Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Sacrocolpopexy or Sacrohysteropexy surgery for prolapse

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Sacrocolpopexy or Sacrohysteropexy Surgery for Prolapse

Patient Information

Gynaecology Services

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Introduction

This leaflet has been written to answer some questions you may have about sacrocolpopexy and sacrohysteropexy. It is not intended to replace the personal contact and conversations between you and the doctors and Nurses. You should read this leaflet together with the NICE Patient Decision Aid for either uterine prolapse surgery:

surgery-for-uterine-prolapse-patient-decision-aid-pdf-6725286112.pdf

or vaginal vault prolapse surgery surgery-for-vaginal-vault-prolapse-patient-decision-aid-pdf-6725286114.pdf

These leaflets give more information about other treatments which are available, and they are described and compared. If at any time you have any concerns, worries, or questions not covered by the leaflets please feel free to discuss them with members of staff.

What is a Sacrocolpopexy or Sacrohysteropexy?

Both procedures are similar:

A **Sacrocolpopexy** is an operation to correct a prolapse of the vault (top) of the vagina (possibly following a previous hysterectomy). This type of prolapse is called **"A vaginal vault prolapse".**

A **Sacrohysteropexy** is an operation to correct a prolapsed uterus (sometimes called a dropped womb).

Both procedures lift the top of the vagina / uterus back into its normal position using a synthetic mesh. The mesh will remain permanently in the body. You will be asleep throughout under a general anaesthetic. The procedure is usually carried out laparoscopically (Keyhole Surgery) through four very small incisions in your tummy (abdomen). Occasionally it may not be possible to carry out the operation using keyhole surgery and then an incision will be made just below the pubic hairline (a bikini line incision).

If, you have had previous abdominal surgery e.g. hysterectomy or caesarean section and the procedure is an open operation the incision will usually be in the same place. The synthetic mesh is attached between the uterus / vagina and tissue (ligaments) in front of the lower part of the spine (sacrum), It is stitched into position on the uterus or vagina using dissolving stitches. Titanium staples are used to fasten the mesh to the ligament and bone of the sacrum. Titanium is a metal which does not degenerate and is safe in MRI scanners.

As with all operations for prolapse, there isn't any guarantee that prolapse will not come back. The reason for developing prolapse is that the tissues in that area are weak.

This operation does have around an 8090% success rate. With 9 out of 10 ladies permanently cured of the vault/uterine prolapse. Prolapse of the vaginal walls (front and/or back) may still be present and this can be treated during the same operation.

Benefits of treating Prolapse

The benefit for you in treating a prolapse is to improve your quality of life by making you more comfortable. Occasionally it may also improve bowel or bladder function however this is not always true.

If a prolapse is not treated it will not cause any harm. The feelings of discomfort will remain.

Risks

All operations carry a small risk from the anaesthetic and your doctors will explain this.

Bleeding

- Occasionally during the operation or afterwards heavy bleeding may occur. The risk of bleeding is very low if keyhole surgery is used. If bleeding does occur after the operation a second operation (return to theatre) may be necessary to stop the bleeding and you may need a blood transfusion.

Risk of damage to nearby organs

- The bowel, bladder and ureters (tubes from kidney to bladder) are close to the operation site this raises a very small risk that they could be damaged during surgery. Any possible damage would usually be repaired at the time which may require an open operation unless it is minor damage to the bladder which can be repaired with keyhole surgery.

Urinary complications

- A small risk of difficulty in passing urine. This will usually settle after a few days. If it persists some women will need a catheter in the bladder for a short time.

- In about one in ten women there may be irritation of the bladder causing frequent visits to the toilet and occasional leakage especially if a very large prolapse has been corrected. This usually gets better gradually.

- Sometimes when a prolapse comes down it makes a kink in the urethra (tube from the bladder through which urine passes). This can make it difficult to pass urine (wee) but it can also stop urine leaking out. When the prolapse is repaired the urethra is straightened out and you may become aware of urine leaking with coughing and exercise which was

not happening before surgery. This happens in up to 10% (1 in 10) of women who have surgery and unfortunately there is no good test to predict who will get this. If this does occur treatment can be offered.

Post-operative Infection

- There is a small risk of infection either in the pelvis at the site of the operation or a urinary (water) infection. This risk is much lower if the procedure is done with keyhole surgery. Antibiotics are given during the procedure to reduce this risk even further.

Venous thrombosis and embolism

- A small risk of developing Deep Vein Thrombosis (DVT) (blood clot in the leg veins) or a clot traveling to lungs, pulmonary embolism (PE). To reduce this risk you will receive a blood thinning injection. This risk is much lower if the procedure is carried out with keyhole surgery.

Recurrence of prolapse

- A possible risk following a prolapse operation is that it will not cure all of the symptoms even if the prolapse is effectively repaired. It is possible that over time a prolapse can return. This may not be a prolapse in the same part of the vagina which has been repaired. In about 10% (1in10 patients) the same prolapse will recur after a sacrocolpopexy / sacrohysteropexy.

Exposure of mesh

- After a sacrocolpopexy there is a small possibility (1in100) that the synthetic mesh will work its way through the skin of the vagina causing a vaginal discharge and possible

bleeding from the vagina. The piece of mesh that has worked its way through will have to be removed. This will generally be removed through the vagina. The risk of the mesh working its way through any other organs such as bladder and bowel is very small. In a sacrohysteropexy procedure when the mesh is fixed to the uterus this complication is almost unknown.

Lower back ache

- There are rare reports of inflammation developing in the spinal disc due to the staples that are used to fix the mesh to the inside of the sacrum. Low backache has also been reported.

Painful sexual intercourse

- Persistent discomfort during intercourse (sex) can be a problem for one in ten women.

What to expect after the operation

- Immediately following the operation a drip will be inserted in the arm to provide fluid until you can eat and drink properly. There may also be a system where you can press a button to provide pain relief as required. (Patient controlled analgesia or PCA).

- You may have a catheter in your bladder to drain urine. The catheter will usually be removed the following day.

- You will be given an injection to thin your blood to help prevent thrombosis (blood clots) until you are fully mobile

- Soon after your operation you will be seen by a doctor who will explain to you how your operation went and if there were any changes to the previously planned operation. You should be informed of your progress at all times. Don't be afraid to speak to the Doctors or Nurses if you have any questions.

- You will be encouraged to move about after the operation this may be on the same day. Moving around will aid your recovery by reducing the chance of developing any post-operative complications such as possible blood clots in your legs and lungs and also will help prevent you getting a chest infection.

- You will usually stay in hospital one or two days

For further information about recovery after an operation see the two leaflets:

Gyn 058 Prolapse and Gyn 024 Following Major Gynaecological Surgery

The leaflets are available in our clinics or on the following web page:

https://www.wwl.nhs.uk/patient-information-leaflets , listed under letter G-Gynaecology.

How long will the recovery take?

It takes about 6-8 weeks to get back to normal. It is important for you to be as active as possible. Being bedridden can increase the risk of thrombosis (blood clots) occurring in the leg veins and lungs. Although you need to be active you must be sensible and make sure that you have periods of rest when you begin to feel tired.

You are advised to gradually start doing a little more each day without tiring yourself. Do whatever you feel comfortably able to do without too much effort, however, avoid lifting and straining until you are seen again in the out-patients clinic.

It is recommended that you avoid the following until at least twelve weeks after surgery:

- No sit up Exercises.
- No lifting children or other heavy objects.
- No gardening.
- No heavy housework.
- No moving furniture.
- No aerobic exercises.

Follow up

You will receive an appointment for a follow up consultation in clinic 8-12 weeks after your operation.

Contact Information after you have left the hospital

If you have any questions about the information in this leaflet **OR** have any difficulties or problems, please feel free to speak to one of the Nurses on the ward to which you are admitted or by contacting the Consultant who is treating you.



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