Manchester University
NHS Foundation Trust

Saint Mary's Hospital/Trafford General Hospital
Uro-gynaecology Service

Information for Patients

Management of Vaginal Prolapse

Before reading this leaflet you should read 'What is vaginal prolapse?'

If you have a prolapse that is not causing you any problems you do not need any treatment. You should see your Doctor if you notice:

- Pain or discomfort that is interfering with daily activities.
- Sex being painful.
- Something bulging outside or just inside the vagina.
- Any unusual vaginal bleeding or discharge.
- Difficulty emptying your bladder or bowels.

Lifestyle advice

- **Avoid standing for long periods of time**. Many women find their symptoms become worse when standing and get better when they lie down. Try to make time to put your feet up.
- **Avoid high impact exercise** such as high impact aerobics, running, trampolining.
- **Pelvic floor exercises** may help to prevent prolapse or improve symptoms.
- **Try to avoid becoming constipated and having to strain to empty your bowels**, as this may weaken the vaginal muscles even more. Eat a high fibre diet (fresh fruit, vegetables, wholemeal cereal and bread) and drink plenty of fluids, between 1.5-2 litres (3-4 pints) each day.
- **If you are overweight, try to lose weight.** This will relieve pressure from your pelvic area.
- **Reduce persistent coughing as this may worsen prolapse:** seek advice from your GP about stopping smoking and better management of chest problems.
- **Avoid heavy lifting.**

Treatment of vaginal prolapse

If your prolapse is causing discomfort, pain, difficulty emptying your bowels or bladder, or difficulty having sex you should be referred to a specialist healthcare professional for investigation and treatment.

There are surgical and non-surgical treatments. The choice of treatment depends on:

- The type of prolapse.
- Severity of symptoms.
- Your age.
- Other health problems.
- Whether you are sexually active.
- Whether you wish to have children in the future.
- Your personal preference.

Before deciding on a treatment you should talk to your specialist about the risks, benefits and success rates.

1. Non-surgical treatments

- **Hormonal cream**

Cream containing the hormone oestrogen can make the vagina more comfortable. You can get this with a prescription from your GP or hospital doctor.

- **Pelvic floor muscle exercises**

A physiotherapist or nurse specialist will assess the strength of your vaginal pelvic floor muscles and create an individualised regime of pelvic floor exercises for you. This will help to strengthen the vaginal muscles and may reduce the prolapse and associated symptoms. You will need to practice your exercises every day for a few months before you see any improvement and will need to keep doing them to prevent the prolapse returning.

- **Vaginal pessaries**

A pessary is a plastic or silicone device which is placed into the vagina by your doctor or nurse to support the vaginal walls so that your prolapse is no longer noticeable.

Pessaries come in various shapes and sizes and it might take several attempts to find the right size and shape that works for you. This is usually possible at your first appointment, but sometimes a pessary may fall out when you get home. You will be told who to contact if this happens and given their telephone number so you can arrange to try another pessary or discuss other treatment.

The type of pessary you have will depend on the type and severity of your prolapse and whether or not you want to be sexually active. Your doctor or nurse will discuss this with you.

Once you have a pessary that is comfortable and stays in place it will need to be changed every 3-12 months, depending on the type. This can be done by your nurse or doctor at the hospital or GP surgery, or if you wish you can be taught to do this yourself.

Occasionally, pessaries can irritate the vaginal walls and cause bleeding and discharge. Having your pessary changed regularly will lower the risk of this, but if it does happen you should make an appointment to see your doctor or nurse. The pessary may need to be left out for a few weeks while the area is treated with vaginal cream.

If you notice any change in your bladder or bowel function that you are not happy with, the pessary may not be the treatment for you and you should contact your nurse for advice. For some women a pessary is a long term treatment but pessaries do not work for everyone.

2. Surgical treatment

Before surgery

It is very common to have more than one type of prolapse so it is important that your doctor examines the vagina thoroughly before deciding which operation will be best for you.

Having a prolapse can change the way your bladder and/or bowel work; after prolapse surgery your bladder and/or bowel may work differently. Tests of the bladder and bowel may be needed before surgery to assess this.

There is limited information about the impact of prolapse surgery on future pregnancies. This includes whether prolapse surgery might affect the ability to get pregnant or the outcome of the pregnancy, whether the repair will hold during and after a future pregnancy or the best way to deliver a baby. If you are not certain whether you wish to get pregnant in the future, it is important to discuss this with the doctor when deciding what surgery to have.

2.1 Treating prolapse of the bladder (cystocele) and urethra (urethrocele)

- **Anterior repair (anterior colporrhaphy)**

Under general or spinal anaesthetic a cut is made in the front (anterior) wall of the vagina. The bladder and urethra are pushed back into place and the vaginal wall stitched together to provide new support.

- **Para vaginal repair**

Under general or spinal anaesthetic the vagina is lifted using sutures (stitches). It can be done through the vagina, by keyhole surgery or through a cut in your tummy.

2.2 Treating prolapse of the small bowel (enterocele) and rectum (rectocele)

- **Posterior repair (posterior colporrhaphy/ colpoperinorraphy)**

Under general or spinal anaesthetic, a cut is made in the back (posterior) wall of the vagina. The rectum and/or small bowel are then pushed back into place and the vaginal walls are stitched together to provide new support.

- **Repair with mesh**

If this is not your first operation for prolapse a mesh material may be used to provide extra support. Using mesh may provide better long term support but may increase the risk of painful sex and there is a risk of the mesh eroding through the vaginal skin or surrounding areas.

2.3 Treating prolapse of the uterus (womb)

This can be done by leaving the womb in place and supporting it or by removing the womb.

- **Sacrohysteropexy**

This operation lifts up the uterus for women who want to keep their uterus (womb).
It is usually done through keyhole surgery. One end of a strip of mesh is attached to the cervix and top of the vagina, and the other end to the bone at the base of your spine (the sacrum).

This lifts the vagina to support the uterus (womb).

There is a risk of the mesh eroding through the surrounding tissues.

- **Sacrospinous fixation**

This operation holds the uterus in place by stitching it to one of the pelvic ligaments (the sacrospinous ligament) using stitches not mesh. It is done through the vagina, not the tummy.

Afterwards you may experience pain in your legs, buttocks, genitals and pelvic area, which may last for several weeks.

- **Removing the uterus (hysterectomy)**

This can be done through a cut in your tummy or from the vagina. It is usually done under general anaesthetic. The ligaments that hold the uterus in place are cut and the uterus removed. The ligaments are then shortened to hold up the vagina and the top of the vagina is closed off with stitches.

After hysterectomy:

- There is still a risk of developing other types of prolapse.
- You will no longer have periods.
- You will no longer be able to get pregnant.
- If you have not already been through the menopause and your ovaries are removed, you will go through menopause and may need to take hormone replacement therapy (HRT).

2.4 Treating vaginal vault (top of vagina) prolapse

- **Sacrocolpopexy**

One end of a piece of mesh is attached to the top of the vagina and the other end to a bone at the base of your spine (the sacrum). It is usually done through keyhole surgery. There is risk of the mesh eroding through the surrounding areas.

- **Sacrospinous fixation**

This operation holds the top of the vagina in place by stitching it to one of the pelvic ligaments (the sacrospinous ligament) using stitches not mesh. It is usually done through keyhole surgery.

Afterwards you may experience pain in your legs, buttocks, genitals and pelvic area, which may last for several weeks.

- **Colpocleisis (colpectomy or Le Forts procedure)**

This procedure closes off the vagina by stitching the front and back walls together. It can be done under general, spinal or local anaesthetic.

It is offered to women who have severe prolapse but are too frail to undergo any other surgery and are absolutely certain they do not wish to have penetrative sex ever again.

For more information about a particular surgery please read the appropriate leaflet.

Summary of treatments for vaginal prolapse:

<table>
<tr><th></th><th>For</th><th>Against</th></tr>
<tr><td rowspan="2">Pelvic Floor Muscle Exercise:</td><td>Non-surgical</td><td>• Benefit not proven.
• Have to keep doing them.
• May not work at all.</td></tr>
<tr><td colspan="2"><u>Risks:</u> None</td></tr>
<tr><td rowspan="2">Vaginal Pessary:</td><td>Non-surgical.
No anaesthetic necessary.
1 in 10 women find pessary useful long term. Reversible effect</td><td>• May take several attempts to get the right fit.
• Have to return to nurse/doctor every 3-12 months to have pessary changed.
• May make some symptoms worse or cause new problems.
• May not work at all. Not suitable for all women</td></tr>
<tr><td colspan="2"><u>Risks:</u>
• Bleeding
• Discharge
• Changes in bladder/bowel/sexual function</td></tr>
<tr><td rowspan="2">Surgery:</td><td>2 out of 3 women happy with the outcome of prolapse surgery.</td><td>• Invasive.
• May not get rid of all of your symptoms.
• May make some symptoms worse or cause new problems. May not work at all.
• Not suitable for all women.
• Surgery for prolapse might expose weakness in another area of the vagina so another type of prolapse might develop.
• 1 in 3 women will need another prolapse operation at some time.</td></tr>
<tr><td colspan="2"><u>Risks:</u>
• Anaesthetic
• Infection, bleeding, damage to surrounding organs.
• Changes in bladder/bowel function.
• Vaginal, genital, leg or buttock pain.
• If mesh used - erosion of mesh through vagina or into surrounding areas.
• Painful intercourse.</td></tr>
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