Surgery for Pelvic Organ Prolapse through Laparoscopy or Abdominal Incision

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 performed under general 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 (lowering) 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 performed through small abdominal incisions (laparoscopy) or via an abdominal incision. The doctor will discuss the exact method with you. In some cases, it may be useful to remove the uterus (with/without the cervix) and/or the ovaries/Fallopian tubes, e.g., in case of bleeding disorders, benign changes (uterus, ovaries, Fallopian tubes) or on medical advice after consultation with you. The additional risks will be mentioned.

Surgical technique
At the beginning of surgery, a bladder catheter is placed and a probe inserted into the vagina/intestine. The type of probe depends on whether the uterus (with/without cervix) is also being removed.
During laparoscopy, the following incisions/punctures are made in the abdominal wall: Several skin incisions between 5-15 mm long allow access of the surgical instruments and the camera to the abdominal cavity. At the beginning of the procedure, a thin needle is used to fill the abdominal cavity with carbon dioxide: presentation of the abdominal organs. In an abdominal incision, the incision is made above the ramus of pubis. The prolapsed organs are separated from the surrounding tissue. The weak points in the pelvic floor are reinforced by artificial or biological mesh. The body's own ligaments can serve as fixation points for prolapsed organs. 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. The mesh is anchored to the sacrum. The prolapsed pelvic organs are returned to their normal position. As a result, the function of the organs can improve again, though incontinence can occur as well. In rare cases, in the presence of extensive adhesions or significant bleeding, the procedure cannot be continued through laparoscopy, and an abdominal incision must also be performed.
The bladder catheter is removed at the end of surgery or remains for 1-2 days.

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 to 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 by factors such as obesity, smoking, and confinement in bed.
Skin swelling and shoulder, neck, and abdominal pain can occur immediately after a laparoscopic procedure.
Rarely, the artificial mesh used can infiltrate surrounding organs, or parts of it may protrude into the vagina, which can lead to pain, discomfort during sexual intercourse and injury to the partner.
Occasionally, undesirable stress incontinence may occur after a few weeks/months; this can be treated conservatively or later by inserting a bladder band. It is difficult to estimate this risk preoperatively.
In rare cases, lower abdominal pain (e.g. due to scar formation) and problems/pain during defecation may occur. These can be treated with topical hormones, physiotherapy, stool-regulating medicines and painkillers. Follow-up operations are rarely required.
In very rare instances, fistulous tracts may form, i.e. connections between organs, such as vesicovaginal fistulas; these lead to chronic urinary incontinence. Such fistulas require a follow-up procedure.
Abdominal adhesions occurring after laparoscopy and/or surgery through abdominal incision may later lead to intestinal obstruction. 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.
The operation allows unchanged continuation of intercourse. Rarely, discomfort may occur during intercourse due to scarring at the vaginal end. 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 protocol
(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 received a copy of the interview protocol.
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)

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