PROCEDURE

Anterior vaginal wall repair

Anterior vaginal wall repair is surgery that supports a bladder bulging into the vagina.

PURPOSE
Restore support beneath the bladder

PROCEDURE TYPE
Therapeutic surgery performed through the vagina

WHERE IT IS DONE
Operating theatre

ANAESTHESIA
General, sometimes spinal

HOW LONG IT TAKES
About 30 to 60 minutes

PREPARATION
Fasting and medication review; follow facility instructions

RECOVERY
Same day or overnight; no driving until safe

MAIN RISKS
Bleeding, infection, urinary problems, prolapse recurrence

RESULTS
Initial result immediate; healing assessed around six weeks

Overview

Anterior vaginal wall repair is surgery for anterior vaginal wall prolapse, in which the bladder and its supporting tissues drop and bulge into the front wall of the vagina. It is also called anterior repair or anterior colporrhaphy.

The operation is usually performed through the vagina without abdominal cuts. The surgeon strengthens the supportive tissue between the bladder and vagina using stitches. This is often called a native tissue repair because it uses your own tissue rather than surgical mesh.

Anterior repair may be performed alone or with surgery for prolapse affecting the uterus or top of the vagina.

Why the procedure is performed

The aim is to support the bladder and reduce symptoms such as:

The operation does not reliably treat every bladder problem. Urgency, frequent urination, or urine leakage may remain. Stress incontinence-leakage with coughing, laughing, or exercise-can sometimes become noticeable after the prolapse is repaired.

- Feeling or seeing a vaginal bulge
- Pelvic pressure or dragging discomfort
- Trouble emptying your bladder
- Needing to press on the vagina to pass urine
- Difficulty with exercise, work, or sexual activity
- Symptoms that continue despite non-surgical treatment

Who should and should not have it

Anterior repair may be suitable if you have bothersome prolapse and want surgery after discussing its benefits, risks, and alternatives.

Surgery may not be appropriate when prolapse is mild or does not interfere with daily life. Observation, pelvic floor therapy, or a vaginal support device may provide enough relief.

The procedure may be delayed or avoided if you:

Smoking, poorly controlled diabetes, constipation, chronic coughing, and repeated heavy lifting can impair healing or strain the repair. Discuss these issues before surgery.

Your surgeon should also assess the uterus and top of the vagina. Repairing only the front wall may not be enough if other areas have lost support.

- Have an active urinary, vaginal, or other serious infection
- Have unexplained vaginal bleeding that has not been assessed
- Have a condition that makes anaesthesia or surgery unsafe
- Are pregnant or plan a future pregnancy, which may strain the repair
- Cannot temporarily follow lifting and activity restrictions

How to prepare

Follow your treating facility's instructions, which may vary according to your health, anaesthetic, and any additional procedures.

A preoperative assessment may include a health history, pelvic examination, blood tests, urine testing, and sometimes bladder tests.

Tell the team about all medicines, supplements, allergies, previous operations, and reactions to anaesthesia. Blood thinners and some diabetes medicines may require special instructions. Do not stop prescription medicine unless your treating team tells you to.

You may need to stop eating and drinking for a set time before surgery. Full bowel preparation is not usually required unless another procedure needs it.

Arrange for someone to take you home and plan for reduced lifting and housework. Stopping nicotine before surgery can support wound healing.

What happens during the procedure

You will usually have a general anaesthetic and be unconscious. A spinal anaesthetic, which numbs you from the waist down, may sometimes be offered.

The team may place a catheter into your bladder. The surgeon makes a cut in the front vaginal wall and separates the vaginal lining from the bladder. Weakened supporting tissue is brought together with stitches. Some excess vaginal tissue may be removed, while avoiding excessive narrowing.

The lining is closed with dissolvable stitches. A gauze pack may be placed temporarily to limit bleeding. The pack and catheter are often removed later that day or the next morning.

The operation usually takes 30 to 60 minutes but may take longer with other prolapse or incontinence procedures.

Recovery and what to expect afterward

Vaginal soreness, pressure, or cramping is common. Contact your team if pain worsens instead of gradually improving.

You can usually eat and drink after waking and once nausea settles. Fluids, fibre, and a recommended stool softener can help prevent straining.

Gentle walking is encouraged. Light bleeding or pink, brown, or creamy discharge can occur while stitches dissolve. Use pads, not tampons. Avoid heavy lifting, strenuous exercise, vaginal sex, and inserting anything into the vagina until your team confirms adequate healing, often

around six weeks.

Do not drive home after anaesthesia. Resume driving only when you are not taking medicines that impair alertness, can sit comfortably, and can perform an emergency stop without pain or hesitation. Check any insurer requirements.

Time away from work is often two to six weeks, depending on whether your role is desk-based or physically demanding.

You may go home the same day or stay overnight. Before discharge, the team checks whether you can pass urine. If your bladder does not empty properly, you may temporarily need a catheter and repeat bladder testing.

Risks and possible complications

Possible complications include:

No repair guarantees permanent support. Ageing, tissue strength, constipation, coughing, weight changes, and heavy physical strain can affect the result.

Most standard repairs use stitches and your own tissue. If graft material or mesh is proposed, ask why, where it will be placed, and what additional risks and regulatory restrictions apply.

- Bleeding, bruising, or blood collecting under the vaginal wall
- Urinary, vaginal, or surgical-site infection
- Temporary or ongoing difficulty emptying the bladder
- Injury to the bladder or ureter requiring repair
- New or continuing urine leakage or urgency
- Pain during sex, vaginal tightness, or ongoing pelvic pain
- Blood clots in the legs or lungs
- Reactions to anaesthesia
- Prolapse that continues, returns, or develops elsewhere

Results and follow up

Support is restored during surgery, but swelling can obscure the early result. Bulge and pressure symptoms often improve over several weeks.

Follow-up is commonly arranged at about six weeks. Your clinician may assess healing, bladder

function, symptoms, and when you can resume lifting, exercise, driving, and vaginal sex.

There is usually no laboratory result unless tissue was removed for examination. If a specimen was sent, ask when and how you will receive the result.

Keep your follow-up appointment even if recovery seems straightforward. Report continuing urine leakage, trouble emptying your bladder, pain during sex, or a returning bulge.

Alternatives

Alternatives include:

Your goals, health, sexual preferences, and the location of the prolapse should guide the decision.

- Observation: Avoids treatment risks, but symptoms may continue or change.
- Pelvic floor muscle training: Guided exercises may improve support and symptoms but may not remove a larger bulge.
- A vaginal pessary: A removable silicone device supports the vaginal walls. It requires fitting, cleaning, and review and may cause discharge or irritation.
- Lifestyle changes: Treating constipation or chronic coughing and reducing heavy lifting can lessen strain but cannot rebuild damaged support.
- A different prolapse operation: Prolapse of the uterus or vaginal top may require another operation instead of, or alongside, anterior repair.
- Colpocleisis: Closing most or all of the vaginal canal can provide strong support with a shorter operation, but penetrative vaginal sex is no longer possible.

When to call your healthcare team

Contact your surgical team promptly for increasing pain, fever, chills, foul-smelling discharge, burning when passing urine, difficulty emptying your bladder, persistent vomiting, bleeding that becomes heavier, new calf pain, or one-sided leg swelling.

Seek emergency help for trouble breathing, chest pain, fainting, confusion, rapidly increasing bleeding, or bleeding with marked weakness or dizziness.

Mild soreness, light spotting, and a small amount of discharge can be normal. Report symptoms that persist, worsen, or concern you.

Common questions

Will I be asleep?

Usually. Most repairs use general anaesthesia, although a spinal anaesthetic may be available.

Can I drive home?

No. Arrange transport home. Drive again only when you can control the car safely and are not taking impairing medicine.

How painful is it?

Soreness, pressure, and cramping are expected and usually improve with pain relief and time. Worsening pain needs assessment.

When will I know if it worked?

Support is restored during surgery, but swelling may affect how it feels. The result becomes clearer over several weeks.

Will it stop urine leakage?

Not necessarily. Leakage may improve, remain, or become more noticeable after repair.

When can I have sex again?

Many teams recommend waiting about six weeks and until healing is confirmed. Follow your surgical team's advice.

Sources

- American College of Obstetricians and Gynecologists. Surgery for Pelvic Organ Prolapse
- International Urogynecological Association. Anterior Vaginal Repair patient leaflet
- National Institute for Health and Care Excellence. Urinary incontinence and pelvic organ prolapse in women: management, NG123
- Royal College of Obstetricians and Gynaecologists. Pelvic organ prolapse
- U.S. Food and Drug Administration. Pelvic Organ Prolapse: Surgical Mesh Considerations and Recommendations