Laparoscopic Sacrocolpopexy

Gynaecology

Introduction

This leaflet will provide information for women who have a vaginal apex (vault) prolapse and are considering laparoscopic sacrocolpopexy (an operation to repair the prolapse).

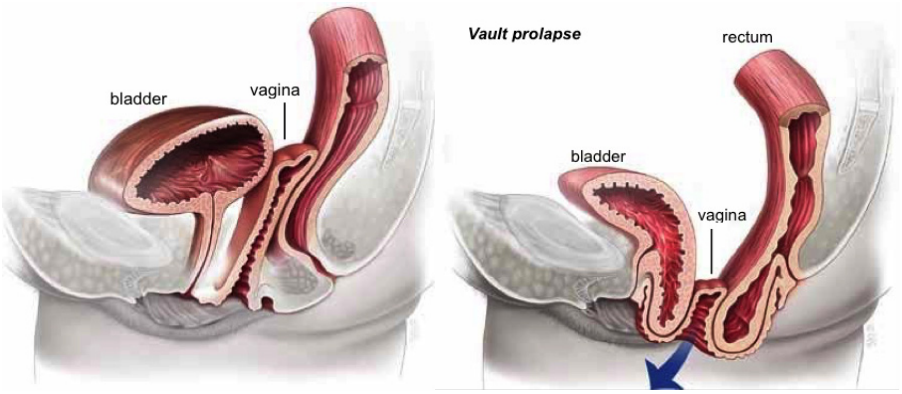
What is prolapse of the vaginal apex?

A prolapse is herniation (coming down) of the vaginal walls and pelvic organs away from their normal positions inside the body. In severe cases, it can protrude outside the vagina.

Apical vaginal prolapse is a prolapse from the top of the vagina. The apex is the deepest part of the vagina where the uterus (womb) is usually located. A vaginal vault prolapse is a prolapse arising from the top of the vagina (vault) where the uterus (womb) was situated. Affecting ladies who have undergone a hysterectomy (removal of womb).

A vaginal vault prolapse is often accompanied by a weakness and prolapse of walls of the vagina such as a rectocele (a bulge of the back wall of the vagina) or a cystocele (prolapse of the front wall of the vagina). Sometimes, further vaginal surgery is required to correct the prolapse at the same time as the sacrocolpopexy procedure. Your surgeon will discuss this with you.

If you have any further questions, please feel free to ask your doctor.



The prevention of infection is a major priority in all healthcare and everyone has a part to play.

- **Please decontaminate your hands frequently for 20 seconds using soap and water or alcohol gel if available**
- **If you have symptoms of diarrhoea and/or vomiting, cough or other respiratory symptoms, a temperature or any loss of taste or smell please do not visit the hospital or any other care facility and seek advice from 111**
- **Keep the environment clean and tidy**
- **Let's work together to keep infections out of our hospitals and care homes.**

What conditions lead to prolapse?

Prolapse occurs over a period of time, to varying degrees, and is usually caused by weakening or injury to the supporting muscles and ligaments of the pelvic floor. This can be as a result of childbirth, abnormally weak collagen type, being overweight, heavy lifting, chronic constipation, smoking and a lack of hormones after the menopause. There are usually multiple factors in the development of prolapse. Many women will have a prolapse of some degree after childbirth; it is not unusual and unless you have symptoms, you do not need to seek treatment.

What are the symptoms of prolapse?

Symptoms may vary depending on type and severity of prolapse. Usually, symptoms are worse towards the end of the day. In general, the symptoms can include:

- Dragging feeling, heaviness or lump down below
- Difficulty opening bowel or bladder
- Difficulty with intercourse or having a loose sensation.

Pain is not usually a symptom of prolapse. Some women with prolapse may not have any symptoms, in which case, no treatment is required.

Vaginal pessaries

Ring pessary

This is a ring made of Flexible PolyVinyl-Chloride (PVC) which is inserted inside the vagina to push the prolapse back up. This usually gets rid of the dragging sensation and can sometimes improve bladder and bowel symptoms.

The ring pessary is very popular and needs to be changed every 6 to 12 months (by your GP or practice nurse). We can show you an example of one in clinic, please ask. Ring pessaries are not always suitable and do not always stay in place. Some couples feel it can interfere with intercourse. If a ring is not suitable, we will need to consider a different type of pessary, for example a shelf pessary.

Shelf pessary / Gel Horn pessary

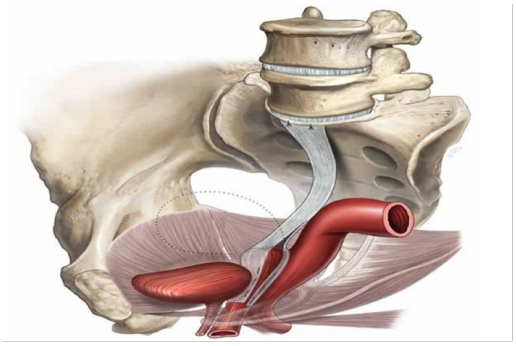
This is a different shape pessary which cannot be used if you are sexually active. It needs to be changed every 6 to 12 months and is usually done in hospital by an experienced specialist.

The choice about which treatment is best for you will be made together with your doctor based on the risks and benefits of the treatment and individual circumstances.

What is sacrocolpopexy?

Sacrocolpopexy is a procedure to correct prolapse of the vaginal vault (top of the vagina) in women who have had a previous hysterectomy. The operation is designed to restore the vagina to its normal position and function.

In this operation, the top of the vagina (vaginal vault) is suspended to a prominent part of the back bone (the sacral promontory) via a piece of synthetic mesh. Success of this operation is approximately 90%.



Vaginal repair

Other types of prolapse may result from stretching and weakening of the walls of the vagina such as cystocele (bulging of the bladder through the front wall) or rectocele (bulging of bowel through the back wall). All of these conditions can result in the feeling of something coming down the vagina.

Following the colpopexy, further repair may be required to correct these kinds of prolapse at the lower part of vagina during your operation. The repair operation tightens the walls of the vagina and the pelvic floor muscles. All the stitches used are dissolvable.

What are the benefits of laparoscopic sacrocolpopexy?

Studies show that 80 to 90% of women having sacrocolpopexy are cured of their prolapse and prolapse symptoms. Following surgery, there is a small risk of prolapse developing in another part of the vagina, such as the front wall that supports the bladder. If this does develop, it may require further surgery.

Are there any risks to this operation?

Sacrocolpopexy is considered major surgery and as with all surgery there are associated risks that you need to be aware of when deciding on the right treatment for you. You and your doctor must discuss these and the benefits of surgery, whilst also considering any alternative treatments. The risks are:

General risks of surgery

- Anaesthetic risk: This is very small unless you have specific medical problems. This will be discussed with you
- Haemorrhage: There is a risk of bleeding with any operation. The risk from blood loss is reduced by knowing your blood group beforehand and then having blood available to give you, if needed. It is rare that we have to transfuse patients after their operation. Please let your doctor know if you are taking an anticlotting drug such as warfarin or aspirin. The risk of excessive bleeding during the operation is about 1 in 100 women
- Infection: There is a risk of infection at any of the wound sites. A significant infection is rare. The risk of infection is reduced by our policy of routinely giving antibiotics with major surgery
- Deep Vein Thrombosis (DVT): This is a clot in the deep veins of the leg. The overall risk is at most 4 - 5% although the majority of these are without symptoms (1 / 10 to 1 / 100 i.e. common). Occasionally, this clot can migrate to the lungs which can be very serious and, in rare circumstances, it can be fatal (less than 1% of those who get a clot). DVT can occur more often with major operations around the pelvis and the risk increases with obesity, gross varicose veins, infection, immobility and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood (heparin).

Specific risks of surgery

- Damage to local organs: This can include bowel, bladder, ureters (pipes from kidneys to the bladder) and blood vessels. This is a rare complication, but requires that the damaged organ is repaired and this can result in a delay in recovery. It is sometimes not detected at the time of surgery and, therefore, may require a return to theatre. If the bladder is inadvertently opened during surgery, it will need catheter drainage for 7-14 days following surgery. If the rectum (back passage) is inadvertently damaged at the time of surgery, this will be repaired, however, inserting the mesh may be delayed till a later date. This will require another operation, and in rare circumstances, a temporary colostomy (bag) may be required
- Prolapse recurrence: If you have one prolapse, the risk of having another prolapse sometime during your life is 30%. This is because the vaginal tissue is weak. The operation may not work and it may fail to alleviate your symptoms
- Pain: General pelvic discomfort usually settles with time. Tenderness on intercourse due to vaginal tethering may occur. Occasionally, pain on intercourse can be permanent

- Mesh exposure / extrusion occurs when the plastic mesh protrudes through the vagina (incidence of around 10%). This may require a repeat operation to trim the mesh and in severe cases may compromise the operation
- Infection of mesh: The mesh and/or the tissues attached to it (vagina and back bone) may get infected. This is usually treated by antibiotics and in rare cases, by removing the mesh
- Change in bladder and bowel function: Changing the axis of the vagina might interfere with the voiding / continence mechanism leading to voiding dysfunction, or worsening or new urinary incontinence. If you experience this, please let us know as this can be treated. Some patients experience worsening constipation following surgery. This may resolve with time. It is important to try to avoid being constipated following surgery to reduce prolapse recurrence
- Reduced sensation during intercourse: Sometimes, the sensation during intercourse may be less and occasionally the orgasm may be less intense.

What are the alternative non-surgical treatments?

Do nothing

If the prolapse (bulge) is not troubling you greatly, then surgery may not be necessary. If, however, the prolapse is outside the vagina and exposed to the air, it can become dried out and eventually become ulcerated.

Even if it is not causing symptoms, in this situation we would recommend supporting it back inside the vagina with a vaginal pessary (see below).

Pelvic Floor Exercises (PFE)

The pelvic floor muscles form a bowl at the bottom of your pelvis. These muscles support your pelvic floor organs (uterus, vagina, bladder and rectum). Every muscle in the body needs exercising to keep it strong so that it functions properly. PFE help strengthen the pelvic floor muscles and, therefore, give more support to the pelvic organs. These exercises may not get rid of the prolapse completely, but they can make you more comfortable and are best taught by an expert (usually a physiotherapist). These exercises have little or no risk and even before surgery is required at a later date as they can help to strengthen the area before surgery. Please discuss with your surgeon for referral to the physiotherapist.

Consent

We must seek your consent for any procedure or treatment beforehand. Your doctor will explain the risks, benefits, and alternatives where relevant before they ask for your consent. If you are unsure about any aspect of the procedure or treatment proposed, please do not hesitate to ask for more information.

What should I expect before the operation?

Before admission for surgery you will be asked to attend a pre-admission clinic to ensure that you are fit and well for your surgery. A nurse practitioner or a doctor will ask about your general health, past medical history and any medication that you are taking. Any necessary investigations will be organised, such as blood tests, electrocardiogram (ECG) and chest X-rays.

You will receive information about your admission, hospital stay, operation and pre and post-operative care. You will also be given the opportunity to ask any further questions that you may have.

Plan ahead, when you come out of hospital you are going to need extra help at home for the first two weeks. Make sure your family knows this.

If you smoke, try to stop completely. This will make your anesthetic safer, reduce the risk of complications after the operation and speed up the recovery time. If you are unable to stop completely, even doing so for few days will be helpful.

Some medicines need to be stopped or altered before the operation. You should check with your GP and bring your list of medications with you when you come to the pre-admission clinic. If you are on the contraceptive pill, you should stop it at least four weeks before the operation and you should use another method of contraception.

What happens on my admission to hospital?

You are usually admitted to hospital on the day of your surgery, but admission times may vary. You will be informed by letter when you will need to come in.

What happens on the day of my operation ?

On the day of your operation you will not be able to eat or drink for a specified time prior to your surgery. A doctor will see you prior to your operation and your written consent will be required before your operation can take place. (This should already have been obtained at the pre-admission clinic). You will have the opportunity to ask any questions not covered during your pre-admission clinic appointment.

You will be asked to put on a theatre gown and a pair of elasticated stockings (TEDS). The stockings help to prevent clots (thrombosis) in your legs. You will need to keep these on until you are discharged from hospital. You will be informed how long to keep them on following discharge.

You will be escorted to theatre. If a pre-med has been given, a theatre trolley will be arranged to collect you from the ward. Otherwise, a member of our team will walk to theatre with you.

You will be taken to the anaesthetic room where you will be asked a few questions. If you are having general anaesthesia, you will be given an injection into a vein usually in the back of your hand. Once you are asleep, you will be taken into theatre.

You will wake up in recovery area once your operation is finished and be escorted back to your bed on the ward.

How is the procedure is carried out?

The operation is performed under general anaesthetic. You will have a drip in your arm. A catheter (a tube for urine drainage) is inserted into your bladder once you are asleep. There will be four small incisions on your abdomen for introducing the camera and the instruments for the operation. A piece of mesh is stitched along the back wall, the top and, if necessary, the front wall of the vagina. The mesh is in turn secured to ligaments over the sacrum (lower backbone). This is to support the vagina and prevent it from prolapsing down, restoring it to its normal position. Eventually, new tissue grows into the mesh, which forms a new strong ligament and remains permanently in the body.

What happens after the operation?

When you wake up from the anaesthetic, you will have a drip in your hand to give you fluids. The surgeon may place a vaginal pack (swabs inside the vagina) to stop any bleeding into the tissues. There will also be a tube in the bladder (catheter) to avoid urinary retention. The pack and catheter is usually removed on the day after surgery.

Will I have pain following the surgery?

Most people experience some pain or discomfort for the first few days and you will be offered pain relief to help ease it.

Initially, you may need to have pain relief by injection to keep you comfortable, after this you will have the choice of tablets or suppositories. You will be encouraged to take pain relief, as being pain-free will speed up your recovery. The anaesthetist will discuss pain relief with you before your operation.

Having an anaesthetic, being in pain and having strong pain relief can sometimes make you feel nauseous or sick. This can be relieved by injections or tablets.

Many women get wind pains a few days after the operation, which can be uncomfortable and make the tummy look distended (swollen). This should not last long and can be relieved by medicines, eating and walking about. You should avoid constipation:

- Drinking plenty of water / juice
- Eating fruit and green vegetables especially broccoli
- Eat roughage, for example. bran / oats.

Will there be bleeding?

After the operation, you may have some vaginal bleeding and you will need to wear a sanitary pad. We advise that you do not use tampons. Your vaginal loss should change to a creamy discharge over the next 2 to 3 weeks. If you have any new pain, fresh bleeding or bad smelling discharge after you go home, you should contact your GP.

Will I have stitches?

You have some stitches on the small incisions on your abdomen which normally dissolve 2 to 3 weeks after your operation. If you have had a vaginal repair, you will have vaginal stitches, which are dissolvable. Threads may come away for up to three months, which is quite normal.

How will I cough?

If you need to cough, your stitches will not come undone. You will be wearing a sanitary towel, and coughing will hurt less if you press on your pad firmly to give support between your legs.

When can I return to my normal routine?

Recovery is a time-consuming process, which can leave you feeling tired, emotionally low or tearful. Although the scars from laparoscopic (keyhole) surgery are small, this does not shorten the healing process. The body needs time and help to build new cells and repair itself.

Depending on what surgery you have had, you will need to take 4 to 6 weeks off work to recover. This also depends on the nature of your work.

After a sacrocolpopexy, most women stay in hospital for approximately 2 days, but it could be longer if necessary. Your date of discharge depends on the reasons for your operation, your general health and how smoothly things go after surgery.

It is important to remember that everyone's experience is different; recovery time varies from woman to woman and it is, therefore, best not to compare your own recovery with that of others on the ward.

When can I drive again?

You can drive as soon as you can make an emergency stop without discomfort, generally after two weeks, but you must also check with your insurance company, as some of them insist that you should wait for six weeks.

When can I exercise again?

It is important to continue to exercise and walking is recommended. Gradually increase the length of your walks, but remember to only walk the distance you can achieve comfortably. Cycling and swimming are equally good.

You are encouraged to do pelvic floor exercises within 1-2 weeks after the operation.

Will I have any follow-up appointments?

We will arrange follow-up after surgery to assess your recovery either as an outpatient clinic appointment or a symptom questionnaire. The clinic appointment will be posted to you.

When can I have sex after the operation?

For many women, following recovery, this aspect of their life is improved because there is no longer any discomfort. We advise that you avoid penetrative intercourse for about six weeks, until after your follow-up appointment.

Take time, feel comfortable, do not be rushed and for the first few times you might find a lubricating gel is helpful. You can buy this from the chemist. Talk to your husband or partner about this, as you will need them to be extra gentle and understanding.

Will I gain weight?

The operation itself should not cause you to gain weight. Initially, because you are feeling better, reduced levels of activity and an increased appetite, might lead to weight gain if you are not careful. By paying attention to what you eat and increasing your activity level as you recover, weight gain need not be a problem.

Will I have an abdominal incision (cut)?

Although the aim is to perform the surgery through a laparoscope (keyhole incisions), sometimes this is not possible. The need for a laparotomy (wider cut in the abdomen) may be required; occasionally, the operation needs to be converted from laparoscopy to laparotomy (abdominal cut) during surgery, especially if there is significant bleeding or damage to surrounding structures. This is very unlikely (less than 1%).

What happens if I feel unwell after I go home?

You may expect some minor bleeding, especially some old, brownish blood for two weeks.

You should contact your GP or Ward D7 if you notice any of the following:

- Increased temperature
- Wound swelling
- Worsening pain
- Bad smelling discharge either from the wounds on your tummy or the front passage
- Blood in your urine or bowel motions
- Abdominal distension (swelling)
- Failure to open your bowel.

You can also contact:

The Emergency Gynae Assessment Unit (EGAU)
01902 307999 ext 84606
Monday to Friday, 8:30am to 4:30pm
Saturday, 8:00am to 1:00pm

Further Information

Patient.co.uk
Website: www.patient.co.uk/doctor/genitourinary-prolapse-pr

Useful support advice and literature is available:

PALS (Patient Advice and Liaison Service)	01902 695362
NHS Direct	0845 4647
Ward D7 on extension	01902 694034

Bladder & Bowel Foundation
SATRA Innovation Park,
Rockingham Road Kettering,
Northants, NN16 9JH

Nurse helpline for medical advice:	0845 345 0165
Counsellor helpline:	0870 770 3246

General enquiries: 01536 533255 Fax: 01536 533240
mailto:info@bladderandbowelfoundation.org
http://www.bladderandbowelfoundation.org

Sacrocolpopexy: http://www.nice.org.uk/guidance/index.jsp?action=download&o=42 887

Hysterectomy and sacrocolpopexy:
http://www.nice.org.uk/guidance/index.jsp?action=download&o=42 894

http://www.easyhealth.org.uk/

English

If you need information in another way like easy read or a different language please let us know.

If you need an interpreter or assistance please let us know.

Lithuanian

Jeigu norėtumėte, kad informacija jums būtų pateikta kitu būdu, pavyzdžiui, supaprastinta forma ar kita kalba, prašome mums apie tai pranešti.

Jeigu jums reikia vertėjo ar kitos pagalbos, prašome mums apie tai pranešti.

Polish

Jeżeli chcieliby Państwo otrzymać te informacje w innej postaci, na przykład w wersji łatwej do czytania lub w innym języku, prosimy powiedzieć nam o tym.

Prosimy poinformować nas również, jeżeli potrzebowaliby Państwo usługi tłumaczenia ustnego lub innej pomocy.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਪੜ੍ਹਨ ਵਿਚ ਆਸਾਨ ਰੂਪ ਜਾਂ ਕਿਸੇ ਦੂਜੀ ਭਾਸ਼ਾ ਵਿਚ, ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

ਜੇ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ ਦੀ ਜਾਂ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

Romanian

Dacă aveți nevoie de informații în alt format, ca de exemplu caractere ușor de citit sau altă limbă, vă rugăm să ne informați.

Dacă aveți nevoie de un interpret sau de asistență, vă rugăm să ne informați.

Traditional Chinese

如果您需要以其他方式了解信息，如易读或其他语种，请告诉我们。

如果您需要口译人员或帮助，请告诉我们。

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