Colposuspension for stress incontinence

Patient Information

Women and Children - Obstetrics and Gynaecology
Colposuspension for stress incontinence

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About this leaflet
We advise you to take your time to read this leaflet, any questions you have please write them down on the sheet provided (towards the back) and we can discuss them with you at our next meeting. It is your right to know about the operations being proposed, why they are being proposed, what alternatives there are and what the risks are. These should be covered in this leaflet.

This leaflet firstly describes what stress incontinence is, it then goes on to describe what alternatives are available within our trust, the risks involved in surgery and finally what operation we can offer.

What is stress incontinence?
- Stress incontinence is the leakage of urine usually caused by an increase in pressure in the abdomen (tummy) e.g. coughing or sneezing (figure 1) due to a weakness in the support of the urethra (urine pipe), and bladder neck.

Figure 1 shows the side view of a woman standing up. You can see the pressure above the bladder and an unsupported (weak) area at bladder neck.

- This weakness is usually caused by childbirth, heavy lifting and constipation, when the pelvic floor muscles are damaged. Further weakening occurs during the menopause because the quality of the supporting tissues deteriorates.
- The pressure in the abdomen rises when one coughs, sneezes, bends down, etc and results in urine leakage. This can cause distress and limit your quality of life.
• It must be understood that these operations will not cure all urinary symptoms. They will only cure urinary symptoms caused by a weakness in the bladder neck. Many urinary symptoms seen in clinic are not caused by a weakness in the bladder neck.

Alternatives to surgery

• Pelvic floor exercises (PFE) – The pelvic floor muscle runs from the coccyx at the back to the pubic bone at the front and off to the sides. This muscle supports your pelvic organs (uterus, vagina, bladder and rectum). Any muscle in the body needs exercise to keep it strong so that it functions properly. This is more important if that muscle has been damaged. PFE can strengthen the pelvic floor and therefore give more support to the pelvic organs. These exercises may not get rid of the prolapse but they make you more comfortable. PFE are best taught by an expert who is usually a physiotherapist. These exercises have little or no risk and even if surgery is required at a later date, they will help your overall chance of being more comfortable.

• Devices – There are numerous devices (none on the NHS) which essentially aim to support the urethra. The devices are inserted into either the vagina or the urethra. They are not a cure but their aim is to keep you dry whilst in use, e.g. during ‘keep fit’ etc. A booklet is available if you require further information.

• Injections into the bladder neck – This involves injecting a substance into the neck of the bladder to make it tighter. Different substances can be used and can be performed whilst you are awake, under local anaesthetic and sedation. The results of the injections are variable and the chance of curing your leaks is less than an operation. About half of the women who have an injection will have been cured of their leaks straight after their injection. However, the effects can wear off over time.

General risks of surgery

• Anaesthetic risk. This is very small unless you have specific medical problems. This will be discussed with you.

• Haemorrhage. There is a risk of bleeding with any operation. The risk from blood loss is reduced by knowing your blood group beforehand and then having blood available to give you if needed. It is rare that we have to transfuse patients after their operation. Please let your doctor know if you are taking an anti-clotting drug such as warfarin or aspirin.

• Infection. There is a risk of infection at any of the wound sites. A significant infection is rare. The risk of infection is reduced by our policy of routinely giving antibiotics with major surgery.

• Deep vein thrombosis (DVT). This is a clot in the deep veins of the leg. The overall risk is at most 4-5% although the majority of these are without symptoms. Occasionally this clot can migrate to the lungs which can be very serious and in rare circumstances it can be fatal (less than 1% of those who get a clot). DVT can occur more often with major operations around the pelvis and the risk increases with obesity, gross varicose veins, infection, immobility and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood (heparin).
Specific risks of a colposuspension

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

- **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 like needing to rush to the toilet or needing to pass urine more often. Sometimes an overactive bladder can make you leak because you can’t 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 doesn’t cause you bother or need any treatment. About 14% of women (one in seven) who have had a colposuspension operation, are more likely to get a prolapse to the back wall of the vagina. It might be small and not need any treatment. Sometimes it needs treating with a pessary (a device inserted into the vagina) or an operation if it is causing symptoms.
- **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 empty the bladder completely) to get the last of the urine out. About one in ten women who have colposuspension have problems emptying their bladder after the operation. The next section of the leaflet explains what your doctor can do when this happens.

- **Pain during sexual intercourse:** Pain during sex can occur after any operation where there are stitches near the vagina. About one in twenty women find sex uncomfortable or painful after a colposuspension. Sometimes the sensation during intercourse may be less and occasionally the orgasm may be less intense.
- **Problems with the stitches:** In a very small number of women, the stitches holding the neck of the bladder in place cause problems. Over time they can wear through to the inside of the bladder. This is rare.

Problems passing urine after the operation

- Some women have difficulty in emptying their bladder after their operation. This may get better, but in a small number of women it lasts forever.
- 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 and infections of the bladder.
- 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.
• Most women pass the catheter tube twice a day, but the number of times it is needed will depend on each woman and how her bladder is behaving.

• Although passing the catheter sounds unpleasant, most women find it is easy to do and 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.

• Sometimes the tests on your bladder give a clue that you may have problems passing urine after an operation for Stress Incontinence. If your doctor thinks you may be more likely to have problems, they may suggest you learn CISC before having the operation. If you then do find you have trouble passing urine after colposuspension, it would not stop you going home and you would be prepared.

Operations available for stress incontinence

Many operations can be done for stress incontinence. Often your doctor will think one of these would be especially good for you. They will have thought about your test results, any medical problems you might have and any treatments you might have tried before. It is important that you have time in clinic to talk about this with your doctor.

We hope that this leaflet gives you an idea of the types of operations available to help you when you talk to your doctor.

• Colposuspension - uses stitches to support the neck of the bladder so that it can’t 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 keyhole surgery.

More than 80 % of women, who have not had an operation for bladder leakage before, 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, 60 out of 100 would feel they had been cured. This may be because our tissues weaken as we get older.

• Tension free vaginal tape (TVT) - This operation involves inserting a 1cm wide synthetic tape through a small cut in the vagina. The tape is looped around the outside of the mid-urethra and the two ends come out through two very small cuts low down on your tummy. The tape is trimmed so that it lies under the skin and you will not be able to feel it is there. The tape is not stitched in but stays in position by itself. The tape does not dissolve and stays inside the body forever.

About 80% of women, who have not had an operation for bladder leakage before, are cured after a TVT. This means that if 100 women had a TVT operation, 80 of them would feel that they had been cured.

• Other types of tape - Since the TVT operation was developed, many similar operations have been developed using slightly different types of tape or different ways of putting the tape in. Some tapes can be put in so that the tape comes out through tiny cuts on your inner thigh (along the underwear line) rather than coming out low down on the tummy wall (trans-obturator tape or TOT). Studies of this type of tape show that it is safe and effective at stopping leakage, with a cure rate similar to the TVT.
A sling operation - This operation uses a piece of your own tissue instead of a strip of artificial tape. The tissue comes from your tummy wall. Studies of this operation show a cure rate similar to colposuspension. However, they have also shown that the risk of having a complication during the operation is higher than colposuspension.

What happens during colposuspension

- The operation is done under a general anaesthetic (so you are asleep) or a spinal anaesthetic.
- A bikini-line cut is made on your abdomen (tummy) which is about 10cm (four inches) long.
- The abdomen is opened to reach the bladder which lies just behind it.
- Stitches are put into the vaginal wall on either side of the bladder neck and sometimes the bladder base. The stitches are tied to some strong fibrous tissue just behind the pubic bone.
- A fine plastic tube, called a drain, is left in to draw-off any spilled blood.
- The abdomen is repaired and a catheter tube may be put through the abdominal wall into the bladder to rest the bladder for 48 hours.
- You usually stay in hospital for up to five days after the operation.

After the operation (in hospital)

- On return from the operating theatre you will have a fine tube (drip) in one of your arm veins with fluid running through to stop you getting dehydrated.
- You may have a bandage in the vagina, called a ‘pack’ and a sanitary pad in place. This is to apply pressure to the wound to stop it oozing.
- You may 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.
- Usually the drip, pack and catheter come out the morning after surgery or sometimes later the same day. This is not generally painful.
• The day after the 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 the legs.
• It is important that the amount of urine is measured the first couple of times you pass urine after the removal of the catheter. An ultrasound scan for 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 have to have the catheter re-inserted back into your bladder for a couple of days more.
• You may be given injections to keep your blood thin and reduce the risk of blood clots in your legs. The injections are normally given once a day until you go home or longer in some cases.
• The wound is not normally very painful but you may require tablets or injections for pain relief.
• There will be slight vaginal bleeding like the end of a period after the operation. This may last for a few weeks.
• The nurses will advise you about sick notes, certificates etc. You may be in hospital for up to four days.

After the operation - at home
• Mobilisation is very important; using your leg muscles will reduce the risk of clots in the back of the legs (DVT), which can be very dangerous.
• 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 repair particularly in the first weeks after surgery. Therefore, avoid constipation and heavy lifting. The deep stitches dissolve during the first three months and the body will gradually lay down strong scar tissue over a few months.

Avoiding constipation
- Drink plenty of water / juice
- Eat fruit and green vegetables esp broccoli
- Plenty of roughage e.g. bran / oats
• Do not use tampons for six weeks.
• At six weeks gradually build up your level of activity.
• After three 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 six weeks and a heavy or busy job in twelve weeks. Always avoid unnecessary heavy lifting, such as luggage and furniture, to protect your pelvic floor.
• You can drive as soon as you can make an emergency stop 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 sexual relations whenever you feel comfortable enough after six weeks, so long as you have no blood loss. You will need to be gentle and may wish to use lubrication (KY jelly).
• Follow up after the operation is usually six weeks to six months. This maybe at the hospital (doctor or nurse), with your GP or by telephone. Sometimes follow up is not required.
Information about the British Society of Urogynaecology Surgical Database (Surgical Register)

The British Society of Urogynaecology ("BSUG") is a national group of gynaecologists with a special interest and expertise in the treatment of incontinence and prolapse. BSUG has developed a database of clinical and surgical data for the purposes of publishing anonymous statistical information for research purposes and to enable individual NHS Trusts and consultants to audit information about operations to ensure that the procedures performed at their hospitals are as safe and effective as possible.

The patient information held in the BSUG database comprises name, hospital number and date of birth, together with clinical and surgical information ("patient identifiable data"). Because this information is confidential to each patient and is that patient's personal data within the meaning of the Data Protection Act 1998, we do not disclose patient identifiable data to BSUG without written consent.

If you agree to allow us to enter your patient identifiable data into the BSUG database, please sign in the relevant section on the operation consent form.

The benefits the BSUG database may bring to you:

- Improving patient awareness of the outcomes of incontinence and prolapse surgery.
- Finding out how long the different operative procedures last.
- Helping to identify individual patients who have received an implant and where there may be a need for urgent clinical review.

The BSUG database will also be used to bring additional long-term benefits by:

- Providing feedback to gynaecological surgeons and teams to help maintain high clinical standards.
- Promoting open publication about the performance of implants used in operations.
- Providing feedback on implant performance to regulatory authorities.
- Providing feedback to suppliers about the performance of their implants.
- Monitoring and comparing the performance of hospitals.

Data collection – its security and confidentiality

The BSUG database uses an electronic system for data collection. The data is sent securely to a protected database, avoiding the need to send paper records through the post, to ensure your data receives maximum protection.

Your personal information is confidential and cannot be used outside of the BSUG database. Strict procedures are in place to protect your information and keep it confidential; it will only be available to you and your surgeon. If you wish, you can obtain access to a copy of your own record in accordance with the Data Protection Act 1998.
BSUG database Consent
I consent to:

1. the processing of my patient identifiable data for the research and auditing purposes described in this information sheet.

2. the disclosure by BSUGs of my patient identifiable data to its IT service provider or any future IT service provider, where such IT service provider has:
   (a) agreed to adopt appropriate technical and organisation measures to protect the security of my patient identifiable data and only to process it in accordance with BSUGDL's instructions;
   (b) been instructed NOT to store my patient identifiable data on a server which is located outside of the United Kingdom; and
   (c) been informed of the existence of my legal right to confidence in respect of my patient identifiable data.

3. the disclosure of my patient identifiable data to the consultant team (and the NHS Trust employing that consultant team) who disclosed it to BSUG.

4. the disclosure of my patient identifiable data to BSUG or any legal entity which is wholly owned by BSUG, for processing in accordance with the consents in this section.

Your participation is voluntary
The form asks for your consent for your personal information to be recorded by the BSUG database. Your participation in the BSUG database is entirely voluntary. You can request access to view your entry on the BSUG database from your consultant team. If you agree and then change your mind, you may revoke this permission at any time by sending a written notice to your consultant OR to the address below. If you do not agree, your data will not be entered.

BSUG Database Limited
c/o BSUG,
Royal College of Obstetricians & Gynaecologists
27 Sussex Place
Regents Park
London
NW1 4RG

If you consent to the above please sign in the relevant section on the operation consent form.

More information about stress incontinence and the operations to treat it
If you would like to know more about stress incontinence and its treatments, you may try the following sources of information.

• Ask your GP.
• Ask the doctor or nurse at the hospital.
• Speak to your local continence nurse advisor. The receptionist at your GP surgery should know who this is.
Things I need to know before I have my operation

Please list below any questions you may have, having read this leaflet.

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Please describe what your expectations are from surgery.

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Useful references

You may find the address and websites useful to obtain more information. We can however bear no responsibility for the information they provide:

- Bladder & Bowel Foundation SATRA Innovation Park Rockingham Road Kettering, Northants, NN16 9JH
- Bladder & Bowel Foundation Nurse Helpline for medical advice: 0845 345 0165
- Bladder & Bowel Foundation Counsellor Helpline: 0870 770 3246
- Bladder & Bowel Foundation General enquiries: 01536 533255
- Bladder & Bowel Foundation Fax: 01536 533240
- mailto:info@bladderandbowelfoundation.org
- http://www.bladderandbowelfoundation.org

Also:

- http://www.iuga.org/?patientinfo
Comments, compliments, concerns or complaints

South Tees Hospitals NHS Foundation Trust is concerned about the quality of care you receive and strives to maintain high standards of health care.

However we do appreciate that there may be an occasion where you, or your family, feel dissatisfied with the standard of service you receive. Please do not hesitate to tell us about your concerns as this helps us to learn from your experience and to improve services for future patients.

Patient Advice and Liaison Service (PALS)

This service aims to advise and support patients, families and carers and help sort out problems quickly on your behalf.

This service is available, and based, at The James Cook University Hospital but also covers the Friarage Hospital in Northallerton, our community hospitals and community health services. Please ask a member of staff for further information.

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