How do I know if I need to have surgery?

Deciding whether or not to have surgery for your bladder, bowel and/or prolapse problems is an individual decision. **The success or failure of someone else's operation should never be the deciding factor for you.** Every woman's situation is different.

Work with the GHS Female Pelvic team to make a plan that works best for you. A lot depends on your individual problems, and more depends on your preferences. A woman should seek treatment whenever her symptoms have negative impact on her life – you don't have to wait until your symptoms are 'really bad'. Uncontrollable urine leakage, while common, is not a normal result of childbirth and aging. You do not just have to 'learn to live with it'. Seeking medical help does not mean that you have to have surgery right away. Some women start with more conservative treatment like physical therapy, and go on to surgery only if their urine loss is not well controlled.

It is important to understand that there are several different surgical techniques which are effective depending on the experience and training of your urogynecologist and the exact nature of your problem. **There is no single operation that is right for every patient.** You and the Female Pelvic team must decide on the specific surgery together. Some of the surgical options for various types of prolapse are listed below. Remember - to be effective, prolapse surgery must correct all of the support defects that you have. Most of the time, a urogynecologist can identify your defects while examining you in his/her office. That exam determines the type of surgery your urogynecologist will perform. Sometimes, however, the findings in the operating room are slightly different than those observed in the office. In those cases, your urogynecologist may decide to add a procedure during the time of surgery - or possibly not do something he/she had planned to do. It is also important to remember that surgery to correct urine leakage is often performed along with prolapse surgery. Your doctor will determine whether to recommend continence surgery based on your medical history, physical exam, and possibly some specialized testing such as urodynamics, anal manometry and radiology studies of the pelvic floor.

There are two main categories of prolapse surgery - **1) Obliterative** & **2) Reconstructive**

**Obliterative** operations actually close vagina completely. The skin of the vagina is removed, and the front and back walls of the vaginal support system are sewn to each other. There are two main types of obliterative surgery - Colpocleisis, and Colpectomy. Both are very effective in getting rid of bulges (prolapse), but there is no possibility of having intercourse after one of these procedures. Therefore it is very important for women to be ABSOLUTELY sure that they no longer want to have intercourse before having one of these operations. The benefit of obliterative surgery is that it tends to be less invasive and quicker than reconstructive surgery.

The goal of all **Reconstructive** operations is to restore normal anatomy and give the patient her best chance at normal quality of life including sexual intercourse. Most urogynecologists agree that the most important aspect of a prolapse repair is restoration of the support to the vaginal apex (or "tip top" of the vagina). Three common procedures that do this are the sacral colpopexy, uterosacral ligament fixation, and sacrospinous ligament fixation. Fixing an enterocele is often part and parcel to any of these operations.

Operations that correct cystoceles are the paravaginal repair and the anterior repair.

Operations that correct rectoceles are the posterior repair (aka rectocele repair).

Operations for uterine prolapse are the same ones mentioned above for fixing the apex of the vagina. They can all be performed with or without the uterus in place. Your doctor should explain the reasons for and against hysterectomy at the time of prolapse surgery.
If I decide to have surgery, what can I expect during the recovery period?

Depending on the extent of your surgery, the hospital stay usually lasts one to four days. Many women have difficulty urinating immediately after the surgery and have to go home with a catheter in place to drain the bladder. These catheters are usually only necessary for 3 - 7 days. Most patients require at least some prescription strength pain medicine for about one to two weeks after surgery. After any surgery to correct urinary incontinence or prolapse, we ask that patients "take it easy" for 6-12 weeks to allow proper healing. This means no lifting more than 8 pounds (the weight of a gallon of milk), no intercourse, and no exercise other than walking.

The amount of time necessary for you to "bounce back" from surgery has a lot to do with the route of surgery. In other words, if an abdominal incision is necessary to perform your operation, you will probably have more pain postoperatively than if your procedure is performed through a laparoscope or through the vagina. However, some patients are not good candidates for the vaginal or laparoscopic approaches. Your doctor should be able to explain his/her choice regarding the type of surgery you need.

Even if your surgery is performed via a less invasive route, prolapse operations tend to be "major surgery". In other words, all of these operations are a pretty big deal in terms of recovery and shouldn't be taken lightly.

If my surgery is successful, how long will it last?

The goal of continence or pelvic reconstructive surgery is to re-create normal anatomy permanently. However, none of these procedures are successful 100% of the time. According to the medical literature, failures occur in approximately 5 - 15% of women who have prolapse surgery. In these cases, it is usually a partial failure requiring no treatment, pessary use, or surgery that is much less extensive than the original surgery. Patients who follow our recommended restrictions for 12 weeks after surgery give themselves the best chance for permanent success.

I have prolapse, but I don't leak urine. Do I still need bladder testing?

Yes, if you are going to have surgery to correct the prolapse, bladder testing (called urodynamics) must be done first. That's because the prolapsed portion of your vagina may be pushing on your urethra and preventing urine leakage. If that is the case, having the prolapse corrected can give you a new problem - urinary incontinence. The only way to tell whether a continence procedure is needed at the time of prolapse surgery is to perform urodynamics while holding the prolapse up in its normal position.

What will happen if I just ignore this problem? Will it get worse?

Yes. It may not happen quickly, but if left untreated, pelvic organ prolapse almost always gets worse. The one exception to that rule can occur shortly after having a baby. “New” prolapse (noticed by a patient or doctor in the early postpartum period) will often get better within the first year after the delivery.
However, treatment of prolapse should be based on your symptoms. In rare cases, severe prolapse can cause urinary retention that progresses to kidney damage or infection. When this occurs, prolapse treatment is considered mandatory. In most other cases, patients should be the ones to decide when to have their prolapse treated - based on the symptoms they are having.

Do I have to have a hysterectomy as a part of my surgery?

No. Any or all of the operations for prolapse and incontinence can be performed with or without a hysterectomy. However, hysterectomy is often performed along with these operations for a variety of reasons. In some cases, removing the uterus first makes the rest of the surgery easier to perform. In other cases, there is another reason besides prolapse or incontinence (such as cancer or excessive bleeding) to remove the uterus. Any such decision should be between the patient and her surgeon, and it should be individualized from patient to patient.

What is a pessary?

Your doctor can place a PESSARY in the vagina. This flexible, plastic device, usually used for Prolapse (descent of pelvic organs/floor) will help hold the bladder and vagina up, sometimes preventing leakage. Pessaries also come with an incontinence modification. Pessaries should be cleaned about every 5-6 weeks.

What is prolapse?

Pelvic organ prolapse is a condition that results from weakening, breaking and/or stretching of the connective tissue, muscles, and nerves that make up the pelvic floor. This weakening and stretching allows pelvic organs to drop, bulge, or “prolapse” into the vagina. Commonly, prolapse is related to the pressure and stretching involved in childbirth, but it can also be related to repetitive strenuous work, chronic coughing, smoking and less commonly, accidental injury, or to an inherited weakened tissue.

Loss of pelvic support can involve a variety of problems:

1) the bladder can bulge through the front wall of the vagina as in the pictures below. This is known as a cystocele. Keep in mind that your bulge may not look exactly like the picture. It may be larger or smaller.

2) the rectum can bulge through the back wall of the vagina. This is known as a rectocele. Keep in mind that your bulge may not look exactly like the picture. It may be larger or smaller.

3) the uterus can fall down into or out of the entrance to the vagina. This is known as uterine prolapse.

4) the bowels or intestines can prolapse into the vagina. This is known as an enterocele. Keep in mind that your bulge may not look exactly like the picture. It may be larger or smaller.

Any prolapse can be thought of as a type of hernia. Hernias develop when the abdominal contents bulge through any weakened area in the abdominal or pelvic walls. People are often more familiar with hernias in the groin or at the navel. It is important to understand that the tissue weakness that allows a hernia is still present after any treatment, and you may need to make lifestyle changes if you want to prevent further problems.
It feels like my uterus is hanging down or falling out

You may be experiencing pelvic organ prolapse.

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How do I prevent my uterus from falling out?

We don't fully understand all the factors that cause urinary leakage and prolapse, so it is difficult to recommend ways to prevent these problems. Pelvic floor muscle exercises (Kegel's) - are probably the best way to prevent stress incontinence and prolapse. Other things that might help include not smoking, avoiding repetitive strenuous activities that involve very heavy lifting (for example lifting 50lb boxes onto a truck several hours a day) and avoiding the use of forceps or vacuum assistance during childbirth. There is much discussion among urogynecologists about how much vaginal childbirth (as opposed to cesarean section) and pregnancy itself predisposes to the development of urinary incontinence and pelvic organ prolapse. It is clear that being pregnant and delivering babies are important contributors. However, it is important to remember that there are women who have never been pregnant who leak urine or have prolapse - and women who have delivered many times who do not. There is no clear answer to this question at this time.

If you are troubled by your uncontrolled urine loss or prolapse you should consider seeing your primary care physician or a urogynecologist who can evaluate the problem and recommend appropriate treatment. Seeing a specialist does not mean that you will have to have surgery. Other suggestions are listed below:

Get yearly pelvic exams to watch for changes or problems, call between visits if you have increasing symptoms, and follow these suggestions:

- Avoid heavy lifting (no more than 20 pounds).
- Watch your weight. Being over weight increases pressure on your pelvic floor.
- If you smoke, try to quit. Smoking decreases circulation to your pelvis, and a chronic cough will aggravate pelvic floor prolapse.
- Avoid constipation. Straining with bowel movements increases prolapse. If constipation is a problem for you, talk to us about treatment.
- Learn and practice pelvic floor exercise.
- Hormone replacement may be an option to increase the circulation to your pelvic, and restore some tissue tone.
- Be sure your doctor is measuring your prolapse in a systematic way – so that he/she will be able to notice subtle changes over time.

What do I do about uterine fibroids?

Fibroid tumors of the uterus are usually harmless. They are benign (meaning non-cancerous). Nevertheless, many gynecologic surgeries are performed every year in order to treat symptoms or problems created by fibroid tumors of the uterus. A 'fibroid' tumor can actually exist almost anywhere in the body - but they are most commonly found in the uterus. The correct medical term for a 'fibroid' is leiomyoma uteri which means 'benign tumor of uterine smooth muscle. These tumors consist of a group of cells that form a hard mass within
otherwise normal uterine tissue. Depending on their size or location, fibroids can cause excess menstrual bleeding, pelvic pain, pressure, urinary frequency, constipation and infertility. Those conditions are generally considered good reasons to have surgery to treat fibroids. If a fibroid tumor isn’t causing any problems (which is usually the case) no surgery is required. In other words, if they aren’t bothering you - you probably shouldn't bother them. Sometimes patients require help from a gynecologist to determine whether their fibroids are 'bothering' then in terms of pain or infertility. Even in cases where excess bleeding is the issue, patients need advice from their gynecologist prior to treatment. That's because not all fibroids produce heavy bleeding - and not all heavy bleeding is related to fibroid tumors.

We don't know why fibroids develop, but their growth seems to be dependent on estrogen. That's why most fibroids will shrink after menopause (i.e. when estrogen levels drop).

If surgery is required, there are three main categories of operations to consider - myomectomy (removal of just the fibroid); hysterectomy (removal of the uterus); and uterine artery embolization (cutting off the blood supply of the uterus in hopes of shrinking the fibroid). There are trade-offs associated with all of these procedures. No one surgical procedure is right for everyone.

There are three main types of myomectomies - 1) 'open' myomectomies are done through a traditional abdominal incision; 2) laparoscopic myomectomies are performed through several small holes (called ports) in the abdomen; and 3) hysteroscopic myomectomies are performed through a scope placed in the uterus.

There are three main types of hysterectomy - 1) abdominal hysterectomies are performed through an abdominal incision; 2) vaginal hysterectomies are performed through an incision in the vagina; and 3) laparoscopic hysterectomies are performed through several small 'ports'. When a hysterectomy is performed laparoscopically, the uterus is usually removed through the vagina.

The decision of whether to treat a fibroid - and then which approach to take - should be individualized for each patient. Many factors are considered when developing a treatment plan. Books, web-sites and newspaper article can inform you about treatment options, but to determine which treatment is right for you, you must consult a gynecologist. Urogynecologists are often capable of treating uterine fibroids and are more likely to be comfortable with a vaginal rather than abdominal hysterectomy.