Patient and Carer Information

Laparoscopic Sacrocolpopexy

Surgical treatment for prolapse of the vaginal vault following hysterectomy

What is a vaginal vault prolapse?

After a hysterectomy, the vagina is held in position by the body's natural supporting structures. A vaginal vault prolapse is when these supporting structures become weakened and the vagina slips down from its normal position, sometimes through the vaginal opening. Weakness of these supporting structures may be due to your hysterectomy, ageing, changes in your hormone levels and vaginal childbirth. It can affect quality of life by causing pressure or discomfort in the pelvic area, and can cause problems with sexual intercourse, bowel function and passing urine.

What is laparoscopic sacrocolpopexy?

- **Laparoscopy**

A small needle is inserted through the belly button and gas is gently blown into the abdomen. The gas expands the abdomen to make it easy to see the vagina and other pelvic organs. A small camera (laparoscope) is then inserted through the belly button and two or three more tiny cuts are made low down in the abdomen to perform the operation.

- **Sacrocolpopexy**

Sacrocolpopexy is an operation which lifts the vagina back up to its natural position by attaching a synthetic mesh from the top and back of the vagina to the lower backbone (the sacrum). The mesh provides the vagina with the right amount of support to keep it in the correct position.

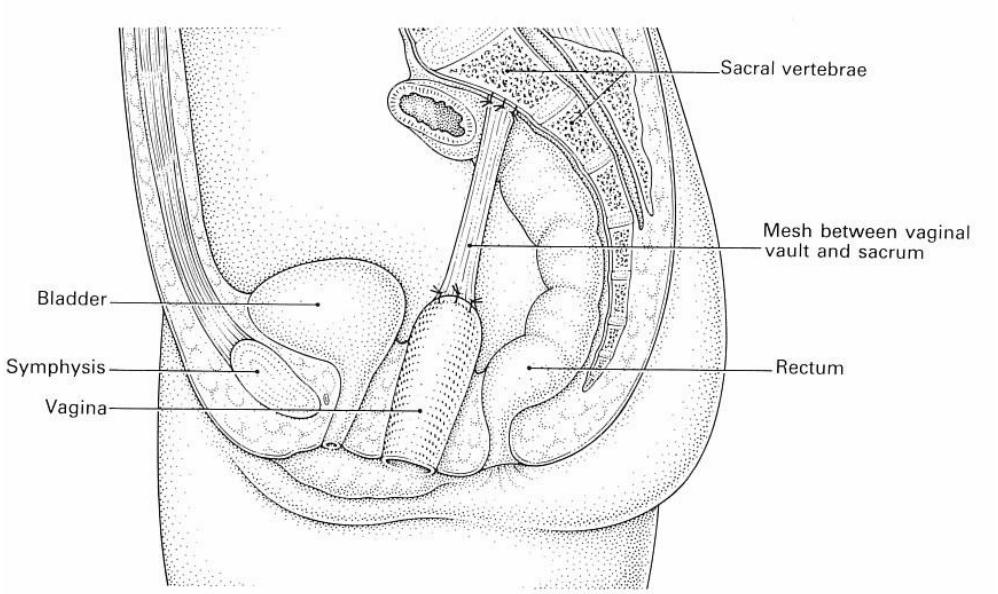

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Figure 1 Diagram showing the mesh attached to the vagina and the sacrum

Are there any alternatives?

A minor prolapse may be treated with pelvic floor exercises and vaginally inserted pessaries (usually a plastic ring) without the need for surgery. More serious prolapse may need surgery if you have symptoms from it. The operations available for vaginal vault prolapse are; vaginal repair with or without mesh, sacrospinous fixation and sacrocolpopexy (laparoscopic or open). Sacrospinous fixation (a vaginal procedure in which the vagina is attached to the sacrospinous ligament with stitches) and sacrocolpopexy are the most effective operations.

How successful is this operation?

Studies have shown us that abdominal sacrocolpopexy (where the abdomen is opened) has success rates ranging from 74-98.8% and that laparoscopic sacrocolpopexy has a success rate of around 92%.

Because laparoscopic procedures are newer than abdominal procedures, there is less knowledge of how successful laparoscopy is in the long term.

What are the risks?

No procedure is risk free and sometimes complications can occur.

Serious risks of laparoscopy alone include:

- The overall risk of serious complications from diagnostic laparoscopy, approximately two women in every 1000 (uncommon)
- Damage to bowel, bladder, ureters (tubes from kidneys to bladder) or major blood vessels which would require immediate repair by laparoscopy or laparotomy which is a cut in the abdomen to open it (uncommon). However, up to 15% of bowel injuries might not be diagnosed at the time of laparoscopy
- Failure to gain entry to abdominal cavity and to complete intended procedure
- Hernia at site of entry
- Deep vein thrombosis (DVT or blood clot) – see below
- Death; 3 to 8 women in every 100000 undergoing laparoscopy die as a result of complications (very rare)

Frequent risks of laparoscopy alone include:

- Wound bruising
- Shoulder-tip pain
- Wound gaping
- Wound infection

Any extra procedures which may become necessary during the procedure:

- Laparotomy

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- Repair of damage to bowel, bladder, ureters or blood vessels
- Blood transfusion

Added risks of sacrocolpopexy are:

- Development of prolapse in another part of the vagina which may require surgery to correct it in up to 1 to 3 women in 10
- Development or worsening of urinary symptoms including stress or urge incontinence in approximately 1 in 10 women
- Damage to surrounding organs in approximately 5 women in every 100
- Bowel obstruction in approximately 2 women in every 100
- Rejection of the mesh by the body resulting in the edges of the mesh protruding into the vagina in approximately 5 women in every 100 – this can be removed and it is rare for the mesh to require full removal
- Infection of the mesh
- Painful sexual intercourse
- Infection and occasionally pelvic abscess
- Rarely - bone infection
- Rarely - return to theatre for an emergency operation

Consent

You will be asked to give your consent to this treatment following further discussion with medical or nursing staff. It is important that you understand what is involved and you will have an opportunity then to ask any questions that you might have.

Blood clot prevention

Without preventative measures, there is a risk of blood clot in the leg (deep vein thrombosis or DVT) in all surgical patients of around 15% - 25%. Please discuss the risks of this particular operation with your surgeon. You will be given additional information about the measures we take to reduce this risk.

What anaesthetic will be used?

The operation will be performed with a general anaesthetic. You will be asleep and unable to feel anything. There is additional patient information from the Royal College of Anaesthetists available. You will meet the anaesthetist before your operation and will have a chance to ask any questions you might have about your anaesthetic.

Infection reduction

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During the operation you will be given a dose of antibiotics into a vein to reduce the risk of infection (prophylactic antibiotics). You may have further doses of antibiotics before discharge.

What to expect after surgery

When you wake up after the procedure you will have a cannula (small plastic tube in a vein) in your hand or arm. You may have a catheter (draining tube) in your bladder and you may have a gauze pack (like a large tampon) in your vagina. This is more likely if you have had vaginal surgery to correct the prolapse along with the laparoscopic sacrocolpopexy. If you have a catheter and/or a vaginal pack they are usually removed the following day. There will be dissolving stitches in the small abdominal wounds and either skin glue or a dressing over them.

You will have some discomfort but it should not be severe. The nurses on the ward will give you pain killing medication. Some women have shoulder pain due to gas under the breathing muscle (diaphragm) or bloating due to the gas. This settles down as the gas is absorbed by the body.

You will be discharged after 24-48 hours.

Plan ahead for discharge home

If you have had vaginal surgery along with the laparoscopic sacrocolpopexy there will be some vaginal discharge which may last up to 6 weeks and may vary in colour and amount. You should use sanitary towels rather than tampons. If the discharge becomes blood stained or is heavy or offensive smelling you will need to contact your own doctor.

The recovery period is usually 3 to 4 weeks. Initially avoid anything strenuous then gradually build back up to normal. Swimming is good exercise once you have recovered.

There is a tendency for women to develop constipation after gynaecological procedures. Make sure you drink plenty of fluids and eat a balanced diet including fruit and vegetables. You may need laxatives from the hospital or your GP.

Initially sex may be a bit uncomfortable and should be avoided during the recovery period as it may impair the healing process. It is a good idea to use some vaginal lubrication at first. After that patients usually find that sex is more enjoyable than before their prolapse was treated.

Most patients will return to work after 4 to 6 weeks depending upon your job.

You should avoid driving for 2-4 weeks. You can start once you can perform a pain free emergency stop without any discomfort. Practice stopping and reversing in the car before

deciding you can drive. People normally start driving at the end of their recovery period. If you are unsure, please consult your insurance company.

Learning to do the PELVIC FLOOR EXERCISES:

Pelvic floor muscles form an important support for your vaginal walls, bladder and bowels. They are important for controlling bowel and bladder function.
Either lie on your back with your knees bent up, or sit on a firm chair with your knees slightly apart in good posture.

TIGHTEN the ring of muscle around your back passage (anus) as though preventing a bowel movement or wind escaping, and then **TIGHTEN** the muscles around your front passages, **LIFT** them up inside, **HOLD**, and then…**RELAX** slowly. Remembering to keep your buttocks and thigh muscles relaxed. Breathe normally throughout.

Exercise programme:

Three times a day aim to exercise you pelvic floor as follows:

- Slow holds: Gradually build up the time you can hold in your pelvic floor muscle, up to a maximum of 10 seconds, aiming to repeat this up to 10 times.

- Fast squeezes: Now quickly tighten your pelvic floor muscles and then relax the muscles completely, aiming to do 10 quick squeezes.

- Once you can do both of these exercises while sitting, progress into a standing position. Your goal is for these exercises to become a lifetime habit to maintain your support to your bladder.

Contact your GP if -

- you have severe pain
- you develop a fever
- you bleed heavily
- you develop smelly or offensive discharge
- either of your legs is painful, hot, red or swollen which may indicate a deep vein thrombosis (blood clot).
- you develop unexplained shortness of breath, chest pain and/or coughing up blood which may indicate a pulmonary embolism (blood clot in your lung).
- you are unhappy with the results of the surgery.

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You may be offered a hospital follow up appointment after 6 to 8 weeks. In any case, if you or your GP feel it is necessary, you will be seen in the out-patient clinic.

Further information

Nidderdale Ward phone number 01423 553648/3647
Patient advice and liaison service coordinator 01423 553158
Patient Experience helpline 01423 555499 (Monday – Friday 9.30am – 4pm). E-mail: thepatientexperienceteam@hdft.nhs.uk
NHS Direct 0845 4647

If you require this information in an alternative language or format (such as Braille, audiotape or large print), please ask the staff who are looking after you.