Vaginal hysterectomy and repair consent form

This form should only be used if the patient has capacity to give consent. If support is required with consent (interpreter, witness, carer, guardian, parent, or any other relevant support) please ensure they are present. If the patient does not legally have capacity, please use an appropriate alternative consent form from your hospital or hub. This form will be the result of a shared decision conversation between a clinician and patient. "You / your / me / my" hereby refers to the patient.

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

You will be provided with additional patient information about your procedure by your hospital or hub site. These will be provided in a language and format that suits you.

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. The risks quoted in this consent form for surgery assume that you have no additional factors which would increase your risk. The clinician discussing the consent with you will explain if you have health conditions or factors that may increase your risk.

Your details (Print or sticker)

First name:

Last name:

Date of birth:

NHS or Hospital number:

Responsible Health Professional:

My requirements: e.g, transport, interpreter, assistance

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 and will not have periods.

The repair may include either an anterior vaginal wall repair, posterior vaginal 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, which is where the bladder drops into the vagina). A posterior (back) repair is an operation to treat the posterior (back) vaginal wall prolapse (which may involve a rectocele, the rectum pushing into the vagina, and/or an enterocele, the bowel pushing into the vagina).

A perineorrhaphy involves repairing the damaged part of the perineum (area between the vagina and anus) immediately below the vagina. There will be stitches deeper in the muscle and some on the skin of the perineum.

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.

Extra procedures:
(Tick as appropriate)

- ☐ **Saprospinous ligament fixation** – This is where dissolvable stitches (sutures) are used to stitch the top of the vagina (vaginal vault) to the sacrospinous ligament.
- ☐ **McCall culdoplasty** – After removal of the uterus, this procedure helps to support the vagina by attaching the uterosacral ligaments (the ligaments connecting the cervix to the bony pelvis) from both sides to each other.

Continued…

Patient name: _____ **NHS or Hospital number:** _____

Details of vaginal hysterectomy and repair continued

Extra procedures:
(Tick as appropriate)

- ☐ **Uterosacral ligament suspension/plication** – If the uterosacral ligaments are weakened, then tightening them (plication), or stitching them to the top of the vagina (suspension), can help to support a prolapsed vagina or uterus.
- ☐ **Cystourethroscopy** – 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.
- ☐ **Other(s)** _____

Indication for, and purpose of surgery / benefits:
(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).
- ☐ **Other(s)** _____

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 be inserted 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 synthetic mesh 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 to consider if you wish to maintain fertility but want treatment for the uterine prolapse. 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 are eventually replaced by scar tissue, which then supports the vagina or uterus.
- ☐ **Open or laparoscopic subtotal hysterectomy with mesh sacrocervicopexy** – The body of the uterus is removed with the fallopian tubes with or without the ovaries, depending on your choice after being informed of the benefits/risks by your surgeon, with the remaining cervix sutured to a synthetic mesh to lift up the cervix rather than remove it.
- ☐ **Manchester repair** – The neck of the womb (cervix) is removed and the womb (uterus) is slightly raised using stitches. The stitches are slowly absorbed over time and they are eventually replaced by scar tissue, which then supports the vagina or uterus.
- ☐ **Other(s)** _____

Patient name: _____ **NHS or Hospital number:** _____

Possible early or short-term risks

Expected
Will probably happen

Vaginal bleeding A small amount of bleeding, which is usually less than a mugful of blood, is to be expected.

Uncommon
Unlikely to happen (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
Probably won't happen (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 structure 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. An example of such a missed complication is trauma to the bowel or bladder causing a fistula. This is an abnormal connection of the bladder or bowel directly to an organ, such as the vagina. This may cause faeces or urine to leak into the vagina.

Blood clots (deep vein thrombosis or pulmonary embolus) Different techniques are used to reduce the risk of blood clots forming; however, these can still arise during 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.

Patient name: _____ **NHS or Hospital number:** _____

Possible late or long-term risks

Expected
Will probably happen

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 Some bleeding should be expected for up to a week or two 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
Might happen (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.

Early menopause Early menopause is when periods stop before the age of 45. In some patients it occurs naturally, but in others it can be a risk of some treatments or procedures. There is around twice the risk of early menopause after a vaginal hysterectomy than if the procedure is not done. Symptoms may require hormone replacement therapy.

Possible late or long-term risks continued

Uncommon
Unlikely to happen (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 is 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
Probably won't happen (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.

Unable to resolve symptoms Sometimes the symptoms of prolapse do not improve despite this surgery. You will need to be reassessed to see if the anatomy has been restored completely and if so, look at other causes of the symptoms.

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.

Patient name: _____ **NHS or Hospital number:** _____

Patient specific risks

Patient Specific Risks	

Patient specific concerns

If you have any **specific concerns or personal risks** to you from your treatment, you can record them here. Please use this space to **record any concerns around allergies / reactions** and also any life saving **procedures that you do not wish to be carried out** without further discussion.

Any extra procedures which may become necessary during the procedure:

☐ Blood transfusion:

☐ Other procedures (please specify): _____

Patient name:

NHS or Hospital number:

Statement of healthcare professional

(to be filled in by health professional with appropriate knowledge of proposed procedure)

– 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 discussed the benefits and risks of any available alternative procedures or treatments including no treatment.
– I have considered any additional patient-specific factors and discussed these with the patient alongside their particular concerns.
– I can confirm that the patient has the capacity to give consent.

Patient information leaflet provided: ☐ Yes / ☐ No – Details:

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

Name:

Job title:

Date:

Signature:

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.

You must consent to the following section to proceed with your surgery:

– I confirm that I have read and understood pages 1 to 5 of the consent form.
– I understand the diagnosis and agree with the course of treatment described on this form.
– I have had the opportunity to discuss treatment alternatives, including no treatment.
– I have had the purpose, aims and possible risks of treatment explained to me.
– I understand that the operating person, who will have appropriate expertise to carry out the procedure, may not have been involved in my pre-operative assessment or care to date.
– I understand my anaesthetic options will be or have been discussed with an anaesthetist where 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 which are necessary prior to treatment or may become necessary during my treatment. This may include permanent skin marks, photographs, and / or tissue samples to help with treatment planning and identification.
– 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 have spoken to my health care professional about any lifesaving procedures I do not wish to happen.
– I understand that relevant and appropriate patient specific data for this procedure will be collected and may be used in the context of providing clinical care, and/or audit purposes in compliance with Data Protection Act (2018).

Statement of: interpreter witness

(where appropriate)

☐ I have interpreted the information contained in this form to the patient to the best of my ability 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:

Additional Consent: ***This section will not stop you from receiving surgery but will help with future learning and training.*** **Please tick if you consent:**

☐ I understand that there may be health care professionals that are training during my procedures such as medical students, and trainee nurses. I consent that they may participate in examinations relevant to my procedure, supervised by a fully qualified professional.

☐ I understand that information collected during my procedure including images, may be used for education 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).

Tick if relevant: ☐ I confirm that there is no risk that I could be pregnant.

Name:

Date:

Signature:

Patient name: **NHS or Hospital number:**

Anaesthesia

Anaesthetic is used to allow surgery to take place painlessly. It may include medicines which put you to sleep or those which only numb the area you are having operated on while you remain awake. This can be done in a variety of ways and your anaesthetist will advise you on your options and talk to you about the risks, complications, and benefits of types of anaesthetic. Further if there are particular anaesthetic risks/concerns for any particular patient these should be separately documented in the patient's records.

Anaesthetic options and risks will be discussed with you on the day of surgery with an anaesthetist. This is a shared decision-making process, and you will jointly decide and agree which anaesthetic option 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 will explain this to you during the procedure.

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

Types

Risks

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

https://www.rcoa.ac.uk/patient-information/patient-information-resources

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

To be filled out by Anaesthetist (On day of surgery)

Name of Anaesthetists 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 what the preferred anaesthetic is.

Please note the preferred method of Anaesthesia as discussed between the patient and anaesthetist below:

Signature:

To be filled out by your responsible healthcare professional (On day of surgery)

Reconfirmation of consent / Withdrawal of consent (where appropriate)

Reconfirmation of consent: ☐ Withdrawal of consent: ☐ See advance decision to refuse treatment: ☐

Name: **Date:**

Signature: