Sacrocolpopexy

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Introduction

This operation is treating a special type of vaginal prolapse called a “vaginal vault prolapse”. This occurs when the top of the vagina loses its support and sags or drops down into the vaginal canal or outside of the vagina.

It may occur alone or along with prolapse of the front (anterior) or back (posterior) wall of the vagina and only happens in women who have had their uterus removed (i.e. after hysterectomy).

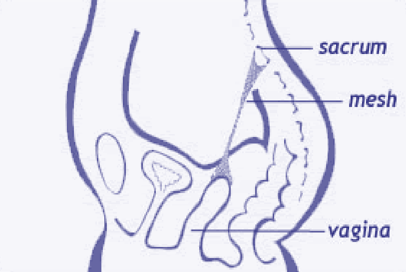
Symptoms can include a bulge from the vagina, discomfort; back ache or a dragging sensation; as well as problems with the bladder, bowel and/ or sexual intercourse.

What is a Sacrocolpopexy?

A Sacrocolpopexy is a repair to the top of the vagina to support it and take away the prolapse symptoms.

It involves attaching the top of the vagina to a ligament on the pelvis using a piece of synthetic “mesh” material. The mesh is made from a permanent plastic which is woven into a mesh. It is a permanent implant and is not intended to be removed.

Overall, Sacrocolpopexy has an 85-90% success rate. The surgery can be performed laparoscopically (keyhole) or through a bikini line incision in the tummy known as a laparotomy. This will be dependent on your individual circumstances which your surgeon will discuss with you.



Extra repairs can be done to either the front wall (anterior) and / or the back wall (posterior) at the same time if needed.

Other investigations you may need before surgery include a pelvic ultrasound to examine a number of structures including the ovaries (if still present) or a bladder test known as “Urodynamics” to check how your bladder is working.

What are my options?

No treatment

Whilst vaginal prolapse can be uncomfortable and unpleasant, it is not life-threatening and having no treatment is a perfectly reasonable option, especially if you are not particularly aware of it and it is not causing any problems.

Lifestyle strategies

Stopping smoking, losing weight and managing your bowels will all help in alleviating symptoms.

Vaginal estrogens

These will not cure a prolapse, but if the tissues lack estrogen (due to the menopause) it can help to reduce the awareness of a prolapse.

Physiotherapy

If a prolapse is mild, supervised physiotherapy (pelvic floor exercises) can help to reduce the symptoms so that surgery can be avoided.

Vaginal Support Pessaries

There are a wide variety of pessaries which hold the prolapse in place. The pessary will need to be changed every 4-6 months, but they can avoid the need for surgery altogether or be used temporarily should you wish to defer surgery.

Combination of the above

Conservative (non-surgical) treatments can be used alongside each other, and if post-menopausal vaginal estrogens are often advised alongside surgical options.

Surgery

Surgery will be offered if clinically indicated. The type of surgery will depend on the type of prolapse, whether you are sexually active, whether you have had previous vaginal surgery, and how medically fit you are.

All procedures, their risks and benefits will be discussed with you and your case reviewed by our multi-disciplinary team (MDT) before a decision, with your input, can be made on which is the right procedure for you.

Before the operation

Pre-operative assessment

This is done well in advance of your surgery date to ensure you are fit and well to undergo surgery and will include a review of your medications, urine and blood test and other tests such as an ECG (heart monitoring test) or chest x-ray. It can often be done immediately following your consultation when you are initially added to the waiting list. If not, you will be sent an appointment. Surgery dates are usually offered with about 4-6 weeks notice. Please notify us of any previous arrangements/ holidays so that we do not offer dates that clash. You should expect to be in hospital for 2-3 days.

Medications

Please **bring all your medications** with you when you attend for your surgery and **only** stop those medications you have been advised to.

You will be asked to stop any anticoagulants (blood thinning medications), but we will liaise with your GP/ Haematology Department about a regime to reduce and come off these medications. (These include warfarin, heparin, dabigatran, rivaroxaban, apixaban and clopidogrel).

Other medications with similar properties (e.g., aspirin, ibuprofen and diclofenac) will need to be stopped 2 weeks before the operation.

Consent

You will be asked to sign a consent form which confirms you have agreed to the procedure. If you do not understand anything, require any further information or would like someone with you, please let the consenting doctor know **before** you sign.

Eating and drinking

You will be advised when you need to stop eating and drinking prior to the procedure depending on the type of anaesthetic and the time your surgery is scheduled.

Pre-existing bladder problems

If you have any urinary symptoms, urodynamic tests will be performed to ascertain their cause, severity and whether additional surgery is needed.

If you have had previous continence surgery, have difficulty emptying your bladder or pass urine slowly with or without the need to strain, you may need to be taught clean intermittent self-catheterisation (CISC) before going on the waiting list, in case these symptoms are made worse by the surgery.

The anaesthetic and operation

The anaesthetic

The operation is usually done under a general anaesthetic (asleep) but can be done under a spinal anaesthetic (numb from the waist down).

The operation

- The length of the operation can vary from 90-180 minutes depending on any previous pelvic surgery.

- Your legs will be held in stirrups. Please let us know if you have any hip or back problems.

- A small bikini cut (or laparoscopic port holes) is made on your abdomen just above your pubic bone.
- The bowel may need to be moved out of the way to gain access to the vagina and back bone.
- The highest point of the vagina is located, lifted, and then attached to a ligament on the back bone using the synthetic mesh.
- When the operation is completed any incisions will be stitched together with dissolvable stitches and a small dressing will be applied.

After the operation

- After the surgery, you will be taken to recovery and then on to the ward.
- You may experience some discomfort/pain for the first 24-48 hours.
- Painkillers will be provided but please let us know if any pain is not relieved by the painkillers you are given.
- An intravenous (IV) cannula will be in your arm. This usually stays in place for 1-2 days to administer any IV medication and / or fluids (drip) until you are drinking normally again.
- If there has been more than average bleeding during the operation a drain (tube) maybe placed in the abdomen (tummy) to drain out any blood that has collected. This is removed once it has stopped draining any excess blood, usually in 1-2 days.
- If you have had a spinal anaesthetic you will have a urinary catheter left in the bladder, usually overnight.
- There will be a small dressing covering the wound or laparoscopic port sites.
- Once you are awake/ready you will be able to drink starting with sips and slowly gradually increase your fluid intake to 1.5 to 2 litres a day. Once you are able to tolerate fluids and have normal bowel sounds you will be able to eat normally.

What are the risks of surgery?

General surgical risks

- **Anaesthetic/ cardiovascular problems** – all anaesthetics carry some risks including chest infection, pulmonary embolus, stroke, heart attacks and very rarely, death. These risks are dependent on the type of anaesthetic you are

having and how fit you are before your surgery. Your surgeon/anaesthetist will discuss your individual risks with you.

- **Pain and discomfort -** It is usual to experience some discomfort. Painkillers will be offered on a regular basis but if your discomfort is not well-controlled please advise the staff that are looking after you.

- **Vaginal Bleeding -** It is normal to have some vaginal bleeding for 48 hours after surgery. This should tail off and become a brown discharge for a couple of weeks before stopping altogether.

- **Urinary infection** - Symptoms include foul smelling urine, frequency, urgency and a burning pain on passing urine. If you suspect an infection, increase you fluid intake and contact your GP to arrange to have a sample tested.

- **Generalised Infection** - Either in the vagina or the wound sites. A swab is often taken and antibiotics will be given if an infection is present.

- **Venous vein thrombosis (VTE**) - The risk of blood clots in the leg (4-5%) or lung (1%) is increased by immobility, if you are overweight or smoke. This risk will decrease by quick mobilisation after surgery and weight loss/ smoking cessation prior to your operation. You will be required to wear TED stockings.

Risks specific to this type of surgery

The terms in the table are designed to give you an idea of relative risks that are reported in medical literature and confirmed /endorsed by the National Institute of Health and Clinical Excellence.

Term	**Number of people**	**Size of group/area**
Very common	1 in 1 to 1 in 10	One person in a **family**
Common	1 in 10 to 1 in 100	One person in a **street**
Uncommon	1 in 100 to 1 in 1000	One person in a **village**
Rare	1 in 1000 to 1 in 10 000	One person in a **small town**
Very rare	1 in 10 000 and above	One person in a **large town**

During surgery

- **Conversion from keyhole to open surgery (Uncommon) -** Even when a laparoscopic approach is planned it is sometimes necessary to perform a laparotomy (open surgery) to proceed with the operation safely. This can be due to previous scarring making visibility difficult, bleeding that is difficult to control laparoscopically or damage to local organs.

- **Damage to local organs (Uncommon) -** This can include bladder and bowel; or the ureters (tubes from kidneys to bladder) but this is rarer. Any damage is generally dealt with when it is identified at the time of your operation but your recovery may be delayed. Any damage undetected during surgery, may require a return to theatre.

- Bladder damage may require a catheter (small tube) to be inserted to give time for the injury to heal. You will be sent home with the catheter during this time and an appointment will be made to have the catheter removed 1 to 2 weeks later.

- Occasionally, further tests such as a cystogram (xray test with dye) may be required to confirm the injury has healed before the catheter is removed.

- **Injury to the bowel requiring a temporary colostomy (bag) (Rare) -** Faeces may need to be directed away from the injury to allow the bowel to heal and your planned prolapse surgery could be delayed till a later date.

After surgery

- **Temporary difficulty in passing urine (Common)**

  - A catheter is inserted to rest the bladder (initially 1-2 weeks). This will be connected to a drainage bag fastened to your leg. You will be shown how to manage it and allowed home.

  - An appointment will be made to remove the catheter so that you can try again to pass urine.

  - If the problem persists (Uncommon) the catheter may be left in for a longer period or you will be taught clean intermittent self-catheterisation (CISC) - or asked to start if taught before surgery.

- **Long-term difficulty in bladder emptying (Rare) -** This may require long term CISC.

- **Haematoma - collection of blood (Uncommon)** - This can present as a tender swelling but in most cases will resolve on its own.

After discharge

- **Vaginal Infection (Common) -** Symptoms include an offensive, greenish vaginal discharge. If you suspect an infection, contact your GP as you may need antibiotics.

- **Wound Infection (Uncommon) -** The wound site may appear red and angry-looking with or without the presence of pus. You may need antibiotics.

- **Vaginal bleeding (Common)** - If the bleeding does not subside, it becomes heavy or associated with pain you should visit your GP as it may indicate an infection.

- **Superficial pain on sexual intercourse (Common) -** If you have had a vaginal repair as well, there will be some scarring on the vaginal wall that can be aggravated by penetrative sexual intercourse causing superficial discomfort. Lubrications or topical vaginal oestrogens (if post-menopausal) may help reduce these symptoms, but if they persist advice should be sort.

- **Long term pain in the pelvis, vagina or during sexual intercourse (Rare)** - Persistent pain needs to be investigated as it may indicate an infection or mesh migration. Nerve or musculoskeletal damage may be ongoing requiring referral to physiotherapy, the pain management team, and / or the need for surgical revision.

- **Mesh erosion/ migration into surrounding structures (Rare).** These complications are dealt with on an individual case by case basis. They can be seen shortly or several years after insertion and can present in a number of ways; unexplained pain, urinary infection, vaginal discharge, infection, bleeding and / or pain during sexual intercourse. Mesh erosion will usually require further surgery and possibly removal of the tape.

- **Mesh infection (Rare) -** If the mesh becomes chronically infected and does not respond to antibiotics, it will normally be removed.

- **Inflammation of a sacral bone (Rare)** - Any suspected infection is first treated with antibiotics, inflammatory medication and painkillers. In extreme cases surgery may be required.

- **Stress incontinence. (Common)** - This could be worsening of pre-existing symptoms or a new symptom. Urodynamic tests performed before your surgery will help predict this risk and any additional need for treatment will be discussed with you.

- **Difficulty emptying your bowel and / or constipation (Common) -** It is important to maintain a healthy diet to avoid constipation but some women find their symptoms are worse following surgery. This usually settles down but must be managed to reduce the risk of recurrent prolapse.

- **Failure or recurrence of prolapse requiring further surgery (Uncommon) -** Any recurrence of symptoms will require re assessment and investigation.

Recovery at home

Medication - You may receive some take-home medication including painkillers and / or antibiotics. Please finish the course of any antibiotics as prescribed.
Any topical vaginal oestrogen cream or pessary (vagifem) should be continued as prescribed once you feel comfortable inserting the applicator (usually after 4 weeks) and any bleeding/ discharge has subsided.

If you have been previously prescribed medication for an underlying overactive bladder, you should continue to take these unless otherwise instructed.

Stitches - All stitches are dissolvable. If you see any stitch material it is better to leave it alone. If it is bothersome, it can be trimmed by your GP or nurse. Do **not** pull them.

Personal hygiene - It is better to shower than bathe for long periods of time for the first couple of weeks. Mild vaginal discharge is part of the normal healing process. If it becomes excessive or offensive it may indicate an infection.

Bowels - *C*onstipation and straining when opening your bowels, puts unnecessary pressure on the repair and should be avoided in the long term.

Sexual intercourse - Avoid penetrative intercourse for 4 - 6 weeks. This will allow time for the vagina to heal and any stitches to dissolve. It may feel superficially tender to start but this should settle down with time.

Exercise - Avoid vigorous sports and swimming for 6- 8 weeks. As a long-term rule avoid sit ups or heavy weight training. You can gradually introduce gentle exercise into your daily routine after 4 weeks. Pelvic floor exercise should resume once you feel comfortable.

Lifting - You should avoid heavy lifting as a long-term lifestyle change if you have had continence surgery.

Driving - You should avoid driving until you feel comfortable moving around the car and you can perform an emergency stop without experiencing any pain/discomfort and to allow the wounds to heal (up to 4 weeks).

It is your legal responsibility to remain in control of a vehicle at all times and you must ensure you remain covered by your insurance policy to drive after surgery. You only need to notify the DVLA of your surgical recovery if it is likely to affect your driving and persist for more than 3 months.

https://www.gov.uk/guidance/miscellaneous-conditions-assessing-fitness-to-drive#driving-after-surgery

Return to work - 4-8 weeks. This will depend on what your work entails and whether it involves heavy manual work.

Follow up

You should be seen in clinic approximately 3 months after the operation by either one of our specialist nurses or doctors.

If you have any acute illness, please contact your GP.

If you need to ask for advice, then please ring the ward you were admitted to or the Urogynaecology Department on Monday to Friday.

Useful contact numbers:

- **Urogynaecology Clinical Co-Ordinator**
  Monday to Friday (excl. BH) - **0151 676 5619**

- **Day Surgery Unit St Helens Hospital (Sanderson Suite)**
  8am-9pm Monday to Friday – **01744 64 6089**

- **Pre-assessment Clinic - 01744 64 6395**
  9am-5pm Monday to Friday

- **Surgical Assessment Unit - 0151 430 1637**
  after 9pm, weekends and bank holidays

- **Outpatients Department, St Helens Hospital**
  9am-5pm Monday to Friday – **01744 64631 / 6300**

- **Main Switchboard – 0151 426 1600**

Further reading

- You can read any of the specific prolapse surgery leaflets available in clinic
- IUGA leaflets - https://www.yourpelvicfloor.org/leaflets/
- BSUG Patient leaflets - https://bsug.org.uk/pages/for-patients/bsug-patient-information-leaflets/154
- Bladder and Bowel organization UK - https://www.bbuk.org.uk/
- http://www.mhra.gov.uk
- http://www.nice.org.uk
- http://rcog.org.uk

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