Surgery for vaginal vault prolapse (sacrocolpopexy) or womb prolapse (sacrohysteropexy)

Department of Gynaecology

Information for Patients

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Introduction

This leaflet explains 2 types key-hole operations done to help with some types of prolapse.

Laparoscopic sacrocolpopexy treats vaginal vault prolapse. The vaginal vault is fixed to the top of the lower back bone (sacrum).

Laparoscopic sacrohysteropexy treats a prolapse in the womb (uterus) without removing it.

Both use tiny cuts in the skin. This is called minimally invasive surgery. They are done under general anaesthetic.

Keyhole surgery means that you recover more quickly. The other way to do the operations is through a cut in the tummy.

What is prolapse?

A prolapse is a bulge of the walls of the vagina or the womb dropping down into the vagina.

The muscles and ligaments that support the vagina/womb separate or stretch. They can no longer support the organs. This is usually due to pregnancy or childbirth. Prolapse can affect the front wall, back wall or the womb (or top of the vagina after hysterectomy).

The bladder sits just above the front wall of the vagina. If the fibrous tissues in the front of the vagina separate, the bladder drops down in to the gap. This is called a cystocoele.

The bowel sits behind the back wall of the vagina. If the fibrous tissues in the back of the vagina separate, the bowel drops down in to the gap. This is called a rectocoele or enterocoele.

When there is a prolapse of the womb itself, the womb drops down into the vagina or even comes right outside the vagina. The top of the vagina can also be affected by prolapse if you have had a hysterectomy before. This is called a vault prolapse.

One, two or all three parts of the vagina can be affected by prolapse in any combination.

The main problems a prolapse causes are

- bulging and aching in the vagina
- pain in the lower tummy or lower back
- problems during sex
- when the prolapse is outside the vagina, the skin can become very sore. It may turn into an ulcer. It can bleed where it rubs on the underwear.

There may also be urinary or bowel problems such as loss of bladder control. Treating the prolapse will not always help with urinary or bowel problems. It may even make them worse.

Treatment options for prolapse other than surgery

1. Doing nothing is a choice if a prolapse is not causing any problems. But a prolapse may get bigger. If it does get bigger, you can come back and see us for treatment.
2. Pelvic floor exercises strengthen the muscles that support the vagina around the gap. They will not get rid of the prolapse but may make you feel more comfortable. A nurse or physiotherapist in our department supervise pelvic floor exercises.
3. Vaginal pessaries are plastic devices that are put into the vagina. They hold up the prolapse. Some patients may be able to look after some types of pessary themselves. Others need to be changed every 4 to 6 months in the GP practice or clinic. Some pessaries may stop you from having sex, cause a vaginal discharge and can sometimes cause bleeding.

(Click on the links or scan the QR code to read the leaflets)

What happens during the operation

These operations are used to treat a prolapse of the womb or the top of the vagina if you have already had a hysterectomy. We do it using a keyhole technique through a few small tummy cuts.

We use a strip of mesh (soft piece of netting which does not dissolve) to lift and support the top of the vagina.

We stitch one end of the mesh to the top of the vagina (vault) or the back of the cervix.

We stitch the other end to strong tissue higher up along the back of the pelvis.

When this is done we check the vagina to see if there are any other areas of prolapse. If we find there is still a prolapse of the front or back wall of the vagina, we may need to do another operation to fix that prolapse. We do this operation through the vagina.

We aim to do your operation using a keyhole technique. It may not always be possible to do this. Up to 1 in 4 operations will be done through a cut in the tummy. This may mean you have a longer hospital stay and recovery at home.

Risks of surgery

- **Anaesthetic risk.** These are very rare. The risk of a serious problem caused by the anaesthetic is 1 in 10,000. Risk of death from the anaesthetic is 1 in 100,000.
- **Heavy bleeding.** There is a risk of bleeding with any operation. Heavy bleeding is uncommon. It is rare that we have to give blood to patients during or after prolapse surgery.
- **Infection.** There is a risk of infection after any operation. A serious infection is rare. We lower the risk of you getting an infection by giving you antibiotics during your operation.
- **Deep vein thrombosis (DVT).** This is a clot in the deep veins of the leg. It can occur in 4 to 5 out of 100 patients. A serious problem sometimes occurs when a clot in the leg travels up to the lungs. If you wear special stockings this lowers the risk of clots. We also give you injections to thin the blood.
- **Damage to other organs.** This can include bowel, bladder, the urine tube between the kidney and bladder (ureter) and blood vessels. These complications are uncommon but serious. Sometimes we do not find these injuries at the time of surgery. You may need to have another operation.
- **Prolapse recurrence.** Prolapse operations are not always successful. A prolapse may occur again in about 1 in 3 women. This is because the vaginal tissue can weaken again.
- **Pain.** General pelvic/vaginal discomfort usually settles with time.
- **Reduced feeling during sex.** Sometimes the feeling during sex may be less. Sometimes your orgasm may be less intense.
- **Change in bowel function.** Sometimes patients can become constipated after the operation, for a time. Often having a poo gets easier after the operation.
- **Change in bladder function.** Overactive bladder symptoms (having to go frequently and to rush) usually get better after prolapse surgery. But bladder problems can sometimes start or get worse after the operation. Sometimes leaking pee with coughing or sneezing can start or get worse. About 1 in 10 women may find they have worse bladder function after surgery. If you have this, please tell us so that we can treat you for it.
- **Possible mesh complications**
    - **Vaginal mesh exposure** is when the mesh is felt through the skin of the vagina. This can cause vaginal bleeding, discharge or pain. It occurs in about 1 in 10 cases. You would need a repeat operation to trim the mesh and to reclose the vaginal skin over it.
    - **Erosion** of mesh into bladder where the mesh is found exposed in the bladder. It casues urine infections and blood in the pee.
    - **Erosion** of mesh into bowel where the mesh is found exposed in the bowel. It causes infections and blood/mucous in the poo.
    - **Long term pain** in the vagina / tummy / back which may be difficult to treat. Pain with sex may occur in up to 1 in 5 women and can sometimes be permanent.
    - **Mesh infection** is usually treated by antibiotics. Rarely, we may need to take out the mesh if the infection is severe and does not get better with antibiotics.

After the operation

In hospital

You will have a tube (catheter) in the bladder. It is removed after 1 to 2 days.

We will give you injections to keep your blood thin and reduce the risk of blood clots. You normally have them once a day until you go home.

We will give you tablets or injections for pain relief.

There will be some bleeding from your vagina, like the end of a period, after the operation. This may last for a few weeks.

You are usually in hospital for between 1 to 4 days.

Your skin stitches will usually be dissolvable stitches.

At home

It is important to avoid putting pressure on the repair. This is very important in the first weeks after surgery. You need to avoid becoming constipated or lifting heavy things.

Moving about is very important. It lowers the risk of clots in the deep veins of the legs.

Do not use tampons for 6 weeks.

At 6 weeks slowly build up your level of activity.

After 3 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 6 weeks, a busy job in 3 months.

You can drive as soon as you can do an emergency stop comfortably. This tends to be after 3 weeks. You need to check with your insurance company. Some of them insist that you should wait for 6 weeks.

You can have sex after 6 weeks or whenever you feel comfortable enough.

Follow up

After the operation. It tends to be between 6 weeks to 3 months. This is at the hospital.

British Society of Urogynaecology (BSUG) database

We will ask for your consent to collect information about your surgery and recovery. The information is stored in a secure online database. The information collected helps us study and keep track of our practice.

Contact numbers for advice

Pre-assessment Clinic (open Monday to Friday, 8am to 4.30pm):	0116 258 4839
Leicester General Hospital - Ward 31 (24 hour service):	0116 258 4843
Leicester Royal Infirmary - Gynaecology Assessment Unit (24 hour service):	0116 258 6259
Urogynaecology Nursing Office:	0116 2047897

Space for your notes:-

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