**Guide for TOT and Other Pelvic/Vaginal Surgeries**

Approximately 85% of all women in childbearing years and beyond experience some degree of stress urinary incontinence. This leakage, which often occurs with coughing, laughing, sneezing, running, or jumping is not only embarrassing but also tends to prohibit many activities of today’s active woman.

Although incontinence is often the most easily recognized symptom of pelvic floor defects, other conditions include prolapsed, which is the herniation or collapse of the vaginal vault/or uterus.

Female pelvis tissues are dependent on estrogen for strength and support. As a woman ages and estrogen depletes, the trauma produced during childbirth in earlier years can be compounded by weight gain, lifting or straining, and constipation.

Only rarely does incontinence exist alone. Most defects are clear upon vaginal examination. Enhanced in-office diagnostics including ultrasound and urodynamics enable physicians to assess accurately each patient’s overall pelvic floor integrity.

**Before your Surgery**

There are a few important things to do before your surgery to help improve your chance of a smooth recovery.

* If you smoke; please stop. (Your surgeon may be able to prescribe medications to help with this.)
* If you consume alcohol regularly; cut down or stop completely. Ask your doctor for help.
* Stop the use of aspirin products or blood thinning medications 1 week before surgery to reduce bleeding.
	+ Aspirin, Ibuprofen, Coumadin, Plavix, Naproxen, Celebrex. (ask your surgeon for details)
* Herbal supplements and vitamins should be stopped one week before surgery.
* Increase fiber and fruit intake to promote regular bowel function before and after surgery
* Begin practicing Kegel exercises to strengthen bladder muscles.
* Let your PCP and/or cardiologist know about the surgery.

**Remember, don’t eat or drink anything after midnight the day of your surgery.** However, it is ok to take your usual morning medications (**EXCEPT** your diabetic meds, blood thinners, or aspirin products) with a sip of water. If you have any questions ask your surgeon.

**During your Hospital Stay**

* When you wake up after your surgery you will be in the recovery room. There, nurses will check your vital signs and get you ready to go home.
* Before you go home your nurse will teach you how to care for your urinary catheter if there is one in place.
* Most patients go home the same day.
* Your follow up appointment will need to be two to three weeks post op.

**Diet**

* Begin with clear liquids, Gatorade and Popsicles.
* After you begin passing gas and have a small bowel movement slowly try some solid foods.
* Most patients report gas pains and bloating for several days after surgery. Take short walks several times a day to relieve gas pains.
* Take a generic brand stool softener daily to prevent constipation.
* Warm prune juice can promote a bowel movement if you are feeling constipated.

**Medications**

Use Advil and Tylenol according to the instructions on the label to help with pain control. If Tylenol is not strong enough then use the narcotic medication prescribed by your surgeon. Limit the use of this as much as possible because it can upset your stomach and causes gas.

***Contact your surgeon if you have:***

* Fever above 101.5° Fahrenheit
* Severe nausea or vomiting
* Heavy bleeding or drainage from the incision
* Persistent bloody urine that won’t clear up
* No urine draining from catheter tube
* Painful swelling in your legs
* Chest pain or shortness of breath
* Problems or questions about your medications

**Post Operative TVT & TOT Sling Instructions**

1. It is unlikely, but you may be discharged from the hospital with a Foley catheter. It will be removed in the office in a few days.
2. Remove the bandages on the abdomen the day after surgery. Leave the underlying steri-strips in place for one week. You may shower and dry the area as usual. Some spotting from the incision is normal as is a moderate amount of bruising in the skin. If bruising occurs, use a heating pad daily for 30 minutes to speed up healing. Please keep the area dry and clean.
3. You may have vaginal spotting as long as three weeks. You should not have any heavy bleeding.
4. Your next menses may be early or late, lighter or heavier than usual and unless very abnormal, no cause for alarm.
5. It is very important not to do any heavy lifting or coughing for six weeks. Any of the above could damage the repair before it is healed. No intercourse for six weeks.
6. You may take a shower, however, dry the incision area well. Tub baths are allowed in one month.
7. You may return to work/light duty in a few days.
8. Constipation is to be avoided; use a daily stool softener.

Care for your Urinary Catheter

A urinary catheter is a flexible plastic tube used to drain urine from your bladder when you cannot urinate by yourself. A doctor will place the catheter into the bladder by inserting it through the urethra, the opening that carries urine from the bladder to the outside of the body. Once the catheter is in the bladder, a small balloon is inflated to keep the catheter in place. The catheter allows urine to drain from the bladder into a bag that is usually attached to the thigh.

A catheter may be needed because of certain medical conditions, such as an enlarged prostate, the inability to control the release of urine, or after surgery on the pelvis or urinary tract. Urinary catheters are also used when the lower part of the body is paralyzed.

**Catheter care**

Always wash your hands before and after dealing with your catheter.

* Make sure that urine is flowing out of the catheter into the drainage bag.
* Make sure the tube doesn't get twisted or kinked.
* Check the area around the urethra for inflammation or signs of infection, such as irritated, swollen, red or tender skin at the insertion site or drainage around the catheter.
* Keep the drainage bag below the level of the bladder. Make sure that the drainage bag does not drag and pull on the catheter.
* Unless you've been told otherwise, it's okay to shower with your catheter and drainage bag in place.
* Clean the area around the drainage tube twice a day, using soap and water. Dry with a clean towel afterward.
* Do not tug or pull on the catheter.
* Do not have sexual intercourse while wearing an indwelling catheter.
* You may wrap a small piece of gauze around the area where the catheter comes out of your body. Change the gauze if it feels wet. Use a new piece of gauze each time you clean your catheter.
* At night you may wish to hang the bag on the side of your bed.
* Do not allow the bag to pull on the catheter.

**Living with a catheter**

Try to prevent constipation, and be sure you drink enough fluids. Most adults should drink between 8 and 10 glasses of water, non caffeinated beverages, or fruit juice each day. Include fruits, vegetables, and fiber in your diet each day. Try a stool softener, such as Colace, if your stools are very hard.

**Draining the urine collection bag**

You will need to empty the bag regularly, whenever it is half-full, and at bedtime.

* Wash your hands with soap and water. If you are emptying another person’s collection bag you may wish to wear disposable gloves.
* Unfasten the tube from the drainage bag.
* Fasten the tubing clamp and remove the drainage bag.
* Drain the urine into the toilet. Avoid touching the tubing or drainage cap on the toilet, the collection container, or the floor.
* Replace the drainage cap, close the clamp, and refasten the collection tube to the drainage bag.
* Refasten the collection tube to the drainage bag.
* Wash your hands with soap and water.

**When to call your surgeon**

Call your surgeon if:

* No urine or very little urine is flowing into the collection bag for 4 or more hours.
* No urine or very little urine is flowing into the collection bag and you feel like your bladder is full.
* You have new pain in your abdomen, pelvis, legs, or back.
* Your urine has large blood clots in it.
* Your urine has a foul odor.
* You have a fever of 101° F or higher or back or flank pain.
* You develop nausea, vomiting, or shaking chills.

**Quick Activity Sheet**

Post Op SCP/TOT/TVT

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| --- | --- |
| **ACTIVITY** | **TIME TO ABSTAIN** |
| Tampons | 6 weeks |
| Drive, automatic | \*24 hours |
| Drive, manual | \*24 hours |
| Making Beds | 1-2 weeks |
| Hanging Wash | 1-2 weeks |
| Stretching/Reaching Overhead | 1-2 weeks |
| Mopping/Vacuuming | 1-2 weeks |
| Lifting Over 10 pounds | 6 weeks |
| Sexual Activity | 6 weeks |

\*as long as you are not taking pain medicine

**Information and Consent for**

**PELVIC ORGAN PROLAPSE/INCONTINENCE SURGERY**

We recommend that you read this handout carefully in order to prepare yourself or family members for the proposed procedure. In doing so, you will benefit both the outcome and safety of the procedure. By signing this form you are stating that you have been fully informed and understand the indications, risks, benefits and expected outcomes of this procedure, and have had time to ask questions. *If you still have any questions or concerns, we strongly encourage you to contact our office prior to your procedure so that we may clarify any pertinent issues.*

* ***Prolapse of Pelvic Organ***

Prolapse of the uterus or vagina simply means the “dropping” of these structures to an abnormally low position. This bulge from the vagina may include your uterus, intestines, bladder, rectum, or any combination of the above. Because of the complex nature of this problem it is common for multiple procedures to be performed at the time of this surgery.

* ***Hysterectomy***

Hysterectomy is the surgical removal of the cervix and uterus. This procedure may be accomplished abdominally, vaginally, or a combination of both.

* ***Enterocele***

Enterocele is a hernia of the small intestine into the vagina. The goals of enterocele repairs are to replace the intestines to its normal position and restore the tissue so it will not recur.

* ***Cystocele***

Cystocele means bladder appearing like a balloon prolapsing (“dropping”) into and out of the vagina. To repair this problem we use either your own tissues or synthetic mesh material.

* ***Urinary Incontinence***

Urinary Incontinence is a very common problem that occurs in conjunction with pelvic organ prolapsed. If this is present, it is generally repaired at the same time as your prolapsed surgery. Repair of this problem usually involves placing a piece of mesh material underneath the mid-portion of your urethra by passing it through small incisions either above the pubic bone or next to the labia. After the procedure a telescope called a “cystoscope” may be placed in the bladder to inspect the inside of the bladder.

* ***Vaginal Augmented Repair***

These mesh graft procedures are new minimally invasive techniques to help repair different types of prolapse. These procedures use small specially designed instruments to pass a minimally reactive sterile medical mesh material to reinforce the areas of poor support in the pelvis. This material acts as a scaffold for your tissue to regain and provide stronger support.

* ***Abdominal Sacral Colpopexy***

This surgery uses an abdominal approach to attach a permanent mesh graft from the top of the vagina to the back of the pelvic bone in order to permanently hold the vagina in place.

**Possible Complication of the Procedure**

All surgical procedures, regardless of complexity or time, can be associated with unforeseen problems. They may be immediate or even quite delayed in presentation. While we have discussed these and possibly others in your consultation, we would like you to have a list so that you may ask questions if you are still concerned. Aside from anesthesia complications, it is important that every patient be made aware of all possible outcomes, which may include, but are not limited to:

* **Urinary Tract Infection or Sepsis**: Although we may give you antibiotics prior to and after the operation it is possible for you to get an infection. The most common type is a simple bladder infection (after the catheter is removed) that presents with symptoms of burning urination, urinary frequency and a strong urge to urinate. This will usually resolve with a few days of antibiotics. If the infection enters the bloodstream, you might feel very ill. This type of infection can present with both urinary symptoms and any combination of the following: fevers, shaking chills, weakness or dizziness, nausea and vomiting. You may require a short hospitalization for intravenous antibiotics, fluids, and observation. This problem is more common in diabetics, patients on long-term steroids, or in patients with disorders of the immune system.
* **Wound Infection**: The incision sites can become infected. While it typically resolves with antibiotics and local wound care, occasionally, part or all of the incision may open and require revision and or catheter replacement.
* **Treatment Failure**: Although usually associated with a high success rate, the procedure can fail in the immediate post-operative period, or months to years later.
* **Urinary Retention**: Retention is the inability to urinate and it occurs in fewer than 5% of cases. Usually, a patient is able to urinate normally within one to two weeks following the procedure. However, if retention is prolonged, a catheter may be necessary. You could learn to self-catheterize or simply have a urethral catheter placed back in for a few days at a time. It would periodically be removed to test whether you are able to urinate. We always encourage patients to be patient, because urinary retention usually resolves with time and observation. In rare instances of prolonged retention, a corrective procedure may be required. Factors which may delay the rapid return of voiding include: excessive sling tension, poor bladder function before the surgery, and multiple repaired organs (i.e. a dropped bladder, a dropped uterus, or a prolapsed rectum) during the same surgery. Urodynamic testing may need to be performed for further assessment.
* **Blood Loss/Transfusion**: The vaginal region is quite vascular. Usually blood loss in this procedure is minimal to moderate. In 1-2% of cases, blood loss can be significant enough to necessitate transfusion.
* **Ureteral Injury/Ureteral Kinking**: Enterocele repair procedures often utilize structures within the pelvis that are near or adjacent to the ureters (tubular structures that carry urine from the kidneys to the urinary bladder). When tension is placed on these structures the ureters can be drawn away from their normal position and partially or completely blocked by kinking. It is also possible to inadvertently injure the ureter by placing an instrument across it, a suture around it or cutting it with surgical instruments. Ureteral injury can be quite serious and requires prompt attention.
* **Organ Injury**: during any part of the surgical procedure, any organ in the abdomen or pelvis (liver, spleen, colon, intestine, bladder, stomach, ureter, etc.) can be inadvertently injured. Often the injury is minor and can be treated with relative ease. In other instances, when the injury is major or the repair is complicated, more extensive surgery may be necessary. Treatment depends on the particular organ injured and the severity of the injury.
* **Bowel/Rectal Injury**: It is possible to make a hole in the deeper tissue of the rectum or bowel. In almost all cases, the hole can be repaired, and there are no long-term problems. In severe injuries, we may ask for a consultation from a general surgeon to ensure that no other protective surgical measures should be undertaken.
* **Painful Intercourse and Vaginal Shortening**: After prolapsed surgery, the shape of the vaginal vault can change. In certain cases, the depth of the vagina may be lessened and the angle changed. While usually not a problem, some women may complain of pain or difficulty with intercourse. Sometimes it is temporary, but it can also be permanent.
* **Deep Vein Thrombosis (DVT)/Pulmonary Embolus (PE)**: In any operation (especially longer operations), you can develop a clot in a vein of your leg (DVT). Typically, this presents two to seven days (or longer) after the procedure as pain, swelling, and tenderness to touch in the lower leg (calf). Your ankle and foot can become swollen. **If you notice these signs, you should go directly to an emergency room and also call our office**. Although less likely, this blood clot can move through the veins and block off part of the lung (PE). This would present as shortness of breath and possibly chest pain. We may sometimes as the medical doctors to be involved with the management of either of these problems.
* **Sling Erosion**: It is possible for the sling material to erode through the tissue that surrounds it. If the vaginal tissue breaks down, the sling can often be removed with a minimal procedure. Often, the patient is still continent because scar tissue from the surgery will continue to support the urethra. On the contrary, if the back of the sling erodes into the urethra, the surgical removal is more involved, and the rates of incontinence afterward are higher.
* **Graft/Mesh Erosion**: It is possible for the permanent graft material to erode through the tissue that surrounds it. If the vaginal tissue breaks down, the graft may need to be removed with another operation. Removal of the graft may lead to repeat prolapse formation and in rare cases chronic pain.
* **Bleeding/Hematoma**: When a small blood vessel continues to ooze or bleed after the procedure is over, the area of collected blood is referred to as a hematoma. The body normally re-absorbs this collection over a short period of time, and surgical drainage is rarely necessary.
* **Lower Extremity Weakness/Numbness**: This, too, is a rare event that may arise due to your position on the operating table. It is possible in procedures in which you are in the lithotomy (legs up in the air) for a long period. The problem is usually self-limited, with a return to baseline expected; rarely is it permanent.
* **Chronic Pain**: As with any procedure, a patient can develop chronic pain in an area that has undergone surgery. Typically, the pain disappears overtime, although some feeling of numbness may persist. If persistent, further evaluation may be necessary.

If you would like a copy of the patent labeling from the manufacturer of the product used in your repair, please inform us and we will obtain a copy for you.

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