

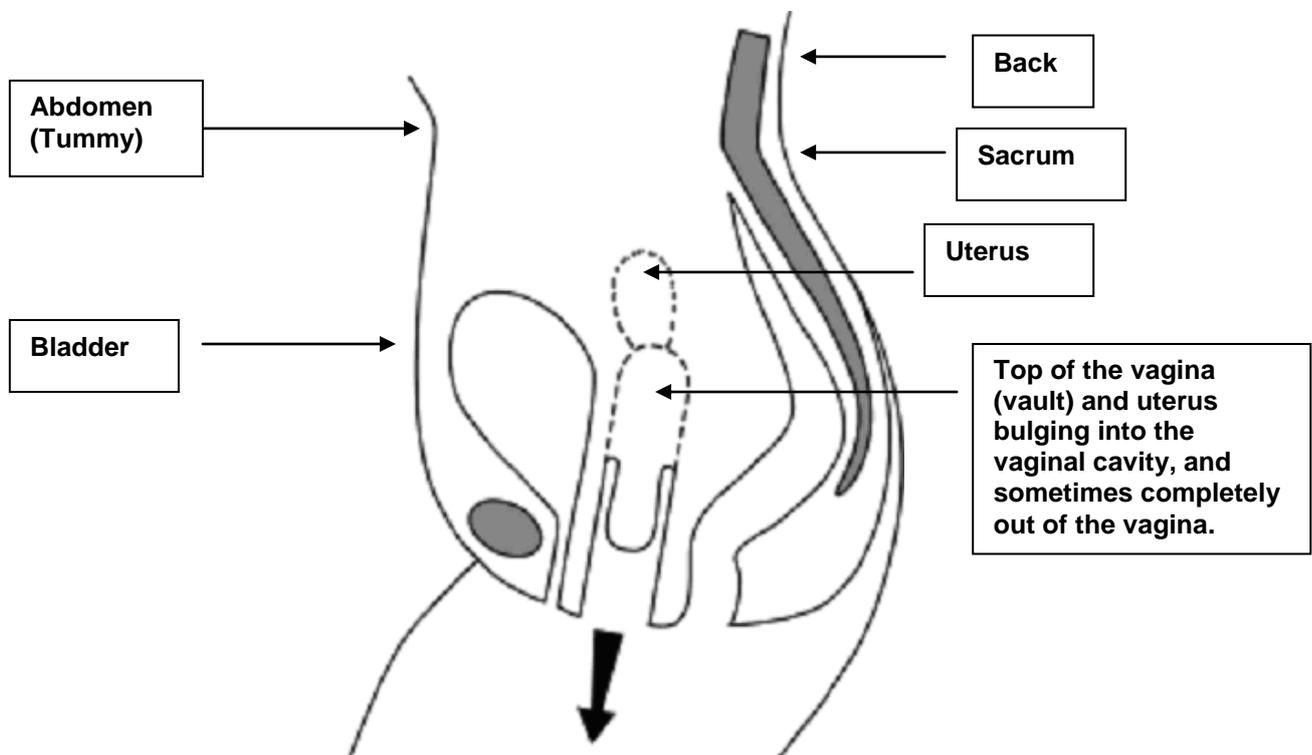
## Gynaecology Department

### Laparoscopic Sacrohysteropexy

#### What is Prolapse of the Uterus / Vaginal apex?

- A prolapse is where the vaginal tissue is weak and bulges downwards into the vagina itself. In severe cases it can even protrude outside the vagina.
- Apical vaginal prolapse is a prolapse arising from the top of the vagina. The apex is the deepest part of the vagina (top of it/ roof) where the uterus (womb) usually is located. If you have had a hysterectomy then the term 'vault' is used to describe the area where your womb would have been attached to the top of the vagina (see diagram below).

**Figure 1: A diagram, sideways on, showing the normal anatomy (dotted line) and a prolapsing vaginal apex (continuous line)**



## Patient Information

- It is often accompanied by a posterior vaginal wall prolapse, either a high posterior vaginal wall prolapse called an enterocele, or a low posterior vaginal wall prolapse called a rectocele, or sometimes both.
- The pelvic floor muscles are a series of muscles that form a sling or hammock across the opening of the pelvis. These muscles, together with their surrounding tissue, are responsible for keeping all of the pelvic organs (bladder, uterus, and rectum) in place and functioning correctly.
- Prolapse occurs when the pelvic floor muscles or the vagina have become weak. This usually occurs after the trauma of childbirth but is most noticeable after the menopause when the strength of the supporting tissue deteriorates.
- With straining, for example on passing a motion, the weakness described above allows the apex of the vagina to bulge downwards and the rectum (back passage) to bulge into the vagina and sometimes bulge out of the vagina.
- Some women have to push the bulge back into the vagina with their fingers in order to empty their bladder or complete a bowel movement.
- Some women find that the bulge causes a dragging or aching sensation.

## Alternatives to surgery

**Do nothing:** if the prolapse (bulge) is not distressing then treatment is not necessarily needed. If, however, the prolapse permanently protrudes through the opening to the vagina and is exposed, it may become dried out and eventually ulcerate. Even if it is not causing symptoms in this situation it is probably best to push it back with a ring pessary (see below) or have an operation to repair it.

**Pelvic Floor Exercises (PFE):** the pelvic floor muscle runs from the coccyx at the back to the pubic bone at the front and off to the sides. This muscle supports your pelvic organs (uterus, vagina, bladder and rectum). Any muscle in the body needs exercise to keep it strong so that it functions properly. This is more important if that muscle has been damaged. PFE can strengthen the pelvic floor and therefore give more support to the pelvic organs. These exercises may not get rid of the prolapse but they make you feel more comfortable. PFE are best taught by an expert usually a physiotherapist. These exercises have little or no risk and even if surgery is required at a later date, they will help your overall chance of being more comfortable.

### Types of pessary

**Ring pessary:** this is a soft plastic ring or device which is inserted into the vagina and pushes the prolapse back up. This usually gets rid of the dragging sensation and can improve urinary and bowel symptoms. It needs to be changed every four to six months and can be very manageable; we can show you an example in clinic. Other pessaries may be used if the ring pessary is not suitable. Some couples feel that the pessary gets in the way during sexual intercourse, but many couples are not bothered by it.

**Shelf pessary or gellhorn:** if you are not sexually active this is a stronger pessary which can be inserted into the vagina and again needs changing every four to six months.

### 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.

**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. 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).

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### Specific risks of this 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 and tenderness on intercourse due to vaginal tethering or mesh erosion this usually settles with time. Occasionally pain on intercourse can be permanent.

**Mesh exposure/extrusion** occurs when the plastic mesh pokes 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 cause problems with faecal and 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 by dietary adjustments 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.

### **The operation – Sacrohysteropexy**

In this operation the cervix (neck of the womb) is lifted upwards toward a prominent part of the back bone (the sacral promontory) using a piece of synthetic mesh. These kinds of operations using a plastic mesh to pull up the vagina toward the backbone have been performed for a long time and are generally successful (90%). More recently we have been performing the same operation in women who still have a uterus, and pulling the cervix / uterus up toward the backbone. There are some theoretical benefits in leaving the womb behind if it is still present:

- Reduce operating time;
- Reduce risk of damage to local organs;
- Reduce risk of bleeding;
- The cervix is a much tougher tissue to place surgical sutures than the vagina so the operation may be more robust.

As we have only started leaving the uterus behind during these operations more recently we cannot be sure at this moment of the long-term results. It can involve a cut on the abdomen (tummy) and or can be done through key-hole surgery.

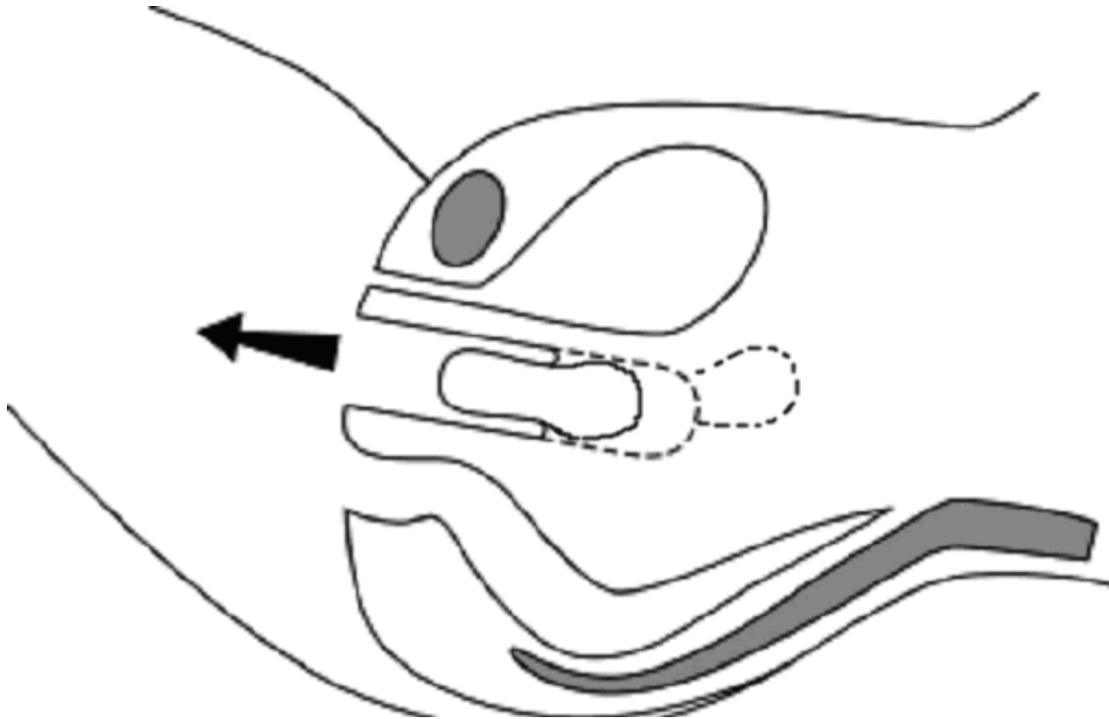
### **How the operation is performed – sacrohysteropexy**

The operation is carried out under general anaesthetic.

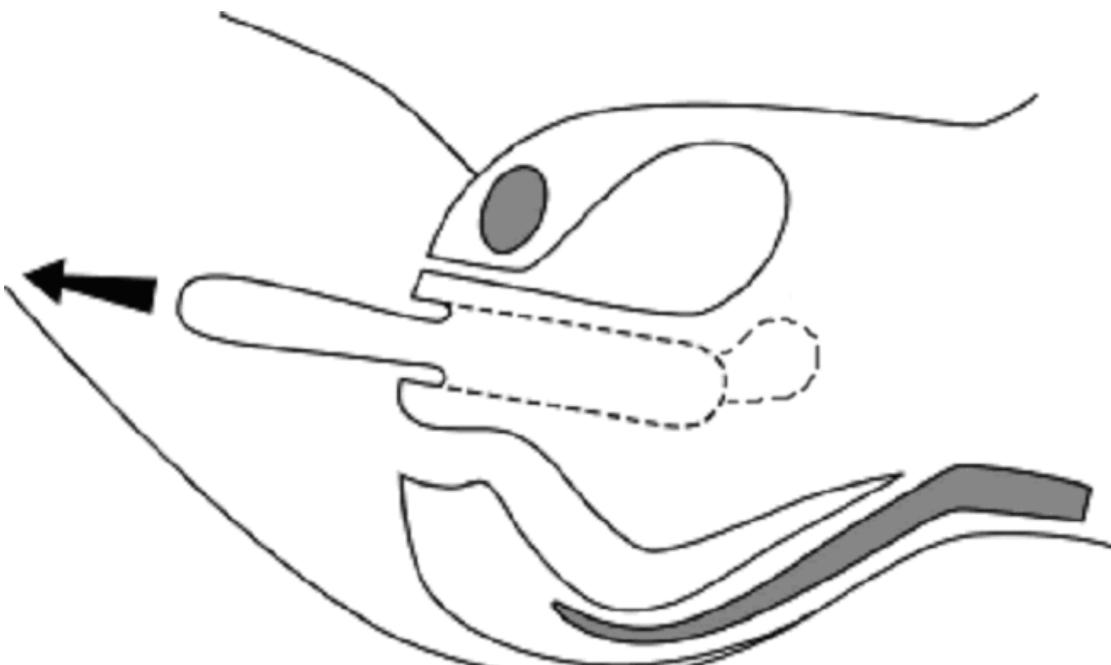
- A general anaesthetic will mean you will be asleep (unconscious) during the entire procedure.
- Your legs are placed in stirrups (supported in the air).
- The operation can be done via keyhole surgery which may mean quicker recovery. If it needs to be done as an open procedure- a horizontal (sideways) or a vertical (up and down) incision is made in the lower abdomen (tummy).
- The prolapse is pushed up from below.
- A synthetic mesh is sutured (stitched) to the cervix and the other end is sutured or stapled (titanium staples) to a prominent part of the back bone (the sacral promontory) internally.
- The mesh remains permanently in the body.
- This effectively suspends the vagina via the graft to a sturdy bone.
- A urinary catheter is left in place overnight.

## Patient Information

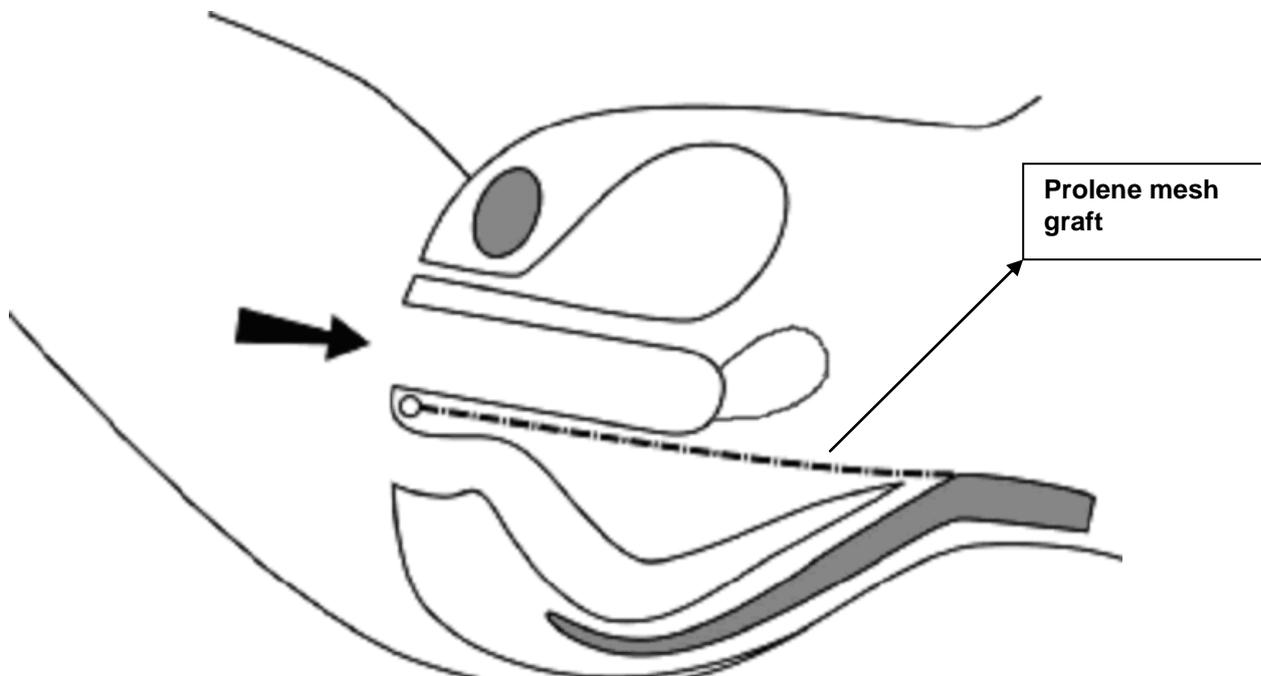
**Figure 2: Diagram of sideward view showing the uterus collapsing down the vaginal canal**



**Figure 3: Diagram showing sideward view of the uterus and vagina protruding outside the vagina**



**Figure 4: Diagram showing uterus (vaginal apex) and posterior vaginal wall supported by a graft.**



### **After the operation in hospital**

- On return from the operating theatre you will have a fine tube (cannula or drip) in one of your arm veins with fluid running through to stop you getting dehydrated.
- You may have a bandage in the vagina, called a 'pack' and a sanitary pad in place. This is to apply pressure to the wound to stop it oozing.
- You may have a tube (catheter) draining the bladder overnight. The catheter may give you the sensation as though you need to pass urine but this is not the case.
- Usually the drip, pack and catheter come out the morning after surgery or sometimes later the same day. This is not generally painful.
- The day after the operation you will be encouraged to get out of bed and take short walks around the ward. This improves general wellbeing and reduces the risk of clots on the legs.
- It is important that the amount of urine is measured the first couple of times you pass urine after the removal of the catheter. An ultrasound scan for your bladder may be done on the ward to make sure that you are emptying your bladder properly. If you are leaving a significant amount of urine in your bladder, you may have to have the catheter re-inserted back into your bladder for a couple more days.

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- You may be given injections to keep your blood thin and reduce the risk of blood clots normally once a day until you go home or longer in some cases.
- The wound is not normally very painful but sometimes you may require tablets or injections for pain relief.
- There will be slight vaginal bleeding like at the end of a period after the operation. This may last for a few weeks.
- The nurses will advise you about sick notes, certificates etc. You are usually in hospital for up to four days.

### **After the operation at home**

- When you arrive home you must continue to move around and not be totally bedbound.
- You are likely to feel tired and may need to rest in the daytime from time to time for a month or more, this will gradually improve.
- It is important to avoid stretching the repair particularly in the first weeks after surgery. Therefore, avoid constipation and heavy lifting. The deep stitches dissolve during the first three months and the body will gradually lay down strong scar tissue over a few months.
- **Avoiding constipation**
  - Drink plenty of water / juice
  - Eat fruit and green vegetables such as broccoli
  - Plenty of roughage for example bran / oats
- Do not use tampons for six weeks.
- There are stitches in the skin wound in the vagina. Any stitches under the skin will melt away by themselves. The surface knots of the stitches may appear on your underwear or pads after about two weeks; this is quite normal. There may be a little bleeding again after about two weeks when the surface knots fall off, this is nothing to worry about.
- At six weeks gradually build up your level of activity.
- After three months, you should be able to return completely to your usual level of activity.
- You should be able to return to a light job after about six weeks. For heavier work you could be off work for up to 12 weeks.

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- You can drive as soon as you can make an emergency stop without discomfort, generally after three weeks, but you must check this with your insurance company, as some of them insist that you should wait for six weeks.
- You can start sexual relations whenever you feel comfortable enough after six weeks, so long as you have no blood loss. You will need to be gentle and may wish to use lubrication (KY jelly).
- Follow up after the operation is usually at three months. This maybe at the hospital (doctor or nurse), with your GP or by telephone.
- As you would still retain your uterus and cervix you should continue to attend routine cervical smears until you are 65 years old.

### **Where can I obtain more information?**

If you have any questions or would like more information, please telephone the **Gynaecology Department on 024 7696 7000**.

You may also find the websites listed below helpful if you would like more information.

#### **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=42887>

#### **Hysterectomy and Sacrocolpopexy:**

<http://www.nice.org.uk/guidance/index.jsp?action=download&o=42894>

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

## Patient Information

The Trust has access to interpreting and translation services. If you need this information in another language or format please contact 024 7696 7000 and we will do our best to meet your needs.

The Trust operates a smoke free policy.

### **Document History**

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