Vaginal Hysterectomy, Anterior and Posterior Vaginal Repair, Sacrospinous Fixation, Cystoscopy

This procedure is performed usually to treat uterovaginal prolapse, however, problems related to the uterus such as menorrhagia, fibroids or adenomyosis can be treated by hysterectomy performed in this way.

Usually this operation is performed under general anaesthetic although regional anaesthesia such as epidural or spinal could be used too.

The uterus is removed through the vagina and vaginal vault is closed. Anterior vaginal wall (related to the bladder) and posterior vaginal wall (related to the rectum) are also repaired by dissection and stitching to help strengthen the tissues and fix the prolapse.

Sacrospinous fixation involves stitching the vault of the vagina to a strong ligament in the pelvic bones called “sacrospinous ligament”. This is done with a permanent non-soluble stitch.

At the end of the procedure cystoscopy is performed which involves looking inside the bladder with a camera (introduced through the urethra) to make sure no trauma to the bladder or ureters has occurred.

Please note that not all of the components described above are always performed. Often under anaesthetic vaginal prolapse appears different to what it looks like when examined in the gynaecologist’s office. Some components described above can be omitted if not required for the purpose of fixing the prolapse. Hysterectomy is sometimes not performed for women who desire to retain the uterus, maintain fertility or if the prolapse does not actually involve the uterus.

At the end of the procedure a catheter is left to drain and rest the bladder and a gauze pack is inserted in the vagina. The catheter can be left in for 1-3 days depending on the extent of the operation, but the pack is usually removed the next day.

The recovery from the procedure is generally quick with women able to go home often after 2-3 days. The pain afterwards is usually able to be managed by oral analgesics such as oxycodone, anti-inflammatory medication, codeine and/or tramadol.

Some sutures may be visible at vaginal introitus afterwards, however, most of the stitches are actually inside the vagina and in deep tissues surrounding the vagina.

As with any surgical procedure potential risks do exist and in particular are as follows:

- Infection
- Postoperative bleeding and/or blood collection
- Blood transfusion
- Urine retention. Occasionally there is a problem where the bladder does not empty completely after the operation and may take several weeks to return to normal. This is normally treated either with an ongoing catheter drainage or by intermittently emptying the bladder with a catheter by the patient.
- Trauma to surrounding structures (bladder, bowel, blood vessels, ureters etc)
- Prolapse recurrence – in some literature this is quoted as 30% lifetime risk. Please note that this may occur a long time after the operation and may not actually be as extensive as the original problem
- Laparoscopy/laparotomy – this could be employed as an emergency measure to control the bleeding for example if such develops during the prolapse operation
- Deep venous thrombosis and/or pulmonary embolus

Sacrospinous fixation, if performed, can cause several weeks of right buttock pain. This invariably settles down and can be treated by rest and the simple analgesia already described.

After the operation it is important to avoid constipation and abdominal straining, such as with lifting. No lifting heavier than 5kg is to be done for 6 weeks. Driving needs to be avoided for 4 weeks. No penetrative intercourse should occur for 6 weeks and no packs/tampons are to be inserted into the vagina for 6 weeks. Swimming and prolonged bathing should be avoided for 4 weeks. (Showering is perfectly fine from the day after the operation).

Some vaginal bleeding and discharge occurs after the operation. This is normal. However if the bleeding is becoming heavier and brighter or the discharge becomes offensive this should be reported as should worsening pain. Some weeks after the operation dissolvable sutures may be found expelled from the vagina. This is normal and they should be discarded and disregarded.

In general I would review the patient in my office 1 and 6 weeks after surgery.