



JAMES BUCHANAN BRADY UROLOGICAL INSTITUTE

LAPAROSCOPIC PELVIC ORGAN PROLAPSE REPAIR (COLPOSUSPENSION)

The purpose of this section of our site is to provide an information guide for women suffering from pelvic organ prolapse who are considering laparoscopic prolapse repair.

For many women, prolapse can include descent of the uterus, vagina, bladder and/or rectum resulting in a “bulging” sensation within the vagina. In some cases, frank protrusion of these organs can occur.

Pelvic organ prolapse can result in symptoms including urinary leakage, constipation, and difficulty with intercourse.

Laparoscopic colposuspension is a minimally invasive surgical technique that provides a safe and durable method for reconstruction of the pelvic floor and its contents without the need for a large abdominal incision.

OUR SURGEONS

Laparoscopic colposuspension is performed by a team of urologist including Dr. E. James Wright, a specialist in female urology and pelvic reconstruction and Dr. Mohamad Allaf, a specialist in pelvic laparoscopy.

Mohamad E. Allaf, MD



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Edward James Wright, M.D.



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APPOINTMENTS

To make an appointment for consultation with Dr. Edward James Wright, M.D., please call **410-550-1700**.

For **directions to Johns Hopkins Bayview Medical Center** please [click here](#)

PRIOR TO THE SURGERY

What to expect during you preoperative consultation

During your preoperative consultation, your surgeon will review your medical history and perform a physical examination. If your surgeon decides that you are a candidate for laparoscopic colposuspension, you will then meet with Mrs. Chanda Nelson to schedule a date for your operation. She will review the paperwork and blood tests that you will need prior to surgery. Any scheduling changes can be made directly through her at 410-550-0412.

Note: It is the responsibility of the patient to inform Mrs. Nelson of any scheduling changes/cancellations at least 4 weeks in advance of the surgery date out of courtesy to your surgeon, the operative staff, as well as other patients.

All billing and insurance inquiries are handled by **Ms. Laura Wheeler at 410-550-3339**.



What to expect prior to the surgery As most insurance companies will not permit patients to be admitted to the hospital the day before surgery to have tests completed, you must make an appointment to have pre-operative testing done at your primary care physician's office within 1 month prior to the date of surgery. Once your surgical date is secured, a letter will be faxed to your

primary care physician requesting the following pre-operative testing:

- Physical exam
- EKG (electrocardiogram)
- CBC (complete blood count)
- PT / PTT (coagulation profile)
- Comprehensive Metabolic Panel
- Urinalysis

These results need to be faxed by your doctor's office to the **Pre-operative Evaluation Center at 410-550-1391** between 1-2 weeks prior to your surgery date.

Preparation for surgery

Drink only clear fluids for a 24-hour period prior to the date of your surgery

Clear Liquid Diet

Remember not to eat or drink anything after midnight the evening before your surgery.

Clear liquids are liquids that you are able to see through. Please follow the diet below.

- Water

- Clear Broths (no cream soups, meat, noodles etc.)
 - Chicken broth
 - Beef broth

- Juices (no orange juice or tomato juice)
 - Apple juice or apple cider
 - Grape juice
 - Cranberry juice
 - Tang
 - Hawaiian punch
 - Lemonade
 - Kool Aid
 - Gator Aid

- Tea (you may add sweetener, but no cream or milk)

- Coffee (you may add sweetener, but no cream or milk)

- Clear Jello (without fruit)

- Popsicles (without fruit or cream)
- Italian ices or snowball (no marshmallow)

Do not eat or drink anything after midnight the night before the surgery. Certain medications can be taken with a sip of water the morning of surgery.

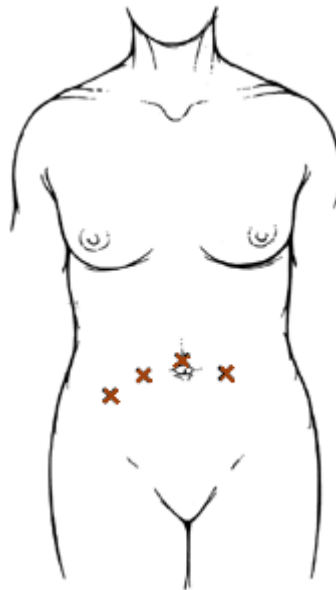
Asprin, Motrin, Ibuprofen, Advil, Alka Seltzer, Vitamin E, Vioxx, Plavix, Ticlid, Coumadin, Lovenox, Celebrex, Voltaren and some other arthritis medications can cause bleeding and should be avoided 1 week prior to the date of surgery.

Bowel Preparation: Drink one bottle of **magnesium citrate** liquid on the evening before surgery (approximately 4-5 pm) and administer a **fleets enema** at home the morning of surgery to help evacuate the bowel contents. These items may be purchased over the counter at any pharmacy.

THE SURGERY

The Operation

Laparoscopic colposuspension is performed using fine laparoscopic instrumentation inserted through 4 keyhole incisions across the mid abdomen (Figure 1).



This is in contrast to the conventional open abdominal colposuspension where a lower midline (Figure 2a) or Pfannenstiel (Figure

2b) abdominal incision is required.

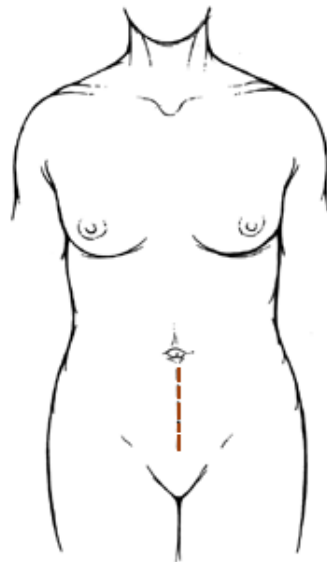


Figure2a

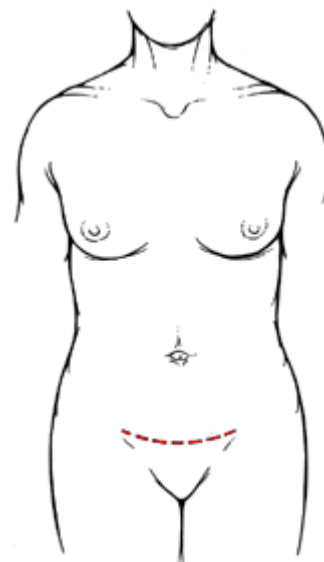


Figure2b

In cases of pelvic organ prolapse, there is laxity of vaginal support resulting in protrusion of the pelvic organs. The goal of laparoscopic colposuspension is to resuspend the vagina and associated pelvic organs through the key-hole incisions. In certain circumstances, a simultaneous hysterectomy, bladder suspension, or rectocele repair may be required, all of which can be accomplished through a vaginal approach.

Laparoscopic colposuspension is a well established procedure at Johns Hopkins Bayview Medical Center and is performed with the assistance of an experienced and dedicated laparoscopic surgical team including nurses, anesthesiologists, operating room technicians, many of whom will meet the day of surgery.



Laparoscopic colposuspension is performed through 4 small keyhole (0.5-1 cm) incisions across the mid abdomen (Figure 1). Through these small incisions, fine laparoscopic instruments are inserted to dissect and suture. Excellent visualization of the pelvic organs is achieved with the use of a high-powered telescopic lens attached to a camera device, which is inserted into one of the keyhole incisions.



The vagina and pelvic organs are then resuspended internally with a combination of sutures and a supportive mesh or fascial graft (Figure 3). If needed, a bladder suspension, vaginal hysterectomy, and rectocele repair can be accomplished at the same time via a vaginal incision. A Foley catheter (i.e. bladder catheter) is placed to drain the bladder. A gauze vaginal packing is also placed at the end of the procedure.

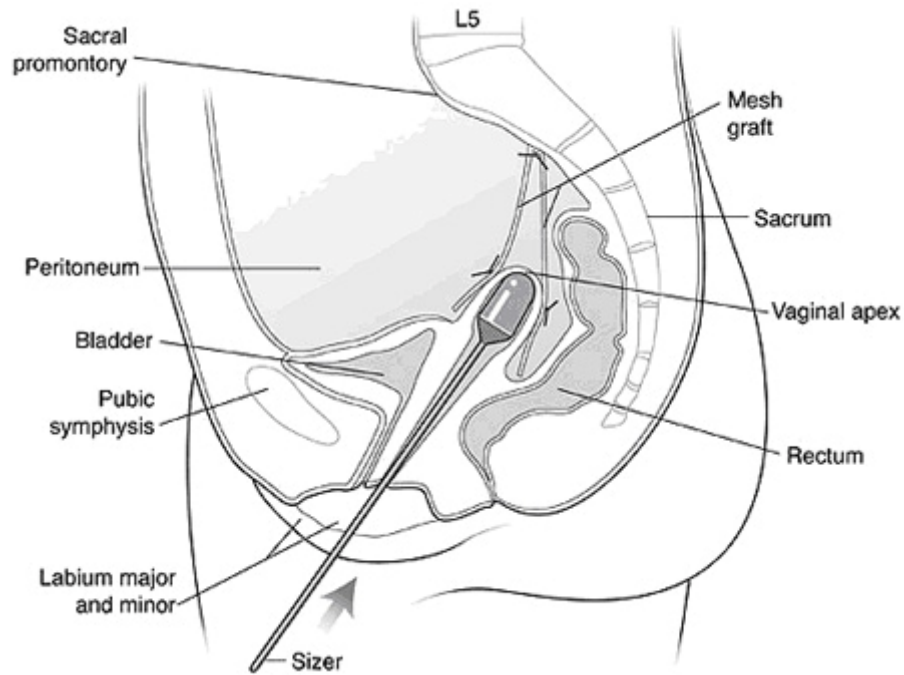


Figure 3 Schematic sagittal view of laparoscopic colposuspension with mesh graft.

The length of operative time for laparoscopic colposuspension can vary greatly (3-5 hours) from patient to patient depending on the internal anatomy, shape of the pelvis, weight of the patient, and presence of scarring or inflammation in the pelvis due to infection or prior abdominal/pelvic surgery.

Blood loss during laparoscopic colposuspension is routinely less than 200 cc and transfusions are rarely required.

Video Clips

 [Laparoscopic Pelvic Organ Prolapse Repair\(COLPOSUSPENSION\)](#)

Potential Risks and Complications

Although laparoscopic colposuspension has proven to be very safe, as in any surgical procedure there are risks and potential complications. Potential risks include:

- **Bleeding:** Although blood loss during this procedure is relatively low compared to open surgery, a transfusion may still be required if deemed necessary either during the operation or afterwards during the postoperative period.
- **Infection:** All patients are treated with intravenous antibiotics, prior to the start of surgery to

decrease the chance of infection from occurring within the urinary tract or at the incision sites.

- **Adjacent Tissue / Organ Injury:** Although uncommon, possible injury to surrounding tissue and organs including bowel, vascular structures, pelvic musculature, and nerves could require further procedures. Transient injury to nerves or muscles can also occur related to patient positioning during the operation.
- **Hernia:** Hernias at the incision sites rarely occur since all keyhole incisions are closed under direct laparoscopic view.
- **Conversion to Open Surgery:** The surgical procedure may require conversion to the standard open operation if extreme difficulty is encountered during the laparoscopic procedure (e.g. excess scarring or bleeding). This could result in a standard open incision and possibly a longer recuperation period.
- **Urinary Incontinence:** Pre-existing urinary incontinence will typically be addressed at the time of surgery with a bladder sling suspension, however, minor incontinence may still exist, which typically resolves with time. On occasion, medication may be required.
- **Urinary Retention:** As with urinary incontinence, postoperative urinary retention is uncommon and usually is present in patients who undergo concurrent bladder sling suspension. Temporary intermittent self-catheterization may be required postoperatively.
- **Vesicovaginal fistula:** A fistula (abnormal connection) between the bladder and vagina is a rare complication of any pelvic surgery involving the vagina, uterus, and bladder. A vesicovaginal fistula typically manifests with symptoms of continuous urinary leakage from the vagina. Although rare, these fistulas can be managed conservatively or by surgical repair through an vaginal incision.

WHAT TO EXPECT AFTER SURGERY

What to expect after the surgery

Immediately after the surgery you will be taken to the recovery room, then transferred to your hospital room once you are fully awake and your vital signs are stable.

- **Post Operative Pain:** Pain medication can be controlled and delivered by the patient via an intravenous patient-controlled analgesia (PCA) pump or by injection (pain shot) administered by the nursing staff. You may experience minor transient shoulder pain (1-2 days) related to the carbon dioxide gas used to inflate your abdomen during the laparoscopic surgery.
- **Bladder Spasms:** Bladder Spasms are commonly experienced as a moderate cramping sensation in the lower abdomen or bladder and are common after colposuspension. These spasms are usually

transient and often decrease over time. If severe, medications can be prescribed by your doctor to decrease the episodes of these spasms.

- **Nausea:** You may experience transient nausea during the first 24 hours following surgery, which can be related to the anesthesia. Medication is available to treat persistent nausea.
- **Urinary Catheter:** You can expect to have a urinary catheter (Foley) draining your bladder (which is placed in the operating room under anesthesia) for approximately 1-2 days after the surgery. It is not uncommon to have blood-tinged urine for a few days after your surgery.
- **Vaginal Packing:** A vaginal gauze packing is routinely placed at the end of the operation while the patient is under anesthesia. This packing will typically be removed the next day.
- **Diet:** You can expect to have an intravenous catheter (IV) in for 1-2 days. (An IV is a small tube placed into your vein so that you can receive necessary fluids and stay well hydrated; in addition it provides a route to receive medication.) Most patients are able to tolerate clear liquids the first day after surgery, and a regular diet the following day. Once on a regular diet, pain medication will be administered by mouth instead of by IV or shot.
- **Fatigue:** Fatigue is common and should start to subside in a few weeks.
- **Incentive Spirometry:** You will be expected to do some very simple breathing exercises to help prevent respiratory infections by using an incentive spirometry device (these exercises will be explained to you during your hospital stay). Coughing and deep breathing is an important part of your recuperation and helps prevent pneumonia and other pulmonary complications.
- **Ambulation:** On the day after surgery it is very important to get out of bed and begin walking with the supervision of your nurse or family member to help prevent blood clots from forming in your legs. You can expect to have SCD's (sequential compression devices) along with tight white stockings on your legs to prevent blood clots from forming in your legs while you are lying in bed.
- **Hospital Stay:** Length of hospital stay for most patients is 1-2 days
- **Constipation:** You may experience sluggish bowels for several days to a week after surgery. Suppositories and stool softeners may be given to help with this problem. Taking one teaspoon of mineral oil and milk of magnesia at home will also help to prevent constipation.

What to expect after discharge from the hospital

- **Pain Control:** You can expect to have some incisional discomfort that may require pain medication

for a few days after discharge, and thereafter Tylenol should be sufficient to control your pain.

- **Showering:** You may shower at home. Your incision sites can get wet, but must be patted dry after showering. Tub baths can soak your incisions and therefore are not recommended in the first 2 weeks after surgery. You will have adhesive strips across your incisions. They will either fall off on their own or can be removed in approximately 5-7 days. Sutures underneath the skin will dissolve in 4-6 weeks.
- **Physical Activity:** Taking daily walks is strongly advised following surgery. Prolonged sitting or lying in bed should be avoided and can increase your risk for forming blood clots in the legs as well as developing pneumonia. Climbing stairs is possible but should be limited. Driving should be avoided for at least 2 weeks after surgery. Absolutely no heavy lifting (greater than 20 pounds) or exercising (jogging, swimming, treadmill, biking) for six weeks or until instructed by your doctor. Most patients return to full activity an average of 3 weeks after surgery.
- **Sexual Activity:** If a vaginal incision is required during surgery, the patient may feel pain during intercourse. Therefore, the patient should abstain from sexual activity for 4-6 weeks after surgery.
- **Diet:** No restrictions. Drink plenty of fluids.
- **Medications:** You can resume your usual medications after surgery with the exception of aspirin or other blood thinners, which can increase the risk of bleeding.
- **Follow-up Appointment:** You will need to call soon after your discharge to schedule a follow up visit for 2 weeks after your surgery with Dr. James Wright. **For an appointment with Dr. Wright please call The Johns Hopkins Bayview Medical Center at 410-550-7008.**