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THE FEASIBILITY OF VAGINAL PROLAPSE SURGERY IN DAYCARE

Hypothesis / aims of study

In the Netherlands women are usually admitted to the hospital for several days when vaginal prolapse surgery is planned. An exception is the TVT procedure, which is increasingly performed on a daycare basis. However, complication rates during and shortly after vaginal surgery are low. We studied if vaginal prolapse and anti incontinence surgery in daycare is feasible and acceptable for patients.

Study design, materials and methods

From January 2003 to February 2004 a total of 91 consecutive women underwent surgery for urinary incontinence, vaginal prolapse or both in a daycare setting. The inclusion criteria were ASA 1 or ASA 2 patients with urinary incontinence and or vaginal/uterine prolapse, who completely understood the written information and who had assistance at home after surgery from one of their relatives. The surgery consisted of various combinations of TVT, anterior colporrhaphia, posterior colporrhaphia and sacrospinous ligament fixation of the prolapsed uterus or vaginal cuff. All the surgery was done under spinal analgesia or general anesthesia. No vaginal hysterectomies were performed.

The preoperative procedure consisted of a consultation with the surgeon, detailed written information about the procedure and the period at home, a perioperative medication schedule (rofecoxib 25 mg before surgery and two times daily afterwards if needed, ondansetron 8mg once before surgery and paracetamol freely up to 4 times 1000 mg a day). All surgeries were performed in the morning and the patients could leave after they were mobile.

In case of a single TVT procedure, the woman left the operating room without a bladder catheter. After the first micturition a postvoidal residue was measured with a single bladder catheterization. If a postvoidal residue in excess of 100 milliliters was found on two occasions, an indwelling bladder catheter was placed and the woman was discharged. In case of vaginal prolapse surgery an indwelling bladder catheter was left for 3 days and a vaginal pack was placed. The woman was instructed to remove the vaginal pack 24 hours after surgery. All women received a direct telephone number of the gynecology department in the University Hospital, which was available to them on a 24 hour basis.

The evaluation was 3 days after surgery. All women completed a questionnaire that consisted of questions about the logistics around the surgery, satisfaction, pain (visual analogue scale from 0 = no pain to 10 = unbearable pain), number of rofecoxib and paracetamol tablets used, and recommendation to others. In the analysis we compared women with an isolated TVT procedure to those with additional or other genital prolapse surgery. A second analysis was done for women who had a sacrospinous ligament fixation (SSF) as compared to those who had not. We expected the most problems with daycare surgery in women who had more invasive surgical techniques performed, especially the SSF. Chi-square statistics and comparison of means with a t-test were performed in SPSS 10.0 database.

Results

A total of 56 women (62%) had isolated TVT procedure, 13 women had a TVT procedure with additional genital prolapse surgery (8 anterior colphorrhapia, 1 anterior/posterior colphorrhapia, 1 posterior colphorrhapia and 3 anterior colphorrhapia/SSF). A total of 16 SSF were performed, all with additional prolapse or TVT surgery. All women were discharged the same day except for one who had a peri-operative blood loss of over 400 ml. She was transferred to the University Hospital for observation and discharged the following day.

Table 1 shows the results of the questions regarding the satisfaction about the whole procedure. In addition, 81 women (89.0%) would recommend to others to have their surgery done in this way, 8 women (8.8%) did not know whether they would or not, and 2 women would not advise it. When comparing women who had a isolated TVT procedure to the others, no difference in recommendation figures were found (Pearson Chi-square p =0.68). This also applied when comparing women with a sacropinous ligament fixation to the others (Pearson Chi-square 0.33)

The mean pain score for the whole group was 3.1 (SEM 0.3), the number of rofecoxib tablets used 3.0 (SEM 0.24) and paracetamol 500 mg 3.0 (SEM 0.4). When comparing women who had an isolated TVT procedure to the others, the mean pain score (TVT 2.95 and others 3.42) did not significantly differ (t-test p = 0.446). Again, when comparing women who had a SSF to those who had not, no significant difference in pain score was found (SSF 4.26 versus others 2.89, t-test p = 0.152). However, the number of rofecoxib (t-test p = 0.018) and paracetamol (t-test p=0.045) used, were significantly higher in the SSF group.

Table 1 Satisfaction with the procedure

	Satisfied	Satisfied, but could improve	Moderately satisfied	Dissatisfied
Satisfaction				
Preoperative information	90.1	8.8	1.1	
Preoperative preparation	86.8	8.8	2.2	2.2
Care on operation day	97.8	2.2		

Values are percentages

Interpretation of results

Over 90% of women were very satisfied with the operative procedure in daycare and would recommend it to others. With an adequate analgesia regiem, the pain can be minimilized. Athough a more complex operative procedure, like the sacrospinous ligament fixation, produces more pain, the pain score is not significantly higher as compared to other surgery. Furthermore, this slight increase in pain does not affect satisfaction and recommendation figures.

Concluding message

In otherwise healthy, well prepared and informed women, daycare surgery for most vaginal genital prolapse and incontinence surgery is very well tolerated. By reducing the numbers of nights spend in Hospital to almost zero, this approach reduces the costs of health care substantially.