

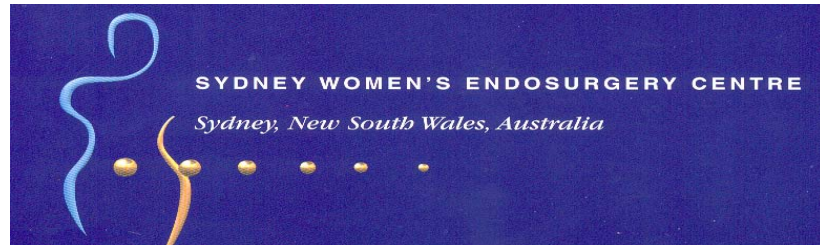
# VAGINAL SURGERY AND PELVIC FLOOR RECONSTRUCTION

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## Information Sheet for patients having a Vaginal prolapse Operation



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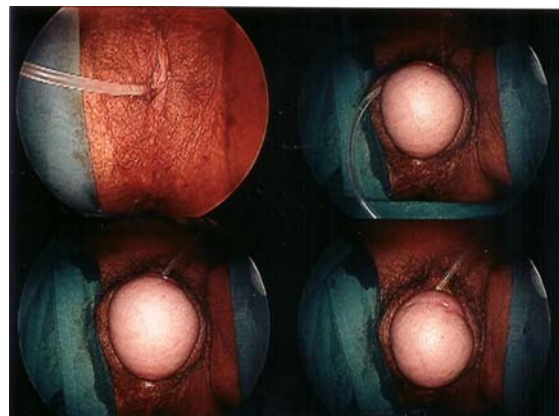
### WHAT IS THE PELVIC FLOOR?

The female pelvic floor is composed of voluntary muscles, fascia and ligaments. These structures have a supportive component and a functional component. They support the bladder, vagina and uterus and the rectosigmoid and are involved in bladder storage, voiding and continence. They are also involved in providing support for the vaginal wall and the cervix and uterus, and also with sexual function. They have a major role in defecation and continence of faeces. Abnormalities of the pelvic floor manifest themselves as urinary incontinence, uterovaginal prolapse, sexual dysfunction and obstructed defecation and faecal incontinence.

### What is the role of traditional vaginal surgery?

Vaginal prolapse affects about **50%** of women and at least **10%-20%** of women present for surgery for prolapse often associated with urinary incontinence. Vaginal surgery has been carried out for approximately 150 years following the first repair of a bladder fistula. The surgery was refined 100 years ago and again more recently over the last 10 to 12 years. With the advent of abdominal surgery for prolapse and incontinence repair about 40 years ago and the arrival of laparoscopic surgery for prolapse repair in the last 12 years, we

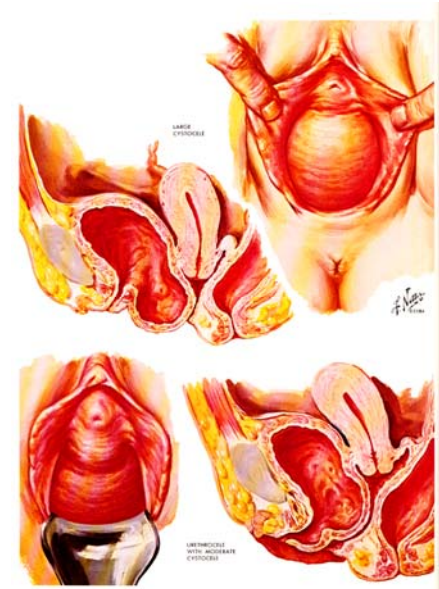
have seen a decreasing role in traditional vaginal surgery. There is however a significant place for vaginal operations. Some repairs of the anterior compartment are best performed from below. These include treatment of urethral prolapse or **urethrocoele** and central prolapse of the bladder base called **central cystocele**. Even the lateral bladder defects or paravaginal defects can be repaired vaginally particularly now with the advent of **mesh** which is revolutionising both vaginal and laparoscopic reconstructive surgery. Mesh can be



used to repair prolapse of the bladder base and also for urinary incontinence. The latter technique is called a **TVT**. This procedure is performed as an alternative to the “Burch Colposuspension” for urinary stress incontinence and is very effective particularly in patients who have no other pelvic floor problems. It is also useful in the elderly or patients where there are major medical problems which might be complicated by a longer general anaesthetic and patients who are considered a poor risk for laparoscopic surgery.

Vaginal surgery can be used to resuspend the middle compartment or the vaginal vault which can prolapse after a hysterectomy. This is done by attaching the vaginal vault to the uterosacral ligaments through the open vaginal vault particularly after vaginal hysterectomy or attaching the vaginal vault to the sacrospinous ligaments found laterally towards the bony pelvic side wall. This is called a **sacrospinous fixation technique**. Mesh can also be used vaginally to resuspend the vaginal vault using a technique called a “Posterior IVS”. This technique is still in its infancy however and has not been validated yet.

Posterior compartment defects can be repaired vaginally. The upper part of the posterior vaginal wall can be affected by a true hernia of the peritoneal cavity which is called an **enterocele**. This can be repaired vaginally but there is a significant recurrence rate with this type of surgery. The middle and lower half of the posterior vaginal or rectal wall can prolapse causing a **rectocele**. This is commonly repaired from below using a repair of the fascia and the levator muscles or more recently using mesh. Patients can also have a deficient perineum where the distance between the vagina and the anus is reduced and the vagina appears to pout. This can be built up using a surgical technique to tighten the muscles of the vaginal ring posteriorly and lengthen the perineum. This is called a **Perineorrhaphy**.



### How effective is this technique?

Traditional vaginal surgery has up to a 33% failure rate but it is hoped that with the addition of new surgical techniques and mesh in particular that this rate will be significantly decreased.

### How safe is this procedure?

Vaginal surgery like any other surgery has its risks. Some of these are related to the anaesthetic and some to the procedure itself. This involves possible trauma to the urethra, bladder or bowel, injury to the ureter or major blood vessels, haemorrhage, postoperative infection and the formation of fistulas and blood clots. These risks would appear to be low with the most serious complications less than 1%.

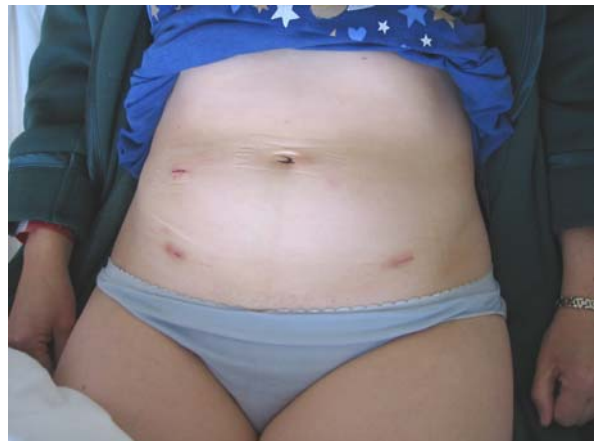


## POSTOPERATIVE RECOVERY

Following vaginal surgery you may return to the Ward with a **catheter** which may be either urethral or suprapubic and a gauze **vaginal pack** which is usually removed on the morning following the surgery. Once the pack is removed usually the urethral catheter will also be removed and you will be commenced on a trial of void programme. This is well covered in the information sheet on postoperative care following laparoscopic surgery for urinary incontinence and prolapse.

The only part of the prolapse repair that is usually associated with significant pain is the posterior repair of the perineum. This can cause rectal pain which is either superficial or deep and occasionally can cause quite marked rectal pain in the second week after surgery. This is usually relieved by simple analgesics or suppositories. Sometimes severe perineal pain can delay the onset of voiding. This is of no consequence and does not interfere with the outcome of the surgery. If there are no voiding problems most patients are usually discharged home by the third to fifth postoperative day. They need to restrict their activities around the house for the first two weeks and usually return to work after four weeks. It is essential not to get constipated and strain with defaecation. For this reason, stool softeners and high fibre diets are often required.

Following the surgery there may be a discharge which is associated with the inflammatory reaction around the dissolvable sutures in the vagina and this can last for 4-6 weeks. This is normal as long as it is not very offensive. It may be associated with bleeding on occasions as the sutures dissolve and this is all part of a normal postoperative recovery phase. Sexual intercourse cannot be resumed until after review by the Doctor. This is usually 4-6 weeks following surgery. At this time all normal activities can be undertaken but it is important not to undergo heavy exertion for the first three months after any reconstructive operation.



### What is the cost of the procedure?

This practice charges the fees set by the **AMA**. The Medicare schedule does not reflect the difficulty or complexity of ground breaking operations like this and in fact have not even gone to the trouble of providing an item number for this operation despite the fact that we have been doing them for over 10 years. Advanced laparoscopic surgery requires many years to master and is only performed by a small group of surgeons in Australia who are certified to perform this operation in particular. It takes up to 2 times longer than the open operation yet only attracts the same Medicare rebate. The Medicare system considers operations like this in a similar fashion to plastic surgery where there is a very poor rebate. They feel that the great cosmetic advantage and early release from hospital as well as early return to work are a **luxury** that people should pay for. There is therefore a considerable gap to pay despite our attempts to lobby the government for a review.

***The exact fees and gaps can be easily obtained from my secretary prior to the operation and from the anaesthetist and hospital in a similar fashion. Obviously the big decrease in hospital bed days and the early return to family and work do offset the gap considerably. Please discuss this with me if you have a problem.***

