Vaginal Prolapse

What you need to know

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VAGINAL PROLAPSE
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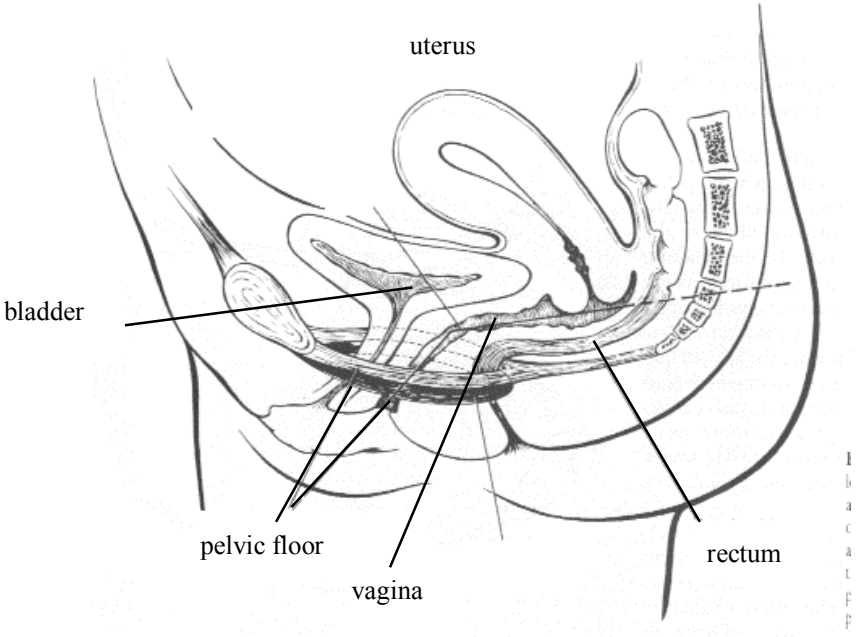


THE VAGINA SOME BASIC FACTS

The vagina is a hollow muscular organ with immense ability to expand as occurs during childbirth. The total length of the vagina varies in women, but the normal range is from to 8—10cm.

The vagina has four walls. The lower part of the vagina can easily be felt by gently spreading open the lips of the vaginal opening (labia).

1. The roof of the vagina is closed by the cervix. It can also be felt easily by inserting your fingers as far as they will go and the cervix is usually felt as a large round firm structure with a small hole in its centre. This hole is called the cervical OS and it not only produces mucous to help the sperms swim through on their way to the fallopian tubes, but also provide an opening for the menstrual blood to flow out of the uterus into the vagina.
2. The front wall of the vagina lies in close proximity to the bladder and the urethra (opening of the bladder). With your fingers deep in the vagina, if you press upwards and forwards, there will be a sensation of wanting to pass urine. This is because your fingers in this position are pushing on the bladder.

3. The back wall of the vagina (posterior wall) is closely related and lies in front of the lower part of the bowel (rectum). The back wall of the vagina is longer than the front wall by approximately 3cm.
4. The sidewalls of the vagina are supported by muscular attachments.

At the upper part of the vagina, close to the cervix the ureter (tube which drains the urine from kidney into the bladder) lies very close to the vagina.

The pelvic floor or pubococcygeus muscle (see diagram) forms the floor of the pelvis and circles and supports the base of the bladder, the middle third of the vagina and the rectum. This muscle is under voluntary control and can be made to contract at pelvic floor exercises. You can appreciate this by placing one or two fingers in the vagina and tightening the vaginal walls around them. If your muscle tone is good you should feel the vaginal walls tighten around your fingers.
This muscle also helps you to control the flow of urine and stop the urine flow voluntarily if necessary.

Prolapse occurs when the ligaments and muscles supporting the vagina weaken, leading to stretching of the vagina causing various organs to "fall out" of the vagina.

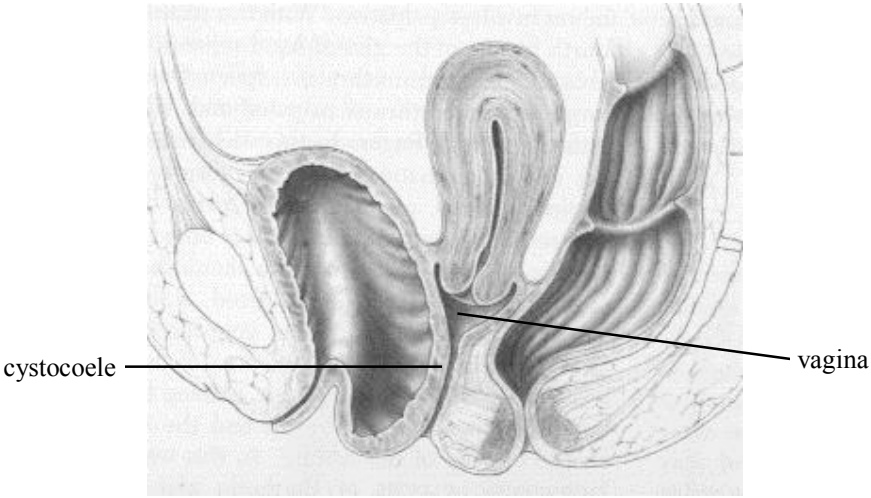
CAUSES OF PROLAPSE

- **Childbirth**
  Some women find that after having several children, their vagina becomes excessively stretched and loses tone. These women may also notice that during sexual intercourse, the vaginal muscles are unable to grip the shaft of the penis firmly and that the penis seems to be "lost" inside their large vagina. A very relaxed vaginal opening, thus reduces the ability of the penis to stimulate the clitoris and vagina during sexual intercourse. Of course all these things serve to reduce sexual enjoyment and satisfaction.
- **Menopause**
  In most women, prolapse tends to occur or becomes noticeable around the time of menopause when there is decreased oestrogen production, which leads to thinning of the vaginal walls and lack of tone of the supports of the vagina and uterus.
- **Obesity**
  Obesity, chronic cough or constipation, smoking, straining and heavy lifting are risk factors.
- **Inherited weakness of the pelvic floor connective tissue**

TYPES OF PROLAPSE

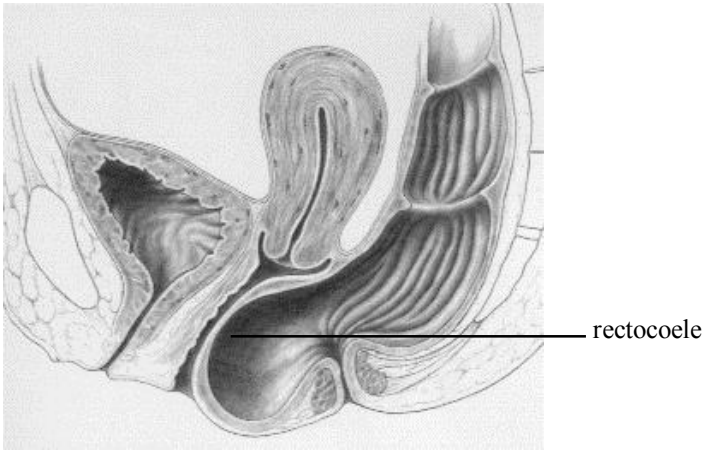
1. Prolapse of the anterior vaginal wall (front wall)

Prolapse of the anterior vaginal wall may affect the bladder and causes a swelling, which projects into the vagina and is noticed as a bulge which is visible at the opening of the vagina. This is called a **cystocoele**.

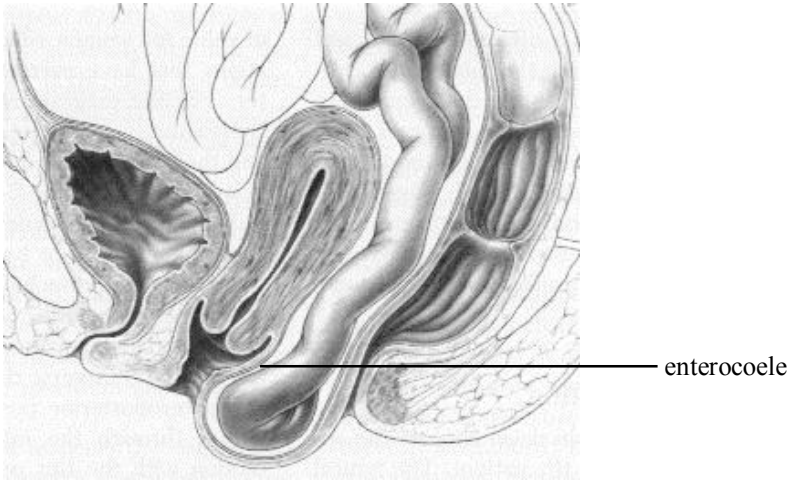


2. Prolapse of the posterior vaginal wall (back wall)

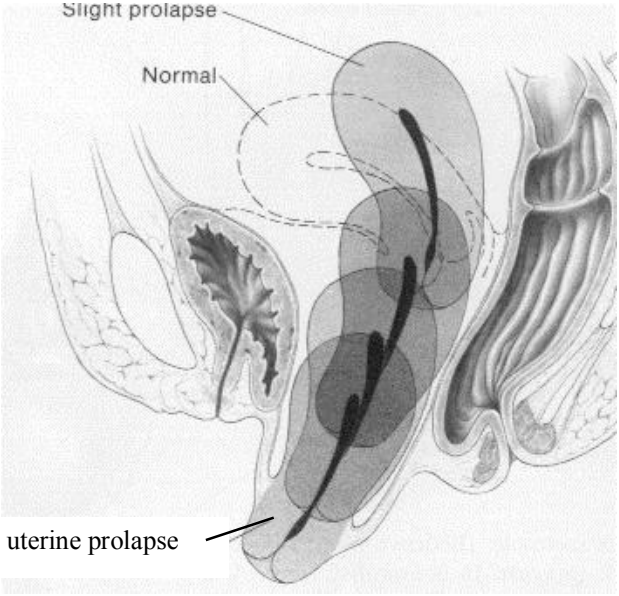
This occurs when the back wall of the vagina is excessively loose and stretched. This causes the lower part of the bowel (rectum) to sag forward into the lower part of the vagina. Some women may notice that at time of defaecation, or during straining a bulge appears at the opening of the vagina. This is called a **rectocoele** (see diagram)



Sometimes stretching of the upper part of the back wall of the vagina causes the space between the vagina and rectum (the pouch of Douglas) to bulge into the upper part of the vagina. This is called an **Enterocoele.**



3. Prolapse of the uterus (uterine prolapse)
This can occur independently or may occur in association with any of the other types of prolapse mentioned above. Uterine prolapse is categorised into three degrees depending on the position of the cervix in the vagina. This is shown in the diagram below.



SYMPTOMS AND SIGNS

These are generally dependent on the severity of the prolapse as well as the site of the prolapse. Some symptoms, however, are common to all forms of prolapse and these include the following –

1. A sense of fullness in the vagina associated with dragging discomfort.
2. Presence of a visible bulge at the vaginal opening or a visible protrusion of the cervix (like an egg)
3. Low back pain which tends to become worse at the end of the day.

PROLAPSE OF THE FRONT WALL (CYSTOCOELE)

The symptoms will depend upon the severity of the prolapse and may include one or more of the following.

1. Frequent desire to empty the bladder.
   This occurs as a result of incomplete emptying of the bladder because of distortion of the angle between the bladder and urethra.

2. Repeated attacks of urinary tract infection.

3. Sensation of incomplete emptying of the bladder or difficulty in emptying the bladder.

4. Involuntary loss of urine associated with any activity, which causes a rise in intra abdominal pressure (coughing, laughing, and straining)

PROLAPSE OF THE BACK WALL OF THE VAGINA (RECTOCOELE, ENTEROCOELE)

The main symptom is difficulty with evacuation of faeces. You may notice that inserting your finger into your vagina may help to empty your bowels.

The other symptom is the awareness of a bulge in the vagina (feels like an egg between your legs).

PROLAPSE OF THE UTERUS

1. The main symptom is one of pressure in the vagina and ultimately the cervix becomes visible at the vaginal opening.

2. There may be considerable discomfort and lower backache, which becomes worse at the end of the day.

MANAGEMENT OF PROLAPSE

The management of prolapse depends on the severity of the prolapse and your medical condition.

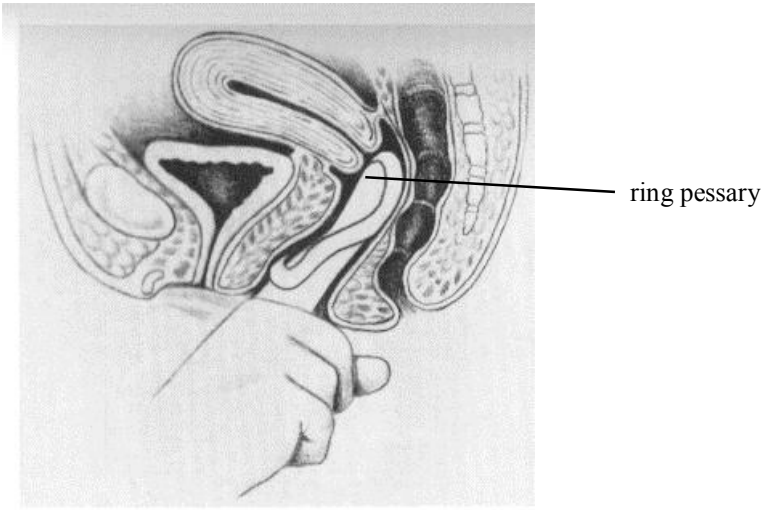
CONSERVATIVE TREATMENT

If there is only a minor degree of prolapse, you want more children or you are unfit for major surgery then the following may help:

1. Some women find considerable improvement with pelvic floor exercises. This usually occurs in women with minor degrees of prolapse. A physiotherapist specialising in pelvic floor exercises often helps. Devices such as vaginal cones or Epi-No may also help contracting pelvic muscles.

2. Local oestrogen creams to the vagina, especially if you are past the menopause. This helps thicken the skin of the vagina.

3. Inserting a vaginal ring pessary. This involves measuring the size of your vagina and ordering the ring size that fits you. The ring pessary needs to be washed every 4 to 6 months or else infection may occur. Obviously you will not be able to have sexual intercourse with the pessary inside your vagina.



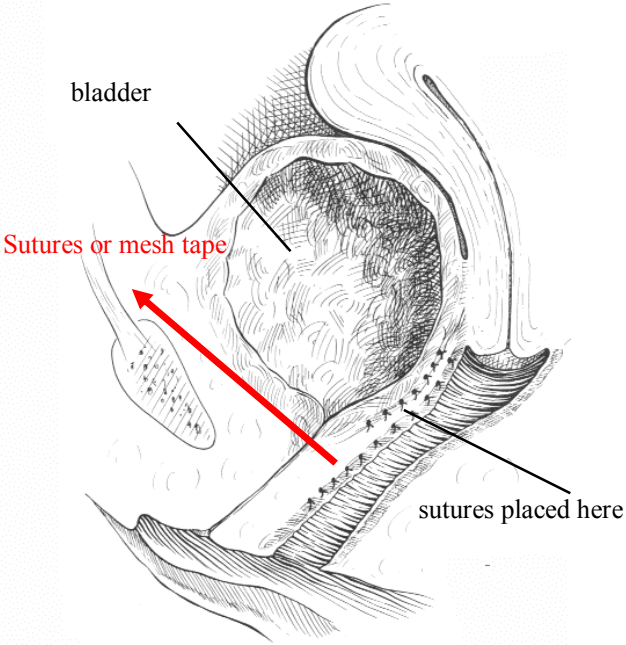
SURGICAL TREATMENT

Gross prolapse or prolapse causing considerable symptoms which have not improved with exercises or hormonal therapy is optimally treated with surgery.

1. **Cystocoele**

   This operation requires removal of the excess vaginal wall. The bladder is then pushed up and held in place by re-suturing the tissues, which normally support the bladder.

   If there are symptoms of urinary incontinence (involuntary control of urine) then further sutures are placed to re—construct the angle of the bladder. This may be performed either by placing a mesh tape under the urethra (Monarc procedure) . I will discuss this with you, if this is required.



2. **Rectocoele and Enterocoele**

   This involves removal of the excess and stretched skin on the back wall of the vagina. The rectum is then pushed backwards and the pelvic floor is re-approximated by bringing together the muscles that form a sling around the vagina.

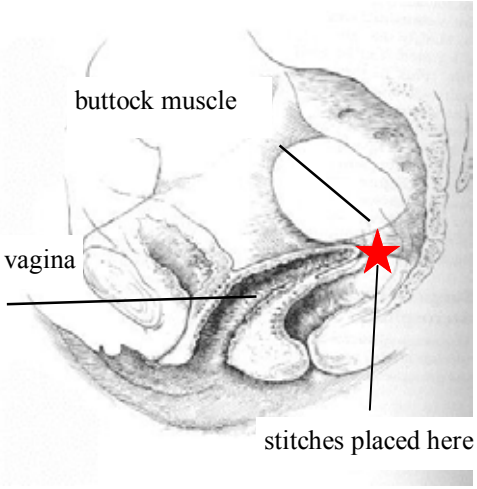
   If an Enterocoele is present, the space behind the uterus (the hernial sac) is opened and once again redundant tissue is removed and the space is closed.

   Following the above procedures, the vaginal skin is closed and repaired with dissolving sutures.

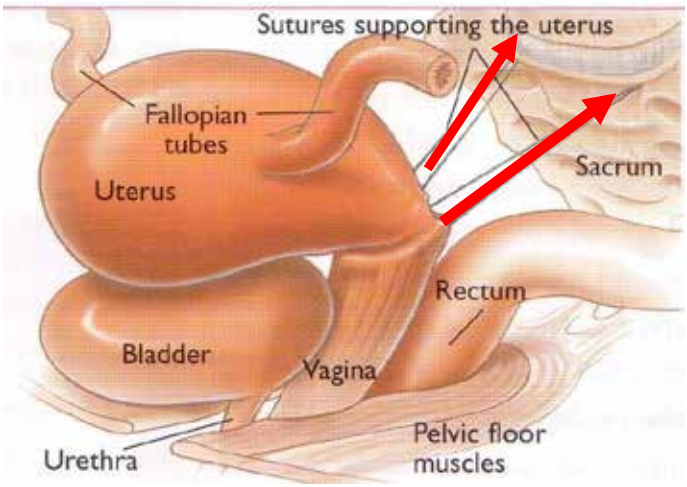
3. **Uterine/Vault Prolapse**

If the uterus and top of the vagina (vault) is prolapsed, support is required to elevate the vault. The treatment often involves a hysterectomy, and sutures or mesh to elevate the vaginal vault. This can be done in 3 ways:

- **Vaginal colpopexy with sutures or mesh.** This involves placing stitches from the top of your vagina and attaching this to your buttock muscle or ligaments to pull the vaginal vault up. You may feel like you have been kicked in the backside for several weeks, but this should improve.



- **Laparoscopic vault suspension procedure.** Via key hole surgery I will place permanent stitches on each side of the pelvis to elevate the vault to your tail bone through the uterosacral ligaments. I believe this achieves a better elevation hence result coming from above to achieve the elevation, than through the vagina. However it may not be possible to have this I will discuss this with you if you are suitable to have the operation performed this way.



- **Sacrocolpopexy.** This involves placing a synthetic mesh attached to the vault and stitching the other end to your sacrum (backbone) to elevate the vagina. This is usually reserved for women with recurrent prolapse or those that have a very short vagina. It is a significantly bigger operation than the former 2 operations.

POINTS OF DISCUSSION TO YOUR OPERATION

In order for me to carry out the correct procedure it is extremely important that you provide me with the following information .

1. Are you sexually active or are you contemplating resuming sexual intercourse following the operation?
2. Do you have any urinary symptoms and particularly if there is any leakage of urine during times of stress (exercise, laughing, coughing, etc.)?
3. Do you suffer with repeated attacks of cystitis (bladder infections)?
4. Do you intend to have any more children in the future? Generally I would recommend you finish you family before contemplating any prolapse surgery as pregnancy and childbirth may damage the repair.
5. Do you suffer with heavy or painful periods?

COMPLICATIONS OF VAGINAL REPAIR

All major surgery may be accompanied by some form of complications. The main complication can be divided into two categories.

General complications

These include possibility of haemorrhage, infection and blood clots. In order to prevent these complications from occurring the following precautions will be taken:

1. You will be given intravenous antibiotics during your operation
2. Great care will be taken to ligate (tie) all bleeding vessels.
3. You will be given stockings to wear as well as having compression bandages during the operation and post operatively. You will also be given injections to thin your blood.

At the conclusion of the procedure, a vaginal pack maybe inserted into your vagina to provide pressure and hence, prevent oozing. This pack will be removed in 12-24 hours.

Specific complications

- **Failure of the procedure**. Prolapse is a result of wear and tear. There are NO guarantees reagrding the duration of success, but I am confident you will get relief of your symptoms immediately.
- **Recurrent prolapse**. This occurs in up to 30% of women some time after a successful operation.
- **Urinary incontinence**. Some women have occult incontinence which is masked by your prolapse and this is revealed after your prolapse surgery. I will discuss with you the merits of performing a sling procedure at the same time.

- **Injury to your bladder/ urethra or ureters**. Because of the close proximity of these structures there is the potential for injury.This is often recognised at the time of the operation and the damage can be repaired at the same operation. Sometimes the damage is not recognised at the time of operation and declares itself later following the operation as a **fistula** (hole between bladder and vagina) requiring further surgery. However, **this is rare** affecting 1 -2/1000 operations.
- **Injury to the bowel.** Fortunately this is rare, but may require a **laparotomy** (big tummy cut) or very rarely a temporary colostomy (bag on the tummy). Often it can be repaired through the vagina with minimal problems.
- **Painful intercourse.** Can occur in 1-5% of women due to narrowing of the vagina. This may occur as a result of excessive removal of the loose vaginal skin or may occur later as a result of scar tissue formation. Careful assessment of the extent of surgery prior to the operation is helpful in preventing this complication from occurring. Hormonal treatment following the operation is also helpful in preventing narrowing of the vagina. This is particularly important in postmenopausal women.
- **Mesh erosion**. In 5-10% of cases after mesh insertion, the mesh may be rejected or become infected or invade other nearby organs. In severe cases the mesh may need to be removed.

POST-OPERATIVE MANAGEMENT

1. You will most likely have a pack in your vagina and hence will feel pressure and discomfort for the first 12-24 hours until the pack is removed.

2. Your bladder will be kept empty by means of a catheter. This catheter is usually removed after 1-3 days. The catheter maybe inserted through your urethra or inserted via the abdominal skin (supra pubic catheter).

3. You should be able to start drinking on the first day after the operation and should gradually resume a full diet within 72 hours.

4. The intravenous drip usually comes out in about 24-48 hours.

5. A repair operation is not associated with severe post-operative pain and you should be able to move around and walk without much discomfort.
   If you have had a vaginal colpopexy, you may get pain in your buttock for a while, but this will settle down with time.

6. **Most women spend anywhere from 3-5 days in hospital**. Occasionally because of difficulty in passing urine, your stay in hospital could be longer. Please do not get disheartened, as your normal bladder function will return in time.

7. Once you are home, you should rest as much as possible. You should take Fibogel or Metamucil to soften your bowel motions so you DO NOT strain.
You should not have sexual intercourse until I review you in the rooms again. This will be in 4 to 6 weeks.

COMMONLY ASKED QUESTIONS

Q. Do I have to have any surgery for my prolapse?

A. Vaginal prolapse is usually non life threatening so treatment is **elective** and depends entirely on your symptoms. Minor degrees of prolapse can be managed without surgery, but major degrees of prolapse are optimally treated with surgery.

Q. Will I be able to have intercourse after surgery?

A. There is no reason why you cannot have sex after full recovery. Indeed sex may be better because the vagina has been tightened.

Q. What activities can I do at home, post surgery?

A. You should rest and you should NOT strain for 6 weeks after the operation, to avoid breaking the sutures.