University Hospitals Plymouth NHS Trust

What you need to know about

Abdominal Repair Surgery for Prolapse

- **Sacrocolpopexy**
- **Sacrohysteropexy**

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What is a ‘Prolapse?’

A prolapse is like a hernia and is caused by the uterus (the ‘womb’) and/or the vagina losing support and ‘dropping down’. A prolapse is usually caused by having children and getting older (‘wear and tear’). Excess weight, family history, excessive lifting or chronic cough might play a role.

There are various types of prolapse which can happen on their own or often together:

- A prolapse of the front of the vagina is called a ‘cystocele’ (often referred as a ‘bladder prolapse’).
- A prolapse of the back of the vagina is called a ‘rectocele’ (often referred as a ‘bowel prolapse’).
- A prolapse of the ‘womb’ is called a ‘uterine prolapse’.
- A prolapse of the top of the vagina in women who have had a hysterectomy in the past is called a ‘vaginal vault prolapse’.

Your surgery explained

Choice of Surgical Procedure:

It is possible to treat a prolapse using different operations. Some operations are performed through the vagina (with all the cuts done inside the vagina). Other operations require an abdominal incision (a cut in your tummy similar to that performed to deliver a baby by Caesarian Section).

The Surgeon will suggest the most suitable procedure for you. The choice will depend on the type of prolapse, how severe it is, whether you are having a first or repeat operation, how fit you are, your age, your weight and whether you are sexually active. Sometimes more than one procedure is required and patients might undergo a combined abdominal and

vaginal operation (with a cut on your tummy and also cuts in the vagina).
Sometimes a final decision on the type of surgery needs to be made when you are under anaesthetic (and your Surgeon can make a better assessment).

Sacrocolpopexy:

This means ‘lifting the vagina to the sacrum’ (the sacrum is the lower end of the spine). This operation is performed on women who have had a hysterectomy in the past and are experiencing a prolapse of the vagina (because the top of the vagina has lost support).
A strip of mesh is stitched to the top of the vagina and the other end is attached to the front of the sacrum at the lower end of the spine.

Sacrohysteropexy:

This means ‘lifting the womb to the sacrum’ (the sacrum is the lower end of the spine). This operation is the same as a sacrocolpopexy but is performed on women who still have a womb and wish to avoid a Hysterectomy (often because they have not yet completed their family).

Use of Mesh:

Mesh has been developed to make repairs stronger (because repairs without mesh may fail or may not last long).

For Sacrocolpopexy and Sacrohysteropexy mesh is needed to lift the vagina to a secure point of support (the sacrum at the lower end of the spine). This is because the vagina is not long enough to reach it directly. The mesh therefore functions as a ‘bridge’ between the vagina and the spine. This is similar to how the vagina is naturally supported by its ligaments.

Using mesh during these procedures is not new and these operations have a long record of safety and success.

Mesh can be made of plastic (synthetic) or animal tissues (biomesh). Both meshes can be used, but plastic mesh has been shown to have better success rates and is more commonly used during **abdominal** surgery.

Concerns regarding Mesh:

As a result of serious surgical complications, concerns have been raised by patient support groups and the press regarding the safety of procedures using mesh for the treatment of urinary incontinence or prolapse. The greatest concerns have focused on the use of plastic mesh to treat prolapse **when it is inserted through the vagina** (this is because the vagina needs to be opened to place the mesh inside).

Although complications due to the mesh (see later for details) can also happen after operations such as Sacrocolpopexy and Sacrohysteropexy, they are quite uncommon because **the mesh is inserted through the abdomen** (without needing to open the vagina). Inquiries have been made by several governing bodies (the FDA in the USA, SCENIHR for the European Commission, the MHRA for the UK and the Scottish Independent review). The general agreement is that the use of mesh for prolapse procedures can continue, although restrictions may apply (especially when plastic mesh is used through the vagina). In the reports, Sacrocolpopexy and Sacrohysteropexy are recognised as successful and safe procedures for the treatment of a prolapse.

Alternatives to plastic mesh for Sacrocolpopexy and Sacrohysteropexy:

Biological mesh can be used instead of plastic mesh, but there is evidence that the benefits might not be as durable and long-lasting.

Open or Laparoscopic Surgery:

Open surgery involves having a cut in the lower part of the abdomen (similar to a cut for a Caesarian Section to deliver a baby). Laparoscopic surgery involves multiple small cuts so that surgery can be performed using a ‘camera’.

There are no major differences between these 2 methods to perform surgery. Both methods are acceptable and success rates and complications rates are similar. There are however subtle differences that might make one method preferable in individual cases. Also different Doctors might prefer to use one method over the other depending on individual training and preferences.

Are there any alternatives to surgery?

Sometimes women prefer to cope with their prolapse if their symptoms are mild. Pelvic floor exercises can help in such situations.
Sometimes women prefer wearing a pessary (e.g. a ring) inside the vagina.

How is a Prolapse Repair going to help me?

The main effect of a repair operation is to treat the uncomfortable bulge that you feel at the entry of the vagina.

Bladder, bowel and sexual problems might not be related to the prolapse and might not improve. This will be discussed in detail by your Surgeon.
Vaginal pain and backache are not usually due to a prolapse and are not expected to improve.

How successful is Abdominal Repair surgery?

Abdominal prolapse repairs are the most successful repair procedures. Only a small minority of patients (less than one in ten) will experience a return of the prolapse in the future (this might happen early as well as late). Repeat surgery might be needed.

Preparations before the operation

- You will be seen in **pre-assessment** (to check your fitness for surgery and discuss admission details). Sometimes this can be done by Telephone. You will be placed on the waiting list for surgery following your pre-assessment appointment.
- You might have **swabs** taken (to check for germs that might cause serious infections such as MRSA).
- You will be given 3-5 weeks**' notice** of your surgery date.
- You will usually be seen by your Surgeon 1-3 weeks before the operation to sign your **consent** and discuss details. Please note that the appointment date for your consent is included in your admission letter.

- **Personal Care**: Have a shower or bath on the day of surgery. Avoid using body creams, talcum powder or deodorants. Avoid putting on make-up and nail varnish. Remove all jewellery, including body piercing. Your Surgeon might ask you to shave (this needs to be done a few days before the operation to avoid scratches on the skin that might increase the risk of infection). You should avoid becoming constipated before your operation (this is to avoid excessive straining afterwards). Use laxatives if necessary.

What should I bring to Hospital?

- Dressing gown, slippers, pyjamas (or night dress), comfortable clothes (e.g. track suit) to walk around while you are recovering.
- A wash bag with toiletries and a small towel.
- Your medicines.
- A small amount of change.
- Other items (if used): glasses, contact lenses, hearing aids, dentures, etc.
- **Please try to avoid bringing valuables into hospital. Remember, the hospital cannot accept responsibility for loss or damage to any personal property unless you have handed it over to staff for safekeeping.**

What happens on the day of my operation?

- **Fasting:** You should not eat for 6 hours before your operation. This means that if you have a **morning** operation you should not eat after midnight; if your operation is in the **afternoon** you can have an early breakfast and should not eat after 7.30 a.m. You can drink water (or any drink cartons provided) before you leave your home (and up to 2 hours before your operation).
- Advice on **your medications** will be given at pre-assessment.
- **Admission** is usually at 7.00 a.m. for morning surgery and 11.00 a.m. for afternoon surgery.
- You will be seen by Nurses and Doctors. Your **Anaesthetist** will usually see you on the day of your operation.
- When your turn comes you will be taken to the operating theatres.
- After the operation you will wake up in recovery with a drip (to receive fluids), a catheter (to empty the bladder) and a vaginal pack (to stop vaginal bleeding) if you also had a cut in the vagina.

What Pain Relief is available?

The degree of pain and discomfort experienced following surgery varies a great deal. Often pain relief is given by mouth, rectally (as a suppository) or by injection. Pain can also be given by patient controlled analgesia (an infusion into the arm, which is triggered by the patient pressing a button). After about 12-24 hours the strong painkillers (containing Morphine) will not usually be required and can be stopped. Tablets and suppositories should be sufficient to reduce any discomfort. This will allow you to get out of bed and

mobilise (which is very important to reduce the risk of complications).

What happens after the surgery

Mobilisation / Eating and Drinking

Immediately after the surgery you will be allowed to drink water. Once the strong (Morphine based) painkillers have been stopped, you should be able to eat and drink freely and get out of bed. The vaginal pack, drip and catheter are usually removed the day after the operation.

Physiotherapy

Early mobilisation is very important as it reduces the risk of complications. The best way to keep your chest clear and maintain good circulation is sitting out of bed and walking, ideally from the first day after your operation. Regular use of pain relief can help you to move and cough while keeping you comfortable. Perform deep breathing exercises and cough if you have phlegm in your chest.

Hygiene

You will probably be able to have a shower on the first or second day following your operation and then daily. Having a short bath will be possible when you can comfortably get in and out.

Bladder and Bowel Function

The **bladder** might not be able to empty well after surgery. The catheter is usually removed 24-48 hours after the operation, but some patients need it for longer and might need to go home with a temporary catheter (and come back to have it removed at a later date). After removing the catheter, patients often feel irritation

when passing urine and the flow is slower than before the operation (this can last for a few days).
The **bowels** might also be slow to work and constipation is very common after repair surgery. Laxatives are usually provided. It is very important to avoid hard motions and excessive straining.

Discharge from Hospital

Patients will usually go home 2-3 days after abdominal surgery. You should be mobile and comfortable and there should be no evidence of complications.

What happens after discharge from Hospital?

Wound healing / vaginal discharge

The suture ('stitch') in your tummy normally gets removed 5 days after the operation. This can be done in the Ward or in the community and will be organised at the time of discharge from Hospital. Vaginal stitches (if you have any) do not need to be removed and will dissolve in 2 months.

Pain, discomfort and bruising over the cut in your tummy and in the vagina should settle within a week or two. Unusual sensations such as tingling, numbness or itching are common (and can be long-lasting).
The vagina feels 'lumpy' if you also had a vaginal cut.

A slight discharge/bleeding is usual for up to 6-8 weeks (as the vagina heals and stitches dissolve). It is possible for the discharge to contain threads from dissolving vaginal stitches. If it should become offensive smelling or bright red/heavy, then please inform your own G.P. (these might be signs of infection).

Hygiene

It is very important to give yourself a good wash down below at least twice a day and change your pads frequently. Showers are fine. Baths should be short and avoid the use of 'bubble bath' in the water.

Pelvic floor exercises

Pelvic floor muscles support your bladder and bowel and strengthening them may avoid continence problems in the future. You can perform pelvic floor exercises as soon as you feel comfortable.

Lifting

Heavy lifting should be avoided for up to 3 months after your operation to allow for adequate healing. You can lift without concerns anything that can be lifted easily and without a strong effort. When you are lifting, brace your pelvic floor muscles and your stomach muscles to help support your back and the organs in your pelvis.

Rest and mobility

After surgery it is normal to feel tired and you will need to take it easy and rest for at least two weeks (get help for household jobs). However, it is important to remain mobile (get up and walk regularly). It is quite safe to go up and down stairs from the day you go home if you feel well.

If your mobility is reduced for any reason it will be important to move your legs as often as possible to reduce the risk of thrombosis (developing clots in your legs and lungs). It might be advisable to use your hospital stockings (TEDS) for a few weeks (be advised by your Doctor).

Build up your activity gradually and be guided by how your body responds.

Eating

Some people find that their appetite is small and they get a ‘bloated’ feeling or indigestion after meals. These symptoms usually clear up by themselves as you become more active. Small meals taken regularly can reduce the likelihood of this happening.

Driving

It is usually safe to drive a car 4-6 weeks after your operation but it depends if you are confident to do an emergency stop and whether you can concentrate enough to drive.

Back to work

You will need to be off work for 6 weeks. If you have a very physical job that requires lots of lifting you may need to be off work for longer (2-3 months). Be advised by your Surgeon. A Medical Certificate can be arranged for you at discharge from hospital.

Sport and activity hobbies

Gentle swimming is good exercise and can be started after 4-6 weeks. More strenuous sports can be started after 12 weeks but should be built up gradually over a few weeks.

Making love

You are advised to wait approximately 8 weeks after the operation to be sure that the vagina is completely healed. Obviously your husband or partner should be gentle at first. It may also help to use a lubricant such as K.Y. jelly.

Post-operative check

Most women now have their postoperative check done in the community with a telephone call from one of our nurses (usually 3 months after the operation). The nurse will contact you beforehand to book the time of the call. She will ask you about your progress and you will be able to discuss any relevant issues. If necessary, she can organise an appointment in clinic. If you have any concerns beforehand, you need to see your G.P. and an earlier telephone call or Consultant appointment can be arranged if necessary.

Complications of surgery

Surgery for prolapse is generally safe, but risks and complications can occur. You need to know about them for two important reasons:

- To help you and your Doctor **make a decision** on the most appropriate treatment for you. This might involve alternatives to surgery.
- To help you **recognise the complications early**, so that treatment is not delayed.

Risks and complications related to the **anaesthesia** are rare and will be explained separately by your Anaesthetist.

If your risk of complications is increased your Doctor will tell you. The risks are generally increased when your operation is more major and / or when you are affected by conditions that make the surgery more risky (for example diabetes, heart or chest problems, excess weight, etc). Having had surgery before in the same part of the body also increases risk as the tissues will be ‘glued’ together by scar and adhesions.

Many complications are linked to **reduced mobility** and being unable to get out of bed. It is very important that you regain mobility as soon as possible. Painkillers will be provided and you will get help from Nurses and Physiotherapists.

All operations (major and minor) can occasionally cause **bleeding, infection and thrombosis** (development of clots in legs and lungs). In general, the more major the procedure, the greater the risk. These complications can be serious, but are usually easily manageable when detected at an early stage. Blood transfusion can be lifesaving and is very safe. If you have objections to blood transfusion you must inform your Surgeon at the earliest possible time. Please inform your Surgeon if you take medications that can affect blood clotting (e.g. Aspirin, Clopidogrel, Rivaroxaban, Warfarin, Hormones, etc.).

All operations can lead to **discomfort and pain**. This is usually short lasting (hours or days), but occasionally scars can lead to long lasting pain. When scars are in the vagina the result can be **pain during intercourse**. Prolonged pain due to scars can be difficult to treat. The use of Mesh materials can increase the risk of prolonged pain.

Surgery can occasionally cause **injury to internal organs** that are close or attached to the vagina. These are the bladder, the bowel and the ureters ('waterpipes' that carry urine from kidneys to bladder). The risk is usually very small (around 1%) but may be greater when surgery is difficult (e.g. scar from previous surgery).

Often these injuries are recognised and treated during the surgery. This can involve more major surgery than originally planned. Unfortunately injury to internal organs sometimes shows at a later stage, even after discharge from hospital. If you have any concerns you must report them to your Doctor.

Adhesions commonly develop after surgery inside the abdomen (they look like ‘cling film’ and have the effect of ‘sticking’ tissues together). Rarely adhesions can result in a bowel blockage. This might happen soon or long after the operation.

Problems with bladder or bowel function:
Constipation is common and usually temporary and easy to manage. It is advisable to come for surgery having had a recent bowel motion.
Long lasting constipation is occasionally reported after pelvic surgery.

Difficulty with passing urine (this is called urinary retention) is also common and usually temporary. It requires the use of catheters and patients may be discharged home with a temporary catheter (usually for no longer than a week or two).

Prolonged or permanent urinary retention (requiring long-term use of catheters) is rare (around 1% of patients) and usually occurs in patients who have neurological (‘nerve’) problems (e.g. back problems with disc prolapse). It can be difficult for Doctors to predict this complication in advance.

Urinary incontinence (a ‘leaky bladder’) can occur after surgery because of infection, nerve irritation or changes in the relationship between the vagina and the bladder. Sometimes having a prolapse can stop women from leaking urine and treating the prolapse with surgery can ‘unmask’ a leaky bladder. This problem may need further surgery (this is more likely if the prolapse was severe).

Mesh is routinely used for abdominal prolapse repairs. Synthetic (plastic) mesh is chosen because it is very strong and permanent. Putting mesh through a ‘tummy cut’ (without opening the vagina) is considered safer and less likely to cause complications. However, problems due to plastic mesh (such as chronic pain, pain during intercourse or mesh ‘erosion’ on the vaginal surface) can happen in a small group of patients (less than one in twenty).

Unfortunately problems due to plastic mesh can sometimes be difficult to treat.

Using biological mesh is possible and is likely to reduce the complication rate. However the long-term success rate might also be lower (this is because biological mesh is likely to degrade and absorb after some time).

Your Surgeon will tell you about any specific concerns which may apply to you personally. Please feel free to discuss your concerns and ask questions when you come for your Consent.

Summary of complications of surgery

Complication	Very Common (up to 1 in 10)	Common (1 in 10 to 1 in a 100)	Uncommon (1 in 100 to 1 in 1000)
Bleeding (mild)		X	
Bleeding (severe)			X
Infection (mild)		X	
Infection (severe)			X
Cystitis	X		
Thrombosis		X	
Injury to internal organs			X
Bladder retention (temporary)	X		
Bladder retention (permanent)			X
Stress urinary Incontinence	X		
Urge urinary Incontinence	X		
Constipation	X		
Sexual Dysfunction		X	
Chronic Pain		X	
Mesh ‘erosion’		X	
Recurrence in future*	X		

*Success rate is 90%

Further Information

The Internet is a useful and powerful source of information. We have selected reputable sites where patients can obtain valid information about their condition and proposed surgery. Please follow the instructions to navigate each site.

International Urogynecological Association (IUGA)
http://www.iuga.org

Go to 'Patient information' / 'Patient Leaflets' (remember to 'select language')

Pelvic organ prolapse. Sacrocolpopexy. Vaginal pessary for POP.

British Society of Urogynaecology (BSUG)
http://www.bsug.org.uk

Go to 'Information for Patients'

Sacrocolpopexy for vault prolapse. Sacrohysteropexy for uterine prolapse.

Useful contacts

Re-scheduling of surgery: Lisa Parsons
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General Inquiries:
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Jocelyn Rawlinson: 01752 431335

Your notes:

This leaflet is available in large print and other formats and languages.
Contact: Administrator
Tel: 01752 431768

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