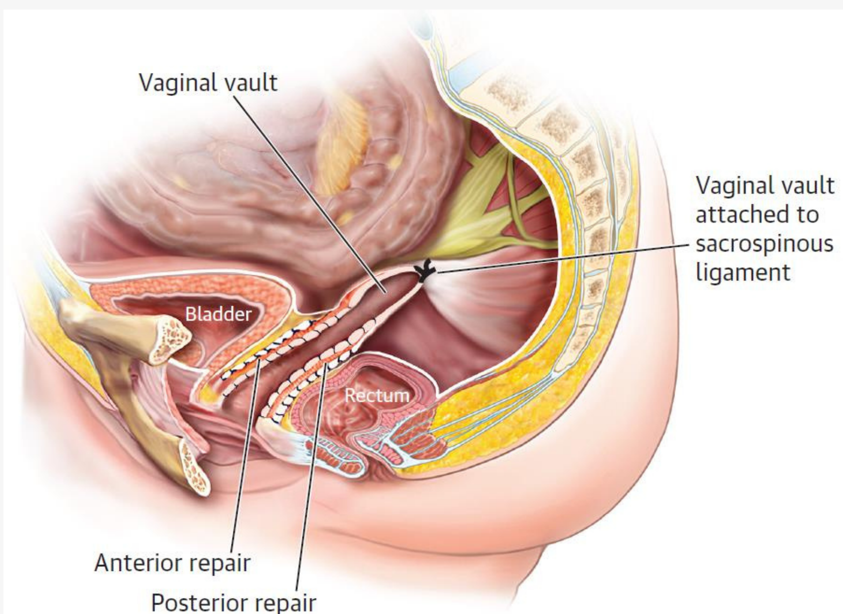
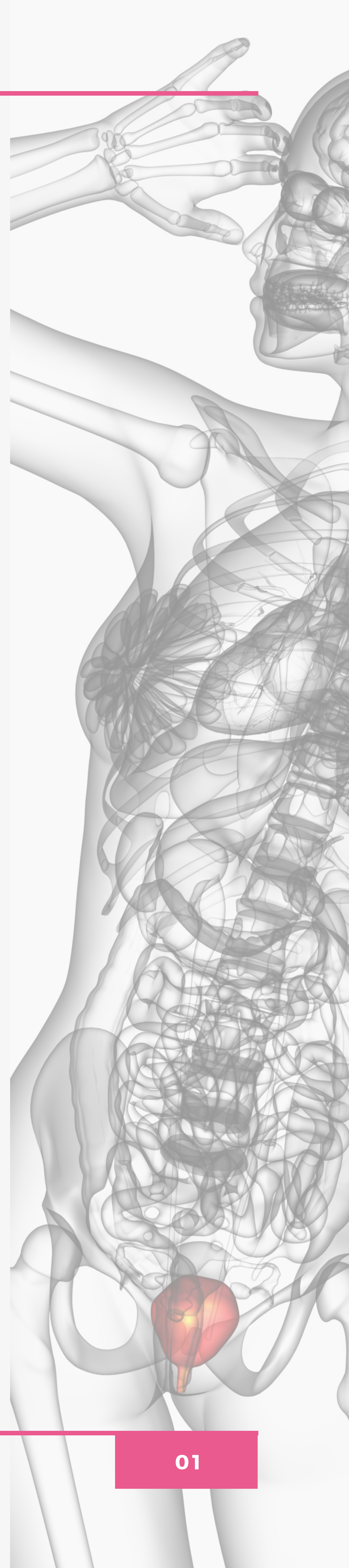
HYSTERECTOMY, VAGINAL REPAIR AND APICAL SUSPENSION

THE UROGYNAECOLOGICAL SOCIETY OF AUSTRALASIA

When is hysterectomy with vaginal repair and apical suspension indicated?
Usually performed for the treatment of utero-vaginal prolapse. It is widely accepted that the best results for vaginal repairs are obtained when suspension of the upper vagina (apex) is included at the time of traditional vaginal repair. In women with uterine prolapse a hysterectomy maybe performed at the time of the vaginal repair and apical suspension. The decision regarding hysterectomy or uterine preservation is best discussed with your individual gynaecologist however, relative contraindications to uterine preservation include: uterine abnormalities, abnormal or postmenopausal bleeding, recent cervical changes on pap smear, Lynch syndrome, Tamoxifen therapy, Body Mass Index >35, Familial cancer BRAC1&2, or being unable to comply with ongoing pap smear screening.

The repair involves suturing the torn tissues (plication) under the bladder and in front of the bowel with delayed absorbable sutures. The vaginal apex is suspended to the sacrospinous ligament. Hysterectomy can be performed vaginally or laparoscopically (key hole) and the decision regarding the best approach is best decided with your gynaecologist based upon your individual situation. For instance, the laparoscopic approach may be preferred if the fallopian tubes and/or ovaries were to be removed.





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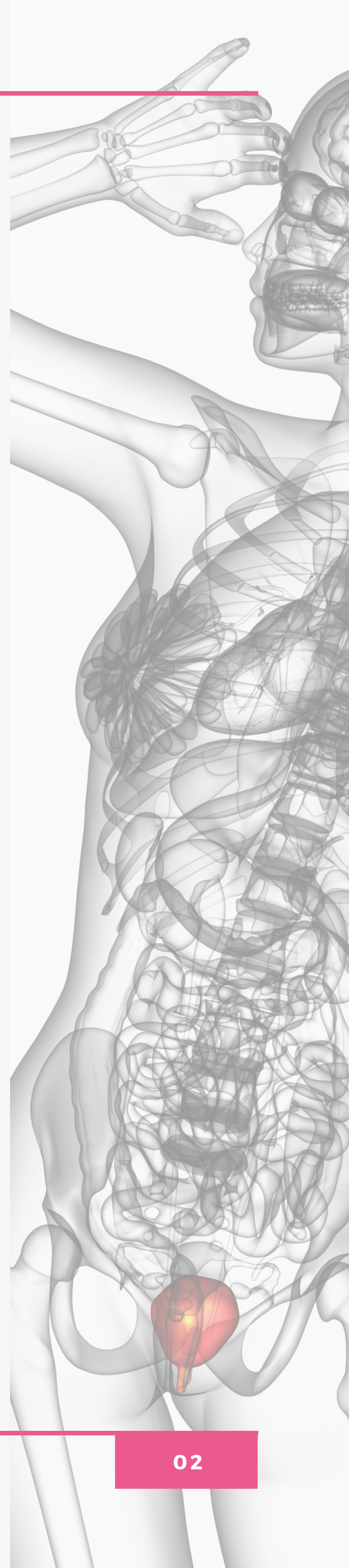
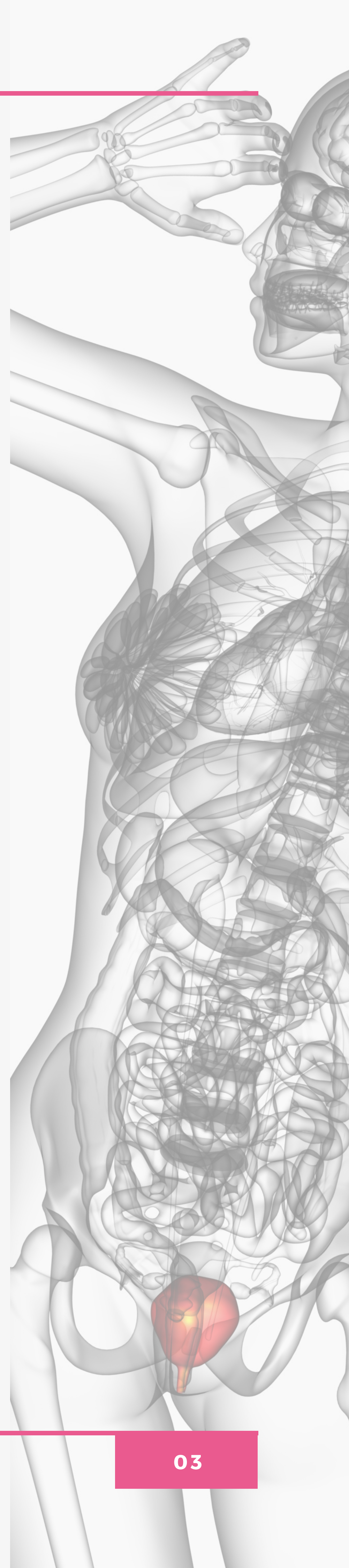
While hysterectomy with vaginal repair and vault suspension is a safe and effective surgery for utero-vaginal prolapse no surgery is without risk and potential complications are listed below.

- Recurrence of prolapse in 15-20%
- Haemorrhage requiring transfusion occurs in 1-2% and reoperation may be required
- Urinary incontinence after the surgery that was not present prior to surgery in 5%
- Urinary retention after the surgery that may require temporary catheters to be placed (clean intermittent self-catheterisation) in 3-5%
  Damage to the bladder, ureter or bowel are rare and occur in less than 1% of cases and further surgery may be required to manage these problems
- Bowel evacuation is frequently improved following correction of the rectocoele however improvement in constipation or faecal incontinence are rarely reported
- Sexual function is also usually improved following prolapse surgery however painful intercourse occurs in 5% after the surgery. Rarely revision surgery is needed.
- Significant right sided buttock pain can occur in 5-10% after the apical suspension suture to the sacrospinous ligament, however this usually resolves within 10-12 weeks. Rarely these sutures may need to be removed.
- Urinary tract or wound infection in 2-5%
- Clotting in legs or lungs in <1%

Surgery will be covered with antibiotics to decrease the risk of infection and blood-thinning agents will be used to decrease the risk of clots forming in the postoperative phase. For the first 24 hours postoperatively a vaginal pack is often inserted into the vagina to decrease the risk of bleeding and a catheter is used to drain the bladder.





In hospital and recovery

You can expect to stay in hospital between 2-3 days. The vaginal pack and bladder catheter, are removed on the first or second day. In the early postoperative period you should avoid situations where excessive pressure is placed on the repair i.e.. lifting, straining, coughing and constipation. Pain or discomfort in the vagina, perineum and lower abdomen is to be expected for 4-6 weeks after surgery. This can usually be managed successfully with a combination of paracetamol and anti-inflammatories (for example, Nurofen or Voltaren). Sometimes women need stronger pain relief for the first few weeks after surgery. Driving can normally be commenced 2-4 weeks after discharge depending upon your recovery. Maximal healing around the repair occurs at 3 months and care needs to be taken during this time. If you develop urinary burning, frequency or urgency you should see your local doctor. You will see your gynaecologist at 6 weeks for a review and sexual activity can usually be safely resumed at 6-8 weeks. You can return to work at approximately 4-6 weeks depending on the amount of strain that will be placed on the repair at your work and on how you feel.

Avoiding heavy lifting (>15kg), weight gain, constipation and weight bearing exercises can minimise failure of the procedure in the long term. If you have any questions about this information, you should speak to your doctor before your operation. A more detailed information sheet on post-operative recover after prolapse surgery is also available.

This statement has been developed by the Urogynaecological Society of Australasia (UGSA).

Disclaimer: This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.