Patient information and consent to colposuspension for stress urinary incontinence

Key messages for patients

- Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation. You will need to starve for six hours before the operation and drink only clear fluids; water is best for three hours before, the staff will advise you the times for this.

- Please read this information carefully, you and your health professional will sign it to document your consent.

- It is important that you bring the consent form with you when you are admitted for surgery. You will have an opportunity to ask any questions from the surgeon or anaesthetist when you are admitted. You may sign the consent form either before you come or when you are admitted.

- Please bring with you all of your medications and its packaging (including inhalers, injections, creams, eye drops, patches, insulin and herbal remedies), a current repeat prescription from your GP, any cards about your treatment and any information that you have been given relevant to your care in hospital, such as x rays or test results.

- Simple painkillers such as paracetamol and ibuprofen may be required after surgery. Simple bowel medication such as senna and lactulose may be required after surgery. It is suggested that you discuss with your pharmacist and have a seven day supply of these medications at home to take as you need according to the instructions.

- Take your medications as normal on the day of the procedure unless you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. If you have diabetes please ask for specific individual advice to be given on your medication at your pre-operative assessment appointment.

- Please call the urogynaecology nurse specialist on telephone number 01223 245151 and ask for bleep 159216 or 157952 if you have any questions or concerns about this procedure or your appointment.

After the procedure we will scan the consent form in your electronic medical notes and you may take this information leaflet home with you.

Important things you need to know

Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist, unless the urgency of your treatment prevents this.
We will also only carry out the procedure on your consent form unless, in the opinion of the health professional responsible for your care, a further procedure is needed in order to save your life or prevent serious harm to your health. However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form.

We are unable to guarantee that a particular person will perform the procedure. However, the person undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 2018 and the resultant General Data Protection Regulations (GDPR).

**About Colposuspension for stress urinary incontinence**

Colposuspension is an operation to correct stress urinary incontinence (SUI). This is the leakage of urine caused by an increase in pressure in your abdomen (tummy) when you cough, sneeze, exercise or lift something heavy. It is due to poor closure of the bladder neck or weakness in the pelvic floor muscles supporting the bladder neck.

Colposuspension involves putting stitches on either side of the bladder neck to support and prevent downward movement during periods of increased abdominal pressure. The procedure is done under a general anaesthetic or a spinal anaesthetic (when you are awake but numb from your tummy down to your toes). It is usually done through a horizontal ‘bikini-line’ cut on your abdomen about 10cm long but can also be performed using ‘keyhole’ (laparoscopic) surgery. The abdomen is opened to reach the bladder and stitches are placed on either side of the bladder neck which are then tied to the strong fibrous tissue (Cooper’s ligament) attached to the pubic bone on each side.
Intended benefits

- The aim of this procedure is to cure or improve stress urinary incontinence. It will not improve symptoms of urinary frequency and urgency.
- It improves symptoms in 80 out of 100 women in whom it is performed. (Long term cure rates are seen in 70 out of 100 women).

Who will perform my procedure?

This procedure will be performed by a consultant urogynaecologist or a qualified doctor undergoing training under the direct supervision of the consultant.

Preparing for your operation

You should maintain a sensible diet. Daily exercise in the run up to the operation will improve your recovery. A 30 minute brisk walk, three to four times a week should be sufficient. Swimming is a good alternative. Avoid alcohol and cigarettes in the month before the operation.

Discuss the operation with your GP and get her/him to review your medications. Medications such as low dose aspirin and non-steroidal anti-inflammatory drugs (such as Ibuprofen [Nurofen], Diclofenac [Voltarol]) should be stopped at least seven days before the operation. It is recommended that you stop blood thinning medication such as warfarin and use an alternative drug (low molecular weight heparin) before the operation. Hormone replacement therapy and the oral contraceptive pill should be stopped four weeks before your surgery and are not recommended until six weeks after your operation. We would recommend you use a different form of non-hormonal contraception (such as condoms); pregnancy may have an adverse effect on the surgery and you may have to have a caesarean section delivery. You can discuss this with your consultant or your GP. If you are on medication for high blood pressure you should arrange to have your blood pressure checked by your GP prior to your surgery.

If you have any symptoms of a cold, ‘flu,’ cough or ‘stomach bug’ in the days leading up to the operation you must let your surgeon know, as this may necessitate the cancellation of your operation.

In the two days before the operation take plenty of fluids. It is important to avoid dehydration in the days before the operation.

Before your procedure

You will be required to attend a pre-admission clinic, when you will meet a member of the urogynaecology team. At this clinic, we will ask for details of your medical illnesses and carry out necessary clinical examinations and investigations. This is a good opportunity for you to ask us any questions about the procedure, and feel free to discuss any concerns you might have at any time. You will be provided with a copy of the procedure specific information leaflet and the consent form for the operation.
On the day of surgery, we will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy. Please bring all your medications and any packaging (if available) with you. Please tell the ward staff about all of the medicines you use. If you wish to take your medication yourself (self-medicate), please ask your nurse. Pharmacists visit the wards regularly and can help with any medicine queries.

If you are not diabetic, you will be provided with nutritional carbohydrate drinks in the preadmission clinic. These nutritional drinks are to be drunk in the 24 hours leading up to your surgery. These drinks help your wounds heal faster, reduce the risk of infection and help your recovery overall.

You will need to starve for six hours before the operation and only drink clear fluids, (water is best), for three hours before. The pre-admission staff will tell you what time to do this and also advise you of what time you are to come to the hospital.

This procedure involves the use of general or regional anaesthesia. See below for further details about the types of anaesthesia used. You will see an anaesthetist before your procedure and will have an opportunity to ask questions about the anaesthesia.

You will be taught how to self-catheterise (put a tube into your bladder to empty it) before the procedure. This is in case you have urinary retention (unable to pass urine completely) following the procedure.

You will be given thrombo-embolic (TED) stockings to wear before the surgery; you should wear these until you have returned to your normal activities after the operation.

What do I need to bring in with me?

- Bring basic toiletries with you, such as a toothbrush and some sanitary towels etc.
- Bring some nightwear, a dressing gown and slippers.
- Wear only a minimal amount of jewellery. Only small rings, which will be taped, are allowed into the theatre suite. We cannot take responsibility for any valuables you may bring with you.
- Do not wear makeup, and ensure any nail polish is removed from your finger and toe nails.
- If you wear contact lenses, they will need to be removed prior to your going into theatre. We therefore recommend you bring in your glasses.
- We encourage you to get dressed whilst on the ward but recommend you bring in loose fitting clothing as you will have wound sites on your abdomen.
- Bring something to pass the time such as books and magazines. You are able to bring in your own electronic equipment, such as your mobile phone; however, we cannot take responsibility for any personal valuables and ask you use headphones so as not to disturb other patients. (see Welcome to Daphne Ward Patient Information)
May I bring someone with me?
Yes you are able to have your partner, family member or friend with you whilst you are in the day surgery unit. However, we ask they do not try and visit you on Daphne ward outside of its visiting hours (15:00 to 20:00) as other patients need to be allowed to rest and the staff need to perform their duties.

During the procedure
Before your procedure, you will be given the necessary anaesthetic. See below for details of this and the role of the anaesthetist in your care.

You will be given antibiotics whilst you are asleep; these are administered intravenously (into the vein) by the anaesthetist. This is given as a preventive measure against possible infection. It is therefore important that you tell a member of staff if you are allergic to any antibiotics or any other medication.

The operation is performed using a 10 cm (4 inch) transverse ‘bikini-line’ cut on your abdomen (tummy). The abdomen is then opened to reach the bladder. Long-lasting absorbable or permanent stitches are placed on either side of the bladder neck and tied to the strong fibrous tissue (Cooper’s ligament) attached to the pubic bones (See above diagram). We examine the bladder with a cystoscope (camera) to ensure that no stitches are accidentally placed inside the bladder. We also check for any active bleeding at the operative site before we close the abdominal wall with dissolvable sutures. Finally an indwelling catheter (tube to empty your bladder) is put into the bladder to ensure it is kept empty over the next 24 hours.

After the procedure – in hospital
Once your surgery is completed you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure, respiratory rate, oxygen levels and check for any vaginal bleeding. You may be given oxygen via a facemask; you might also wake up feeling sleepy. Most people will have a drip in one of the veins of their arm. This might be attached to a bag of fluid, which provides you with fluid until you are well enough to eat and drink by yourself. Sometimes, people feel sick after an operation, especially after a general anaesthetic, and might vomit. If you feel sick, please tell a nurse and you will be offered medicine to make you more comfortable.

You will be given appropriate pain relief, generally in the form of a Patient Controlled Analgesia System (PCAS). See Patient Information Leaflet: Analgesia: Patient controlled

After certain major operations you may be transferred to the intensive care unit (ICU/ITU), high dependency unit (HDU), intermediate dependency area (IDA) or fast track/overnight intensive recovery (OIR).

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These are areas where you will be monitored much more closely because of the nature of your operation or because of certain pre-existing health problems that you may have. If your surgeon or anaesthetist believes you should go to one of these areas after your operation, they will tell you and explain to you what you should expect.

**If there is not a bed in the necessary unit on the day of your operation, your operation may be postponed as it is important that you have the correct level of care after major surgery.**

**Eating and drinking.** Usually following surgery you will be able to drink fluids when you feel ready. If you are hungry, you can start with something light to eat soon after the operation.

**Getting about immediately after the procedure.** We will help you to become mobile as soon as possible after the procedure. This helps improve your recovery and reduces the risk of blood clots in your legs or lungs (thromboembolism).

**Leaving hospital.** Generally most people who have had this operation will be able to leave hospital after one or two nights. However, the actual time that you stay in hospital will depend on your general health, how quickly you are recovering from the procedure and your doctor’s advice.

**After the procedure – at home**

You are likely to feel tired and may need regular rests during the day in the first few weeks; this should improve gradually.

**Resuming normal activities including work.** Usually you can resume normal activities including light work within two weeks after your operation. Often you will want to wait a little longer before resuming more vigorous activities like gardening or lifting heavy items such as shopping bags. If you have a physical job or are on your feet for long periods of time you will need a “Fitness for work” certificate which we can give you before you leave the ward (generally for six weeks). If you have not told your employer the reason for your absence and you do not wish for them to know we will respect your confidentiality and will discuss with you what you wish to be written on your certificate.

**Pain:** You may have period-like pains for a few days, this is normal. Simple painkillers that you can buy over the counter such as paracetamol and ibuprofen (Nurofen) should help this. Speak to your GP if you require stronger pain killers.

**Mobilisation:** This is very important as using your leg muscles will reduce the risk of blood clots in your legs and lungs (thromboembolism). To also aid this you will be given a spare pair of the TED (Thrombo-Embolic Deterrent) stockings so you are able to wear these until you have resumed normal activities.
You will also be prescribed blood thinning injections for one week following your surgery to reduce the risk of blood clots in your legs and lungs. You will be shown how to give these to yourself before you go home.

**Bowels:** It is important to avoid constipation after surgery. You will be prescribed regular laxatives on discharge to help with this. We also recommend you drink plenty of fluids and eat lots of fresh fruit and vegetables.

**Hygiene:** You are able to shower or bath following the procedure but do not have the water temperature too hot as this may make you feel faint and dizzy. If you have mobility concerns and find getting in and out of a bath difficult, we suggest you shower only until you feel able to not only get in the bath, but have the upper body strength to get yourself out.

**Housework:** Do not lift anything heavy. This means that you will not be able to do housework for a few weeks. We generally advise complete rest for first two weeks. After this you may gradually increase the amount you do. If you look after your house, start with gentle dusting – but not moving everything around. Increase to cleaning bathrooms etc, but remember you will not be able to lift a vacuum cleaner for approximately eight weeks or to lift buckets of water to wash floors either. You will not be able to lift heavy washing baskets or hang out washings for a few weeks. You will be able to do some ironing after two weeks but you will not be able to put the ironing board up and down.

**Cooking:** You will be able to make yourself light meals when you get home but you should not lift anything heavier than a kettle of water for approximately four weeks. You will therefore not be able to do things like straining saucepans, lifting heavy dishes in and out of the oven and you will not be able to lift shopping bags or push supermarket trolleys.

**Pelvic floor exercises:** It is important that you continue with the physiotherapy exercises you have been advised prior to, or following your procedure.

**Sexual intercourse:** You can resume sexual activity whenever you feel comfortable enough any time after six weeks.

**Next period and future pregnancies:** It is not unusual for your menstrual cycle not to be as regular as before and this is not a concern. You may be able to become pregnant again. You may therefore wish to consider some form of contraception.

**Contraception:** If you have not had a hysterectomy and still menstruate (have periods) it is still possible to get pregnant and this may have an adverse effect on the surgery and you may have to have a caesarean section delivery. You should therefore give consideration to contraception. You can discuss this with your consultant or your GP.
Menopause: A colposuspension will make no difference to your menopause.

Driving: You should only resume driving once you are pain free can apply the emergency brake quickly in case of an emergency situation without straining yourself. It is best to check this by sitting in the car with the engine off. This may be four weeks after your operation. If in doubt check with your GP and your insurance company.

General: Maintaining a normal weight, avoiding chronic heavy lifting and not smoking will improve the long-term success of this procedure.

Special measures after the procedure

Trial of urinary voiding: The catheter will be removed the following morning after your surgery, unless your surgeon has a different plan. Once it is removed and you get the sensation to void (pass urine), please inform the nursing staff. They will provide you with a cardboard liner for the toilet which is used to measure the amount of urine you void. Do not strain to void. The voided amount will be measured following which the nurse will scan your bladder using a bladder scanner. (This is like that used during pregnancy and is not painful). The scanner will be placed on your lower abdomen (tummy) and measures how much urine is left in the bladder (residual urine volume). This will be done for the first couple of times you pass urine after removal of the catheter. If the bladder scan shows that you are able to empty your bladder sufficiently you are advised to maintain an adequate fluid intake (drink to thirst) and not restrict your fluid intake. If the bladder scan shows that you are unable to empty the bladder sufficiently, you may be advised to use clean intermittent self-catheterisation (CISC) after every void to ensure your bladder is empty. The nursing staff will supervise you doing this until you feel confident and give you all the information and equipment you need to manage at home.

The voiding difficulty usually settles in a few days to a few weeks but could on occasion persist for long term.

Pain relief: As already mentioned you may have a PCA for the first night after which you will be given adequate pain relief. The usual options are oral or intravenous drugs, rectal suppositories, self-administrated pain relief (Patient Controlled Analgesia System [PCA] or epidural infusion). We advise regular pain relief in the first few days after surgery. See Patient Information Leaflet – Analgesia: Patient controlled
**Wound care:** The wound is closed with a dissolvable stitch or surgical glue. The dressing can be removed the following day and must be kept clean and dry using a clean towel to pat it dry following a shower. We advise you to shower and avoid long soaks in the bath. Occasionally the stitches can cause an irritation of the skin and we advise that you visit your practice nurse or GP approximately five to seven days after your surgery to have these removed. If the area around your wound becomes red, hot to touch or more painful than before this may be an indication of infection and we suggest you see your GP or contact Clinic 24 (The Emergency Gynaecology Unit) on the numbers listed below.

**Check-ups and results**

When you are discharged from the ward you will have a telephone follow up in approximately six months. You will be asked to complete a questionnaire (before and six months after the surgery) so that we can assess how the operation has helped with your symptoms.

**When to seek help: (RED FLAGS)**

You should see your GP or contact us on the numbers listed below if you develop any of the following:

- Heavy vaginal bleeding
- Smelly vaginal discharge
- Severe pain not controlled by over the counter medications
- High fever
- Pain or discomfort passing while urine or blood in the urine
- Warm, painful, swollen legs
- Chest pain or difficulty in breathing
Significant, unavoidable or frequently occurring risks of this procedure

If you have a pre-existing medical condition, are overweight, or have had previous surgery the risks for serious and frequent complications will be increased.

The table below is designed to help you understand the risks associated with this type of surgery (based on the Royal College of Obstetricians and Gynaecologists [RCOG] Clinical Governance Advice, Presenting Information on Risk).

This is further explained in the following patient information leaflet available from the RCOG (2015): Understanding how risk is discussed in healthcare: Information for you.

<table>
<thead>
<tr>
<th>Term</th>
<th>Equivalent numerical ratio</th>
<th>Colloquial equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very common</td>
<td>1/1 to 1/10</td>
<td>A person in a family</td>
</tr>
<tr>
<td>Common</td>
<td>1/10 to 1/100</td>
<td>A person in street</td>
</tr>
<tr>
<td>Uncommon</td>
<td>1/100 to 1/1000</td>
<td>A person in village</td>
</tr>
<tr>
<td>Rare</td>
<td>1/1000 to 1/10,000</td>
<td>A person in small town</td>
</tr>
<tr>
<td>Very rare</td>
<td>Less than 1/10,000</td>
<td>A person in large town</td>
</tr>
</tbody>
</table>

Serious risks

- Bladder injury can occur in 5-10/100 cases (common). This is usually resolved during the operation. After a bladder injury you may need a urinary catheter for 10 days.
- As with any major operation there is 5/1000 risk of developing a blood clot in your legs (deep vein thrombosis or DVT) that can travel to your lungs (pulmonary embolus or PE).
- Small risk of injury to bowel (1:100), large blood vessels (1:1000) or the ureter (tubes carrying urine from the kidneys to the bladder) as these structures are in close proximity to each other in the abdomen and pelvis. Previous surgery in this area, pelvic infection and endometriosis can increase the risk of this complication.

Frequent risks

- Wound haematoma (blood clot) or hernia can occur in 15/100 cases (very common)
- Infection (wound infection, an infection inside the pelvis or a urinary infection) can occur in 5-13/100 cases (common/very common). If it occurs, it is usually treated with antibiotics. The risk of infection is reduced by routinely giving you a dose of intravenous antibiotic during your operation. Chest infection may also occur with general anaesthesia.
- Failure to improve or cure stress urinary incontinence in 10-20/100 (very common).
- Urinary retention (unable to pass urine) requiring catheterisation occurs in 10/100 cases (common). In majority of the cases, it resolves within six months. Approximately 5/100 cases (common) may need to continue to practise clean intermittent self-catheterisation long term.
• An increase in urinary frequency and urgency due to overactive bladder is noted in 17/100 cases (common).
• Recurrence of stress urinary incontinence occur in 10/100 (common) cases, even if symptoms initially improve.
• Prolapse of the posterior (back) vaginal wall is seen in 14/100 (common). It may be small and may not need any treatment. If it is bothersome, treatment with a vaginal pessary device or an operation (pelvic floor repair) may be required.
• Pain during sex can occur after any operation where there are stitches near the vagina. About 2-5/100 women find sex uncomfortable or painful. Sometimes the sensation during intercourse may be reduced or an orgasm may be less intense.

Blood transfusion

During surgery, you may lose blood. If you lose a considerable amount of blood your doctor may want to replace the loss with a blood transfusion as significant blood loss can cause you harm. The blood transfusion can involve giving you other blood components such as plasma and platelets which are necessary for blood clotting. Your doctor will only give you a transfusion of blood or blood components during surgery, or recommend for you to have a transfusion after surgery, if you need it.

Compared to other everyday risks the likelihood of getting a serious side effect from a transfusion of blood or blood component is very low. Your doctor can explain to you the benefits and risks from a blood transfusion. Your doctor can also give you information about whether there are suitable alternatives to blood transfusion for your treatment. There is a patient information leaflet for blood transfusion available for you to read. Will I need a blood transfusion?

Alternative treatments that are available for Stress Urinary Incontinence

Conservative treatment: Stress urinary incontinence can be treated without surgery. We recommend that all patients try non-surgical treatment before having an operation, because it avoids the complications of surgery.

• Pelvic floor exercises: The pelvic floor muscle supports your pelvic organs (uterus, vagina, bladder and rectum). Like any muscle in the body, pelvic floor muscles need exercise to keep them strong and ensure that they function properly in providing support to the pelvic organs. We recommend supervised pelvic floor muscle training by an experienced PF physiotherapist. PFE may improve symptoms in 50-70% women but it may not be a sustained (long-term) improvement. Even if physiotherapy fails to improve your symptoms it will improve the outcome of surgery.

• Continence pessaries/devices: These are inserted temporarily inside either the vagina or the urethra to stop urinary leakage that occurs only during exercise. They are not a cure but their aim is to keep you dry while in use. A booklet is available if you require further information. They can be prescribed by your GP.
• **Surgical treatment:** There are several operations used to treat stress urinary incontinence. Each has advantages and disadvantages, and different operations may be better for different people. You should discuss these with your surgeon before coming to a decision.

• **Injections into the bladder neck:** This is a minor procedure and involves injecting a substance into the bladder neck to make it tight. The results of the injections are variable; they may cure around 50-70 in 100 women. Some women may need more than one injection and the effect may wear off over time. The procedure can be performed with a local anaesthetic or under a general anaesthesia, depending upon your preference.

• **Autologous sling procedure:** This involves a small cut on your bikini line to remove a piece of strong tissue from your abdominal wall (strip of rectus sheath). This tissue is then inserted as a sling to support your bladder neck. It is a very effective procedure and improves stress incontinence in 8 to 9 out of 10 women. It has significant risks of wound problems, voiding difficulty (possibly long term) and an overactive bladder.

An alternative to this surgery is a decision not to have surgery. If you decide not to proceed with surgery your problem may remain the same or get worse. There is no definite way of predicting this. Life style modifications may help your symptoms. These changes may help whether you have an operation or not:

- adjusting your daily routines to help you cope better
- weight loss if you are overweight
- managing a chronic cough if you have one
- giving up smoking

Your GP or gynaecologist may be able to help you achieve some of these.

**Information and support**

• Urogynaecology Clinical Nurse Specialists
  01223 245151 and ask for
  Bleep 159216 or 157952
  Available Monday to Friday 08.00 – 16.00
  Email: urogynaenurses@addenbrookes.nhs.uk

• Clinic 24 (Emergency Gynaecology Unit and Early Pregnancy Unit)
  Telephone: 01223 217636
  Open 08:00 – 20:00 Monday to Friday
  08:30 – 14:00 at weekends
  Closed Bank holidays

• Daphne ward (Inpatient Gynaecology ward)
  Telephone: 01223 257206
  At all other times
Further information:

- International Urogynaecological Association
  www.iuga.org
  https://www.yourpelvicfloor.org/media/Colposuspension_RV1.pdf
- Bladder and Bowel Community
  0853 450165
  www.bladderandbowel.org

Anaesthesia

Anaesthesia means ‘loss of sensation’. There are three types of anaesthesia: general, regional and local. The type of anaesthesia for a colposuspension procedure is either general or regional. It is recommended by your anaesthetist depending on the nature of your surgery as well as your health and fitness. Sometimes they can be used in combination.

Before your operation

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation and pain relief after your surgery. To inform this decision, he/she will need to know about:

- your general health, including previous and current health problems
- whether you or anyone in your family has had problems with anaesthetics
- any medicines or drugs you use
- whether you smoke
- whether you have had any abnormal reactions to any drugs or have any other allergies
- your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.

Pre-medication

You may be prescribed a ‘premed’ prior to your operation. This is a drug or combination of drugs which may be used to make you sleepy and relaxed before surgery, provide pain relief, reduce the risk of you being sick, or have effects specific for the procedure that you are going to have or for any medical conditions that you may have. Not all patients will be given a premed or will require one and the anaesthetist will often use drugs in the operating theatre to produce the same effects.

Moving to the operating room or theatre

You will usually change into a gown and put on the TED stockings before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting. This is called the WHO check.
Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted. If a regional anaesthetic is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

**General anaesthesia**

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement.

**Regional anaesthesia**

Regional anaesthesia includes epidurals, spinals, caudals or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic. Regional anaesthesia may also be used to provide pain relief after your surgery for hours or even days. Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.

**What will I feel like afterwards?**

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

You may have fewer of these effects after local or regional anaesthesia although when the effects of the anaesthesia wear off you may need pain relieving medicines.

**What are the risks of anaesthesia?**

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years.
The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.

**Very common (1 in 10 people) and common side effects (1 in 100 people)**
- Feeling sick and vomiting after surgery
- Sore throat
- Dizziness, blurred vision
- Headache
- Bladder problems
- Damage to lips or tongue (usually minor)
- Itching
- Aches, pains and backache
- Pain during injection of drugs
- Bruising and soreness
- Confusion or memory loss

**Uncommon side effects and complications (1 in 1000 people)**
- Chest infection
- Muscle pains
- Slow breathing (depressed respiration)
- Damage to teeth
- An existing medical condition getting worse
- Awareness (becoming conscious during your operation)

**Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications**
- Damage to the eyes
- Heart attack or stroke
- Serious allergy to drugs
- Nerve damage
- Death
- Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK.

For more information about anaesthesia, please visit the Royal College of Anaesthetists’ website: [www.rcoa.ac.uk](http://www.rcoa.ac.uk)
Information about important questions on the consent form

1 Creutzfeldt Jakob Disease (‘CJD’)

We must take special measures with hospital instruments if there is a possibility you have been at risk of CJD or variant CJD disease. We therefore ask all patients undergoing any surgical procedure if they have been told that they are at increased risk of either of these forms of CJD. This helps prevent the spread of CJD to the wider public. A positive answer will not stop your procedure taking place, but enables us to plan your operation to minimise any risk of transmission to other patients.

2 Photography, Audio or Visual Recordings

As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment; they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research. Please do not be alarmed if the images are taken on a mobile phone: only certain people are allowed to do this and they have a specific app to do so. Once the images are updated to your medical records, they are immediately deleted from the mobile phone. Only staff with legitimate reasons for accessing your medical notes will be able to view these images on the hospital EPIC (medical records) system.

3 Students in training

Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

4 Use of Tissue

As a leading biomedical research centre and teaching hospital, we may be able to use tissue not needed for your treatment or diagnosis to carry out research, for quality control or to train medical staff for the future. Any such research, or storage or disposal of tissue, will be carried out in accordance with ethical, legal and professional standards. In order to carry out such research we need your consent. Any research will only be carried out if it has received ethical approval from a Research Ethics Committee. You do not have to agree and if you prefer not to, this will not in any way affect the care and treatment we provide. The leaflet ‘Donating tissue or cells for research’ gives more detailed information. Please ask for a copy.

If you wish to withdraw your consent on the use of tissue (including blood) for research, please contact our Patient Advice and Liaison Service (PALS), on 01223 216756.
5. ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)

It is Trust policy that before we commence any treatment plan we discuss your wishes in the unlikely event there is a complication/emergency resulting from the treatment. The ReSPECT process creates a personalised recommendation for your clinical care in emergency situations where you are not able to make decisions or express your wishes. This enables your health professional to make clinical decisions and to act in your best interests and for your benefit.

The conversation helps us to understand your priorities of care and use those to develop an agreed plan that records what types of care or treatment:

- you would want to be considered for in an emergency
- you would not want to receive
- would not work or be of overall benefit to you.

There is further information available at: ReSPECT - Easy read Patient Information

Privacy & dignity

Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

We are a smoke-free site: smoking will not be allowed anywhere on the hospital site. For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

Other formats:

If you would like this information in another language or audio, please contact Interpreting services on telephone: 01223 256998, or email: interpreting@addenbrookes.nhs.uk For Large Print information please contact the patient information team: patient.information@addenbrookes.nhs.uk.

Document history

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Colposuspension for stress urinary incontinence, 101376, Version 1; November 2019
Colposuspension for Stress Urinary Incontinence (open/laparoscopic)

A Patient’s side  left / right or  N/A

Consultant or other health professional responsible for your care

Name and job title: ____________________________________________

☐ Any special needs of the patient (e.g. help with communication)?

Please use ‘Procedure completed’ stamp here on completion: ____________

B Statement of health professional (details of treatment, risks and benefits)

1 I confirm I am a health professional with an appropriate knowledge of the proposed procedure, as specified in the hospital’s consent policy. I have explained the procedure to the patient. In particular, I have explained:

a) the intended benefits of the procedure (please state)
   - Improvement in symptoms of stress urinary incontinence causing leakage of urine with certain activities such as coughing, sneezing, running etc.

b) the possible risks involved. Addenbrooke’s always ensures any risks are minimised. However all procedures carry some risk and I have set out below any significant, unavoidable or frequently occurring risks including those specific to the patient.
   - Bladder injury can occur in 5-10/100 cases (common). Smallerisk of clots in legs/lungs (5/1000 cases).
   - Injury to bowel (1:100 cases), large vessels (1:1000 cases) or the ureter (5:1000).
   - Wound haematoma (blood clot) or hernia seen in 15/100 cases (very common).
   - Infection (wound infection/vaginal infection/urinary tract infection) can occur in 5-13/100 cases (common/very common).
   - Urinary retention or difficulty in passing urine can occur 10/100 cases (common) requiring catheterisation for a few days after surgery. It is very rare for this problem to be long-term.
   - An increase in urinary frequency and urgency is noted in 17/100 cases (common).
   - Prolapse (a bulge in the vagina caused by vaginal walls sagging) seen in 14/100 cases which may sometimes require further surgery. Failure to improve or cure symptoms in 10-20/100 (very common).

Please read the full text for the rest of the statement.
Consent Form

Colposuspension for Stress Urinary Incontinence (open/laparoscopic)

d) any extra procedures that might become necessary during the procedure such as:
[ ] Blood transfusion [ ] Other procedure (please state)

2 The following information leaflet has been provided:

Colposuspension for stress urinary incontinence (open/laparoscopic)

Version, reference and date: Version 1, 101376, November 2019

or [ ] I have offered the patient information about the procedure but this has been declined.

3 This procedure will involve:
[ ] General and/or regional anaesthesia [ ] Local anaesthesia [ ] Sedation [ ] None

Signed (Health professional): ........................................................ Date: D.D./M.M./Y.Y.Y.Y

Name (PRINT): ........................................................................ Time (24hr): H.H.:M.M

Designation: ........................................................................... Contact/bleep no:

C Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

Important: please read the patient information about this procedure and then put a tick in the relevant boxes for the following questions:

1 Creutzfeldt Jakob disease (CJD)
Have you ever been notified that you are at risk of CJD or variant CJD for public health purposes? If yes, please inform your health professional. [ ] Yes [ ] No

2 Photography, Audio or Visual Recording
a) I agree to the use of any of the above type of recordings for the purpose of diagnosis and treatment. [ ] Yes [ ] No

b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting. [ ] Yes [ ] No

3 Students in training
I agree to the involvement of medical and other students as part of their formal training. [ ] Yes [ ] No

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File: in the procedures and consents section of the casenote

Colposuspension for stress urinary incontinence, V1, November 2019
Consent Form

Colposuspension for Stress Urinary Incontinence (open/laparoscopic)

4 Use of Tissue
   a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research.
      □ Yes □ No
   b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records.
      □ Yes □ No

I have listed below any procedures that I do not wish to be carried out without further discussion.

I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): .............................................................. Date: D.D./M.M./Y.Y.Y.Y.
Name of patient (PRINT): ................................................

If signing for a child or young person; delete if not applicable.
I confirm I am a person with parental responsibility for the patient named on this form.
Signed: ........................................................................ Date: D.D./M.M./Y.Y.Y.Y.
Relationship to patient: ....................................................

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.
Signed (Witness): .............................................................. Date: D.D./M.M./Y.Y.Y.Y.
Name of witness (PRINT): ................................................
Address: ........................................................................

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D Confirmation of consent

Confirmation of consent (where the treatment/procedure has been discussed in advance)
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): .................................................. Date: .............

Name (PRINT): ................................................................. Job title: .................................

Please initial to confirm all sections have been completed: ..............................................

E Interpreter’s statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): .......................................................... Date: .............

Name (PRINT): .................................

Or, please note the language line reference ID number: ..............................................

F Withdrawal of patient consent

☐ The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): ................................................................. Date: .............

Signed (Health professional): .................................................. Date: .............

Name (PRINT): ................................................................. Job title: .................................