NHS
Mersey and West Lancashire Teaching Hospitals
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Colposuspension for urinary stress incontinence

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如果您需要其他語言或無障礙格式的資訊，請聯繫工作人員，他們將為您安排。

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ئەگەر پێویستیت بەم زانیاریانە هەیە بە زمانێکی جیاواز یان شێوازێکی تر، تکایە لەگەڵ ئەندامێکی ستافەکە قسە بکە کە دەتوانێت بۆت ڕێکبخات

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About this leaflet

The information provided in this leaflet should be used as a guide. There may be some variation in how each gynaecologist performs the care procedure on the ward immediately after your operation and the advice given to you when you get home. You should ask your gynaecologist about any concerns that you may have.

You should take your time to read this leaflet. A page is provided at the end of the leaflet for you to write down any questions you may have. It is your right to know about your planned operation, why it has been recommended, what the alternatives are and what the risks and benefits are. These should be covered in this leaflet. You may also wish to ask about your gynaecologist's personal experience and results of treating your condition.

What is colposuspension?

Colposuspension is an operation which uses stitches, to support the neck of the bladder so that it cannot move about and cause stress incontinence.

It has been used to treat stress incontinence for over 40 years, so we have a lot of information about how well it works and whether it lasts. It is usually done through a bikini-line cut but can sometimes be done with laparoscopic (keyhole) surgery.

What is stress incontinence?

Stress incontinence is the leakage of urine caused by an increase in pressure in the abdomen (tummy) e.g. coughing, sneezing and exercise, due to a weakness in the support of the urethra (water pipe), and bladder neck. This weakness is usually caused by childbirth, persistent heavy lifting or constipation, when the pelvic floor muscles are damaged. Further weakening occurs during the menopause because the quality of the supporting tissues deteriorates.

Before considering surgery

It is recommended that you should have tried pelvic floor exercises for at least 3 months, supervised by a trained women's health physiotherapist, before considering surgery. Surgery is not usually recommended if you plan to have further children, as pregnancy and delivery can result in a recurrence of the stress incontinence even if you are delivered by caesarean section.

Although urodynamic tests are not absolutely essential before the first surgery that is tried to treat stress incontinence, they are often carried out to confirm that you do have stress incontinence. These tests should however be carried out before repeat surgery or if you also have symptoms of urgency.

Discussion at a Multidisciplinary Team (MDT) meeting is considered good practice before carrying out surgery for stress incontinence. Your medical notes and the results of any tests are reviewed at the MDT meeting which is attended by urogynaecologists, specialist nurses and physiotherapists as well as urologists in many hospitals. Taking into account any preferences you have expressed, a team decision is made as to whether your proposed treatment is appropriate.

What happens during colposuspension?

The operation is done under a general anaesthetic (you are asleep) or a spinal anaesthetic (you are awake but numb from tummy down to your toes).

Most of the time, colposuspension is performed using an abdominal incision – a horizontal cut in the "bikini-line".

Some surgeons may be able to perform the procedure laparoscopically or "keyhole".

Long-lasting absorbable or permanent stitches are placed on either side of the bladder neck and tied to the strong fibrous tissue attached to the pubic bones.

A fine plastic tube, called a drain, may be left in the abdomen to drain away any blood which collects after the operation. This is usually removed the day after the operation.

A catheter is needed to drain the bladder for 1-2 days. This is likely to come out through the urethra (urethral catheter). However occasionally it will be placed through the abdomen (suprapubic catheter) depending on the surgeon's preference.

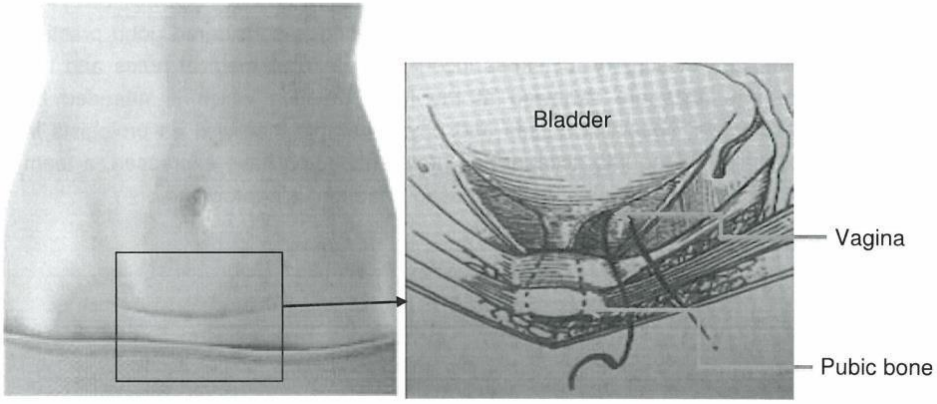
You usually stay in hospital for a few days after the operation. Your hospital stay is shorter if your operation is done laparoscopically.

It must be understood that colposuspension is a treatment for stress incontinence and symptoms of an overactive bladder will not usually be helped by a colposuspension.

Figure 1

Bikini line incision to the abdomen

View inside the abdomen where stitches are put either side of the bladder neck and used to lift it



Risks and benefits

Benefits

More than 80% of women who are having a first operation for stress incontinence, are cured by a colposuspension. This means that if 100 women had a colposuspension, 80 of them would feel that they had been cured, and 20 would not feel they had been cured.

However, 20 years after the operation has been done, only 70 out of 100 would feel they had been cured. This may be because our tissues weaken as we get older.

General risks of surgery

Anaesthetic risk - this is very small unless you have specific medical conditions, such as a problem with your heart or breathing. Smoking and being overweight also increases any risks.

A colposuspension can be performed with you asleep (a general anaesthetic) or awake (a spinal anaesthetic), whereby you are awake but numb from the waist down. This will be discussed with you.

What can I do? - make the anaesthetist aware of medical conditions, such as problems with your heart or breathing. Bring a list of your medications. Try to stop smoking before your operation. Lose weight if you are overweight and increase your activity.

Bleeding - there is a risk of bleeding with any operation. It is rare that we have to give patients a blood transfusion after their operation. Excessive bleeding is uncommon during a colposuspension.

What can I do? - please let your doctor know if you are taking a blood thinning tablet such as warfarin, aspirin, clopidogrel or rivaroxaban as you may be asked to stop them before your operation

Infection - there is a small risk of infection with any operation (about 5 to 13 cases in 100 operations). If it occurs, an infection can be a wound infection, an infection inside the pelvis or a urinary infection, and is usually treated with antibiotics. The risk of infection is reduced by routinely giving you a dose of antibiotic during your operation. Chest infections may also occur because of the anaesthetic

What can I do? - treat any infections you are aware of before surgery. After surgery, regular deep breathing exercises can help prevent chest infections; the nurses will guide you how to do this.

Deep Vein Thrombosis (DVT) - this is a clot in the deep veins of the leg. Occasionally this clot can travel to the lungs (pulmonary embolism) which can be very serious and in rare circumstances, it can be fatal (less than 1 in 100 of those who get a clot). The risk increases with obesity, severe varicose veins, infection, immobility and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood.

What can I do? - do not arrange surgery the day after a long car journey or flight. As soon as you are awake, start moving your legs around. Keep mobile once you are at home and continue to wear your compression stockings during times when you are less mobile.

Wound complications - the wound on the abdomen can become infected or occasionally stitches can become loose, allowing the wound to open up or tighten causing discomfort. There are no wounds within the vagina in a colposuspension.

What can I do? - keep the surrounding area clean and dry carefully after washing using, a clean towel or a hairdryer on a cool setting.

Specific risks of colposuspension

Some risks are specific to operations for stress incontinence, and some risks are specific just to the colposuspension operation. You should have the chance to discuss these with your doctor.

Difficulty passing urine - you might notice that the flow of urine is different after the operation. Sometimes it is slower and sometimes women notice that they have to change position on the toilet (such as leaning forward) to get the last of the urine out.

About 1 in 10 women who have colposuspension, have problems emptying their bladder after the operation. It is normal to leave a small bit of urine behind after going to the toilet. We call this the “residual volume”.

However, if too much is left behind, it can lead to problems such as having to go to the toilet too often or sometimes infections of the bladder. Some women have difficulty in emptying their bladder after their operation. This mostly gets better but in a small number of women, it can be long term.

If the residual volume is too high, you may want to learn to empty your bladder using Clean Intermittent Self-Catheterisation (CISC). CISC involves emptying out the urine that has been left behind using a fine catheter tube. This is passed along the urethra (water pipe) into the bladder so the urine can drain into the toilet. Once the urine is out, the catheter is removed and thrown away. A new catheter is used each time, and they are available on prescription, like tablets, from your doctor.

Although passing a catheter might sound unpleasant, most women find it is easy to do, and it gives more control and freedom than using a permanent catheter. The normal feeling of wanting to pass urine is not altered, so you know when to empty your bladder. The catheters are very small and can easily be hidden in a handbag.

Failure to work - no operation for stress leakage works for everyone.

Overactive bladder - the bladder becomes irritable or overactive in up to 17% of women. This gives symptoms such as needing to rush to the toilet or needing to pass urine more often. Sometimes an overactive bladder can make you leak because you cannot get to the toilet in time.

Prolapse - a prolapse is a bulge in the vagina caused by the vaginal walls sagging. It is very common and often does not cause you bother or need any treatment. About 14% of women (1 in 7) who have had a colposuspension, will get a prolapse at the back wall of the vagina (rectocele). It might be small and not need any treatment, but sometimes it needs treating with a pessary (a device inserted into the vagina) or an operation if it is causing symptoms.

Pain during sexual intercourse - pain during sex can occur after any operation where there are stitches near the vagina. About 1 in 20-50 women find sex uncomfortable or painful after a colposuspension.

Problems with the internal stitches - in a very small number of women, the stitches holding the neck of the bladder in place cause problems. If permanent stitches are used, over time they can wear through to the inside of the bladder or through the vaginal wall. This is rare.

Bowel disturbances - you may initially experience changes with your bowel function. This may result in constipation. This can be treated with mild laxatives but to help avoid this we recommend that you drink approximately 1500mls of fluid a day and increase the amount of fruit and fibre in your diet.

Fatigue - it is normal to feel tired following an operation and this should improve as you recover. However, if you continue to feel unexpectedly tired with no sign of improvement you should see your GP.

Damage to bladder or bowel - these are potential but very rare complications which would be dealt with when they are identified, usually at the time of operation. A urinary catheter would be left draining freely into a bag for 7-10 days to allow the area in the bladder to heal. If the bowel is damaged, faeces would also be directed away from the area to allow for healing, sometimes in the form of a temporary colostomy. A small tube called a naso-gastric tube is inserted through your nose to drain excessive secretions.

Before the operation

Pre-op assessment

Usually, you are seen in a pre-operative clinic some weeks before your planned operation. At that visit you will be seen by a nurse and possibly also a doctor. You will be asked about your general health and any medications you take. Your blood pressure will be checked, and you may have tests to assess your heart and breathing.

Blood tests will be taken to check you for anaemia and other things according to your medical condition. Swabs may be taken from your nose and groin to make sure that you do not carry MRSA (bacteria that are very resistant to antibiotics and may cause problems after your operation).

Consent

You will be asked to sign a consent form which confirms you have agreed to the procedure. If you do not understand anything or would like someone with you, please let the consenting doctor know before you sign.

Eating and drinking

You will be advised when you need to stop eating and drinking before the procedure depending on the type of anaesthetic.

After the operation

In hospital

Pain relief - pain can be controlled in a number of ways depending on the preference of your anaesthetist and/or gynaecologist. Options are an epidural, injection of local anaesthetic into the tissues during the operation, self-administration of pain relief, Patient Controlled Analgesia (PCA), drugs in a drip, tablets or suppositories. It is often best to take the pain killers given to you on a regular basis, aiming to take a pain killer before the pain becomes a problem.

Drip - this is to keep you hydrated until you are drinking normally. The drip is usually removed within 24 hours.

Catheter - as described earlier on in this leaflet, you will have a tube (catheter) draining the bladder. The catheter may give you the sensation as though you need to pass urine, but this is not the case. This false sensation goes away after the catheter is removed. It is important that the amount of urine is measured for the first couple of times you pass urine after the removal of the catheter. An ultrasound scan of your bladder may be done on the ward to make sure that you are emptying your bladder properly.

If you are leaving a significant amount of urine in your bladder, you may need the catheter re-inserted back into your bladder for a couple more days.

If you have a suprapubic catheter this can be closed off, to see whether you can pass urine normally and opened up again to see how much urine has been left behind or to allow urine to drain if you cannot pass urine at all.

Vaginal bleeding - this is usually a minimal amount or none at all.

Eating and drinking - you can drink fluids soon after the operation and will be encouraged to start eating as soon as tolerated.

Preventing DVT - the same day or the day after your operation, you will be encouraged to get out of bed and take short walks around the ward. This improves general wellbeing and reduces the risk of clots in your legs. You may be given a daily injection to keep your blood thin and reduce the risk of blood clots until you go home or longer in some cases.

Going home - you are usually in hospital for a few days. If you require a sick note or certificate, please ask.

At home

Mobilisation is very important; using your leg muscles will reduce the risk of clots in the back of the legs (DVT).

- Bath or shower as normal.
- Any of the stitches on the skin will often melt away by themselves, but some surgeons use stitches that need to be removed and, in these cases, arrangements will be made for this to be done.
- You are likely to feel tired and may need to rest in the daytime from time to time for a month or more, this will gradually improve.
- It is important to avoid stretching the wound, particularly in the first few weeks after surgery. Therefore, avoid constipation and heavy lifting. The body will gradually lay down strong scar tissue around the supporting stitches over a few months.

- Avoiding constipation:
    - Drink plenty of water/juice
    - Eat fruit and green vegetables e.g. broccoli
    - Eat plenty of roughage e.g. bran/oats
- Any constant cough should be treated promptly. Please see your GP as soon as possible.
- At 6 weeks, gradually build up your level of activity.
- After 3 months, you should be able to return completely to your usual level of activity.
- You should be able to return to a light job after about six weeks and a busy job in 12 weeks. Avoiding all unnecessary heavy lifting, will possibly reduce the risk of the incontinence recurring.
- You can drive as soon as you can operate the pedals and look over your shoulder without discomfort, generally after three weeks, but you must check this with your insurance company, as some of them insist that you should wait for six weeks.
- You can start having sex whenever you feel comfortable enough after about 6 weeks. You will need to be gentle initially.
- You usually have a follow-up appointment anything between 6 weeks and 6 months after the operation. This maybe at the hospital (doctor or nurse), with your GP or by telephone. Sometimes a follow-up is not required.

What to report to your doctor after surgery

- Heavy vaginal bleeding
- Smelly vaginal discharge
- Severe pain
- High fever
- Pain or discomfort passing urine or blood in the urine
- Difficulty opening your bowels
- Warm, painful, swollen legs
- Chest pain or difficulty breathing

Alternative treatments

Non-surgical

Do nothing - if the stress incontinence is not bothersome, treatment is not necessarily needed. Incontinence may or may not get worse over time, but it is not easy to predict if this will happen.

Weight loss - losing weight has been shown to reduce leakage of urine.

Pelvic Floor Exercises (PFE) - the pelvic floor muscles support the pelvic organs. Strong muscles can help to prevent or reduce the leakage of urine. A women's health physiotherapist can explain how to perform these exercises with the correct technique. It is important that you try these to help to manage the symptoms of your prolapse and to prevent it becoming worse. It is also very important to continue with your pelvic floor exercises even if you have opted for other treatment options. These exercises have little or no risk.

Duloxetine - this is a medication that can help reduce incontinence. It needs to be taken continuously, as stopping the drug will result in the leakage returning. Some women find that it causes unacceptable side effects. It is not usually recommended as first line treatment but is an option to consider if you do not want to have a surgical procedure or are unfit to do so.

Devices - there are a number of devices (an example of a vaginal ring is shown below) which can be inserted to block the urethra. The devices are inserted into the vagina. Devices inserted into the urethra are not recommended. They are not a cure, but their aim is to keep you dry whilst in use, e.g. during exercise etc. Some women find inserting a tampon useful, though care should be taken not to leave in place for too long as this can be harmful.



Surgical

The following table lists the different operations that can be considered to treat stress urinary incontinence. Further information on the operations is available in separate leaflets.

All operations are not available in all hospitals. Your consultant may recommend a particular operation depending on their preference and expertise, or your individual needs.

Treatment	Advantages	Disadvantages
Urethral bulking injection	No incisions (cuts). It can be done under local anaesthetic with or without sedation. Can be done as an outpatient treatment. Less pain compared to the other operations. Lower risk of complications compared to other operations. Quick recovery.	Long term success lower than for the other procedures.
Midurethral synthetic mesh tape	Good chance of curing or improving stress incontinence	Worsening of urinary urgency. Difficulty passing urine.

		Mesh complications – mesh exposure and erosion into vagina, urethra or bladder – can cause pain in the pelvis which sometimes persists long term
Colposuspension (suspension of the neck of the bladder and urethra through the tummy)	Does not involve insertion of mesh. Can be done via key-hole surgery. Success rate similar to a mesh tape. Treats prolapse of the anterior (front) wall of the vagina (cystocele)	Usually requires a general anaesthetic. Worsened urinary urgency similar to a mesh tape. Difficulty passing urine similar to a mesh tape. Higher risk of bleeding than mesh tape. Stitches causing bladder stones if they work their way into the bladder over time. Developing a prolapse of the posterior (back) wall of the vagina (rectocele). Longer recovery

Autologous fascial sling (a suspension of the urethra and bladder neck using your own tissue)	Does not involve insertion of mesh. Success rate similar to a synthetic mesh tape.	Usually requires a general anaesthetic. Requires a cut across the bottom of your tummy (not done via key-hole surgery). Longer recovery. Higher risk of difficulty passing urine than with other procedures. Higher risk of urinary urgency than other procedures. Similar risk of bleeding to Risk of hernia developing through the scar. Not available in all hospitals.

More information

If you would like to know more about stress urinary incontinence and the treatments available for it, you may try the following sources of information.

- Ask your GP or practice nurse
- Ask the doctor or nurse at the hospital
- Speak to your local continence advisor. The receptionist at your GP surgery should know who this is.
- For Southport & Ormskirk patients:
    - Urogynaecology CNS, telephone 01695 656953
- For Whiston and St Helens patients:
    - Urogynaecology clinical co-ordinator
      Monday to Friday (excl. BH) - 0151 676 5619
    - Day surgery unit St Helens hospital (Sanderson suite)
      8am-9pm Monday to Friday – 01744 64 6089
    - Pre-assessment clinic - 01744 64 6395
      9am-5pm Monday to Friday
    - Surgical assessment unit - 0151 430 1637
      after 9pm, weekends and bank holidays
    - Outpatients department, St Helens hospital
      9am-5pm Monday to Friday – 01744 64631 / 6300

Write to or telephone the continence foundation

The Continence Foundation

307 Hatton Square

16 Baldwins Gardens

London

EC1N 7RJ

Telephone: 020 7404 6875

Look at websites such as:

- The continence foundation at www.continencefoundation.org.uk
- The international continence society: www.continet.org.sg
- The incontinence knowledge centre at: www.incontinencenet.org
- https://www.yourpelvicfloor.org/leaflets/
- NHS choices at: http://www.nhs.uk/pages/home.aspx
- Patient UK at http://patient.info/health
- Royal College of Obstetricians and Gynaecologists Surgery for Stress Incontinence at: https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/gynaecology/surgery-forstress-incontinence.pdf
- International Urogynaecology Association (IUGA) patient information leaflet: http://www.yourpelvicfloor.org/media/Colposuspension-english.pdf

- The British Association of Urological Surgeons (BAUS) patient information leaflet: https://www.baus.org.uk/userfiles/pages/files/Patients/Leaflets/

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