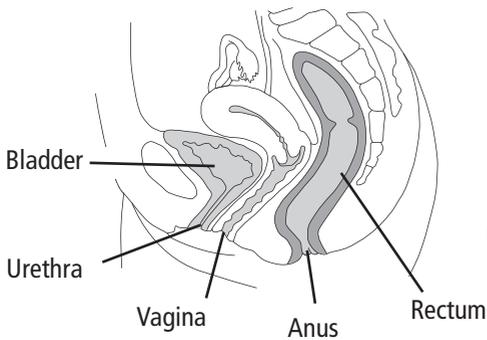


Treatment options for gynaecological prolapse

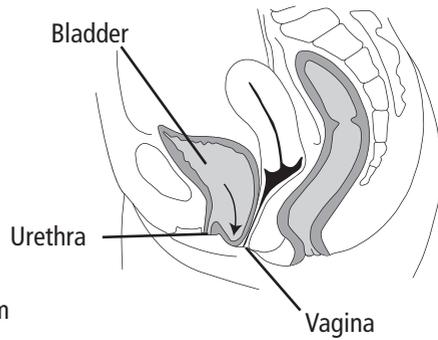


What is prolapse?

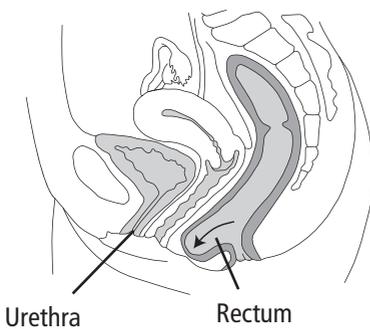
Prolapse occurs when pelvic organ support structures become weakened. This can cause the bladder at the front (a 'cystocele') or the bowel at the back (a 'rectocele') to push against the vaginal walls forming a 'bulge' that may protrude beyond the vaginal opening. The uterus (womb) can also slide down the vagina so that the cervix (neck of the womb) can be felt beyond the opening. Any woman can experience prolapse and it is extremely common.



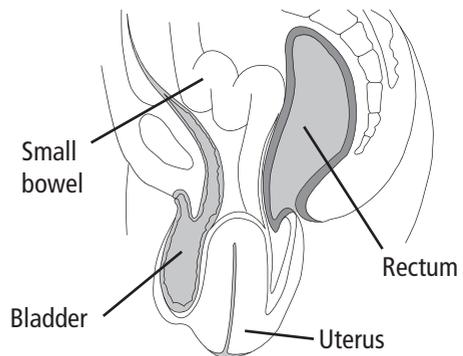
Normal pelvis



Cystocele



Rectocele



Womb prolapse

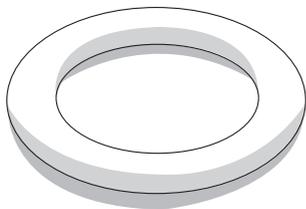
Does it need treating?

This is a personal choice that depends upon whether you are affected by any symptoms. Even severe prolapse may be only mildly annoying but you may

want treatment if it is very uncomfortable or it is affecting bladder or bowel function. It is extremely rare for prolapse to cause any serious long term problems so treatment is not essential. If you choose to leave it alone, the prolapse may not get any worse. However, if it does, the treatment options remain the same and the delay is unlikely to reduce its success. If you choose surgery, you need to understand that all available operations are major procedures with potentially serious risks.

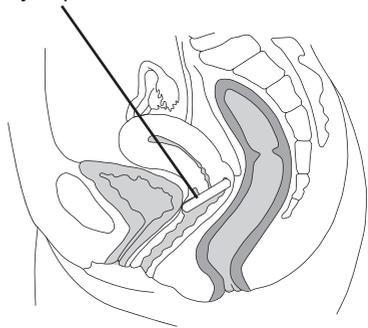
Is treatment always an operation?

No. A small vaginal device, a pessary (see image of vaginal ring pessary below), may be placed in the vagina to support the vaginal walls and uterus. A pessary is worn continuously and changed by a doctor or nurse every four to twelve 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 wear 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 but not all women are suitable for a pessary.



Vaginal ring pessary

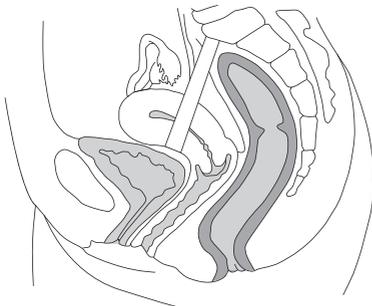
Pessary in position



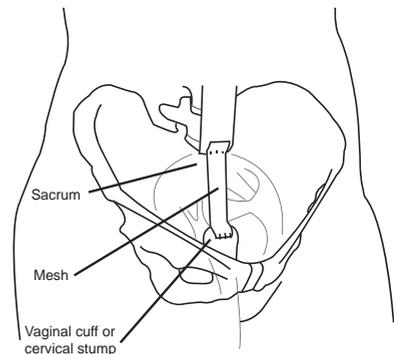
What surgical treatments are available?

- **'Stitch' repair of the vaginal walls** – this is the most commonly performed operation. It involves using absorbable stitch material to strengthen the fibrous tissue between the vaginal wall and the bladder at the front and the bowel at the back. This holds the 'bulge' back. The operation is undertaken from within the vagina, usually under a general anesthetic.
- **Vaginal hysterectomy** – this is removal of the womb from within the vagina. It is sometimes performed as part of the repair operation if the womb is not well supported. The ovaries are usually left in place.
- **Sacrospinous ligament fixation** – this may be performed as part of the repair operation to attach the upper vagina or the neck of the womb to strong ligaments behind the top of the vagina. Stitches may be used on their own or a mesh can be used.
- **Abdominal or laparoscopic (keyhole) re-suspension operations** – synthetic mesh is attached from a ligament in front of the pelvic back bone (sacrum) to the prolapsing womb (sacrohysteropexy) or to the top of the vagina if it has prolapsed after hysterectomy (sacrocolpopexy).
- **Mesh repair of the vaginal walls** – mesh repair of vaginal walls is not recommended.

Sacrohysteropexy



Sacrocolpopexy



How do I choose which operation to have?

The challenge is that every woman's problems are slightly different and there is only limited medical research to guide surgeons and their patients. All prolapse operations have surgical risks as well as the potential to cause future bowel, bladder or sexual problems and further prolapse in years to come. Vaginal prolapse repairs using stitches (with or without hysterectomy) may also have a higher failure rate. Keyhole mesh re-suspension operations may have higher success rates but with extra complications associated with the mesh insertion.

What are the risks and benefits of mesh insertion in prolapse surgery?

Synthetic 'nylon' mesh in the body strengthens natural support tissues and so it is used in the repair of abdominal wall hernias (ruptures). Its use in the vagina is not recommended as the mesh may rub against adjacent organs, causing damage and pain, especially with intercourse.

Synthetic mesh in keyhole prolapse surgery

Synthetic mesh has been used in re-suspension of the vagina after hysterectomy (sacrocolpopexy) for over 30 years, both as an open operation and, more recently, as a keyhole operation. Success rates are excellent and mesh risks are only small because it is not placed from within the vagina. This has led NICE (the national body that reviews the effectiveness and safety of treatments in England and Wales) to report that this operation is an excellent and safe treatment option. Sacrohysteropexy is a very similar operation in which the mesh is attached to the cervix, a much tougher structure than the vagina.

Keyhole operations have the advantage of no scars within the vagina and may be associated with a shorter recovery time. However, they are associated with a higher risk of damage to the bowel with vaginal operations. They are not suitable for some women because they do not correct prolapse of the lower vagina.

Following concerns over mesh use for prolapse and urinary incontinence operations, use of synthetic mesh for keyhole prolapse surgery should be subjected to high vigilance scrutiny.

Biological mesh in vaginal prolapse surgery

Following concerns on use of vaginal mesh, use of biological mesh in vaginal pelvic organ prolapse surgery is not recommended.

Conclusions

You must first decide whether your prolapse symptoms are severe enough for you to want treatment. If they are, you then need to choose between pessary or surgical treatment. Surgery may not be appropriate if you plan further pregnancies or have severe other medical problems (heart conditions etc). If your gynaecologist recommends a particular operation, the decision will be based upon your unique situation - your symptoms, previous surgical history and examination findings - as well as their professional views, training and experience. Different surgeons may make different selections and achieve the same final surgical result. If an operation is offered, you need to decide whether your priority is to achieve a strong repair, accepting a higher complication rate or whether you would prefer a more traditional operation that may be associated with fewer risks but a higher failure rate. All operations have risk and there is no 'risk-free' surgical option.

For further detailed information of recovery after this operation see www.rcog.org.uk/recoveringwell

If you would like this leaflet in large print, braille, audio version or in another language, please contact the General Office on 01872 252690

