Bladder and Bowel Community

Factsheet: Pelvic Floor Repair Surgery (Colporrhaphy)

The most common surgery for prolapse is a pelvic floor repair, which is a broad term used to describe surgical repairs of the pelvic floor. More specifically, the term anterior repair refers to correction of the front wall of the vagina; and posterior repair refers to correction of the back wall of the vagina. If the uterus is prolapsing, it may be removed (hysterectomy). If you have already had a hysterectomy, then the top of the vagina (vault) can be lifted up and supported.

Surgeons often carry out more than one of these repairs simultaneously.

Anterior Vaginal Repair Surgery

Anterior repair is a surgical procedure to repair or reinforce the weakened layers between the bladder and the vagina. The aim of the surgery is to relieve the symptoms of vaginal bulging/ laxity and to improve bladder function, without interfering with sexual function.

Success rates for anterior repair are 70-90%, however there is a chance that the prolapse may recur or another part of the vaginal wall may prolapse.

The surgery can be performed under general, regional or local anaesthetic. There are many ways to perform an anterior repair, but a common method is by an incision being made along the centre of the front wall of the vagina, starting near the entrance and finishing near the top of the vagina. The weakened layers are then repaired using absorbable stitches. Sometimes superfluous vaginal skin is removed.

If you have a severe prolapse or this is a repeat operation, reinforcement material such as mesh may be used to strengthen the anterior vaginal wall.

Posterior Vaginal Repair Surgery

A prolapse of the back wall of the vagina (posterior) is usually due to a weakness in the strong tissue layers that divides the vagina from the lower part of the bowel.

Posterior repair is a surgical procedure to repair or reinforce the weakened layers between the rectum and the vagina. The aim of the surgery is to relieve the symptoms of vaginal bulging/ laxity and to improve bowel function, without interfering with sexual function.

Success rates for posterior repair are 80-90%, however there is a chance that the prolapse may recur or another part of the vaginal wall may prolapse.

The surgery can be performed under general, regional or local anaesthetic. There are many ways to perform a posterior repair, but a common method is by an incision being made along the centre of the back wall of the vagina starting at the entrance and finishing near the top of the vagina. The weakened layers are then repaired using absorbable stitches.

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If you have a severe prolapse or this is a repeat operation, reinforcement material such as mesh may be used to strengthen the posterior vaginal wall.

After an Anterior and Posterior Vaginal surgery

After surgery, if you have had a general anaesthetic, you will be given intravenous fluids and you may have a catheter in your bladder. You may also have a pack inside the vagina to reduce bleeding into the tissue. Usually both the pack and catheter are removed within 24 - 48 hours after the operation. Once the catheter has been removed it is normal to monitor how much your bladder holds and whether or not you completely empty your bladder when you go to the toilet. For two or possibly three visits to the toilet your urine output will be collected and measured. Then using a portable ultrasound machine your bladder will be scanned to ensure it has completely emptied.

Healing takes around 3 months, so during this time you should avoid any task that can put pressure on the repair i.e. lifting, straining, vigorous exercise, coughing and constipation.

You should plan to take 6 weeks off work, but this all depends on the type of role you have.

You should be able to drive and be fit for light activities within 3-4 weeks of surgery. But it is advisable to check your own car insurance policy for any restrictions following surgery. You should wait 5-6 weeks before having sexual intercourse. As this timescale will probably coincide with your outpatient follow-up appointment with your consultant, it is always useful to wait and get the go-ahead from him/her so that you can be sure your tissues are nicely healed.

Vaginal Hysterectomy

Vaginal Hysterectomy is a procedure which may be performed if you have a uterine prolapse. This is when the uterus (womb) drops down into the vagina and in more advanced cases can extend beyond the entrance to the vagina. A vaginal hysterectomy is the surgical removal of the uterus through the vagina.

Success rates for vaginal hysterectomy are 85%, however some women may develop a further prolapse of the vaginal vault months or even years later.

Vaginal hysterectomy can be performed under general or spinal anaesthetic.

To remove the uterus the surgeon will make a cut at the top of the vagina around the cervix. The surgeon then pushes the bowel and bladder away from the uterus, cuts the connecting tissues and then removes the uterus. Then the surgeon closes the top of the vagina (the vaginal vault). It's common for surgeons to also add additional supporting stitches to the vaginal vault during surgery.

After surgery

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There may be vaginal bleeding or discharge for 10 – 14 days after surgery. Healing takes around 3 months, so during this time you should avoid any task that can put pressure on the repair i.e. lifting, straining, vigorous exercise, coughing and constipation. You should also avoid heavy lifting such as picking up children, heavy shopping, gardening etc.

You should plan to take 6 weeks off work, but this all depends on the type of role you have.

You should be able to drive and be fit for light activities within 3-4 weeks of surgery. But it is advisable to check your own car insurance policy for any restrictions following surgery. You should wait 5-6 weeks before having sexual intercourse. As this timescale will probably coincide with your outpatient follow-up appointment with your consultant, it is always useful to wait and get the go-ahead from him/her so that you can be sure your tissues are nicely healed.

Complications

As with all operations there is an element of risk involved and complications can occur. Below we have listed some complications that are more specifically related to anterior and posterior vaginal wall surgery.

- Constipation
- Pain during intercourse
- Damage to the bladder or ureters
- Damage to the rectum
- Incontinence
- Mesh complications

You may also experience some pain/discomfort in the groin area, vagina and lower abdomen following surgery. This usually settles after a week or two and simple analgesics like paracetamol may help.

The risk of developing deep vein thrombosis is increased following surgery. Your doctor may give you compression stockings and a daily blood thinning injection to minimise this risk. You can also perform small exercises whilst in bed to reduce the risk, such as rotating your ankles in a circular motion and bending and straightening your legs.

Recovering at home

You will experience tiredness following your operation as the body repairs itself and it is important to have periods of rest during the day in the initial period after surgery. Whilst at home you should try to avoid any activity that can put increased pressure on the repair as this can cause the prolapse to recur. Try not to pick up children or shopping bags and see if someone else can do the housework and gardening for you. A few weeks free from daily chores is better than having to go through surgery again due to a recurrent prolapse.

Constipation is a common problem following surgery so it's important to keep your bowels regular and your stool soft with the right diet. Excessive straining to pass a bowel motion can put pressure on the healing tissues in the vagina, so eating healthy balanced meals containing plenty of fibre will help avoid this. Aim for at least five portions of fruit and vegetables a day. Choose wholegrain varieties of bread, pasta and rice, rather than white versions. Try to avoid foods that are high in fat such as cakes, biscuits and fried foods.

You should also drink between 1.5-2 litres (6-8 glasses) of fluid a day to help keep the body hydrated and the bladder and bowel healthy.

Further Information

Prolapse can recur in 15 – 20% of cases. The incidence is higher if you are overweight, have a chronic cough (usually from smoking), suffer from constipation or are involved with regular weight bearing jobs.

If you develop a strong smelling vaginal discharge or excessive bleeding, burning or stinging on passing urine, difficulty passing urine, increasing abdominal pains, vomiting, fever, painful swollen legs, shortness of breath or chest pain, you should seek medical advice.

If you start to experience any other problems following surgery such as incontinence, please make an appointment to see your doctor, continence nurse or specialist physiotherapist. A continence nurse and specialist physiotherapists are healthcare professionals who specialise in bladder and bowel problems.

To find out where your nearest NHS continence service is visit our Find a Healthcare Professional section in our Help and Info section on www.bladderandbowel.org

Pelvic floor muscle exercises are also very useful for strengthening the muscles that support the bladder and bowel. Performing these exercises can help alleviate symptoms and can often prevent the problem from worsening. For more information about pelvic floor muscle exercises, please see our Pelvic Floor For Women factsheet in the Resources section of our website.

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