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FACT SHEET

Vaginal Hysterectomy and Prolapse Repair

The Condition

The uterus (also known as the womb) is a pear shaped organ that sits between the bladder and the rectum (back passage).

The most common conditions of the uterus, for having a hysterectomy are:

- Uterine disease
- Diseases of tubes and ovaries
- As part of the treatment for a prolapse
- Bleeding not controlled by conservative treatment.

The Operation

Vaginal Hysterectomy

This is the removal of the uterus through the vagina. The vagina is stitched from below and there is no cut in the abdomen.

Laparoscopically-Assisted Vaginal Hysterectomy

Sometimes, a laparoscope (telescope type of instrument) is also used. If it is difficult to remove the uterus through the vagina or the tubes and/or ovaries need to be removed, the surgeon may start with a laparoscopy and then complete the operation through the vagina. The surgeon will discuss with you the best surgery for your condition.

Total Laparoscopic Hysterectomy

The hysterectomy with or without removal of tubes and/or ovaries is complete via a laparoscopic technique. This is more likely to be done if a prolapse repair is not required.

Vaginal Repair and Sacrospinous Colpopexy

Women needing hysterectomy often have other co-existing problems. These relate to prolapse of other organs into the vagina. These are prolapse of the bladder (cystocele), urethra (urethrocele), rectum (rectocele) and bowel (enterocele). Women may also have a weak perineal body (an attachment for the pelvic floor). This is usually related to birth trauma. These conditions will require repair at the same time as the hysterectomy.

The vaginal repair is done by 'double breasting' the tissues in the front and back walls of the vagina (vaginal repair). The vagina is often hitched up to a ligament at the back of the pelvis (sacrospinous colpopexy) to help reduce recurrence of the problem. Your doctor will discuss with you the most appropriate procedure for your condition.

Mesh repairs

Vaginal mesh for the repair of prolapse has gone out of favour due to an unacceptable level of complications. If mesh is required, this is done via a laparoscopic approach which is associated with fewer complications.

Due to the restoration of the pelvic organs back to their normal positions, this surgery may uncover hidden problem such as incontinence and overactive bladder. If there is a high suspicion that this may occur, your doctor will order urodynamic testing and consider doing incontinence surgery at the same time as your vaginal hysterectomy and repair. Pre- and post-surgery physiotherapy may be required. The most appropriate procedure will be discussed with you.

Benefits of having the surgery

The decision to have a hysterectomy depends on the type of problems you are having and how bad they are. It also depends on whether you need major surgery to make your life better or, if you have a life threatening illness, to prolong your life. You need to discuss this with your surgeon.

Risks of not having the procedure

This depends on the reason for the surgery: For prolonged bleeding, you may develop anaemia, which may need blood transfusions, and continued problems with heavy and irregular periods.

If you have a prolapse, the uterus can drop down into the vagina and even outside the vagina where it can develop ulcers and cause considerable pain and discomfort. If you have a suspected tumour, then possible spread of tumour may result.

Anaesthetic

Your anaesthetist will discuss the anaesthetic risks prior to your procedure.

General risks of a procedure

There are risks with any operation, and these risks can happen with a hysterectomy. They include:

a) Small areas of the lungs may collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
b) Clots in the legs with pain and swelling. Not infrequently, the clot may break off and go to the lungs which causes serious breathing troubles and can be fatal
c) A heart attack because of strain on the heart or a stroke.
d) Death is possible but very, very rare.

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Specific risks of this procedure

The risk	What happens	What can be done about it
Excessive bleeding (rare)	Severe bleeding from large blood vessels about the uterus or vault of vagina may occur. This is not common.	Emergency surgery to repair the damaged blood vessels either during or after the operation. A blood transfusion may be required to replace blood loss. A vaginal pack may be used to control the bleeding.
Infection (common)	Infection in the operation site or pelvis or urinary tract may occur. This is not uncommon.	Commonly treated with oral antibiotics. There may be a need for hospital admission for intravenous antibiotics and possibly surgery to wash out the wound/s or pelvis
Bladder or Bowel injury (rare)	Nearby organs such as the ureter(s) (tube leading from kidney to bladder), bladder or bowel may be injured. The rate of occurrence is about 1 in 140 women.	Further surgery will be needed to repair the injury. For bladder injuries, a catheter (plastic tube) may be put into the bladder to drain the urine away until the bladder is healed. For ureter injury, a plastic tube (stent) is placed in the ureter for 6 weeks and then removed by cystoscopy or sometimes a ureteric reimplantation via laparotomy will be necessary. If the bowel is injured, part of the bowel may be removed, with a possibility of a temporary or permanent colostomy (opening onto the abdomen so that waste can pass out).
A leak between the bladder and vagina or bowel and vagina (very rare)	Rarely a connection (fistula) may develop between the bladder and the vagina or the bowel and the vagina. This causes leakage of urine or faeces through the vagina, which you will have no control over.	This is a difficult problem to fix and will require further corrective surgery.
Bowel blockage (rare)	The bowels may not work after the operation. This may be temporary or in the longer term, a bowel obstruction can develop.	Treatment may be a drip to give fluids into the vein and no food or fluids by mouth. If it doesn't resolve, bowel surgery may be necessary which may include a colostomy. This can be temporary or permanent.
Pain in the perineum (common)	Pain and discomfort in the perineum (the area between the vagina and the back passage) for up to 6 weeks after operation	Pain killers are used as required depending on the level of discomfort.
Change in bladder and bowel habits (rare)	A change in the sensory nerves of the bladder and bowel due to surgery. Constipation and bladder problems. Incontinence (uncontrolled passing of urine) may result later in life.	Medication may be used to control constipation. Advice on managing incontinence.
Feelings of depression and anxiety (rare)	Psychological changes after surgery. Feelings of depression and anxiety can be prolonged after surgery.	Counselling may be of benefit. Anti-depressants may be prescribed for a short while.
Prolapse of pelvic organs	Women who have had a hysterectomy prior to menopause are at increased risk of pelvic organ prolapse after the menopause. This is less common if a vaginal repair was done.	Surgery to correct prolapse is required in about 10% of women at some time after the hysterectomy.
Onset of menopause	If one or both ovaries are spared, menopause generally occurs at the usual time between 49 and 54 years of age. If the ovaries are removed, menopause is immediate.	Depending on symptoms, hormonal and non-hormonal treatments may be required.
Increased risks in obese patients.	An increased risk of wound infection, chest infection, heart and lung complications, thrombosis.	If overweight, any weight loss prior to surgery is welcomed, even 5 kg loss. Ideally the BMI should be less than 28kg/m^2 to reduce risk to close to baseline risk.
Increased risks in smokers.	An increased risk of wound infection, chest infection, heart and lung complications, thrombosis.	Giving up smoking before operation will help reduce the risk. Even ceasing for 48 hours before surgery will make a difference.
Death (very rare)	A rare event as a result of hysterectomy – at a rate of 6 women in 10,000 cases.	

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