Anterior and posterior vaginal repair (colpoperineorrhaphy)

Repair of cystocele and rectocele by the vaginal route

01 What is it?

A prolapse, or organ descent, occurs when the walls of the vagina and the muscles of the perineum no longer hold the pelvic organs firmly enough. The bladder may bulge into the front wall of the vagina: this is a cystocele. The rectum may bulge into its back wall: this is a rectocele.

This sheet, given to you by Dr Gatri, is intended to complement the explanations given during your consultation. Do not hesitate to ask her if you have any questions.

The operation repairs these two walls by the natural route, through the vagina.

This sheet is based on the patient information sheet of the CNGOF and the SCGP "Prolapsus traitement par voie vaginale" (2025), adapted to the practice of the clinic.

02 Why this procedure?

A prolapse is not dangerous, and generally not painful. It does, however, cause a feeling of heaviness, pressure or discomfort, and can interfere with daily life, sport or your sex life. It is this discomfort that justifies the operation, the aim of which is to improve your quality of life.

03 How does the procedure take place?

The operation takes place at the Clinique de la Muette, under general anaesthetic. The operation lasts about 2 hours 30 minutes. This is day surgery: you go home the same day.

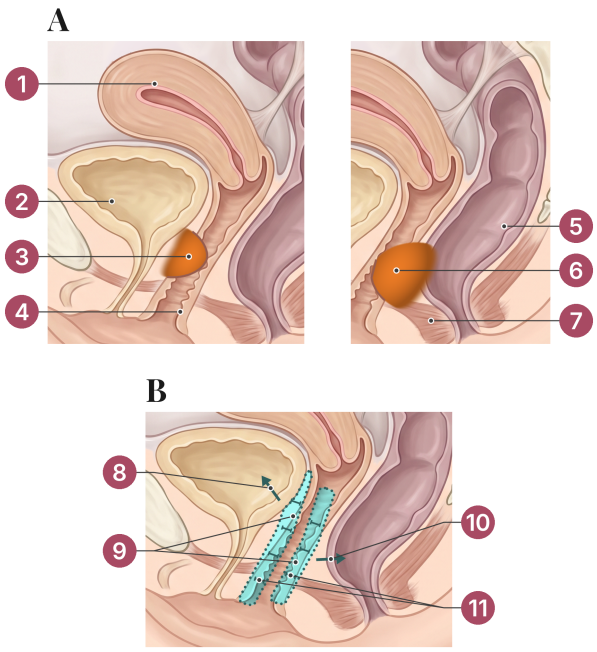


FIGURE 1 — Cystocele, rectocele and their repair (diagram, side view).

A — Organ descent: cystocele (left), rectocele (right)

1. Uterus
2. Bladder
3. Cystocele
4. Vagina
5. Rectum
6. Rectocele
7. Perineum

B — The repair, with your own tissues, without mesh

8 Put back in place

9 The wall of the vagina is opened

10 Put back in place

11 Supporting tissues tightened, dissolvable stitches

In orange: the organ bulging into the wall of the vagina.

In blue-green, outlined with dots: the operated area, the front wall and the back wall of the vagina.

Side view: the belly is on the left of the image, the back on the right.

Diagram Wagram Clinic, 2026.

You are placed in the gynaecological position, and a catheter is usually inserted into the bladder.

The surgeon opens the wall of the vagina, separates the bladder or the rectum and puts them back correctly in place. The supporting tissues are then tightened with dissolvable stitches. This repair is done with your own tissues, without mesh.

An unexpected finding or event may lead the surgeon to carry out steps other than those planned, or even to stop the operation.

04 What the procedure does not guarantee

The result is usually good and long-lasting, but it cannot be guaranteed. The prolapse can come back, which is not exceptional: excess weight, a chronic cough, constipation or changes in the vaginal lining at the menopause increase the risk. A recurrence can be treated without surgery or lead to a further operation.

05 Risks and complications

In the majority of cases, the operation goes ahead without complication.

During the operation, the bladder may be injured when the surgeon separates it from the vagina, especially if you have already had surgery. This injury may make it necessary to stop the operation; the urinary catheter is then kept in for longer. An injury to the rectum is exceptional and is repaired immediately. Injuries to blood vessels, nerves or the bowel are exceptional, and sometimes cannot be cured.

In the days that follow, bleeding or a haematoma is rare; it exceptionally requires antibiotics, a further operation or a transfusion. Pain usually remains moderate. A urinary infection is always possible. Frequent or urgent needs to pass urine are not rare. Passing urine may also become very difficult: a catheter then has to be reinserted, or you may need to learn to catheterise yourself several times a day, for a while.

In the longer term, persistent pain is exceptional. Digestive problems, including difficulty opening your bowels, may appear or worsen; appropriate treatment can make them disappear. An obstruction of the bowel is exceptional, as the abdomen is not normally opened. Leaks of urine on exertion may appear or increase, and later require pelvic floor rehabilitation or another operation. A fistula, an abnormal connection between two hollow organs, is exceptional, especially after several operations; it is usually treated surgically. The operation usually improves your sex life; rarely, pain or a lack of lubrication makes intercourse uncomfortable.

As with any surgery, there is also a risk to life, which cannot always be foreseen.

06 Alternatives

Not having the operation is always possible. Pelvic floor rehabilitation and the pessary, a device placed in the vagina to support the organs, avoid surgery. Acting on what encourages recurrence is also part of the decision.

07 Contraindications

Your health, your medical history or a medicine you are taking may increase certain risks. So tell the doctor about all your medical history, personal and family, and all your treatments.

If you have a urinary infection, the operation is postponed until it has cleared. A blood clotting disorder or an anticoagulant treatment that has not been adjusted are also contraindications, as is a current pregnancy or one planned in the near

future, because giving birth could undo the repair.

If you smoke, stopping six to eight weeks before the operation removes the additional complications caused by smoking.

08 Before the procedure

Tests, including a urine test, may be requested. You will see the anaesthetist in consultation a few days beforehand.

A local treatment based on oestrogens or hyaluronic acid, as a cream or pessaries, may be prescribed to help healing, as well as compression stockings against phlebitis, to be worn during the operation and until you are walking again.

09 After the procedure and your instructions

- Your surgeon decides when to remove the urinary catheter and, if one has been left, the vaginal pack.
- Bowel movements usually return within two days; constipation lasting a few days may justify a laxative, so that you avoid straining.
- Some vaginal discharge is normal during this period.
- For 4 to 6 weeks: no baths, no swimming pool and no sexual intercourse. For about six weeks, avoid exertion, sport and heavy lifting. Avoid strenuous effort for two months.
- At the follow-up consultation, 3 to 4 weeks later, your surgeon will tell you when to resume all your activities.
- Plan for a period of recovery: time off work, prescribed by your doctor, is of a length suited to the work you do.

10 When to seek medical advice without delay

Once you are home, contact your doctor without delay if you have significant difficulty passing urine, a fever, burning when passing urine, foul-smelling discharge, heavy bleeding, unusual pain, pain in a calf or difficulty breathing.

11 Your questions for Dr Gatri

This information sheet probably cannot answer all your questions. In any case, do not hesitate to ask your doctor any question that comes to mind, either orally or in writing.