Anterior Vaginal Wall Prolapse and Anterior Repair

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Anterior vaginal wall prolapse
About 1 in 10 women who have had children require surgery for vaginal prolapse. Anterior means towards the front, so an anterior vaginal wall prolapse is a prolapse of the front wall of the vagina and is usually due to a weakness in the strong tissue layer (fascia) that divides the vagina from the bladder. This weakness may cause a feeling of fullness or dragging in the vagina or an uncomfortable bulge that extends beyond the vaginal opening. It may also cause difficulty passing urine with a slow or intermittent urine stream or symptoms of urinary urgency or frequency. Another name for an anterior wall prolapse is a cystocele. An anterior repair also known as an anterior colporrhaphy is a surgical procedure to repair or reinforce the fascial support layer between the bladder and the vagina.

What is an anterior repair?
An anterior repair also known as an anterior colporrhaphy is a surgical procedure to repair or reinforce the fascial support layer between the bladder and the vagina.

Why is it performed?
The aim of surgery is to relieve the symptoms of vaginal bulge and/or laxity and to improve bladder function with- out interfering with sexual function

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<th>Normal anatomy, no prolapse</th>
<th>Anterior wall prolapse</th>
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<tbody>
<tr>
<td>uterus</td>
<td>uterus</td>
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<tr>
<td>rectum</td>
<td>bladder</td>
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<td>bladder</td>
<td>vagina</td>
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How is the surgery performed?

The surgery can be performed under general, regional or even local anaesthetic: your doctor will discuss which is best for you. There are many ways to perform an anterior repair. Below is a general description of a common repair method.

- An incision is made along the center of the front wall of the vagina starting near the vaginal entrance and finishing near the top of the vagina.
- The vaginal skin is then separated from the underlying supportive fascial layer. The weakened fascia is then re-paired using absorbable stitches, which will absorb over 4 weeks to 5 months depending on the type of stitch (suture) material used.
- The excessive vaginal skin is removed and the vaginal skin is closed with absorbable sutures, these usually take 4 to 8 weeks to fully absorb.
- Reinforcement material in the form of synthetic (permanent) mesh or biological (absorbable) mesh may be used to repair the anterior vaginal wall. Mesh is usually reserved for cases of repeat surgery or severe prolapse.
- A cystoscopy may be performed to confirm that the appearance inside the bladder is normal and that no injury to the bladder or ureters has occurred during surgery.
- A pack may be placed into the vagina and a catheter into the bladder at the end of surgery. If so, this is usually removed after 3-24 hours. The pack acts like a compression bandage to reduce vaginal bleeding and bruising after surgery.
- Commonly anterior vaginal repair surgery is combined with other surgery such as vaginal hysterectomy, posterior vaginal wall repair or incontinence surgery.

Alternatives to surgery

Do nothing – if the prolapse (bulge) is not distressing then treatment is not necessarily needed. If, however, the prolapse permanently protrudes through 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.

Pelvic floor exercises (PFE). The pelvic floor muscle runs from the coccyx at the back to the pubic bone at the front and off to the sides. This muscle supports your pelvic organs (uterus, vagina, bladder and rectum). Any muscle in the body needs exercise to keep it strong so that it functions properly. This is more important if that muscle has been damaged. PFE can strengthen the pelvic floor and therefore give more support to the pelvic organs. These exercises may not get rid of the prolapse but they make you more comfortable. PFE are best taught by an expert who is usually a Continence Nurse Advisor or Women’s Health Physiotherapist. These exercises have no risk and even if surgery is required at a later date, they will help your overall chance of being more comfortable.

Types of Pessary

Ring pessary - this is a soft plastic ring or device which is inserted into the vagina and pushes the prolapse back up. This usually gets rid of the dragging sensation and can improve urinary and bowel symptoms. It needs to be changed every 6-9 months, or earlier if there is any bleeding or discharge, and can be very popular; we can show you an example in clinic. Other pessaries may be used if the Ring pessary is not suitable. Some couples feel that the pessary gets in the way during sexual intercourse, but...
many couples are not bothered by it.

**Shelf Pessary or Gellhorn** - If you are not sexually active this is a stronger pessary which can be inserted into the vagina and again needs changing every 4-6 months.

**What will happen to me after the operation?**

When you wake up from the anesthetics you will have a drip to give you fluids and may have a catheter in your bladder.

The surgeon may have placed a pack inside the vagina to reduce any bleeding into the tissues. Both the pack and the catheter are usually removed within 48 hours of the operation.

It is important that the amount of urine is measured the first couple of times you pass urine after the removal of the catheter. An ultrasound scan for your bladder may be done on the ward to make sure that you are emptying your bladder properly. If you are leaving a significant amount of urine in your bladder, you may have to have the catheter re-inserted into your bladder.

The day after the operation you will be encouraged to get out of bed and take short walks around the ward. Your stay is likely to be one night.

You may be given injections to keep your blood thin and reduce the risk of blood clots normally once a day until you go home or longer in some cases.

The wound is not normally very painful but sometimes you may require tablets or injections for pain relief.

It is normal to get a creamy discharge for 4 to 6 weeks after surgery. This is due to the presence of stitches in the vagina; as the stitches absorb the discharge will gradually reduce. If the discharge has an offensive odor contact your doctor. You may get some blood stained discharge immediately after surgery or starting about a week after surgery. This blood is usually quite thin and old, brownish looking and is the result of the body breaking down blood trapped under the skin.

**How successful is the surgery?**

Quoted success rates for anterior vaginal wall repair are 70-90%. There is a chance that the prolapse may come back in the future, or another part of the vagina may prolapse for which you need further surgery.

**Are there any Complications?**

With any surgery there is always a small risk of complications. The general complications can happen after any surgery:

- **Anesthetic problems.** With modern anesthetics and monitoring equipment, complications due to anesthesia are very rare.
- **Bleeding.** Serious bleeding requiring blood transfusion is unusual following vaginal surgery (less than 1%).
- **Post operative infection.** Although antibiotics are often given just before surgery and all attempts are made to keep surgery sterile, there is a small chance of developing an infection in the vagina or pelvis.
- **Bladder infections (cystitis) occur in about 6% of women after surgery and are more common if a catheter has been used. Symptoms include burning or stinging when passing urine, urinary frequency and sometimes blood in the urine. Cystitis is usually easily treated by a course of antibiotics.**
- **Overactive bladder (Increased frequency and urgency of passing urine).**
- **Deep Vein Thrombosis (DVT).** This is a clot in the deep veins of the leg. The overall risk is at most 4-5% although the majority of these are without symptoms. Occasionally this clot can migrate to the lungs, which can be very serious, and in rare circumstances it can be fatal (less than 1% of those who get a clot). DVT can occur more often with major operations around the pelvis and the risk...
increases with obesity, gross varicose veins, infection, immobility and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood (heparin).

The following complications are more specifically related to anterior vaginal wall repair:

- **Constipation** is a common postoperative problem and your doctor may prescribe laxatives for this, try to maintain a high fibre diet and drink plenty of fluids to help as well.
- **Pain with intercourse** (dyspareunia). Some women develop pain or discomfort with intercourse. Whilst every effort is made to prevent this happening, it is some times unavoidable. Some women also find intercourse is more comfortable after their prolapse is repaired.
- **Damage to the bladder or ureters during surgery** is an uncommon complication, which can be repaired during surgery.
- **Incontinence.** After a large anterior vaginal wall repair some women develop stress urinary incontinence due to the unkinking of the urethra (tube from the bladder). This is usually simply resolved by placing a supportive sling under the urethra (see the leaflet on stress urinary incontinence in the patient information section).
- **Prolapse recurrence.** If you have one prolapse, the risk of having another prolapse sometime during your life is 30%. This is because the vaginal tissue is weak. The operation may not work and it may fail to alleviate your symptoms.
- **Mesh Complications.** If mesh is used for reinforcement there is a 5-10% risk of mesh extrusion requiring trimming as an office procedure or a brief return to theatre. Rarely pain can develop associated with the mesh requiring part or all of the mesh to be removed.

**When can I return to my usual routine?**

In the early postoperative period you should avoid situations where excessive pressure is placed on the repair, i.e. lifting, straining, vigorous exercise, coughing and constipation.

Do not use tampons. For 6 weeks.

Maximal strength and healing around the repair occurs at 3 months and care with heavy lifting >10kg/25lbs needs to be taken until this time.

It is usually advisable to plan to take 2 to 6 weeks off work, your doctor can guide you as this will depend on your job type and the exact surgery you have had.

You should be able to drive and be fit enough for light activities such as short walks within 3 to 4 weeks of surgery but you must check this with your insurance company, as some of them insist that you should wait for six weeks.

You should wait six weeks before attempting sexual intercourse; some women find using additional lubricant during intercourse is helpful. Lubricants can easily be bought at supermarkets or pharmacies.
Useful references - Where can I obtain more information?
Bladder & Bowel Foundation SATRA Innovation Park Rockingham Road Kettering, Northants, NN16 9JH
Nurse Helpline for medical advice: 0845 345 0165
Counsellor Helpline: 0870 770 3246
General enquiries: 01536 533255 Fax: 01536 533240

Adaptation of BSUG and IUGA Leaflets