Bradford Teaching Hospitals
NHS Foundation Trust

Cystocoele or Rectocoele Repair

information for patients

What is a Cystocoele or Urethrocoele?

When the front wall of the vagina becomes stretched it bulges downwards and causes an uncomfortable sensation when standing or straining. At the same time supports under the bladder are weakened and this can lead to urine leaking when coughing or sneezing. The abnormality is called a **Cystocoele** or a **Urethrocoele** (or a prolapse of the front wall of the vagina).

What is a Rectocoele?

When the back wall of the vagina is stretched, the supports in front of the back passage (rectum) are weakened and you can see or feel a bulge. This is called a **Rectocoele** (or a prolapse of the back wall of the vagina).

How can these be treated?

The operation to repair a Cystocoele or Urethrocoele is an **anterior repair**, the operation to repair a Rectocoele is called a **posterior repair**.

Both anterior and posterior repairs involve the surgeon removing a piece of vaginal skin, then stitching the bladder and the urethra, or the rectum, back into their normal position and then repairing the vagina.

If you have not previously had a hysterectomy (an operation to remove your womb) it may be necessary to perform one if your womb is falling down in the vagina (a prolapse of the womb).

Sometimes as well as prolapse of the vaginal walls, in women who have had a hysterectomy before, there is prolapse of the top (vault) of the vagina. In this situation, as well as performing the vaginal repair your gynaecologist may perform an additional procedure called a sacrospinous fixation. This involves supporting the top of the vagina by fixing it to some ligaments within the pelvis with a special suture inserted through the vagina.
These operations are carried out under a general or a spinal anaesthetic and can take 30 to 60 minutes.

How is the surgery performed?

The surgery is usually performed vaginally. There are no external stitches but there will be dissolving internal stitches.

Are there any alternatives to surgery?

These would have been discussed with you by your Gynaecologist and are:

Physiotherapy treatment – This would be in the form of pelvic floor exercises, which are taught by the physiotherapist. This may not cure or improve all your symptoms but if properly supervised by a physiotherapist and properly performed can help to reduce the symptoms.

The use of a 'ring pessary' – The pessary is designed to elevate the weakened muscle and to help the related symptoms. The pessary would need to be fitted by a Gynaecologist and you would be given instructions on its use.

You could choose to have no treatment but your present symptoms would continue.

Advantages of having the operation

- The aim is to relieve your symptoms of a vaginal bulge/ swelling and vaginal discomfort.
- The operation may improve continence (your ability to not leak urine) and may make opening your bowels easier.

What are the risks relating to this operation?

Whilst prolapse surgery is very successful we cannot guarantee that all your symptoms will disappear, e.g. backache is a very common symptom in women with prolapse but the back pain may not be due to the prolapse. You also need to understand that prolapse can recur and about 1 in every 3 women who undergo prolapse surgery will have problems with further prolapse at some stage in their life.

An anterior or posterior repair is a major operation. There are risks with all major operations. It is important you are aware of these before you consent to your surgery.

General risks for surgery:

- There is a small risk of damage to nearby blood vessels.
- There is a 1 in 100 possibility that you may need to return to theatre because of bleeding.
- You could develop a wound infection, chest infection or urine infection.
- You could develop a thrombosis (blood clot) in your leg, which can also move to your lungs (pulmonary embolus).

Specific risks relating to surgery for a rectocoele:

- There is a small risk of injury to the rectum (back passage)
- There is a risk of constipation following the surgery.
- There may be some pain or discomfort when you have intercourse after the operation.

Specific risks relating to surgery for a cystocoele:

- There is a small risk of injury to the bladder.
- You may have difficulty passing urine, retaining urine in your bladder which would mean a catheter would need to be inserted to empty the bladder. Usually the catheter will be left in for 24 hours. Very rarely the catheter may need to be left in a little longer to allow normal bladder emptying to return. In this case you would be taught how to manage the catheter so that it needn't delay your discharge home.

Specific risks relating to sacrospinous fixation:

- In addition to the risks mentioned above there is a small risk of buttock pain which may last several months.

Risks relating to having an anaesthetic:

- An anterior or posterior repair usually requires a general anaesthetic, which has an increased risk if you are older, have heart or chest problems or you smoke. The risk of death from general anaesthesia is 1 in 100,000.

Pre-assessment clinic

You will be put on a waiting list for the operation. When you are given a date to come in to hospital, you will also be given a date to attend pre-assessment clinic, approximately a week before you come for your operation. The pre-assessment clinic is on the Women's Health Unit, Level 3, Women's and Newborn Unit at the BRI.

It is important to attend this appointment, where you will be seen and assessed whether you are suitable to have an anaesthetic. You will also be given more information about coming into hospital, your operation and care afterwards, including pain relief. You will have the opportunity to discuss any questions or concerns.

When you come into hospital you will be asked to remove all jewellery, this includes body piercings, you may wish to do this before you come into hospital. If you cannot remove tongue or vaginal piercings, it could result in your operation being cancelled.

Giving consent for your operation

Before any operation, you have to give your written consent and sign to say you wish the operation to take place. The consent form will be completed by a doctor, at the outpatient clinic or on Ward 12.

At any time you can change your mind and withdraw your consent but you must tell a member of staff. If you sign your consent form at the outpatient clinic, we will ask you to confirm if you still consent to the operation when you are admitted to hospital.

Coming in to hospital

You will come into Ward 12 at the BRI. You will be asked to come in to the ward at least several hours and in some cases the day before your surgery, even if you have attended the pre-assessment clinic. This allows time for the nursing and medical staff to ensure the relevant blood tests and investigations have been performed and results are available. It will also give you chance to settle in to the ward and ask any further questions you may have.

If you have not been to the pre-assessment clinic it is essential to be admitted in plenty of time to complete blood tests and to obtain consent for your operation.

Your surgeon and anaesthetist will see you before your operation.

The anaesthetist will discuss the type of anaesthetic planned and will ask you questions regarding your health, so that they are aware of any health problems you may have. They will also discuss any concerns you may have regarding the anaesthetic and discuss the pain relief you will have after the operation.

Preparation for the operation

Prior to having the general anaesthetic and the operation you will be asked to 'starve'. We will ask you to **not** eat any food or drink any fluids. The nursing staff will advise you about this depending on the planned time of your operation.

When you are in hospital it is essential to wear a wristband at all times to ensure your safety during your stay.

The wristband will contain accurate details about you on it including all the essential information that staff need, to identify you correctly and give you the right care. All hospital patients including babies, children and older people should wear a wristband at all times.

If you do not have a wristband whilst in hospital, then please ask a member of staff for one. If it comes off or is uncomfortable, ask a member to staff to replace it.

It may be necessary to trim pubic hair before your operation. Ideally this needs to be done a few hours before your operation and whenever possible you may do this yourself.

It may also be necessary to have a small enema to empty your bowel prior to surgery. The nursing staff will advise you regarding any preparation needed.

Most women need to wear knee length anti-embolic stockings (which will be provided on the ward) and are given injections to prevent deep vein thrombosis (blood clot in the leg).

After the operation

When you are ready to return to the ward, a nurse will collect you from theatre. You will have an intravenous infusion (IVI or drip). This will ensure your body receives the fluid it needs as you may be too sleepy to drink.

You may have oxygen via an oxygen mask in place for the first 24 hours.

During the operation, a catheter (a small plastic tube) may have been passed up the urethra (the tube to the bladder), to drain urine and keep the bladder empty. The catheter may be left in for 1 to 2 days. Sometimes a catheter may be inserted directly into your bladder just above the pubic hairline. This is usually left in place for several days, until you can pass urine normally and then it is removed.

A vaginal pack, made up of gauze, may be inserted to prevent any post-operative bleeding; this will be removed by a nurse the next day.

You will probably be very sleepy for 24 hours following surgery. During this time you will be aware of the nursing staff regularly checking your blood pressure and for signs of bleeding.

The nurses will give you small amounts to drink as soon as possible. We will give you plain water initially because tea, coffee and juice tend to make you feel sick.

Pain relief will usually have been discussed with you before the operation.

Pain relief may take the form of regular injections according to your needs or you may have pain relief via a P.C.A. (patient controlled analgesia). P.C.A. is a pump connected to your IVI (drip) and allows you to give yourself painkillers as and when you need them.

Often more than one type of pain relief can be used, for example you may have a P.C.A. and also be given pain-killing suppositories (in the rectum).

Please note that the pain relief is very closely monitored to ensure you are kept comfortable without the possibility of becoming dependent on the pain relief.

Although you may not have visible stitches you may have internal stitches that need time to heal. These stitches do not need to be removed but will dissolve, this can take several weeks.

Will there be any vaginal bleeding?

A small amount of bleeding similar to a period, in the first few days is normal. The amount and length of time women bleed for varies, it can last for several weeks. It should not be heavy nor should it have an offensive (foul) smell. It should be similar to the end of a period. If your blood loss becomes heavy or offensive after discharge you must see your GP because you may have an infection which will need treatment. Always use sanitary towels not tampons until the bleeding following your operation has stopped.

You should have a bath every day using clear water.

How long will you be in hospital?

You have had major surgery therefore your hospital stay is dependent on the speed in which you recover from the operation but the average stay is 2 to 3 days after your operation. Occasionally it may be necessary to stay longer until your bladder or bowels are functioning normally.

Visitors

You will probably be sleepy on the day of your operation therefore we suggest that you only have one visitor that day. A group of people visiting can be quite disturbing when you do not feel well.

After the first day we would appreciate if you could limit visitors to 3 at any one time, as per the Bradford Teaching Hospitals Trust Policy. This helps to maintain safety, minimize the risk of hospital acquired infection and also reduces disturbance to other ill patients who may be on the ward.

Visiting times on the ward, which we ask you to abide by, are:

Monday to Friday: 11.00am to 12.00 noon and
6.00pm to 7.30pm.

Saturday, Sunday and Bank Holidays: 1.00pm to 7.30pm.

Your family is welcome to telephone but we will not give any details of your surgery to them.

Diet

We do not usually recommend that you eat anything for several hours after your surgery; you will then be assessed as to when you can eat. We will usually suggest something light to start with, such as soup or toast.

Constipation can be a problem after your operation. A diet that includes plenty of fruit and vegetables, and drinking 1 to 2 litres of fluid per day should help to reduce this.
You may be prescribed a mild laxative as well.

Rest and activities

You will need to take things easy for the first few weeks when you get home. After 3 to 4 weeks you should be feeling much better and becoming more active. Normal activities can be resumed within 6 weeks, except for heavy lifting or particularly strenuous activity.

How long should I wait before I have sexual intercourse?

You will have internal stitches, which need to be completely healed before you take part in penetrative sex. This usually takes up to six weeks, so if you have no abnormal vaginal discharge, it is safe to resume sexual activity at this time.

The vagina may be left slightly narrowed but this does not usually interfere with sexual intercourse. Your Gynaecologist will discuss this with you.

You may find it helpful at first to use a little lubricant such as KY jelly, available from the chemist; and you may find you need to experiment to find a more comfortable position. Remember to be patient, if your sex life was good before your operation, it soon will be again.

When can I start to exercise?

Swimming is an excellent form of exercise and may begin as soon as your vaginal loss has stopped. Other more strenuous forms of exercise can usually begin at about 6 weeks after your operation. Remember to start gently, doing too much too soon may do you more harm than good.

Before you leave hospital you should receive advice and an information leaflet from our physiotherapist. This will give you detailed explanations of exercises designed to strengthen your pelvic floor muscles as well as some common sense advice.

How soon can I drive?

We suggest that you do not drive for 4 weeks. It is not only the physical effort that driving requires; you also need to be mentally alert. The stress of major surgery and an anaesthetic can slow down your reactions. You must feel confident and well before you drive. Start with short journeys.

Returning to work

Heavy lifting should be avoided after surgery for prolapse.

Follow up after the operation

You will receive an appointment for a telephone clinic run by a urogynaecology nurse specialist at about 6 weeks after your operation and then a gynaecology clinic appointment at about 12 weeks post-operatively. If the nurse specialist is concerned about any problems that you are having, she can arrange for you to attend clinic sooner than your 12 week appointment.

Finally do not be afraid to ask. There is very little we have not heard before however silly it may seem to you. If you need to contact us after you have left the ward please ring Ward 12 01274 364380 - 24 hours.

Smoking

Bradford Teaching Hospitals NHS Foundation Trust is a smoke-free organisation. You are not permitted to smoke or use e-cigarettes in any of the hospital buildings or grounds.

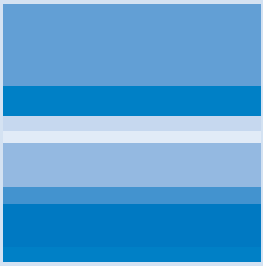
Next Generation Text

We use Next Generation Text for people with hearing difficulties. To contact us ring 18001 01274 364380

If you need this information in another format or language, please ask a member of staff to arrange this for you.

Notes

Please write down any questions you may have below.



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Author: Gynaecology guidelines group, Carmel Ramage and Sue Calvert
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