. Life style modifications may help your symptoms. These changes may help you to decide whether you have an operation or not.

- Adjusting your daily routines to help you cope better
- Weight loss if you are overweight
- Managing a chronic cough if you have one
- Giving up smoking
- Trying medication for your bladder if it is a problem

Your GP or your gynaecologist may be able to help you achieve some of these.

What are the risks of the surgery?

See under each operation listed above.

What are the risks of general anaesthesia?

- In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but in recent years, modern equipment, training and drugs have made it a much safer procedure. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or whether your operation is complicated, long or done in an emergency. Please discuss any pre-existing medical condition with your anaesthetist.
- Very common and common side effects (1 in 10 or 1 in 100 people) Feeling sick and vomiting after surgery, sore throat, dizziness, blurred vision, headache, itching, aches, pains and backache, pain during injection of drugs, bruising and soreness, confusion or memory loss.

- Uncommon side effects and complications (1 in 1000 people) Chest infection, bladder problems, muscle pains, slow breathing (depressed respiration), damage to teeth, lips or tongue, an existing medical condition getting worse, awareness (becoming conscious during your operation).
- Rare or very rare complications (1 in 10,000 or 1 in 100,000) Damage to the eyes, serious allergy to drugs, nerve damage, death, equipment failure.

Information and support

You might be given some additional patient information before or after the procedure, such as leaflets that explain what to do after the procedure and what problems to look out for. If you have any questions or anxieties, please feel free to ask a member of staff.

Pre admissions sisters

Monday to Friday 0700 to 1430 hours

Telephone 01223 586847 (internal ext 6847)

E-mail: preadmission.nurses@addenbrookes.nhs.uk

The Pre - admission Sisters will be available in the office between 0700 to 0900 hours. Otherwise please leave a message on the answer machine and your call will be returned.



We are currently working towards a smoke free site. Smoking is only permitted in the designated smoking areas.

For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169

Help with this leaflet:



If you would like this information in another language, large print or audio format, please ask the department to contact Patient Information: 01223 216032 or patient.information@addenbrookes.nhs.uk

Polish

Jeżeli chciałbyś uzyskać te informacje w innym języku, w dużej czcionce lub w formacie audio, poproś pracownika oddziału o kontakt z biurem Informacji Pacjenta (Patient Information) pod numerem telefonu: 01223 216032 lub pod adresem patient.information@addenbrookes.nhs.uk

Portuguese

Se precisar desta informação noutra língua, em impressão de letras grandes ou formato áudio, por favor peça ao departamento que contacte a secção de Informação aos Doentes (Patient Information) pelo telefone 01223 216032 ou através do e-mail patient.information@addenbrookes.nhs.uk

Arabic

إذا كنت تود الحصول على هذه المعلومات بلغة أخرى، بالأحرف الكبيرة أو بشكل شريط صوتي، يمكنك أن تطلب من القسم الاتصال بمعلومات المريض على الرقم: 01223216032 أو عبر البريد الإلكتروني: patient.information@addenbrookes.nhs.uk

Cantonese

如您需以另一語言版本、特大字體或錄音形式索取本資料，請要求部門聯絡病人諮詢服務：電話 01223 216032，電郵地址 patient.information@addenbrookes.nhs.uk

Turkish

Eğer bu bilgileri başka bir dilde veya büyük baskılı veya sesli olarak isterseniz, lütfen bulunduğunuz bölümdeki görevlilere söyleyin Hasta Bilgilendirme servisini arasinlar: 01223 216032 veya patient.information@addenbrookes.nhs.uk

Urdu

اگر آپ کو یہ معلومات کسی دیگر زبان میں، بڑے الفاظ میں یا آڈیو طریقہ سے درکار ہوں تو برائے مہربانی اس شعبہ سے پیشینٹ انفارمیشن سے ذیل کے ذریعہ رابطہ کرنے: 01223 216032 یا patient.information@addenbrookes.nhs.uk کی درخواست کریں:

Bengali

আপনি যদি এই তথ্য অন্য কোন ভাষায়, বড় অক্ষরে বা অডিও রেকর্ডিং পেতে চান তাহলে 'প্যাশেন্ট ইনফরমেশান' এর সঙ্গে 01223 216032 নম্বরে ফোন করে বা patient.information@addenbrookes.nhs.uk ঠিকানায় ই-মেইল করে যোগাযোগ করার জন্য ডিপার্টমেন্টটিতে অনুরোধ জানান।

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Authors	Mr Mark Slack
Department	Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 0QQ www.cuh.org.uk
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