Stanford HEALTH CARE

Los Olivos Women's Medical Group

Explanation of Risks for Pelvic Prolapse and Incontinence Surgery

I have read, and have signed the Consent to Surgical Treatment. I understand the general surgical risks of infections, hemorrhage, blood transfusion, drug reaction, blood clots and injury to other organs.

The following are more specific risks of pelvic prolapse and/or urinary incontinence surgery.

A. Possible complications:

1. Failure to correct incontinence and recurrence of incontinence. Surgery to correct urinary incontinence has significant failure and recurrence rates. Failure rates for incontinence surgery can be as high as 15-20% initially and increase with time, as high as 30% or more within 10 years after surgery. Recurrence rates after initially successful surgery may also be in that range. Repeat operations for recurrent urinary incontinence may have higher failure, recurrence, and complication rates.

2. Recurrence of vaginal wall prolapse: Recurrence of vaginal wall prolapse may occur any time after surgery despite proper performance of the surgery. This has to do with the elasticity of the tissues being operated upon, age, weight, and general health of the patient, and for reasons not entirely understood. There is a significant recurrence rate for prolapse after surgery, up to 25-50%. Recurrent prolapse may be treated conservatively or with additional surgical procedures, which may cause even lower success rates or high complication rates.

3. Irritative voiding symptoms: Irritative voiding symptoms including pain, pressure, frequency, nocturia (voiding in the middle of the night) may be a result of incontinence surgery. These symptoms are usually transient, but may be permanent. Treatment is with antispasmodic medications. If obstruction of the bladder neck is present, catheterization or repeat surgical procedures may be necessary to relieve the obstruction.

B. Additional, but rare, complications:

1. Injury to the bladder or ureter: This may occur during hysterectomy or repair or anterior vaginal wall prolapse (cystocele), or bladder neck repairs for urinary incontinence surgery. Injury to the bladder may require prolonged urinary catheterization and may result in bleeding, infection, or infrequently, fistula into the vagina (urine comes out through a hole into the vagina), and painful or frequent voiding. Injuries to the bladder usually heal well, but may result in prolonged catheterization or major surgery to correct the injury, including permanent damage to the ureter or kidney.

2. Bladder neck obstruction: Obstruction to the flow of urine is a known complication of surgery to correct urinary incontinence. Obstruction may be temporary, or permanent, requiring additional surgical procedures to reliever the obstruction. Initially obstruction is usually treated with urinary catheters, either indwelling, or the patient is taught to catheterize herself several times a day until the obstruction is relieved. "Sling" procedures carry a higher risk of obstruction than traditional bladder neck elevation procedures, as high as 25% in some reports. Catheters may be required for weeks after surgery until voiding becomes normal, or a decision is made to re-operate to relieve the

obstruction. Operations to relieve bladder neck obstruction may not be entirely successful or multiple surgeries may be necessary. Permanent symptoms of obstruction including pain, pressure, urgency, and frequency may result.

3. Stricture of the vagina: Stricture, or narrowing, of the vagina may occur as a result of surgery to repair vaginal wall prolapse. This stricture may cause pain and difficulty with sexual intercourse. Stricture may be treated by vaginal dilatation or may require additional surgical procedures, including possible skin grafting. Stricture may be difficult to correct surgically and may result in permanent symptoms.

4. Injury to the bowel/rectum: This may occur during hysterectomy or repair or posterior vaginal wall prolapse (rectocele). A fistula (hole) may result in stool coming out into the vagina, requiring a temporary colostomy (surgery to divert the stool into a bag). Incontinence (leakage) of stool or gas may be a permanent result of rectal sphincter injury. More extensive surgery or resection (cutting out) of a portion of the bowel may be necessary for significant injury to a portion of the bowel.

5. Infection, rejection, or erosion of graft material into the vagina, bladder, or rectum: Graft materials, either synthetic, or natural, may sometimes be used for anti-incontinence operations or to reinforce the surgical repair of prolapsed, or sagging vaginal walls. The graft material may become infected, and/or erode, slough, or become visible, through the vaginal wall, necessitation additional surgical procedures to remove the exposed portion or the graft, or remove the graft entirely. The graft may also erode into the bladder or rectum, necessitating additional procedures to remove the graft and repair the affected organ. Permanent damage to the vagina, bladder, or rectum may result. Surgical procedures to do so carry additional risk or failure to correct incontinence or prolapse, injury to adjacent structures, fistula, and other complications as listed above.

6. Injury to the lumbo-sacral spine and pelvic nerves: This may occur secondary to either positioning of the body required for vaginal surgery or from retractors used for abdominal surgery. Injury to the discs is unlikely and rarely injury may occur to the nerves themselves. Symptoms may include back, buttock, pelvic, leg or foot numbness and/arising to these structures are usually transient but rarely, may be permanent.

I understand that this is elective surgery in an attempt to improve my prolapse or incontinence symptoms. I have read the above information on this consent form and I am satisfied with my understanding of it. I have had an opportunity to ask questions concerning the above items and am satisfied with my understanding of the above described risks and complications.

Patient Signature:_____

Physician: _____ Date: _____