

# VAGINAL SURGERY AND PELVIC FLOOR RECONSTRUCTION INCLUDING MESH REPAIRS AND TVT TAPES

## Information Sheet for patients having a Vaginal prolapse Operation



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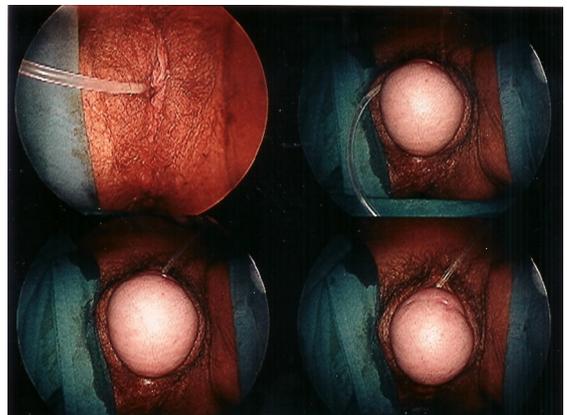
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### WHAT IS THE PELVIC FLOOR?

The female pelvic floor is composed of voluntary muscles, fascia and ligaments. These structures have a supportive component and a functional component. They support the bladder, vagina and uterus and the rectosigmoid and are involved in bladder storage, voiding and continence. They are also involved in providing support for the vaginal wall and the cervix and uterus, and also with sexual function. They have a major role in defecation and continence of faeces. Abnormalities of the pelvic floor manifest themselves as urinary incontinence, uterovaginal prolapse, sexual dysfunction and obstructed defecation and faecal incontinence.

### WHAT IS THE ROLE OF TRADITIONAL VAGINAL SURGERY?

Vaginal prolapse affects about **50%** of women and at least **10%-20%** of women present for surgery for prolapse often associated with urinary incontinence. Vaginal surgery has been carried out for approximately 150 years following the first repair of a bladder fistula. The surgery was refined 100 years ago and again more recently over the last 20 years. With the advent of abdominal surgery for prolapse and incontinence repair about 50 years ago and the arrival of laparoscopic surgery for prolapse repair in the last 20 years, we have seen a decreasing role in traditional vaginal surgery. There is however a significant place for vaginal operations. Some repairs of the anterior compartment are best performed from below. These include treatment of urethral prolapse or **urethrocoele** and central prolapse of the bladder base called **central cystocele**.



Even the lateral bladder defects or paravaginal defects can be repaired vaginally particularly now with the advent of **mesh** (**synthetic** polypropylene or derived from **biologic** or animal tissue) which is revolutionising both vaginal and laparoscopic reconstructive surgery. Mesh can be used to repair prolapse of the bladder base and also for urinary incontinence. The latter technique is called a **TVT**. This procedure is performed as an alternative to the “Burch Colposuspension” for urinary stress incontinence and is very effective particularly in patients who have no other pelvic floor problems. It is also useful in the elderly or patients where there are major medical problems which might be complicated by a longer general anaesthetic and patients who are considered a poor risk for laparoscopic surgery.

Vaginal surgery can be used to resuspend the middle compartment or the vaginal vault which can prolapse after a hysterectomy. This is done by attaching the vaginal vault to the uterosacral ligaments through the open vaginal vault particularly after vaginal hysterectomy or attaching the vaginal vault to the sacrospinous ligaments found laterally towards the bony pelvic side wall. This is called a **sacrospinous fixation technique**. Mesh (synthetic and biologic) can also be used vaginally to resuspend the vaginal vault using a technique which employs specially designed mesh kits (anterior and posterior) to resuspend the vagina with mesh arms to the sacrospinous ligaments.

Posterior compartment defects can be repaired vaginally. The upper part of the posterior vaginal wall can be affected by a true hernia of the peritoneal cavity which is called an **enterocele**. This can be repaired vaginally but there is a significant recurrence rate with this type of surgery. The middle and lower half of the posterior vaginal or rectal wall can prolapse causing a **rectocele**. This is commonly repaired from below using a repair of the fascia and the levator muscles or more recently using mesh. Patients can also have a deficient perineum where the distance between the vagina and the anus is reduced and the vagina appears to pout. This can be built up using a surgical technique to tighten the muscles of the vaginal ring posteriorly and lengthen the perineum. This is called a **Perineorrhaphy**.



## [THE MESH STORY and complications \( FAILURE RATES VS COMPLICATIONS\)](#)

Vaginal surgery like any other surgery has its risks. Some of these relate to the anaesthetic and some to the procedure itself. Inadvertent damage to the bladder, urethra, bowel or ureters occurs rarely in less than 1% of cases. It is usually repaired during the surgery but occasional further surgery is required. About 10% of patient have voiding or bladder emptying problems (particularly with incontinence operations) which may require longer term catheterisation in less than 1% of cases. Up to 5% patients develop urinary tract infections usually associated with catheterisation and 1-5% develop constipation. After a large apical or bladder prolapse repair patients may develop incontinence for the first time as a weakness masked by the prolapse is revealed. This is usually easily fixed with a follow up day surgery. **The most important complication of all is failure** and the **major improvement in success rates** appears to **far outweigh** the mostly minor new complications

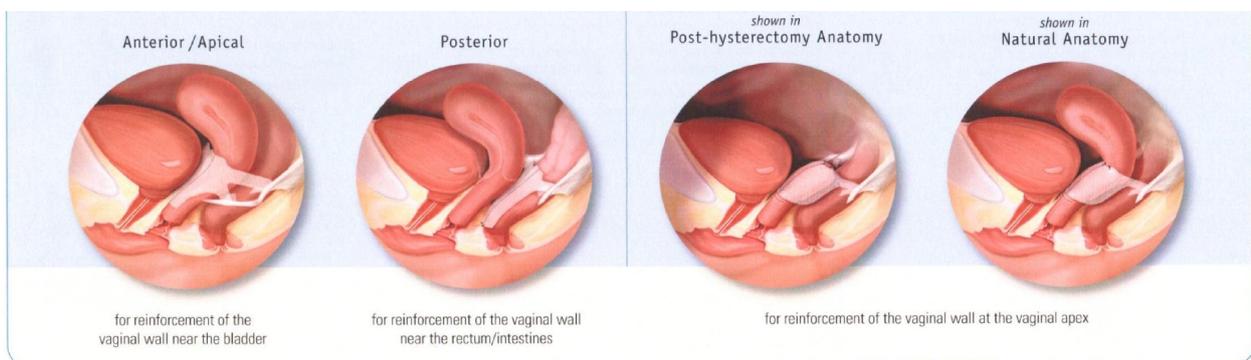
for most women, but particularly for patients with **major** prolapse affecting upper level support systems and those who have already experienced a **recurrence** of their prolapse

The vast majority of women who have incontinence tapes or prolapse meshes find them highly effective and safe, but with all surgery there is an element of risk.

The introduction of mesh to vaginal and laparoscopic surgery has meant a great improvement in the success rates compared to native tissue repairs, particularly with recurrent prolapse repairs. It does however introduce some **mesh specific complications** not seen with traditional surgery. These mesh complications occur in **5-15%** cases when the mesh is inserted vaginally compared to 1-2% when inserted laparoscopically or abdominally. They are also very infrequent (1-2%) with incontinence TVT tapes only.

There is a lifetime risk of at least a 33% reoperation rate for failure with traditional surgery and in fact non mesh vaginal repair may have more than a 50% failure particularly with bladder and apical and recurrent prolapse repairs. Posterior native tissue repairs are still very successful (70-80%) especially if the only prolapse is of the rectum or lower half of the back wall. The failure rate for mesh repairs drop dramatically to 5-15%.

Mesh infection or exposure rates are quoted at 5-15%. Most of these will require no treatment at all or local oestrogen cream or simple trimming in the rooms. In a smaller group of patients simple excision of the mesh and suture with or without a bridging biologic mesh are usually all that is required. Approximately 1-5% of patients develop exaggerated scarring over the mesh with pelvic pain or pain with sex occurring. This is also very uncommon and usually requires no intervention. In rare cases the mesh may have to be removed surgically.



Extensive clinical research has shown very clearly that the total important mesh complication rate is still low at below 10% and the major complication rate is less than 2% in Australia , the UK and the USA. Some of the mesh products have been withdrawn from the market because of the economic realities in this litigious society and not because of the dangers of the products. The media have completely ignored these facts opting and opted for hysteria rather than reason.

### **POSTOPERATIVE RECOVERY**

Following vaginal surgery you may return to the Ward with a **catheter** which may be either urethral or suprapubic and a gauze **vaginal pack** which is usually removed on the morning following the surgery. Once the pack is removed usually the urethral catheter will



also be removed and you will be commenced on a trial of void programme. This is well covered in the information sheet on postoperative care following laparoscopic surgery for urinary incontinence and prolapse.

The only part of the prolapse repair that is usually associated with significant pain is the posterior repair of the perineum.

This can cause rectal pain which is either superficial or deep and occasionally can cause quite marked rectal pain in the second week after surgery. This is usually relieved by simple analgesics or suppositories. Sometimes severe perineal pain can delay the onset of voiding. This is of no consequence and does not interfere with the outcome of the surgery. If there are no voiding problems most patients are usually discharged home by the third to fifth postoperative day. They need to restrict their activities around the house for the first two weeks and usually return to work after four weeks. It is essential not to get constipated and strain with defaecation. For this reason, stool softeners and high fibre diets are often required.

Following the surgery there may be a discharge which is associated with the inflammatory reaction around the dissolvable sutures in the vagina and this can last for 4-6 weeks. This is normal as long as it is not very offensive. It may be associated with bleeding on occasions as the sutures dissolve and this is all part of a normal postoperative recovery phase. Sexual intercourse cannot be resumed until after review by the Doctor. This is usually 4-6 weeks following surgery. At this time all normal activities can be undertaken but it is important not to undergo heavy exertion for the first three months after any reconstructive operation.

**Please report to my practise nurse any unusual nausea or vomiting, persistent abdominal or lower back pain (especially if it does not respond to painkillers), persistent vaginal bleeding or odour, or fevers over 38 Degrees Celsius, difficulty emptying your bladder or pain with passing urine. If the practise nurse or Dr Cario cannot be contacted please contact your GP, the hospital where your operation was performed or your local Accident and Emergency.**

#### **WHAT IS THE COST OF THIS PROCEDURE?**

This practice charges the fees set by the **AMA**. The Medicare schedule does not reflect the difficulty or complexity of these operations and has not kept pace with any average cost of living adjustments or the CPI.

***The exact fees and gaps can be easily obtained from my secretary prior to the operation and from the anaesthetist and hospital in a similar fashion. You must be aware of the out of pocket expenses which must be paid prior to the operation to confirm your booking at the hospital.***