

University College Hospital

Laparoscopic colposuspension

An operation for stress urinary incontinence

Urogynaecology and Pelvic Floor Unit

Women's Health

If you require the services of an interpreter, contact us on 020 3447 4735. We will do our best to meet your needs.

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1 Introduction

Stress urinary incontinence means leakage of urine when you are coughing, sneezing, exercising or lifting. It might also happen during other activities such as walking, changing position, or even just standing up.

This leaflet provides information about an operation called a laparoscopic colposuspension. It is one of the operations that we offer to treat stress urinary incontinence. This leaflet has been made to help you understand why this operation has been recommended and what surgery might involve.

This leaflet contains information from medical research studies and guidance from independent organisations that specialise in this type of surgery. We have tried to simplify this information and make it easy to understand for patients. We hope that this leaflet will help you decide if you want to go ahead with surgery.

We will review this information every two years. This is to make sure that any information from new research studies is included. We may do this sooner if we think important new information becomes available that you need to be aware of.

2 What does laparoscopic colposuspension mean?

Laparoscopic colposuspension is an operation to help with stress urinary incontinence. Using keyhole surgery, internal stitches are placed to lift up and support the base of the bladder. This helps to prevent leakage during coughing, sneezing, or activities such as exercise.

2 How can a laparoscopic colposuspension help?

If you have symptoms of stress urinary incontinence, this operation is likely to help you. Although the operation is effective, no operation will work for everybody. Some women will find that their stress urinary incontinence is not helped by the surgery. Occasionally, the operation works well initially but the problems start again some time later.

The most reliable medical research studies (called randomised trials) have shown that at five years, most women are satisfied:

- Around 70 to 80 out of 100 women will be cured of their stress urinary incontinence or very much improved.

Other types of research have continued to monitor patients for up to 10 years after surgery. These studies suggest that the success of the procedure may drop very slightly in the long term.

Whilst this surgery is performed to help with stress urinary incontinence, it may also help with urinary urgency. Urgency means having to suddenly rush to the toilet to pass urine without warning. Most of the research would suggest that:

- Around 60-70 out of 100 women will find that their urinary urgency improves after surgery or even disappears.

4 What are the risks of laparoscopic colposuspension?

All treatments and procedures have risks and we will talk to you about the risks of laparoscopic colposuspension. Problems that occur during or after surgery are called complications. These are undesirable or unwanted effects that happen as a result of surgery. If a complication affects you, it does not mean that something must have gone wrong during the surgery. If you have a complication, you can expect us to explain what has happened, and whether any further treatment is required.

We always provide additional care and support for patients who experience problems after an operation.

We will use numbers to explain how often we might expect problems to happen after laparoscopic colposuspension. For example, a '10 in 100' chance of a problem means that if we performed 100 operations, the problem would happen 10 times. This is the same as a 10 per cent chance.

Problems that may happen straight away

Bleeding during surgery

- Bleeding that might need a blood transfusion: 1 in 100.

Infections after surgery

- Urine infection immediately after surgery: 30 in 100.
- Urine infections that might be a recurrent problem: 5 in 100.
- An infection of the small 'keyhole surgery' wounds: 1 in 100.
- Infection inside the pelvis: This has been reported but we do not know how often this happens. It is likely to be very uncommon.

How are infections treated? Most infections are easily treated with antibiotics. A serious infection might rarely need a second operation. Life-threatening infection after laparoscopic colposuspension is extremely rare.

Damage to other organs during surgery

- Damage to bladder: 5 in 100.

- **Damage to the urethra:** The urethra is the tube that you pass urine out of. Damage to the urethra has not been reported in research studies so it is likely to be rare. It could still happen but we are not sure what the chance of it happening is.

If you are affected, the damaged organs will be repaired during the operation. Sometimes a cut on your abdomen called a laparotomy is needed in order to fix things. If you have had previous abdominal or pelvic surgery the risk of damage may be higher.

Rarely, damage might occur that is not recognised during the operation. If this happened, you might experience no symptoms, or you could become ill after your surgery. You would need extra tests to find out if this was the case. You might need another operation to repair the damage.

How is bladder or urethral damage repaired? We use stitches to repair the bladder. A catheter tube is left in the bladder for around two weeks afterwards whilst the bladder heals. If the urethra is damaged, it is also repaired with stitches. You may need a catheter tube to be left in place for longer if the urethra is damaged.

Bladder symptoms after surgery

Even if your stress urinary incontinence improves after surgery, there is small chance that you could develop other problems.

These problems might include:

- New or worsening urinary urgency: 5-10 in 100.
- Difficulty emptying your bladder:
 - Short term catheter use for a few days: 10 in 100.
 - Catheter use for six weeks or more: 3 in 100.

- Being unable to pass urine at all after surgery: We are not sure how often this happens but it is likely to be rare.

How is urinary urgency treated? Problems with urinary urgency after surgery often settle down on their own. If treatment is needed, medication or other non-surgical treatments are usually effective.

How are problems with bladder emptying dealt with?

Sometimes women can pass urine after surgery but the bladder does not empty very well. If this happens you might have to go home with a catheter tube in the bladder. It is removed after a few days and things usually go back to normal. If the bladder is still not emptying fully, you may have to use intermittent self-catheterisation up to four times a day. This means that you would pass a small catheter tube through the urethra yourself to empty the bladder. You would still pass urine normally and self-catheterisation would drain off any urine left behind. We would teach you how to do this. Things usually settle down in a few weeks although it can take longer. Permanent problems are uncommon.

What if I cannot pass urine at all? If this happens we will initially leave a catheter in place and send you home. We usually try to remove the catheter after a week. If you still cannot pass any urine we may allow a further week with a catheter tube in place. We might also teach you how to self-catheterise. If there is no improvement at all we sometimes recommend removing the internal stitches. Things may go back to normal afterwards, although your stress incontinence would come back. Sometimes the internal stitches are removed but problems with bladder emptying continue long term.

Pelvic pain or problems with painful sexual intercourse

If you do not have problems with pelvic pain or painful sexual intercourse before surgery, it is unlikely that you will have problems afterwards. The risk of developing problems is low:

- New or worsening pain in the pelvis or groins: 5 in 100.
- New or worsening painful sexual intercourse: 1-5 in 100.

If you already experience chronic pain in other areas of the body, the risk of pain after surgery is higher. Sometimes, pain can be a long-term problem.

What if I have persistent pain after surgery? If you have problems, you will be checked to see if there is a problem with the operation, or another cause. If no problem is found the pain could be coming from nerves that have been damaged by surgery. If this happens, you will be referred to a specialist in pain medicine and you may be prescribed medication.

What causes painful sex? After surgery, the position of the vaginal walls can be slightly different. This is because the stitches we put in to lift up the bladder can pull on the vagina. Although this does not usually cause problems, it can make sex uncomfortable for some women. This normally settles down in time. Painful sex can also be caused by a lack of hormones in the vagina. This can be treated with a hormone cream or tablet.

Can the internal stitches be removed if I have problems? Severe pain after surgery is rare. If this happened, we might offer removal of the internal stitches. This would require another operation. This might help to improve your pain but in some cases the pain carries on. If the stitches were removed your stress incontinence would probably come back. This might need further treatment.

Problems that may happen later

Your stress urinary incontinence might come back

Whilst the operation is usually successful, it will not work in some cases. Sometimes the operation does not work right from the start. This can occur even if the operation went well. Sometimes surgery works initially but then the leakage comes back after a few months or years. Overall, around 30 in 100 women will find that the surgery will not work long term.

You could develop a prolapse

Prolapse is a condition where the womb or vaginal walls drop down from their normal position. You may feel that 'something is coming down' in the pelvis or have symptoms of a lump or bulge in the vagina. Having a laparoscopic colposuspension can sometimes make it more likely that you will develop vaginal prolapse.

The internal stitches used to lift up the base of the bladder also pull on the vaginal walls. This can weaken the tissues that support the womb and the vaginal walls, causing prolapse. Most of the time, the back wall of the vagina is affected. This is the lower vagina covering the bowel. Occasionally, the womb can be affected. Sometimes put some extra stitches in during your operation to try and prevent this happening. Five years after surgery, around 10-15 in 100 women might have problems with prolapse. Sometimes this requires extra treatment that might include surgery.

Sometimes, we recommend putting in some extra stitches to try and prevent womb prolapse developing after surgery. This makes the operation a little longer. This additional procedure is called a suture sacrohysteropexy. We have a separate information leaflet on this procedure that we will give to you. Not everyone will need a suture sacrohysteropexy. We will talk to you about this before your operation.

Problems that are rare, but serious

- Damage to major blood vessels and life-threatening bleeding: 1 in 1000.
- Blood clots in the legs that can travel to the lungs: 5 in 1000.
- Damage to the ureters: 5 in 1000.
- Damage to bowel: 1 in 100.
- Internal stitches migrating into the bladder: 1-10 in 1000.

The ureters are the tiny tubes that carry urine from the kidneys to the bladder.

If any organs are damaged during surgery, they will be repaired whilst you are asleep. Sometimes a cut on your abdomen called a laparotomy is needed in order to fix things. If you have had previous abdominal or pelvic surgery the risk of damage may be higher.

Rarely, damage might occur that is not recognised during the operation. If this happened, you might experience no symptoms, or you could become ill after your surgery. You would need to extra tests to find out if this was the case and you might need another operation.

How is serious bleeding dealt with during surgery?

Damage to major blood vessels is rare but can cause life-threatening bleeding. If this happens, a large cut on the abdomen is needed to repair the damage. You would require a major blood transfusion that would be life saving. **Please ensure to tell you doctor if you would not accept a blood transfusion on religious or other grounds. This is extremely important.**

What happens if I develop a blood clot? After surgery, blood becomes stickier, and clots more easily. Blood clots can form in the legs, break off, and travel through the bloodstream to the lungs. These blood clots stop the lungs working properly, causing breathing difficulties. This condition is known as 'venous thromboembolism'. If this happens, your hospital stay will be prolonged, and you will be given blood-thinning medication for a few months. Thankfully, the condition is only life-threatening for a very small number of affected patients. To reduce the risk of this problem, you will wear special stockings on your legs, and receive a small, daily injection of blood thinning medication in hospital.

What happens if my ureters are damaged? Damage to the ureters is repaired with stitches. Tiny plastic tubes, known as stents, are placed inside the ureters whilst they heal. Rarely, it may be necessary to perform a bigger operation to change how the ureters and the bladder are connected to fix things. This is known as a 'ureteric re-implantation'. If this happens, you may need to see a specialist for a regular check up after your surgery. This is to make sure you do not develop any problems after the repair.

How is bowel damage repaired? Bowel is usually repaired using stitches. Rarely, a small piece of bowel has to be removed. We would not expect this to cause any long-term problems. If the damage is serious, a stoma might be required. This is an opening on the front of your abdomen that diverts your faeces into a bag whilst the bowel heals. The stoma would be a temporary measure whilst the bowel heals. The stoma is usually reversed within a few months.

Problems with the anaesthetic

You will be given a general anaesthetic for your operation. This means that you will be unconscious and will not feel anything during your surgery. Anaesthetists are doctors who specialise in anaesthetics. Your anaesthetist will give you your anaesthetic medication and gently place a tube through your mouth into your throat. This is to keep your windpipe open so oxygen can get to your lungs.

Some problems are very common after an anaesthetic. They normally settle down very quickly after surgery or are easy to treat. Sore throat or throat pain, feeling sick and vomiting, or shivering after surgery, can affect up to half of patients.

Some problems are more likely to affect certain groups of patients. If you are older, overweight, a smoker, or have other medical problems, you are more likely to be affected:

- Chest infection after surgery: 1-10 in 100.
- Permanent nerve damage: 1 in 1000.
- Permanent loss of sight: 1 in 100,000.
- Death as a result of anaesthesia: 1 in 100,000.

Older patients, especially those with dementia, poor eyesight or hearing, can become confused after an operation. It is not known how often this happens.

Damage to the lips and tongue may occur but this is usually minor. Tooth damage is more likely to happen if you have diseased teeth and gums, or have had extensive dental work:

- Damage to the lips and tongue: 5 in 100.
- Damage to teeth: 5 in 10,000.

Some problems can happen to anyone as a result of an anaesthetic:

- The eyeball getting grazed or damaged: 4 in 10,000.
- Being aware of what is happening during surgery despite the anaesthetic: 5 in 100,000.
- Life-threatening allergic reaction: 1 in 10,000.

5 What will happen if I choose not to have laparoscopic colposuspension?

If you decide not to have this operation you could simply carry on as you are. You will continue to have symptoms of stress urinary incontinence. Whilst these symptoms can be distressing, you are unlikely to come to any harm.

6 What alternatives are available?

After reading this leaflet, you may decide that you want to look at other options. We provide a separate leaflet on the available treatments for stress urinary incontinence and we should have given you this to read. Please ask for this leaflet if you do not already have it.

The non-surgical alternatives to laparoscopic colposuspension include:

- Pelvic floor physiotherapy.
- Weight loss.
- A continence pessary.

Other surgical options include:

- Synthetic midurethral sling.
- Autologous sling.
- Urethral bulking agents.
- Artificial urinary sphincter.

Sometimes your doctor may suggest that one treatment might be better than another in your particular case. They will obviously provide you with the reasons why this is so.

Will physiotherapy work? You will be taught how to strengthen your pelvic floor muscles with an expert physiotherapist. If you keep doing the exercises, they seem to keep working. If you stop, your problems will come back. Around 60 in 100 women will improve and not request any more treatment.

Can weight loss help? If you are overweight, weight loss can reduce urinary leakage. In research studies, women who lost just 5-10 per cent of their body weight saw big improvements. This is the same as weighing 15 stones and losing a stone and a half. In these studies, women only leaked half as often after losing weight. Some women became completely dry. If you need advice or guidance to help you lose weight, please speak to your GP.

What is a continence pessary? These are flexible plastic or silicone rings that are inserted into the vagina. They gently press on the urethra to help with leakage. If you use a pessary, you will need a check up every six months so that your vagina can be examined. Pessaries can sometimes rub on the vaginal walls, or cause a little bleeding or discharge. This affects around 5 in 100 women. Rarely a minor infection can develop. Pessaries can be safely used long term. You can learn to remove and replace the pessary yourself. This is helpful if you only use it at certain times when your symptoms are worse. Some women use continence pessaries only when they are exercising. This can be useful if they only leak when they are active. Some women remove their pessary overnight. Continence pessaries can make sex difficult as they might get in the way. If you learn to remove the pessary yourself, you can take it out before sex.

Synthetic midurethral sling A thin strip of soft, plastic mesh is implanted in the pelvis to support the urethra. The mesh is inserted through a small cut just inside the vagina and two tiny cuts at the very bottom of the abdomen. It is as effective as laparoscopic colposuspension and the main risks of surgery are similar. However, there are some extra complications that may happen because the operation uses mesh. Your hospital stay and recovery might be slightly shorter if you chose a synthetic midurethral sling.

What is an autologous sling? This is a similar procedure to the retropubic midurethral sling but does not use mesh. A thin strip of your own body tissue is used instead of the mesh. This tissue, called 'fascia', is normally taken from the lower abdomen. This needs a larger cut on the abdomen and might make your recovery a little longer. The autologous sling is just as effective as the retropubic midurethral sling. Problems with urinary urgency and difficulty passing urine are more common after an autologous sling.

What are urethral bulking agents? A soft gel is injected into the urethra. This makes it more difficult for urine to escape. The gel is injected using a cystoscope, which is a camera passed down the urethra. No cuts are needed and you go home the same day. There is a much lower risk of complications compared with other procedures but it is not as effective. We are also unsure how well the procedure works long term.

What is an artificial urinary sphincter? This is a mechanical valve that controls urine flow through the urethra. The valve is inserted through a cut on your lower abdomen. A small pump is then placed under the labial skin. By pressing the pump, you can control when you want urine to flow. Although very effective, the device may need to be repaired because it breaks down or removed because of infection. Because of these problems, it is usually reserved for patients in whom other treatments have failed.

7 How should I prepare for laparoscopic colposuspension?

The Preoperative Assessment Clinic (PAC)

Before your operation, you will be seen in the PAC to make sure that you are fit for your surgery. Specialist nurses and anaesthetists run the clinic. This normally happens a few weeks before your operation. When you come to your appointment, you should bring the following:

- A list of your medical conditions and previous operations.
- A list of your current medications and allergies.

Sometimes, certain types of medication need to be stopped before your operation. The team in PAC will tell you if any of your medication needs to be stopped and which ones you

should take on the day of your operation. **Please do not stop any medication before your operation unless you are asked to do so. Stopping important medication before your surgery may mean that your operation is cancelled or you come to harm.**

Some patients may need to take additional medication the day before their surgery to clear their bowels. This is called 'bowel preparation'. Not all patients require bowel preparation and if it is needed, we will discuss it with you before your operation.

What if the PAC finds a problem? Occasionally, a new health problem is found. Sometimes, an existing problem may need further treatment before surgery. If this happens, your surgery will need to be delayed. Your GP will be asked to arrange any extra tests, treatment, or consultations with other specialists. Whilst we understand how disappointing this might be, the PAC team are there to make sure your surgery is conducted safely. If your operation is delayed, we will arrange another date for you as quickly as possible when you are cleared for surgery. Unfortunately, we are unable to speed up any tests or extra appointments requested by PAC.

The day of your surgery

On the day of surgery, you will come to the Surgical Reception on the First Floor of University College Hospital at 07:00 in the morning. You will receive a letter confirming these details. Your operating surgeons will see you for final checks. Please note that your operating surgeon may not be the same specialist as you saw in clinic. The nurses will then prepare you for your surgery.

You may be given an enema to clear out the lower bowel before your operation. You will not need this if you took bowel preparation.

On the day of surgery, you should follow the instructions given to you at the PAC appointment about the following:

- Which medications to take on the morning of surgery.
- When to stop eating and drinking before your surgery.

If you are confused about any of the instructions, you must contact them before your surgery. Their details are at the end of this leaflet.

- Bring your regular medications along with you.
- Pack a bag with clothes and toiletries for your stay.
- Bring the copy of your consent form that we gave you.

Please be aware that your surgeons will be operating through the day until 19:00. They are often unable to leave the operating theatre between patients. For this reason, they see all patients in the morning, even if surgery is planned for later in the day.

If your surgery is in the afternoon, you may be allowed to drink some water. You might also be able to leave the Surgical Reception for a little while until you are due for surgery. Please do not drink, or leave the Surgical Reception, until instructed to do so. Drinking at the wrong time may mean that your operation is cancelled.

There is a very small chance that your surgery may be cancelled on the day you come in to hospital. This might happen because the hospital is full and there is no bed for you. This is uncommon but obviously very distressing if it occurs.

Whilst beds often become available as the day passes, this is not always the case. If it looks like your surgery will have to be cancelled, we will let you know as early as we can. We will then work with our management team to rearrange your surgery as soon as possible.

Making plans for after your surgery

Please make plans well in advance:

- You will be in hospital for one or two nights. Up to two people can visit you in hospital between 09:00 and 20:00 every day.
- Please ensure that your travel plans are flexible. Remember that your stay might also be extended on medical grounds.
- You will need an escort to help you get home and you will not be able to use public transport to get home alone.
- You will need at least four weeks off work. If you have a strenuous job you may need slightly longer to recover.
- You should avoid carrying anything heavier than 5kg for the first four weeks after surgery.
- You will need friends and family to help with groceries and household chores, particularly in the first two weeks.

Unfortunately, we will be unable to extend your hospital stay if you have not made transport arrangements. If you already use hospital transport because of a medical illness, we will be able to help arrange this. Unfortunately, hospital transport is not available for other patients.

8 Asking for your consent

We want to involve you in all the decisions about your care and treatment. If you decide to go ahead with treatment, by law we must ask for your consent and will ask you to sign a consent form. This confirms that you agree to have the procedure and understand what it involves. Staff will explain all the risks, benefits and alternatives before they ask you to sign a consent form. If you are unsure about any aspect of your proposed treatment, please ask to speak with a senior member of staff again. Our contact details are at the end of this leaflet.

9 What happens during a laparoscopic colposuspension?

The operation takes around two hours and is performed using 'keyhole surgery'.

- A camera, known as a cystoscope, is passed into the bladder through the urethra. Two thin tubes may then be passed through the ureters to protect them during your surgery. These tubes are called 'ureteric catheters'.
- Four or five small cuts are made on the abdomen and special tubes, known as 'ports', are placed through these cuts.
- A tiny camera and special operating instruments are inserted through the ports.
- Pictures of the inside of the abdomen are sent from the camera to television screens that the surgeons watch.
- Your surgeon will place internal stitches to support the base of the bladder. These stitches are not placed into the bladder itself. They are inserted into strong tissue, known as fascia, which is between the front wall of the vagina and the bladder. Two stitches are placed in the fascia on each side.

- The other ends of the stiches are pulled up and tied up to the back of the pubic bone.
- The stitches do not dissolve and are permanent.
- Once this part of the operation is finished, we check inside the bladder using a cystoscope inserted through the urethra. This is to make sure that none of the internal stitches passed through the bladder by accident. If all is well, we then remove the ureteric catheters.
- You will have a drip in your hand and a catheter tube in the bladder.

The drip will be removed the day after surgery. The catheter might be removed whilst you are in hospital, depending how long you stay. Sometimes we will send you home with a catheter draining into a bag on your leg for a few days. This is to let the bladder rest after surgery. If you go home with a catheter tube still in the bladder, it will need to be removed by a few days later. The urogynaecology nurses usually do this in the outpatient clinic a few days after you are sent home. You will be given an appointment for this if it is needed.

We explained earlier that laparoscopic colposuspension might make it more likely that you develop prolapse in the future. This can happen many months or even years after the operation. If it does, the back wall of the vagina is usually affected. This is the lower vagina covering the bowel.

Occasionally, womb prolapse can be a problem after laparoscopic colposuspension. Whilst we are operating, we can sometimes see that the womb is being pulled down by the internal stitches we are putting in. This might lead to womb prolapse in the future, which can cause symptoms.

If this happens, we might put in some extra internal stitches to help lift the womb up. This procedure is called a laparoscopic suture sacrohysteropexy.

This procedure does not significantly increase the risks of surgery but the operation may take a little longer. We provide an additional information leaflet on laparoscopic suture sacrohysteropexy for patients.

10 What should I expect after laparoscopic colposuspension?

The first two weeks after surgery

- You will need to rest and take regular painkillers.
- You should take regular medicine, known as a laxative, to keep your bowels opening every day.
- You will spend much of your time at home but you may take short walks. You should avoid anything strenuous and lifting anything heavier than 5kg.
- You should try to shower, rather than have a bath, to allow the keyhole stitches to heal. If you do take a bath, do so in shallow water for a maximum of ten minutes.
- You can remove the plasters from the keyhole scars after three days and then keep the areas clean and dry.
- You will receive a telephone clinic appointment through the post. This is normally scheduled for two to three weeks after surgery. The urogynaecology nurses will call you by phone on this day to check on your progress.

We will give you a two-week supply of painkillers, laxative medication, and any other drugs you will need at home. If you need further supplies after you have gone home, you will need to contact your GP.

Weeks two to four after surgery

- You will be able to reduce your regular painkillers, start taking them only if needed, and eventually stop using them.
- You will continue to use your laxatives to keep your bowels opening daily. If you can do this by eating plenty of fruit and fibre, and drinking enough water, you can stop the laxatives.
- You can increase your activity, go out for longer walks, and visit friends and family, provided you take things easy.
- You will continue to avoid lifting anything heavier than 5kg.
- You can start driving again but you should inform your insurance company that you have had surgery. They must be happy for you to drive again. You should only start driving again if you feel safe to do so. You must be able to perform an emergency stop if needed.

Four weeks onwards

- You can get back into your normal routine and return to work. If you have a strenuous job, you may need slightly longer to recover. Please let us know if this is the case.
- If you exercised regularly before your surgery, please discuss this with us before you go home. We might suggest some changes to your usual exercise programme.
- You can start having sexual intercourse after six weeks.

We will send you a clinic appointment through the post for three months after your surgery. At the appointment, we will ask you how things are and examine you. This is to make sure that the operation has worked and that you do not have any problems.

What serious problems should I look out for? Serious problems after surgery are rare but they need to be checked urgently. If you develop the following symptoms, you should go to your nearest Accident and Emergency department.

- **High fever.**
- **Repeated vomiting.**
- **Pain in the abdomen that is getting worse.**
- **Swelling of the abdomen that is getting worse.**
- **You are unable to pass urine or pass very little.**
- **Swelling, redness, or tenderness in the lower legs.**
- **Difficulty breathing, or chest pain.**

If you have to go to hospital, please contact the urogynaecology nursing team afterwards to let them know. Their contact details are below.

What I have other less urgent problems? You should discuss these problems with the urogynaecology nursing team or your GP within 24 hours. Such problems might include:

- Burning when you are passing urine.
- Difficulty passing urine.
- Not opening your bowels for three days.
- Redness around your abdominal wounds.
- A smelly vaginal discharge.

The urogynaecology team will usually return telephone calls and messages the same day, or the next working day. You should ring them first if you have problems. If you call them on Friday and do not hear back the same day, you should see a GP. At the weekend, you should see a GP or go to Accident and Emergency if there is no other help available.

11 Where can I get more information?

The British Society of Urogynaecology

Website: www.bsug.org.uk/patient-information.php

Email: bsug@rcog.org.uk

Telephone: 020 7772 6211

Fax: 020 7772 6410

The International Urogynecological Association

Website:

<http://www.iuga.org/general/custom.asp?page=patientinfo>

Email at: www.iuga.org/general/?type=CONTACT

UCLH cannot accept responsibility for information provided by other organisations.

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13 Contact details

Urogynaecology nursing team

(For medical problems and questions only)

Direct line: 020 3447 6547
Mobile: 07951 674140
Fax: 020 3447 6590
Email: urogynaecology@uclh.nhs.uk

Gynaecology outpatient appointments

(Contact for outpatient clinic appointments only)

Direct line: 020 3447 9411
Fax: 020 3447 6590

Preoperative Assessment Clinic (PAC)

(Contact for questions about PAC only)

Direct line: 020 3447 3167
Fax: 020 3383 3415

Gynaecology Admissions

(Contact for surgery dates and scheduling only)

Direct line: 020 3447 2504

Urogynaecology secretary

Direct line: 020 3447 2516
Fax: 020 3447 9775

University College Hospital

Switchboard: 020 3456 7890
Website: www.uclh.nhs.uk

14 How to find us

The Urogynaecology and Pelvic Floor Unit
Clinic 2, Lower Ground Floor
Elizabeth Garrett Anderson (EGA) Wing
University College Hospital
25 Grafton Way
London
WC1E 6DB

Space for notes and questions

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