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Posterior Vaginal Repair

Repair of the posterior vaginal wall or rectocoele (bulging of the rectum into the vagina as the vaginal wall is weak) aims to relieve the symptoms of vaginal bulge and/or laxity or a feeling of lack of support and to improve or maintain bowel function without interfering with sexual function.

It most reliably addresses the symptom of bulge.

Surgical technique

- An incision (or cut) is made on the posterior (back) wall of the vagina starting at the entrance and finishing at the top of the vagina, near the cervix or vault if there is no cervix.
- The rectovaginal fascia (tough tissue between the vagina and rectum that is torn usually during childbirth, leading to the bulge) is found and the fascial defects or gaps are corrected by plication (stitching together) using dissolving stitches, in much the same way a hernia is repaired.
- The perineal (the supporting tissue between vaginal and anal openings) defects are repaired by placing deep sutures into the perineal muscles to build up the perineal body (Often a repair of the perineal body is performed at the same time as a rectocele repair).
- The overlying vaginal and vulval skin is then closed with absorbable sutures
- A pack is usually placed into the vagina and a catheter into the bladder at the end of surgery and removed the following morning. Surgery will be covered with antibiotics to decrease the risk of infection and blood thinning agents will be used to decrease the risk of clots in the legs and pelvis (deep vein thrombosis) forming in the postoperative phase.

Complications

- Return of the prolapse in 10%
- Failure to correct symptoms like incomplete bowel evacuation or constipation in 50% as these may have been the original cause of the prolapse
- Painful intercourse in 1-5% rarely requiring surgery to relieve excessive constriction
- Blood loss requiring transfusion <1%
- Inadvertent damage to the rectum is **very** uncommon but if leads to a connection between the vagina and rectum (fistula) may require further surgery or a temporary stoma
- Other general issues related to immobility/lying still and anaesthesia such as deep venous thrombosis (clots in the legs), infection at the site of an IV drip are uncommon. Your anaesthetist will more fully discuss the anaesthetic with you prior to

surgery and you may be asked to have some tests (blood tests, ECG – heart trace) before surgery.

In hospital recovery

After the operation you will have an IV drip usually your arm for fluids and pain relief. You can expect to stay in hospital between 2-3 days (usually until after your bowels are open). You will have a vaginal pack and urinary catheter for at least the first night.

In the early postoperative period you should avoid situations where excessive pressure is placed on the repair, i.e. lifting, straining, coughing and constipation. Maximal fibrosis or **scarring** around the repair occurs at 3 months and care with heavy lifting >10kg needs to be taken until this time. If you develop urinary burning, frequency or urgency you should contact me – my nurse is the best first call in hours or the call service out of hours 9387 1000.

You will be reviewed at six weeks and sexual activity can usually be safely resumed at this time. You can return to work at approximately 2-6 weeks depending on the amount of strain that will be placed on the repair at your work and on how you feel.

You may be asked to use topical estrogen cream (Ovestin) each night **before** and then for a while after your repair to assist with healing. This is usually needed if you are post menopausal. It is very important throughout the period of your recovery to make sure your bowels open easily.

I am happy to answer any questions you have and can give you more specific advice.