Vaginal hysterectomy for uterine prolapse

Introduction

This information should be used as a guide for women who have been advised to have a vaginal hysterectomy. It outlines common reasons for the operation, benefits, risks, recovering from the operation and what to expect when you go home. Please take time to read this leaflet and ask your Gynaecologist about any concerns that you may have.

What is a vaginal hysterectomy?

A vaginal hysterectomy is an operation to remove the uterus (womb), including the cervix, through the vagina.

What conditions does a vaginal hysterectomy treat?

- Uterine prolapse (dropped womb)
- Heavy periods

What is prolapse?

The pelvic floor muscles form a sling or hammock across your pelvic floor. These muscles together with surrounding connective tissue are responsible for keeping all your pelvic organs (bladder, uterus, vagina and rectum) in place and functioning correctly. (Fig 1) Pelvic organ prolapse occurs when your pelvic floor muscles, their attachments and/or the surrounding connective tissue become weak or damaged allowing your uterus (womb): Fig 2 or the walls of your vagina to drop.

This normally occurs as a result of childbirth but is most noticeable after the menopause. The descent of the pelvic organs tends to be worse when you are tired or straining to empty your bowels. The amount of prolapse varies from person to person, and individual women may have prolapse affecting the uterus only, the front wall of the vagina only (Cystocele: Fig 3), the back wall of the vagina only (Rectocele: Fig 4) or any combination of these. There may be bladder and bowel symptoms as well.

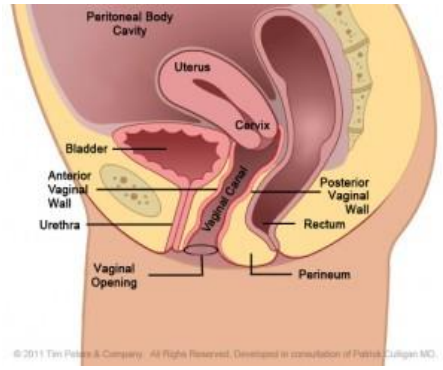

Fig 1: Normal Pelvic Floor

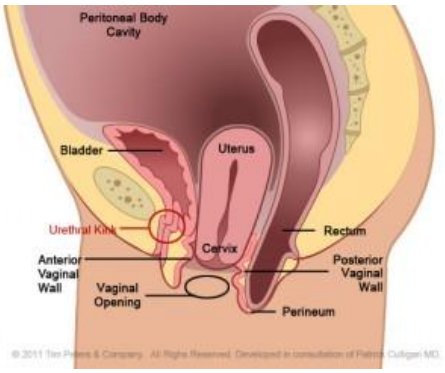

Fig2: Uterine prolapse

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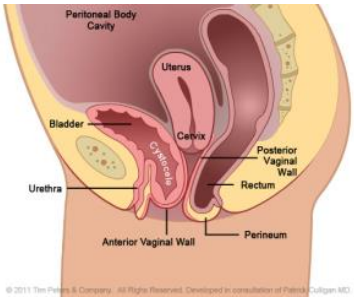

Fig 3: Anterior wall prolapse (Cystocele)

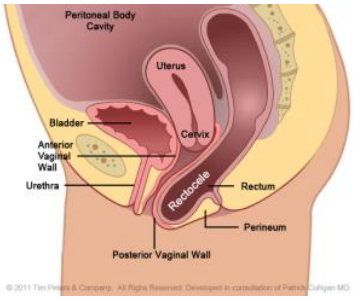

Fig 4: Posterior wall prolapse (Rectocele):

How is a vaginal hysterectomy done?

A vaginal hysterectomy can be performed with you asleep (a general anaesthetic) or awake (a spinal anaesthetic) whereby you are awake but numb from the waist down. The womb is removed through the vagina, so there are no cuts in your tummy, unless there are complications.

Other operations which may be performed at the same time

Your doctor may suggest that a vaginal hysterectomy is all that is required to help your prolapse. Sometimes, additional operations are done at the same time as a vaginal hysterectomy and your doctor should advise you regarding these before your operation.

Vaginal repairs

Sometimes there is also a prolapse of the front wall (anterior – Cystocele) or back wall (posterior-Rectocele) of the vagina and your doctor may suggest repairing them at the same time as your hysterectomy, which is quite common. This may alter the risks of the operation, for example, painful intercourse (sex) is more likely if a repair is done, although it is still uncommon. You should, therefore, discuss this with your doctor who may have an extra information leaflet for you about vaginal wall repairs.

Continence Surgery

Sometimes an operation to treat any bothersome urinary leakage can be performed at the same time as your vaginal hysterectomy. Some Gynaecologists prefer to do this as a separate procedure at a later date. You should also refer to an information leaflet about the planned additional procedure.

Benefits

- Relief from prolapse symptoms
- No more periods
- No need for cervical smears in the future
- Removes risk of problems with the womb and cervix in the future, e.g. cancer
- Some women who have difficulty passing urine before surgery notice this improves after a vaginal hysterectomy, especially if they have a large prolapse
- Some women report an improvement in overactive bladder symptoms, e.g. less urgency, passing urine less frequently.

Risks

General Risks of Surgery

Anaesthetic risk
This is very small unless you have specific medical conditions, such as a problem with your heart, or breathing. Smoking and being overweight also increase any risks. A vaginal hysterectomy can be performed with you asleep (a general anaesthetic) or awake but numb from the waist down (a spinal anaesthetic). This will be discussed with you.

What can you do?
Make the anaesthetist aware of medical conditions such as problems with your heart or breathing. Bring a list of your medications. Try to stop smoking before your operation. Lose weight if you are overweight and increase your activity.

Bleeding
There is a risk of bleeding with any operation. It is rare that we have to give patients a blood transfusion after their operation. Excessive bleeding is unusual during a vaginal hysterectomy. If this happens, you may require a cut in your tummy to stop the bleeding.

What can you do?
Please let your doctor know if you are taking a blood-thinning tablets such as Warfarin, Aspirin, Clopidogrel or rivaroxaban as you may be asked to stop them before your operation.

Infection
There is a small risk of infection with any operation (approx. 5-13 cases in 100 operations). If it occurs, it can be a wound infection, vaginal infection or a urinary infection, and is usually treated with antibiotics. The risk of infection is reduced by routinely giving you a dose of antibiotic during your operation. Chest infection may also occur because of the anaesthetic.

What can you do?
Treat any infections you are aware of before surgery. After surgery, regular deep breathing exercises can help prevent chest infections; the nurses will guide you how to do this.

Deep Vein Thrombosis (DVT)
This is a clot in the deep veins of the leg. Occasionally this clot can travel to the lungs (pulmonary embolism) which can be very serious and in rare circumstances it can be fatal (less than 1 in 100 of those who get a clot). The risk increases with obesity, severe varicose veins, infection, immobility and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood.

What can you do?
Stop taking Hormone Replacement Therapy (HRT) if using oral Oestrogen (transdermal Oestrogen does not need to be stopped). These can usually be restarted 4 weeks following surgery when the risk of blood clots has reduced. Do not arrange surgery the day after a long car journey or flight. As soon as you are awake start moving your legs around. Keep mobile once you are at home and continue to wear your compression stockings during times when you are less mobile.

Wound complications
The wound within the vagina can become infected or occasionally stitches can become loose allowing the wound to open up or tighten causing discomfort.

What can you do?
Keep the surrounding area clean, and dry carefully after washing using a clean towel or a hairdryer on a cool setting. Do not douche the vagina or use tampons.

General risks of prolapse surgery

Getting another prolapse
There is little published evidence of exactly how often prolapse recurs. Recurrence of the same prolapse probably occurs in about 1 in 10 cases but it is generally believed that about 3 in 10 women who have an operation for prolapse will eventually require treatment for another prolapse. This is because the vaginal tissue is weak. Sometimes even though another prolapse develops it is not bothersome enough to require further treatment.

What can you do?
Keeping your weight normal for your height (normal BMI), avoiding unnecessary heavy lifting, and not straining on the toilet, may help prevent a further prolapse, although even if you are very careful it does not always prevent it.

Failure to cure symptoms
Even if the operation cures your prolapse it may fail to improve your symptoms.

Overactive bladder symptoms
Urinary urgency and frequency with or without incontinence usually improve after the operation, but occasionally can start or worsen after the operation.

What can you do?
If you experience this, please let your doctor know so that treatment can be arranged.

Stress incontinence
Having a prolapse sometimes causes some kinking of the tube through which you pass urine (urethra). This can be enough to stop urine leaks on coughing, laughing or sneezing. By correcting the prolapse this kink gets straightened out and the leaks are no longer stopped. It is difficult to define an exact risk but it is reported to be in the order of 10% (1 in 10).

What can you do?
Doing pelvic floor exercises regularly can help to prevent stress incontinence.

Bladder emptying or voiding problems
Generally, these improve after surgery for prolapse but there may be problems emptying the bladder in the first few days. Your doctor may wish to do bladder tests (urodynamics) prior to surgery to predict post-operative voiding difficulties. There can be persistence of voiding problems in 1 in 10 women.

What can you do?
If you experience difficulty passing urine, you may wish to lean forwards or even stand slightly to allow better emptying of your bladder. Make sure that you have your legs apart rather than having your knees together when sitting on the toilet. Waiting for two minutes after the initial void and trying again may help. This is known as the double void technique.

A change in the way your bowel works
Some patients experience worsening constipation following surgery. This may resolve with time. It is important to try to avoid being constipated following surgery to reduce prolapse recurrence.

What can you do?
If you are struggling with constipation after simple changes in diet and fluid intake, your doctor/GP may prescribe some laxatives.

Painful sexual intercourse
The healing usually takes about 6 weeks and after this time it is safe to have intercourse. Some women find sex is uncomfortable at first, but it gets better with time. You will need to be gentle and may wish to use lubrication initially. Occasionally pain on intercourse can be long-term or permanent.

Altered sensation during intercourse
Sometimes the sensation during intercourse may be less and occasionally orgasm may be less intense. On the other hand, repair of your prolapse may improve it.

Specific risks of vaginal hysterectomy

Damage to the bladder or bowel
Damage to the bladder or bowel (overall 5-6 injuries in 1000 operations) can occur because these organs are immediately next to the vagina. The risk is greater if you have had pelvic surgery or pelvic infection in the past or if there is inflammation of the tissues. It is usually possible to repair the damage straight away, but it may slow down your recovery. Occasionally the damage is not recognised at the time of surgery and has to be repaired later. Risk of making a hole in the bladder is about 5 in 1000 operations. Risk of a fistula (abnormal communication) between bladder and vagina is about 2 in 10,000 operations. Risk of bowel injury is about 1 to 5 in 1000.

Damage to the ureter(s)
The ureter is a narrow tube which transports urine from each kidney to the bladder. It can be damaged during a hysterectomy. The risk of damage is about 2-4 for every 10,000 operations.

Before the operation - Pre-op assessment

Usually you are seen in a preoperative clinic some weeks before your planned operation. At that visit you will be seen by a nurse and possibly also a doctor. You will be asked about your general health and any medications you take. Your blood pressure will be checked and you may have tests to assess your heart and breathing. Blood tests will be taken to check you for anaemia and other things according to your medical condition. Swabs may be taken from your nose and groin to make sure that you do not carry MRSA (bacteria that are very resistant to antibiotics and may cause problems after your operation).

After the operation - in hospital

Pain relief
Pain can be controlled in a number of ways depending on the preference of your anaesthetist and/or gynaecologist. Options are an epidural, injection of local anaesthetic into the tissues during the operation, self-administration of pain relief (patient-controlled analgesia - PCA), drugs in a drip, tablets or suppositories. A vaginal hysterectomy is not a particularly painful operation but sometimes you may require tablets or injections for pain relief. Some women describe the pain as similar to a period. It is often best to take the pain killers supplied to you on a regular basis, aiming to take a pain killer before the pain becomes a problem.

Drip
This is to keep you hydrated until you are drinking normally. The drip is usually removed within 24 hours.

Catheter
You may have a tube (catheter) draining the bladder. The catheter may give you the sensation as though you need to pass urine but this is not the case. It is usually removed the morning after surgery or sometimes later the same day.

A vaginal pack
Some gynaecologists insert a length of gauze into the vagina at the end of the operation. It acts as pressure bandage and is usually removed the following day.

Vaginal bleeding
There may be slight vaginal bleeding like the end of a period after the operation.

Eating and drinking
You can drink fluids soon after the operation and will be encouraged to start eating as soon as tolerated.

Preventing DVT (deep vein thrombosis)
The same day or the day after your operation, you will be encouraged to get out of bed and take short walks around the ward. This improves general wellbeing and reduces the risk of clots in the legs. You may be given a daily injection to keep your blood thin and reduce the risk of blood clots until you go home or longer in some cases.

Going home
You are usually in hospital for one or two days. If you require a sick note or certificate please ask.

After the operation – at home

- Moving around is very important; using your leg muscles will reduce the risk of clots in the back of the legs (DVT).
- Bath or shower as normal.
- Do not use tampons for 6 weeks and avoid douching the vagina. Any of the stitches under the skin will melt away by themselves. The surface knots of the stitches may appear on your underwear or pads after about 2 weeks, this is quite normal. There may be a little bleeding again after about 2 weeks when the surface knots fall off, this is nothing to worry about.
- You are likely to feel tired and may need to rest in the daytime from time to time for a month or more, this will gradually improve.
- It is important to avoid stretching the wounds particularly in the first weeks after surgery. Therefore, avoid constipation and heavy lifting. The stitches dissolve during the first 3 months and the body will gradually lay down strong scar tissue over a few months.
- Avoiding constipation. Drink plenty of water or juice. Eat fruit and green vegetables especially broccoli. Eat plenty of roughage e.g. bran / oats.
- Any constant cough is to be treated promptly. Please see your GP as soon as possible.
- At 6 weeks gradually build up your level of activity.
- After 3 months you should be able to return completely to your usual level of activity.
- You should be able to return to a light job after about 6 weeks, a busy job in 12 weeks. Avoiding all unnecessary heavy lifting will possibly reduce the risk of the prolapse recurring.

- You can drive as soon as you can operate the pedals and look over your shoulder without discomfort, generally after 3 weeks, but you must check this with your insurance company, as some of them insist that you should wait for 6 weeks.
- You can start having sex whenever you feel comfortable enough after about 6 weeks. You will need to be gentle and may wish to use lubrication.
- You usually have a follow up appointment anything between 6 weeks and 6 months after the operation. This may be at the hospital or by telephone. Sometimes follow up is not required.
- See link: https://www.rcog.org.uk/globalassets/documents/patients/patientinformation-leaflets/recovering-well/vaginal-hysterectomy.pdf

What to report to your doctor after surgery

Contact your doctor if you experience any of the following symptoms or have other concerns:

- Heavy vaginal bleeding
- Smelly vaginal discharge
- Severe pain
- High fever
- Pain or discomfort passing urine or blood in the urine
- Difficulty opening your bowels.
- Warm, painful, swollen leg
- Chest pain or difficulty breathing

Treatment Alternatives

Non-surgical

Do nothing

If the prolapse is not too bothersome treatment is not necessarily needed. If, however, the prolapse permanently protrudes through the opening to the vagina and is exposed to the air, it may become dried out and eventually ulcerate. Even if it is not causing symptoms in this situation, it is probably best to push it back with a ring pessary (see below) or have an operation to repair it. Weight reduction in overweight women and avoiding risk factors such as smoking (leading to chronic cough), heavy weight-lifting jobs and constipation may help with symptom control. The prolapse may become worse with time but it can then be treated.

Pelvic floor exercises (PFE)

The pelvic floor muscles support the pelvic organs. Strong muscles can help to prevent a prolapse dropping further. PFE are unlikely however to provide significant improvement for a severe prolapse protruding outside the vagina. A women's health physiotherapist can explain how to perform these exercises with the correct technique. It is important that you try the pelvic floor exercises to help to manage the symptoms of your prolapse and to prevent it becoming worse. It is also very important to continue with your pelvic floor exercises even if you have opted for other treatment options.

Pessary

A vaginal device (pessary) may be placed in the vagina to support the vaginal walls and uterus. A pessary is usually used continuously and changed by a doctor or nurse every 4-6 months depending upon the type used and how well it suits you. Alternatively, if you prefer, you may be taught to replace the pessary yourself. It is possible to lead a normal life with continuation of activities such as bathing, cycling, swimming and, in some cases, sexual intercourse. Ongoing care is often at the GP practice, but some women will need to be kept under review in the Gynaecology clinic. Pessaries are very safe and many women choose to use one long term rather than have an operation. On occasions their use

has to be discontinued due to bleeding, discharge, sexual difficulties or change in bladder function but these all stop quickly after removal. Sometimes it will take several visits to the clinic to determine the best size for you. A pessary is not suitable for all women.

More information

If you would like to know more about uterine prolapse and the treatments available for it, ask your GP, gynaecologist or nurse at the hospital.

Please remember that this leaflet is intended as general information only. We aim to make the information as up to date and accurate as possible, but please note that it is subject to change. Please therefore always check specific advice on any concerns you may have with your doctor.

How can I help reduce healthcare associated infections?
Infection prevention & control is important to the well-being of our patients and for that reason we have infection prevention & control procedures in place. Keeping your hands clean is an effective way of preventing the spread of infections. Please follow our infection prevention and control guidelines when visiting our healthcare sites. Further information is available on our website.

Patient Advice Sheet
If you would like a copy of this information on audiotape, in large print or translated, please call the Patient Advice Liaison Service on 01296 831120 or email bht.pals@nhs.net