Vaginal Hysterectomy and Repair Consent Form

This form should only be used if the patient has capacity to give consent. If the patient does not legally have capacity, please use an appropriate alternative consent form from your hospital or hub.

Note to patients: Please note it is common NHS practice for a patient's consent to be taken by a clinician other than the operating or listing surgeon. This clinician will be suitably trained and competent to take your consent. They will be referred to as your 'responsible healthcare professional' in this form.

You may have questions before starting, during or after your procedure. Contact details are provided for any further queries, concerns or if you would like to discuss your treatment further.

Patient details (print or sticker)

First name: _____ **Last name:** _____

Date of birth: _____ **Patient identifier:** _____

Responsible Healthcare Professional: _____

Special requirements: e.g., transport, interpreter, assistance _____

The patient has been given the following leaflets:

NICE Surgery for uterine prolapse Patient Decision Aid Yes No

British Society of Urogynaecology- Operations to treat Prolapse of the Uterus Yes No

Other leaflets- please specify:
British Society of Urogynaecology- Anterior Repair Yes No

British Society of Urogynaecology- Posterior Repair Yes No

Details of vaginal hysterectomy and repair

Vaginal hysterectomy and repair procedure:	This procedure involves an operation to remove the womb (uterus) and the neck of the womb (cervix) through the vagina without needing to make cuts on the abdomen. You will not be able to get pregnant after this operation. The repair may include either an anterior vaginal wall repair, posterior repair, perineorrhaphy or a combination of any of these. Pelvic floor repairs require the surgeon to open the vagina with a cut, then use special stitches to support a bulge in, or coming from the vagina, caused by poor support of the bladder, bowel or womb (a prolapse). Further stitches are then used to close the cut. An anterior repair is an operation performed within the vagina to treat an anterior (front) vaginal wall prolapse (also known as a cystocoele). A posterior (back) vaginal wall repair is an operation to reinforce the vaginal tissues between the vagina and the rectum (also known as a rectocele). A perineorrhaphy involves repairing the damaged part of the perineum (skin between the vagina and anus) immediately below the vagina. All of these repairs involve making a cut in the relevant vaginal wall, and reinforcing stitches being put into the supporting tissue. All the sutures are inside the vagina except the perineorrhaphy where some stitches will be outside, on the perineum.

Patient name: _____ **Patient unique identifier:** _____

Extra procedures:	☐ Saprospinous ligament fixation - This is where dissolvable stitches (sutures) are used to stitch the top of the vagina (vaginal vault) to the sacrospinous ligament. ☐ Cystourethroscopy and biopsy - This is where a small camera is inserted through the tube that connects the bladder to the outside (urethra) to look inside your bladder. A small sample (biopsy) of bladder wall may be taken at the same time, if required.
Indication for, and purpose of surgery: (Tick as appropriate)	☐ Prolapse - To treat and reduce the symptoms of prolapse (a bulge in, or coming from the vagina, caused by poor support of the bladder, bowel or womb) ☐ Investigation of lower urinary tract concerns (when cystoscopy and biopsy is also planned)
Alternatives considered: (Tick as appropriate)	**Nonsurgical management** ☐ **Pelvic floor muscle therapy (PFMT)** PFMT is a type of physiotherapy, which uses exercises to strengthen the pelvic floor muscles. Supervised PFMT has been shown to assist with symptoms of prolapse and can reduce mild and moderate prolapse severity. Some people feel they do not need surgical therapy after undergoing PFMT. ☐ **Use of pessaries for prolapse** Pessaries are plastic/rubber devices that can go into the vagina to try and support the prolapse and reduce its effects. They are not always suitable for all vaginal prolapse. **Alternative surgical options** ☐ **Colpocleisis** A colpocleisis is an operation to close the vagina. You will not be able to have vaginal sexual intercourse after this operation. It involves suturing together the front and back wall of the vagina, and if you have a uterus (womb), lifting it up slightly higher in the vagina. This operation is not always possible depending on the type and severity of prolapse. Your surgeon will be able to tell you if your prolapse is suitable for this operation. ☐ **Sacrohysteropexy** This is an operation that uses mesh (synthetic or biological) to lift up the uterus (womb) rather than remove it. This is particularly worth considering if you wish to maintain fertility but want treatment for the uterine prolapse. Synthetic mesh is similar to that used in hernia operations and will be covered in a

	layer of your own tissue called peritoneum. This operation is considered safe, but there is always the risk of mesh exposure and related complications. Your surgeon will be able to tell you more. Leaflets are also available from the British Society of Urogynaecology (BSUG) website, which describe this operation in more detail. ☐ **Vaginal sacrospinous ligament hysteropexy** This is another operation particularly worth considering if you wish to maintain fertility but want treatment for the uterine prolapse treated. Using dissolvable stitches (sutures), the uterus is lifted up rather than removed. This operation does not use mesh. Instead, the sacrospinous ligament is located via the vagina and stitches are put in it to sew the cervix onto the ligament. The stitches are slowly absorbed over time and they are eventually replaced by scar tissue, which then hopefully supports the vagina or uterus ☐ **Manchester repair** The neck of the womb (cervix) is removed and the womb (uterus) is slightly raised using synthetic stitches.

Surgical care during the coronavirus (COVID-19) pandemic

During the current coronavirus pandemic there are additional considerations regarding having an operation in a hospital or hub. We need to make you aware that your surgical care may be disrupted, delayed or performed different during the pandemic.

Despite precautions, coming into hospital might increase your chances of contracting COVID-19, and if you come into the hospital and test positive your operation may be cancelled. If COVID-19 infection occurs when you have surgery or while in hospital, this could make your recovery more difficult, or increase your risk of serious illness or death.

We will do everything we can to perform your operation, keep you safe, and to provide you with information at all stages. Your hospital or hub site will provide you with key information regarding infection control, risks and responses and any further relevant information to you.

Additional resources

Information for you about treatment of uterine or vaginal prolapse – British Society of Urogynaecology

https://bsug.org.uk/pages/for-patients/bsug-patient-information-leaflets/154

Anterior vaginal wall repair without the use of mesh – British Society of Urogynaecology

Posterior vaginal wall repair without the use of mesh – British Society of Urogynaecology

Patient name:

Patient unique identifier:

Information for you after a vaginal hysterectomy – Royal College of Obstetricians and Gynaecologists

https://patient.concentric.health/info/662t

Information for you after a pelvic floor repair – Royal College of Obstetricians and Gynaecologists

https://patient.concentric.health/info/8x8t

If you do not wish to access the additional patient information contained within this consent form digitally, please speak to your responsible healthcare professional and they will provide you with hard copies. These will be provided in a language and format that suits you.

Anaesthesia

Anaesthetic is used to allow surgery to take place painlessly. It may include medicines that put you to sleep, or those which only numb the area being operated on while you remain awake. This can be done in various ways and your anaesthetist will advise you on your options and talk to you about the risks, complications and benefits of your choice. There is no legal requirement to obtain written consent for the type of anaesthesia given to a patient; this section of the consent form is for your information only.

On the day of surgery, an anaesthetist will discuss anaesthetic options and risks with you. This is a shared decision-making process, and you will jointly decide and agree the anaesthetic option that is best for you. Please remember that if there are any complications during surgery, your anaesthetist may need to alter the type of anaesthesia and they will explain this to you during the procedures.

For further information about the types of anaesthetic you may receive, and potential risks, please see the information below.

Types

Risks

https://www.rcoa.ac.uk/documents/anaesthesia-explained/types-anaesthesia

https://www.rcoa.ac.uk/sites/default/files/documents/2019-11/Risk infographics_2019web.pdf

If you do not wish to access the additional patient information via link or QR code, please speak to your responsible healthcare professional and they will provide you with a hard copy. These will be provided in a language and format that suits you.

Patient name: _____

Patient unique identifier: _____

TO BE FILLED OUT BY CLINICIAN ON THE DAY OF SURGERY:

Name of anaesthetist on the day: Date: _____

_____

□ I confirm I have discussed the different anaesthetic options with the patient, including risks and benefits, and we have jointly decided the preferred anaesthetic.

Please note the preferred methods of anaesthesia as discussed between the patient and anaesthetist below:

You will be told of any additional procedures in addition to those described on this form that may become necessary during your treatment. Please list below any procedures **YOU DO NOT WISH TO BE CARRIED OUT** without further discussion.

Patient name: **Patient unique identifier:**

Immediate risks (during the procedure)

(Your responsible healthcare professional will delete as appropriate)

Expected	**Vaginal bleeding** A small amount of bleeding, which is usually less than a mugful of blood, is to be expected.
Common (more than 1 in 20)	
Uncommon (fewer than 1 in 20)	**Perioperative risks (risks around the time of your operation)** With any operation, there is an increased risk of several perioperative complications. These include allergies and risks of having an anaesthetic, which will be discussed with you by an anaesthetist. Other complications include a chest infection, problems with the heart (including a heart attack), stroke, memory problems or worsened kidney function. Any existing medical problems could also get worse. You might need to stay in hospital for longer, or need additional treatment. In some cases, you will need admission to intensive care, and the complications may be life-threatening. **Significant bleeding** Some bleeding is expected during most procedures; however, significant bleeding may require further treatment. It can usually be dealt with during the procedure, but may lead to a change from the planned procedure, a blood transfusion, or further emergency treatment.
Rare (fewer than 1 in 100)	**Compression injury** A compression injury describes any damage caused by pressure to tissues such as skin or nerves. This type of injury can occur in the operating theatre as you are lying in one position for several hours. Any areas that are at risk, such as bony prominences, are padded during surgery to reduce the risk of compression injury. If this does occur you may experience numbness or a tingling sensation in the affected area. This is usually temporary. **Damage to surrounding structures** Other nearby organs and structures are at risk of being injured during surgery. For this operation there is a risk of injury to the bladder, the ureters – the tubes which carry urine from the kidneys to the bladder, the bowel and to major blood vessels in the area. In the very rare circumstance of significant injury this would usually be repaired immediately and this may need a cystoscopy (camera to look inside the bladder),a larger cut in the tummy (abdomen) and the damaged item repaired. Very rarely, a stoma is needed. This is when a hole is made on the front of your tummy (abdomen) to divert faeces or urine into a bag outside the body. If your bladder is injured, you would usually have a catheter inserted for 7–14 days after surgery. There is a risk of any damage not being noticed at the time of surgery. This would lead to symptoms in the days following surgery, and possibly further surgery. **Blood clots** Different techniques are used to reduce the risk of blood clots forming; however, these can still arise during surgery.
Specific risks to you from your treatment (to be input by your responsible healthcare professional)	

Patient name: **Patient unique identifier:**

Early and late risks (in the days, weeks or months after the procedure)

(Your responsible healthcare professional will delete as appropriate)

Expected

Pain
It is normal to have some mild pain or discomfort in the vagina.

If a sacrospinous ligament fixation is carried out, pain in the buttock cheek on the side where the ligament is 'fixed' occurs for between 1 and 3 patients out of 20.
.
Pain is common after surgery but again, this may be reduced by a lot of local anaesthesia given during surgery and/or additional regional anaesthetic, such as a spinal anaesthetic extra to the general anaesthetic. The local anaesthetic and spinal anaesthetic tend to last a few hours longer than the general anaesthetic alone allowing a longer pain-free duration.

In the days and few weeks after surgery, you may feel some discomfort rather than pain and should be able to carry out routine care of yourself. If you are unable to control the pain, please contact your GP or the hospital to organise appropriate care.

Vaginal bleeding
Vaginal bleeding is when blood is passed from the vagina. Some bleeding should be expected for up to a week after surgery. Pads should be used rather than tampons to reduce the risk of infection. If the bleeding becomes heavier – more like a period – please get in touch with your clinical team as you might have developed an infection or a problem that needs treatment.

Common
(more than 1 in 20)

Urinary infection (water infection or cystitis)
A urinary tract infection (UTI) is an infection of the urine. It often leads to discomfort when passing urine, and can make you feel like you need to pass urine more often. UTIs just affect your bladder but can sometimes lead to more serious infections, including blood infections (sepsis).

Vaginal infection
The area that has been operated on can become infected with bacteria from your vagina, or because of blood collecting in your vagina behind the stitches.

Both urinary and vaginal infections can be managed with antibiotic tablets, but sometimes antibiotics may need to be given through a drip (though a tube inserted into your vein). This may mean you have to stay in hospital. During most operations, some antibiotics are given to reduce the risk of infection anyway.

Wound complications
The risk of developing a wound infection is higher in some patients, including those who are obese, are smokers, and patients with diabetes.

If you feel unwell with a high temperature or any signs of infections including, but not limited to those highlighted here, please go to your local Accident & Emergency Department for a review as this may need urgent treatment and admission.

Urinary symptoms
Bladder emptying and overactive bladder symptoms (feeling an urgent need to pass urine) tend to improve after prolapse surgery. However, some bladder symptoms can worsen after surgery:

- Stress incontinence symptoms (where urine leaks on coughing, laughing, etc.) worsen in around 1 in 10 people after repairing a prolapse. This is because the prolapse may have caused a kink in the urethra (the tube through which urine is passed). Repairing the prolapse may remove the kink and expose the underlying weakness in the urethra.
- Bladder emptying problems usually improve after surgery, but some difficulties continue in 1 in 10 patients. You might have more difficulty passing urine in the first 48 hours after prolapse surgery, and this is managed by having a catheter inserted for a few days. The catheter can usually be removed within a week of surgery when normal bladder function has resumed.

Recurrence of prolapse symptoms (1 in 3 chance)
Symptoms that were initially treated by the procedure may come back and further investigations or treatment may be needed to reduce these symptoms in future. A recurrence of prolapse is seen in 1 in 3 patients. Sometimes, symptoms are not significant enough to consider further surgical treatment, but further prolapse surgery can be done if required.

Dyspareunia (pain during sex)
Most women find that dyspareunia, the medical term for experiencing pain during sex (sexual intercourse), improves after prolapse surgery. Sex should be avoided during the first 6 weeks as the area heals. The procedure makes the vagina narrower, and sometimes shorter, so some discomfort should be expected during the following weeks.

Altered sensation during sexual intercourse (if vaginal wall repair being done for prolapse)
Some women report reduced sensation during sex (sexual intercourse) after the operation, or feel that the vagina is

	too short or too tight. On the other hand, others report that sex is significantly improved after prolapse surgery.
Uncommon (fewer than 1 in 20)	**Need for more surgery** If there are complications after the operation, you may be advised to have another operation during your hospital stay. This would usually be to treat continued bleeding, to drain a collection of blood or pus at the top of the vagina, or because of wound complications. **Constipation** Constipation is when it is difficult to empty your bowels, or if bowel motions are less frequent than usual. Constipation tends to improve after posterior wall prolapse. It can cause pain when opening your bowels, or abdominal pain or discomfort. Drinking plenty of fluids can help to ease any symptoms of constipation. Some suppositories (medication that is inserted into the rectum) can help open your bowels 2 days after surgery. It is important to avoid constipation following surgery to reduce the risk of prolapse occurring again. Your GP may even start you on regular laxatives if they feel your constipation s a problem. **Vaginal vault prolapse** A vaginal vault prolapse is where the top of the vagina (vaginal vault) drops down into the vaginal canal. If this occurred, you may need a pessary for support (described above) or further surgery. **Vaginal vault dehiscence** A vaginal vault dehiscence is where the line of stitches (sutures) at the top of the vagina come apart. This usually needs emergency surgery to securely re-suture the top of the vagina.
Rare (fewer than 1 in 100)	**Blood clots (deep vein thrombosis or pulmonary embolus) (1 in 300 chance)** Blood clots can form in the veins of the legs (deep vein thrombosis), causing pain and redness in the leg. These are more likely to occur after an operation, when people move around less. These clots can occasionally also travel from the legs to the lung (pulmonary embolus) and can cause problems with breathing. Clots in the leg or lung require treatment such as with blood thinning medications. Your risk of getting a blood clot is reduced by getting moving as soon as you can after an operation. To reduce the risk of clots, you will most likely be advised to wear compression stockings or calf compression pumps and have blood thinning injections following surgery. **Death** There is a risk of dying either as a direct result of the procedure or treatment, or from complications in the following days or weeks. The risk depends on many factors, including your age and any underlying medical problems you may have.
Specific risks to you from your treatment (to be input by your responsible healthcare professional)	

Patient name: **Patient unique identifier:**

Statement of health professional

- I am suitably trained and competent and have sufficient knowledge to consent this patient in line with the requirements of my regulatory body.
- I have discussed what the treatment is likely to involve, the benefits and risks of this procedure.
- I have also discussed the benefits and risks of any available alternative procedures or treatments including no treatment.
- I have discussed any particular concerns of this patient.

☐

Copy of consent form accepted by patient: ☐ Yes ☐ No

Signature: **Date:**

Name: **Job title:**

Statement of patient

Please read this form carefully. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

- I agree to the course of treatment described on this form.
- I have had the benefits and possible risks of treatment explained to me.
- I have had the opportunity to discuss treatment alternatives, including no treatment.
- I understand that a guarantee cannot be given that a particular person will perform the procedure. The person will, however, have appropriate expertise.
- I understand I have been/will be given the opportunity to discuss my anaesthetic options with an anaesthetist, and we will jointly decide which option is best for me. I understand that the type of anaesthesia may need to be altered if there are any complications during the procedure.
- I have been told about additional procedures that are necessary prior to treatment or may become necessary during my treatment. This may include permanent skin marks and photographs to help with treatment planning and identification.
- I understand that there may be people present for my procedure who are learning, such as junior doctors, medical students, and trainee nurses, and that I may decline to have any of these people present.

☐ I agree that people who are learning, such as junior doctors, medical students and trainee nurses may participate in examinations if supervised by a fully qualified professional.

☐ I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

☐ I understand that information collected during my procedure/ treatment, including images and video, may be used for education, audit and research (which may be published in medical journals). All information will be anonymised and used in a way that I cannot be identified.

☐ I agree that my health records may be used by authorised members of staff, who are not directly involved in my clinical care, for research approved by a research ethics committee and in compliance with the Data Protection Act (2018).

☐ I understand that patient specific data will be collected and may be used in the context of providing clinical care, in compliance with the Data Protection Act (2018).

☐ I confirm that I have read and understood pages 1 to X of the consent form above.

Please inform your responsible healthcare professional if you wish to withdraw consent for information use.

Statement of interpreter / witness (where appropriate)

□ I have interpreted the information contained in the form to the patient to the best of my abilities and in a way in which I believe they can understand.

or

□ I confirm that the patient is unable to sign but has indicated their consent.

Name:

Signature:

Patient name:

Patient unique identifier:

Tick if relevant

☐ I confirm that there is no risk that I could be pregnant.

Please inform your responsible healthcare professional and/or your clinical care team on the day of your procedure if you could be pregnant. Please note that a pregnancy test may give a negative result if a pregnancy has occurred within 2 weeks of the test.

Date:

Name (PRINT):

Signature: