Information Protocol Surgery for Pelvic Organ Prolapse through the Vagina

Name: First name: Date of birth:

Dear patient,

Examinations have shown that you have a prolapse of the pelvic organs that necessitates operative treatment. This page should provide you with information, not worry you. It is only part of the information you will receive. The planned intervention will be discussed with you in person. Please ask about anything that is unclear or seems important, and don't hesitate to say if you would prefer not to know too much about the forthcoming procedure.
The procedure will be carried out under general or regional (spinal) anesthesia. You will be informed by the anesthetist about the advantages and disadvantages as well as the risks of the anesthesia procedure.

Reasons for the procedure
Prolapse conditions of the pelvic organs such as the urinary bladder, uterus, vagina, intestine. A pronounced prolapse, in which the organs come out, is called an incident. As a rule, surgical treatment is decided on when conservative measures such as pelvic floor physiotherapy, local hormone treatments, and/or pessary placement do not sufficiently alleviate the problem.

Operation method
The operation is through the vagina. The exact method will be discussed with you by the operating physician. In some cases, it may be useful to remove the uterus and/or the ovaries/Fallopian tubes, for example in case of bleeding disorders, benign changes (uterus, ovaries, Fallopian tubes), increased familial risk for uterine/ovarian cancer, or on medical advice after consultation with you. The additional risks will be mentioned.

Surgical technique
If the uterus/ovaries/Fallopian tubes are removed as well, the operation starts as follows: Through the vagina, the uterus is gradually resected from the surrounding tissue and removed. The Fallopian tubes and ovaries are left behind if only hysterectomy is planned. If salpingo-oopherectomy is also planned, the ovaries/Fallopian tubes are also surgically resected from the surrounding tissue.
The further prolapsed organs are separated from the surrounding tissue. This is done via incisions starting from the anterior or posterior vaginal wall. The body's own ligaments can also serve as fixation points for prolapsed organs. However, if the body's own tissue is very weak, if the gap is too large, or if there is recurrent prolapse at the same point in the pelvic floor, artificial or biological mesh may be inserted for reinforcement. The artificial mesh (foreign body) remains in the body, the biological mesh dissolves after some time. Mesh promotes the formation of endogenous connective tissue, which grows into the mesh pores, helping stabilize the pelvic floor. Through closure of the weak point ('gap') and tightening of the suspensive structures, the prolapsed pelvic organs are returned to their normal position. As a result, organ function can improve again, though this may also lead to the recurrence of incontinence. In rare cases and if sexual intercourse is definitely renounced, a significant narrowing or closure of the vagina is a potential treatment.
In rare cases, e.g., in the presence of extensive adhesions or significant bleeding, the procedure cannot be performed through the vagina and laparoscopy or an abdominal incision may be necessary.
During, but at the latest at the end of the operation, a bladder catheter is inserted through the urethra or the abdominal wall, which remains in place from one to several days. Occasionally, a so-called tamponade (as a compression bandage) is inserted into the vagina for 12 to 24 hours for hemostasis.

Risks and complications
Bleeding, which must be stopped immediately, may occur during the operation. Bleeding can also rarely occur after the operation, which may have to be remedied by a second operation. Rarely, blood substitutes or donor blood must be administered.
Rarely, injuries to adjacent organs occur, especially the bladder, urethra, ureters, intestine, or uterus. Such injuries are usually detected during the operation and corrected immediately.

Despite advances in medicine and prophylactic measures with injections, infection, wound healing disorders, thromboses (blood clots) and emboli cannot be completely ruled out. The risk is increased through factors such as obesity, smoking and confinement in bed.

Rarely, changes can occur, which only happen after discharge from the hospital: wound healing disorders leading to scars which can cause pain, esp. during sexual intercourse (see 'After the operation').

Rarely, the artificial mesh used can infiltrate surrounding organs, or parts of it may protrude into the vagina, which can lead to pain, and/or discomfort for you or your partner during sexual intercourse.

Occasionally, undesirable stress incontinence may occur after surgery; this can be treated without surgery or by means of operative insertion of a sling. It is difficult to estimate this risk prior to prolapse surgery.

In very rare instances, fistulous tracts may form, i.e., connections between organs, such as vesicovaginal fistulas; these can lead to unwanted urine loss. Such fistulas require a follow-up procedure.

Occasionally, there may be temporary constipation; this is treated conservatively. Very rarely, involuntary stool loss occurs; this is primarily treated conservatively and, in case of non-response, clarified with a specialist. Despite proper patient positioning and correct equipment connection, pressure-related and other damage to nerves and soft tissues can occur as very rare complications. Only rarely do these leave permanent symptoms (e.g. numbness, painful sensations) or scars.

After the operation
The bladder catheter allows easy bladder emptying; depending on the surgical technique, it is removed immediately after surgery or after 1-2 days. Should bladder emptying disorders occur, another bladder catheter may have to be inserted, which will stay in longer (5-7 days).
Removal of the uterus leads to the absence of menstrual bleeding and infertility.
After removal of the ovaries, premature menopause may occur.
Vaginal wound healing takes at least 6 weeks and is usually accompanied by increased discharge. Sexual intercourse should be avoided during this time.
All operations mentioned allow unchanged continuation of intercourse. Rarely, discomfort may occur during intercourse due to scarring in the vagina. This can generally be corrected through local treatment.

Cost: The operation is a mandatory service of the health insurance company. If you have additional insurance: Has cost coverage been verified?

Your questions:

_____

_____

_____

Explanatory consultation:

Interpreter:

_____

Proposed operation:

_____

Notes of the doctor for the information interview
(waiver of explanation with indication of the reason, individual risk-increasing circumstances: age, heart disease, obesity, etc.).

Alternative treatment possibilities:

Date: Time: Duration of explanatory consultation:

Treatment order:

Dr. _____ has had an informative talk with me. I understood the explanations and was able to ask any questions I had.
I agree with the proposed procedure, as well as with the changes and extensions discussed that may be required during the operation.

Place, date: Patient:

The text on the front page was discussed with the patient, the questions answered, and a copy of this explanation protocol was given to the patient.

Date, time: Doctor:

Operation outline

(Operation method, skin incision, what is removed, reconstructed, etc., side indication, left, right)