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Colposuspension for Stress Incontinence

A Guide for Women

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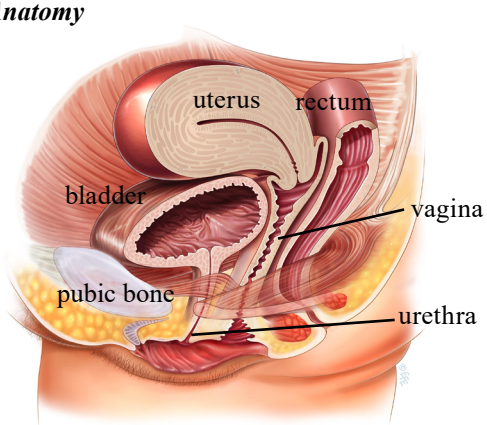
What is colposuspension?
Burch Colposuspension was first performed in 1961 for stress incontinence. Stress incontinence is the complaint of involuntary leakage of urine following exertion or effort, eg coughing, sneezing or exercise. It is a very common and embarrassing problem affecting up to 1 in 3 women. Stress incontinence may be cured or improved with pelvic floor exercises and lifestyle modifications, but if these strategies fail then surgery may be available to you.

Colposuspension is an operation that involves placing sutures (stitches) in the vagina on either side of the urethra and tying these sutures to supportive ligaments to elevate the vagina.

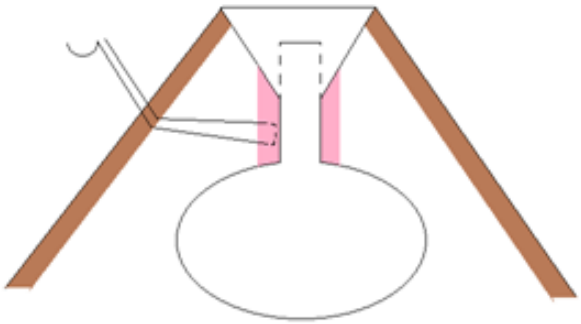
The urethra is the pipe through which the bladder empties. Normally, the urethral sphincter and muscles and ligaments around the urethra prevent involuntary leakage of urine but damage to these structures from childbirth and/or aging can lead to stress incontinence. The sutures in colposuspension elevate the vagina and support the urethra, thus reducing or stopping the leakage.

How is the operation done?
Most of the time, colposuspension is performed using an abdominal incision – a horizontal cut in the 'bikini-line'. Some surgeons may be able to perform the procedure laparoscopically or 'keyhole'. During the operation, the bladder and urethra are identified and the space behind the pubic bone is exposed. Sutures are then placed in the tissue to the side of the urethra and attached to the iliopectineal ligament – a supportive tissue behind the pubic bone. A cystoscopy (camera into the bladder via the urethra) is usually performed to ensure the sutures haven't been placed in the bladder. A drain may be left behind the pubic bone to prevent a haematoma – a mass collection of blood – forming. Additionally, a urinary catheter inserted via the abdomen – a suprapubic catheter – may be introduced.

Normal Anatomy



Colposuspension



Do I need an anaesthetic for the operation?
Yes. The operation is usually performed with you asleep (under general anaesthesia) although sometimes a spinal anaesthetic may be offered. You will get a chance to speak to the anaesthetist prior to your operation.

What are the chances of success of the operation?
One year following surgery, more than 80% of women will find that their stress incontinence has either improved or has been cured. Twenty years following surgery, approximately 60% remain satisfied with the outcome.

What complications can happen?
All operations are associated with risks of haemorrhage, infection, and venous thromboembolism (VTE). It is rare for transfusion to be required following colposuspension. The risk of acquiring infection is reduced by use of intravenous (IV) antibiotics when you are in the operating theatre. VTE generally means a blood clot in the leg veins or in the lung veins and may present with leg pain/swelling, shortness of breath, cough, or chest pain. The risk of VTE is reduced by use of compression stockings and injections of heparin post-operatively to thin the blood. There are also risks associated with anaesthetic which you can discuss with your anaesthetist.

The specific risks of colposuspension include:

- Failure to work (up to 20% at 1 year).
- Overactive bladder symptoms (an urgent feeling to pass urine which may lead to incontinence) occurs up to 17% of the time.
- Difficulty passing urine occurs in up to 10% of women. This usually improves but may be permanent. You may need to pass small catheters (clean intermittent self-catheterisation) to fully empty your bladder.
- Prolapse of the back vaginal wall (rectocele) affects 14% of women post-operatively.
- Difficulty with sexual intercourse may involve pain (5%) or a less intense orgasm due to the incisions and stitches in the vagina.

- Rarely, the stitches may erode into the bladder and require removal.

When can I return to my normal routine?
You should keep mobile to prevent the risk of VTE but avoid heavy lifting for the first few weeks post-operatively. Gradually build up your level of activity 6 weeks following surgery and by three months you will probably be 'back to normal'. Do not use tampons or have sexual intercourse for 6 weeks following surgery. You may be apprehensive about resuming sexual relations and may need to take your time and use lubricants.

Ensure you do not become constipated by drinking plenty of fluids and taking dietary fibre such as fresh fruit and vegetables, brown bread, and oats. You may drive again once you can safely make an emergency stop but you must check with your insurers before returning to the wheel to check your insurance is valid.

My bladder isn't too bad at the moment, but should I have an operation now to prevent it from getting worse in the future?
This operation is an option for women who are bothered by stress urinary incontinence. If the leaking does not bother you, you should not feel compelled to have surgery. Regular pelvic floor exercises are likely to reduce stress incontinence.

I haven't completed my family yet. Can I still have this operation?
It is probably advisable to have this surgery once your family is complete as a further pregnancy may undermine the operation's success.

Is there an alternative to this operation?
Yes. Lifestyle modifications, pelvic floor exercises, vaginal continence devices and other surgical options are discussed in the stress incontinence patient information leaflet.

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