Colposuspension

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Introduction

To stop leakage of urine, the muscles that make up your urethra (water pipe) and the ones around your bladder neck must be able to tighten under 'stress-related' conditions e.g. when you cough, sneeze, exercise or lift heavy items.

If you have a weakness of these muscles, you may not be able to tighten them sufficiently to stop urine leaking out.

Stress incontinence is common in women after childbirth but can also be seen in women who have not had children. A lack of oestrogen, and the effect ageing may have on you (although this is not a direct cause), can also be contributing factors. If you have a severe cough, like bronchitis, are overweight or if you are constipated the leakage may be worse.

What are my options?

No treatment

Whilst the leakage can be unpleasant or distressing, it is not life-threatening and having no treatment is a perfectly reasonable option.

Devices and containment strategies

Devices and pads can provide excellent protection but should not be considered as treatment.

Physiotherapy

Approximately 50-60% of women with stress incontinence will be cured with supervised pelvic floor therapy and in others it can help to reduce the symptoms.

Physiotherapy is the standard first line treatment prior to consideration of surgery.

Medication

Duloxetine is thought to help by increasing the tone in the urethral sphincter (bladder neck) thus reducing leakage and can be successful in 60% of cases although it can cause unpleasant side-effects such as nausea resulting in discontinuation.

Surgery

Surgical procedures include bulking injections, mid urethral tapes and colposuspension.

What is a colposuspension?

A colposuspension is an operation to lift and support the bladder neck. It is performed through a bikini line incision in the tummy.

It is a well-established treatment for stress incontinence and has been the operation of choice since 1968 (when less invasive procedures such as mid urethral tapes became available). The success rates can vary a little depending on your individual circumstances but is usually around 80-85%, although some studies report this higher. Longer term cure (over 15 years) is reported at around 70%.

Factors which can negatively affect results are previous bladder neck surgery and obesity.

Before the operation

Medications

You will be asked to stop any blood thinning medications such as aspirin, ibuprofen, diclofenac or clopidogrel 2 weeks before the operation.

If you are on warfarin or heparin, we will liaise with both you and the haematology department about a regime to come off these medications.

Please bring all your medications with you when you attend the hospital and only stop those medications you have been advised to.

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 prior to the procedure depending on the type of anaesthetic.

The anaesthetic and operation

The anaesthetic

The operation is usually done under a general anaesthetic (asleep) but can be done under a spinal anaesthetic (awake but numb from waist down) if required.

The operation

- The length of the operation can vary from 90-180 minutes depending on any previous pelvic surgery (e.g. hysterectomy, caesarian section).
- Your legs will be held in stirrups. Please let us know if you have any hip or back problems.
- A small bikini cut is made on your abdomen just above your pubic bone.
- 3 permanent stitches are placed each side of the bladder neck and then into a ligament on the pelvis to lift the bladder neck up.
- At the end of the operation a supra-pubic catheter is commonly placed into the bladder through the abdomen to monitor your bladder function following surgery. A wound drain may also be inserted.
- The cut will be stitched together with dissolvable stitches and a small dressing will be applied.

After the operation

- Once you are ready you will be taken to recovery and on to the ward.
- You may experience some discomfort/pain for the first 24-48 hours. Painkillers will be provided but please tell us if any pain is not relieved by the painkillers you are given.
- An intravenous infusion (drip) will be in your arm. This usually stays in place for 1-2 days until you are drinking normally again.
- 1 or 2 wound drains (plastic tubes draining into a plastic bottle) may be situated under your skin near the wound to remove any excess blood. These are removed once they stop draining any excess blood, usually in 1-2 days.
- A supra-pubic catheter passes through your abdomen into the bladder and drains urine from your bladder to allow it to rest.
- There will be a dressing covering the wound.
- Once you are awake/ready you will be able to drink starting with sips and slowly gradually increase your fluid intake to 1.5 to 2 litres a day. Once you are able to tolerate fluids you will be able to eat normally.
- You may receive some take-home medication including painkillers and/or antibiotics.

Removing the Supra-pubic Catheter

The supra-pubic catheter will drain urine directly from your bladder into a bag (free drainage) to allow your bladder to ‘rest’ after the operation. Post operatively the catheter is clamped to see if you can pass urine normally. A set regime is used. The amount of urine left in your bladder (residual) after passing urine normally is assessed. This is done by unclamping the catheter and measuring the amount of urine that then drains into the bag.

When the residual is less than 100mls on two or more occasions the catheter is removed and you can go back to normal again.

If you are unable to pass urine after three attempts at clamping the catheter or the residuals are more than 100mls then the bladder is allowed to drain freely via the

catheter into a bag giving the bladder a further 10-14 days to rest. Should this happen you will be able to go home while the bladder is resting and your nurse will give you complete instructions on how to look after the catheter at home. District nurse support can be arranged.

When you return to the ward the catheter will be clamped to see if you are able to pass urine normally. Most women are able to pass urine after the bladder has been given this extra time to rest. The catheter is then removed.

What if I do not pass urine?

If you are unable to pass urine, despite resting the bladder for this additional time, it may be necessary for you to pass a catheter yourself on an intermittent basis to assist with emptying the bladder properly, thus allowing the supra-pubic catheter to be removed (please see risks).

What are the risks?

No surgery is without its risks and whilst continence surgery is safe, there are some risks associated with this particular kind of surgery:

- Pain - painkillers will be offered on a regular basis, but please tell us if they are not controlling any discomfort.
- Bleeding - this can occur from the wound site or be seen in the urine.
- Infection - either wound, urine or chest. Antibiotics will be given if necessary but a sensible fluid intake (1500mls/24hrs), early mobilisation and stopping smoking will reduce these risks.
- Difficulty in passing urine - it is not abnormal to have a reduced urine flow or have the need to bend forward to empty your bladder following this type of surgery. Occasionally, a few women are taught intermittent clean self-catheterisation (CISC) to assist bladder emptying. If you have any bladder-emptying difficulty identified before the operation you will be advised to be taught CISC before going on the waiting list. This risk tends to increase with age and/or if you have had previous continence surgery.
- Urinary frequency and urgency - this is not uncommon and usually temporary but can indicate a urinary infection if associated with pain and does not subside easily.
- Aggravation of an underlying ‘overactive bladder’ - the symptoms of frequency and urgency can sometimes be made worse. This may mean the introduction of drug therapy to help calm the bladder down. If you are already on drug therapy (such as fesoterodine or solifenacin) to control these symptoms, you may need to increase the dose.
- Dyspareunia - pain on sexual intercourse.
- Thrombosis - the risk of blood clots in the leg or lung is increased by immobility and if you are overweight or smoke. This risk will decrease by quick

mobilisation and weight loss/ smoking cessation prior to your operation. You maybe required to wear TED stockings.

- Recurrence of stress incontinence - although it will provide extra support to the bladder neck it will not cure underlying muscle weakness.
- Prolapse - some women can develop a prolapse (bulging of the vaginal wall or uterus) within five years of a colposuspension. The degree and type of prolapse will determine what treatment is recommended.
- 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 you G.P.
- 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.

Recovery at home

- Personal hygiene - it is better to shower than bathe for long periods of time for the first couple of weeks. It is advisable not to use tampons for around six weeks.
- Bleeding - you can expect some bleeding for a couple of weeks which should gradually tail-off. If it becomes heavy or associated with pain you should visit your GP as it may indicate an infection. Mild vaginal discharge is part of the normal healing process.
- Bowels - avoid constipation and straining when opening your bowels as this puts unnecessary pressure on the repair.
- Stitches – stitches to the skin are dissolvable and should not need to be removed.
- Medication - please finish the course of any antibiotics you may have been prescribed. If you have been previously prescribed medication (e.g. Fesoterodine, Solifenacin) for an underlying overactive bladder you should continue to take these unless otherwise instructed. Any topical oestrogen cream or pessary (Vagifem) should be continued as prescribed.
- Sexual intercourse - avoid penetrative intercourse for 4 - 6 weeks. It may feel superficially tender to start but this should settle down with time.

- Lifting - you should avoid heavy lifting as a long-term lifestyle change if you have had continence surgery.
- Exercise – avoid vigorous sports and swimming for 6- 8 weeks. As a long-term rule avoid sit ups or heavy weight training. You can gradually introduce gentle exercise into your daily routine after 4 weeks. Pelvic floor exercise should resume once you feel comfortable.
- Driving - you should avoid driving for at least 2 weeks to allow the wounds to heal. Once you can perform an emergency stop without discomfort you should be able to resume driving. However, advise your insurance company and follow their advice and policy rules to ensure you are covered.
- Return to work - 6-12 weeks. This will depend on what your work entails and whether it involves heavy manual work.

Follow up

You will be seen in the outpatient clinic at approximately three months after surgery to see how you have got on after the operation.

Useful contact numbers:

- **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**
- **Main Switchboard – 0151 426 1600**

Further reading

- You can read any of the specific surgery leaflets available in clinic
- IUGA leaflets - https://www.yourpelvicfloor.org/leaflets/
- BSUG Patient leaflets - https://bsug.org.uk/pages/for-patients/bsug-patient-information-leaflets/154
- Bladder and Bowel organization UK - https://www.bbuk.org.uk/

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