Pelvic floor repair with mesh (vaginal prolapse)

Urogynaecology unit

Information for Patients

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What is vaginal prolapse?

A prolapse is a bulge coming from the walls of the vagina. It occurs when muscles and ligaments that support the vagina no longer hold it firmly in place. Prolapse can affect the front wall, back wall or top of the vagina.

- A prolapse of the front wall of the vagina (also called a cystocoele) pulls the bladder into it because the bladder sits just above the front wall of the vagina.
- A prolapse of the back wall of the vagina (also called a rectocoele) pulls the back passage into it because the back passage sits just below the back wall of the vagina.
- When there is a prolapse of the top of the vagina, the womb is pulled down with it. The top of the vagina can also be affected by prolapse even if you have had a hysterectomy. If this is the case, just the top of the vagina bulges down.

1, 2 or all 3 areas of the vagina can be affected by prolapse. Many women with prolapse may also have urinary or bowel problems. They may also have problems during sex. Sometimes these problems may be caused by their prolapse but this is not always the case. It is possible for such problems to be completely unrelated to the prolapse.

Treatment options for prolapse apart from surgery

Doing nothing is a choice if a prolapse is not causing any problems. A prolapse may get bigger though. If it does get bigger, you can come back and see us for treatment.

Pelvic floor exercises strengthen the muscles that support the vagina. They may not get rid of the prolapse but may make you feel more comfortable.

Vaginal pessaries are devices that are inserted into the vagina. They help support the prolapse. They need to be changed every 4 to 9 months. This depends on the type of pessary. Pessaries may interfere with sex, cause a discharge and can sometimes cause bleeding.

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Pelvic floor repair with mesh

Mesh is a layer of netting. It helps support a prolapse. Not all prolapse needs to be repaired using mesh. We use mesh if a prolapse has returned after an earlier repair, if it is a large prolapse or if the prolapse involves the top of the vagina. This is a fairly new procedure. There is no long-term outcome data available yet. Studies do show that is strengthens the repair.

How is the repair done?

- You will be asleep
- This operation is carried out through the vagina.
- A cut is made along the front or back wall of the vagina. This depends on where the prolapse is
- A piece of mesh is placed over the prolapse to help hold it back
- The cut in the vagina is then stitched up so that the mesh is completely covered
- The most effective meshes are made of material which does not dissolve, so, it remains permanently under the vaginal skin

Your examination in clinic will give us a good idea whether mesh is needed or not. However, the final decision is made when you are examined after you are asleep in the operating theatre, as this is the most accurate examination. Sometimes we may need to change your operation depending on this examination.

What are the risks of surgery?

Anaesthetic risk: this is very small unless you have specific medical problems. We will discuss this with you.

Heavy bleeding: there is a risk of bleeding with any operation. Heavy bleeding is uncommon. It is rare that we have to give blood (transfuse) patients during or after prolapse surgery.

Infection: there is a risk of infection after any operation. A serious infection is rare. The risk of infection is reduced by giving you antibiotics during your operation.

The mesh may get infected. This is usually treated by antibiotics. Rarely, the mesh may need to be removed if the infection is severe.

Deep vein thrombosis (DVT): this is a clot in the deep veins of the leg. It can occur in 4 to 5 out of 100 patients. A serious problem sometimes occurs when a clot in the leg travels up to the lungs. The risk of clots is reduced by using special stockings and injections to thin the blood.

Damage to local organs: this can include bowel, bladder, the urine tube between the kidney and the bladder (ureter) and blood vessels. These complications are uncommon but can cause a delay in recovery. These injuries are sometimes not found at the time of surgery and you may need to go back to theatre.

Prolapse recurrence: prolapse operations are not 100% successful. About 1 in 5 women develop another prolapse during their lifetime. This is because the vaginal tissue can weaken again.

Pain general pelvic/vaginal discomfort usually settles with time. Sometimes pain on intercourse may occur. It can sometimes be permanent (1in 10 women).

Reduced feeling during sex: sometimes the feeling during sex may be less and sometimes the orgasm may be less intense.

Change in bowel function: sometimes patients can become constipated after the operation but often bowel function is improved.

Change in bladder function: overactive bladder symptoms (having to go frequently and to rush) usually get better after prolapse surgery. Such bladder problems can sometimes start or worsen after the operation. New or worsening problem with leakage of pee with coughing or sneezing can also occur after surgery. 1 in 10 women may have worsening bladder function. If you have this, please tell us so that we can treat you for it.

Mesh exposure/extrusion: this occurs when the mesh protrudes through the vagina. This can cause vaginal bleeding, discharge or pain and occurs in about 1 in 10 cases. This usually needs a repeat operation to trim the mesh and to reclose the vaginal skin over it.

After the operation in hospital

You may have a bandage in the vagina, called ‘a pack’. This is to apply pressure to the wound to stop it oozing. You may have a tube (catheter) in the bladder. Both the pack and the catheter are removed the next day.

You will be given injections to keep your blood thin and reduce the risk of blood clots. You normally have them once a day until you go home.

The wound is not normally very painful. Sometimes you may need tablets for pain relief.

There will be slight vaginal bleeding like the end of a period after the operation. This may last for a few weeks.

You are usually in hospital for up to 3 days.

After the operation at home

Moving about is very important as using your leg muscles will reduce the risk of clots in the back of the legs (DVT). This can be very dangerous.

You are likely to feel tired. You may need to rest in the daytime from time to time for a month or more. This will slowly improve.

It is important to avoid putting pressure on the repair particularly in the first weeks after surgery. Avoid constipation and heavy lifting. If you do have problems doing a poo, you may need to take laxatives at first. It may help to place a small footstool under your feet when you are sitting on the toilet so that your knees are higher than your hips. If possible, lean forward and rest your arms on top of your legs to avoid straining.

The deep stitches dissolve during the first 3 months. Your body will slowly lay down string scar tissue over a few months.

Do not use tampons for 6 weeks.

At 6 weeks slowly build up your level of activity.

For month 1 (4 weeks):

- Only lift light loads such as a 1 litre bottle of water, kettles or small saucepans.
- You should not lift heavy objects.
- Many women should be able to walk 30 to 60 minutes by week 2. You will be back to your previous walking levels by the end of week 3.

At 3 months you should be able to return completely to your usual level of activity.

You should be able to return to your light job after about 6 weeks, a busy job in 12 weeks.

You can drive as soon as you can make an emergency stop comfortably. This is generally after 3 weeks. Check this with your insurance company. Some of them insist that you should wait for 6 weeks.

You can start sexual relations whenever you feel comfortable enough after 6 to 8 weeks, provided you have stopped bleeding.

Follow up

Follow up in the hospital after the operation is usually 6 weeks to 3 months.

Contact the secretary for your Urogynaecology consultant

For Mr Roderick Teo, contact Stephanie on 0116 258 6426

For Miss Aneta Obloza, contact Teresa on 0116 258 3891

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