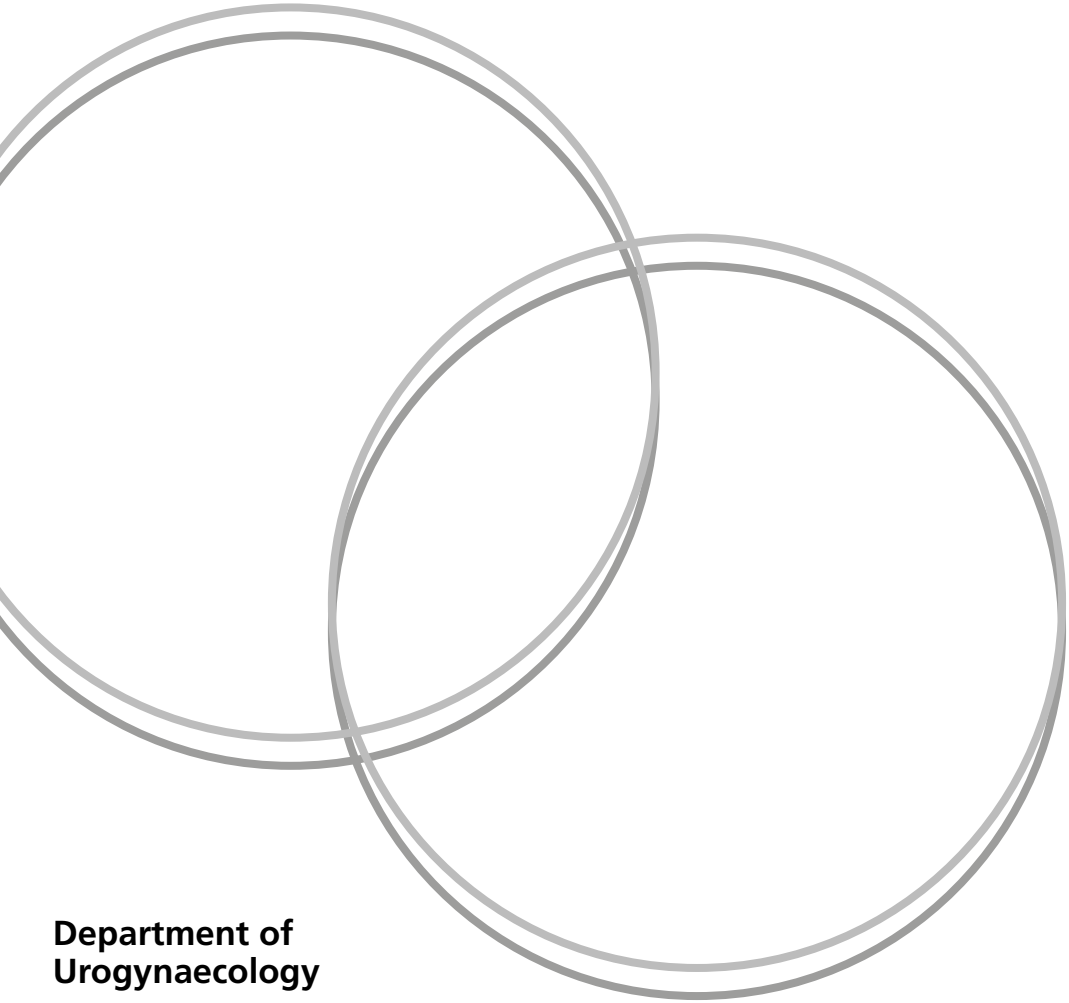
Oxford University Hospitals
NHS Foundation Trust

Laparoscopic hysteropexy

Information for women



Department of
Urogynaecology

You have been given this leaflet because your doctor has recommended that you have a laparoscopic hysteropexy to treat your prolapsed uterus. This leaflet will explain what this procedure is and the common reasons why we recommend this operation. It also describes what will happen when you come into hospital, the potential benefits and risks, recovery from the operation, and what to expect when you go home.

Conditions leading to a prolapse of the uterus

A uterine prolapse is a bulge within the vagina, caused by the uterus (womb) slipping down and out of place. This can happen if one or more of the pelvic organs push into the vagina when its supporting muscles are weak.

Pelvic organs include the uterus (womb), bladder and bowel. Many women have more than one organ prolapse at the same time.

Many women will experience a prolapse of some degree; it is not unusual. Having a child weakens the vaginal muscles and other factors, such as being overweight, heavy lifting, chronic constipation and a lack of hormones after the menopause can weaken these muscles further, creating a prolapse.

The symptoms of prolapse can include:

- a 'dragging' feeling and a feeling of 'fullness' in the vagina
- a lump inside or outside the vagina
- low backache
- constipation or straining to open your bowels, and a feeling of not having emptied them properly
- discomfort or pain during intercourse.

What is a laparoscopic hysteropexy?

Hysteropexy involves lifting the prolapsed uterus back into its normal position. This is done by using a strip of synthetic mesh to lift the uterus and hold it in place. One end of the mesh is attached to the cervix and the other to the ligament over the sacrum (a bone near your spine). Once in place, the mesh supports the uterus. After a few months new connective tissue grows into the mesh, which forms a new strong ligament. The mesh will remain permanently in place.

Hysteropexy is carried out using keyhole surgery (laparoscopy), so only small cuts need to be made on your tummy. It will be carried out whilst you are unconscious under a general anaesthetic.

Alternative treatments

Your doctor will have given you advice about other treatments or options before discussing this procedure. These can include pelvic floor exercises, vaginal pessaries or doing nothing. The choice of the treatment that your doctor recommends depends on how much your prolapse is bothering you, the extent of your condition, as well as personal factors, such as whether you would like to become pregnant in the future. The effect your condition has on your everyday life will also be taken into account.

For many years, the traditional 'standard' surgical treatment for a prolapsed uterus has been a vaginal hysterectomy (removal of the entire uterus through the vagina). If you are also experiencing problems such as heavy or irregular periods or abnormal cervical smears, a vaginal hysterectomy may be a better option for you.

On the next page you will find information about pelvic floor exercises and vaginal pessaries. Please also discuss alternative treatments with your doctor, who can help you to decide whether the option of laparoscopic hysteropexy is the best one for you at this time.

Pelvic floor exercises

Your pelvic floor muscles run from the coccyx at the back of your pubic bone through to the front and off to the sides. These muscles support your pelvic floor organs (uterus, vagina, bladder and rectum).

All muscles in the body need exercise to keep them strong, so that they function properly.

Pelvic floor exercises help strengthen the pelvic floor muscles and give more support to the pelvic organs. These exercises may not get rid of your prolapse, but they can make you more comfortable. To help you perform these exercises correctly we can refer you to a physiotherapist.

These exercises have little or no risk and, even if you need surgery at a later date, they will help you feel generally more comfortable in the meantime.

Vaginal pessary

There are two types of vaginal pessary:

Ring pessary

This is a ring made of a type of plastic called PVC. It is inserted inside the vagina to push the prolapse back up. This usually gets rid of the dragging sensation and can sometimes improve bladder and bowel symptoms. It needs to be changed every 6 months (this can be done by your GP or Practice Nurse) and is very popular.

We can show you an example of a ring pessary in clinic, please ask if you would like to see one. Some couples feel it can interfere with intercourse but other couples are not bothered by it. Ring pessaries are not suitable for every woman and do not always stay in place. If this is the case for, you we will need to consider a different type of pessary, such as a shelf pessary.

Shelf pessary

This is a different type of pessary which cannot be used if you are sexually active. Again this needs to be changed every 6 months, but this normally has to be done in hospital (not by your GP or Practice Nurse).

The benefits of hysteropexy

- Hysteropexy doesn't involve removing any part of your vagina or uterus. The uterus is just suspended back in its normal position by reinforcing weakened ligaments with a mesh.
- Many women choose to preserve their uterus as the prolapse is a disease of the supporting ligaments rather than a disease of the uterus itself.
- An advantage of keeping your uterus is that you can remain fertile if you wish to have children after this procedure.
- The uterus and cervix may have an important role in sexual function. Having a hysterectomy can affect your sexual wellbeing, due to damage to the nerves and supportive structures of the pelvic floor. In some women, removing the uterus may even influence their sexual and personal identity, as they may associate their uterus with feeling feminine.

Benefits of laparoscopic (keyhole) surgery

- A laparoscopic hysteropexy procedure uses only small cuts (incisions) and small instruments. This reduces the risk of damage to surrounding organs, such as the bowel and bladder. The operation can also be carried out in a much shorter time and recovery afterwards is quicker. You will usually be in hospital for one or two nights.
- Laparoscopic hysteropexy is a relatively new procedure. Initial results show that it is as effective as the 'standard' vaginal hysterectomy in curing prolapse. You should keep in mind that even though surgical treatment will repair your prolapse, it may or may not relieve all of your symptoms.

Risks of laparoscopic hysteropexy

Most operations are straightforward and without complications. However, there are risks associated with all operations. You need to be aware of these when deciding whether to have this treatment. The risks of having a laparoscopic hysteropexy are shown below:

- Damage to the bladder or one of the tubes (ureters) which drain the kidneys (1 in 200).
- Very rarely, damage to the bowel (1 in 1000).
- Damage to the blood vessels and excessive bleeding. This may occur during the operation and would mean we would need to carry out a hysterectomy (removal of the uterus) (1 in 100). On rare occasions it is necessary to give a blood transfusion during or after the operation.
- Deep vein thrombosis (DVT). This is the formation of a blood clot in a leg vein, which occurs in about 1 in 250 women. We will give you medication and special stockings to wear to help prevent a blood clot from developing.
- Another prolapse. Although this operation is successful in treating uterine prolapse, it does not always stop you from getting a prolapse of the vaginal walls in the future. This is because the vaginal tissues are weak.

  A study of patients at the OUH Women's Centre suggests 2 to 3 women in every 100 suffered from another prolapse of the uterus (womb). In most cases, the prolapse did not require further treatment.

  As the mesh is a foreign material, there is a risk that it may wear away (erode) the surrounding tissues or cause inflammation. This is very rare and unlikely to happen. There hasn't been a single case of mesh erosion into the bladder, vagina or bowel in more than 500 laparoscopic hysteropexy procedures performed in Oxford.[1]
- If you are planning to have children after this procedure, a pregnancy may damage the repair and cause the prolapse to

happen again. To help prevent this, you may be advised to have a scheduled caesarean section rather than a vaginal birth.

- Infections can occur which may affect the wound, bladder or lungs, or can develop around the operation site internally. Most infections are easily treated with a course of antibiotics but others can be more severe. The risk of infection is reduced by routinely giving you a dose of antibiotic during your operation.
- Abdominal incision (cut). Although the aim is to do the surgery through keyhole incisions (laparoscopically), sometimes this is not possible and we will have to make a larger cut on your abdomen (rare). Very rarely, anatomical anomalies or adhesions in your tummy can make hysteropexy impossible to perform and an alternative operation such as hysterectomy may be required.

Although hysteropexy is a relatively safe operation and serious complications are not very common, it is still major surgery. You and your doctor must weigh up the benefits and risks of surgery, giving consideration to alternative treatments.

Changes in bladder and bowel function

- Stress incontinence. Having a large prolapse can sometimes cause kinking of the pipe through which you pass urine (uretha). This kink can be enough to stop urine leaking when coughing and sneezing. By correcting your prolapse, the kink straightens out and the leaking starts. If you have stress incontinence before hysteropexy, then stress incontinence can be made worse after surgery.
- Bladder emptying or voiding difficulties. This generally improves after prolapse surgery but there may be problems emptying your bladder in the first few days after surgery. If this happens to you, one of the specialist nurses will come and see you on the ward to talk to you about this.
- A change in the way your bowels work. Some patients experience new or worsening constipation following surgery. This may resolve in time. It is important to avoid being constipated following surgery to reduce the risk of prolapse recurring. Simple changes to diet and fluid intake should be enough to prevent

constipation, but sometimes laxatives are required. If necessary we will prescribe laxatives for you to take home.

Anaesthetic risks – general anaesthesia

Anesthesia risks are very small, unless you have specific medical conditions, such as a problem with your heart or breathing. Smoking and being overweight also increases any risks. Try to stop smoking before your operation. Try to lose weight if you are overweight and increase your physical activity.

Pre-admission clinic

Before your surgery you may be asked to come to a pre-admission clinic appointment. This is to check that you are fit and well for the operation.

A nurse practitioner or doctor will see you at this appointment. We will ask you about your general health, past medical history and any medicines that you are taking. We will organise any investigations you may need (such as blood tests, electrocardiogram (ECG or heart tracing), chest X-rays). We will tell you about your admission, the operation itself and your care before and after the operation.

At this appointment you will be given information about not eating or drinking (fasting) before your operation.

This is the time to ask any questions or to raise any concerns you may have. If you also have a prolapse affecting the front and/or back wall of your vagina, your surgeon may suggest repairing this at the same time as carrying out the hysteropexy. This additional surgery is called an anterior (front wall) or posterior (back wall) repair and may alter the risks of the operation. Altered side effect risks, including the risk of painful intercourse (sex), will be discussed with you.

Further details of how anterior or posterior repair surgery is carried out are included later in this booklet (page 12-13).

Preparing for the operation

Plan ahead

When you come out of hospital you are going to need extra help at home for the first two weeks. You should let your relatives/friends know in advance that you will need their support during this time.

Smoking

If you smoke, try to stop completely. This will make your anaesthetic safer, reduce the risk of complications after the operation, and speed up the time it takes for you to recover. Perhaps this is a good opportunity to give up completely. If you are not able to stop completely, even doing so for a few days will be helpful. You will not be able to smoke while you are in hospital.

Driving

We recommend that you do not drive for two to four weeks after the procedure. We also advise checking with your insurance company that you have insurance cover if you choose to drive earlier than we recommend. It may be helpful to first sit in the car while it is parked, to see if you could do an emergency stop, if needed. You must be able to comfortably and safely perform an emergency stop for your safety and that of others before driving again.

Medicines

Some medicines need to be stopped or altered before the operation. You should check this with your GP. In particular, the contraceptive pill should be stopped at least four weeks before the operation and you will need to use another method of contraception. If you have been or are anaemic, your GP will advise that you take iron supplements before the surgery.

On the day of your surgery

You will be given an estimated time for your operation, but this may change, as the operating theatres are also used for emergency surgery.

You will be seen by the anaesthetist and the surgeon (or a senior member of the team). They will confirm with you the purpose of the operation, what will happen during the operation, and the risks associated with it. You will then be asked to sign a consent form, if you have not already done so. You will also have an opportunity to ask any further questions about anything you are still unsure about.

In the anaesthetic room, next to the operating theatre, a narrow tube called a cannula will be placed in your arm or wrist. It will be attached to a tube which will supply your body with fluids and medicines during and after the operation. This will stay in place until you are drinking normally after the operation. Before you are given the anaesthetic we will attach a monitor to your chest with leads, which will measure the activity of your heart (electrocardiogram or ECG).

The operation

Laparoscopic hysteropexy for prolapsed uterus

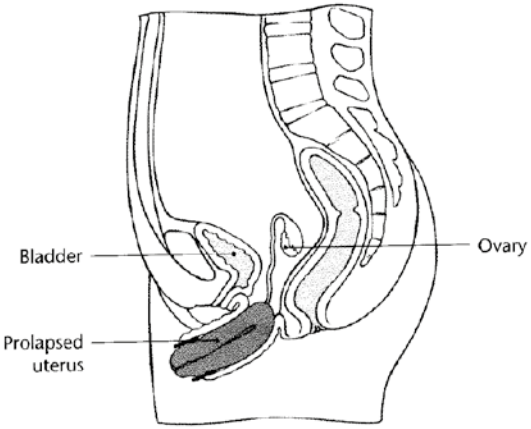
Once you are unconscious under the general anaesthetic, the surgeon will make three 5mm incisions (cuts). Two of these will be on your lower abdomen at your bikini line. The third incision will be within your belly button, so that the small scar will be invisible.

A narrow telescope, called a laparoscope, will be inserted through one of the cuts on your abdomen. A light source and a camera are connected to the laparoscope, which allow the surgeon and assistants a magnified view of the area they are looking at. Additional special keyhole instruments, such as scissors, will be inserted through the other two incisions.

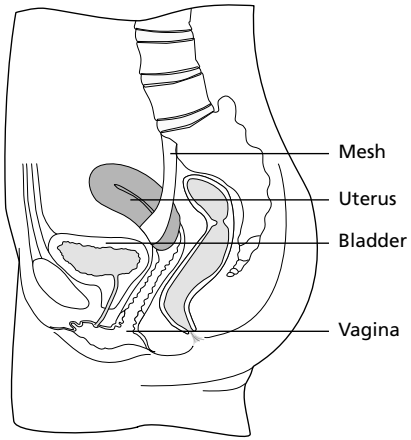
One end of the mesh will be attached to your cervix using non-dissolvable stitches, and the other to a ligament over the back bone (sacrum) near your spine. This gently lifts the uterus back up into its normal anatomical position.

When the procedure is finished, the surgeon will close the small cuts on your abdomen with dissolvable stitches or glue (dermabond).

Before surgery



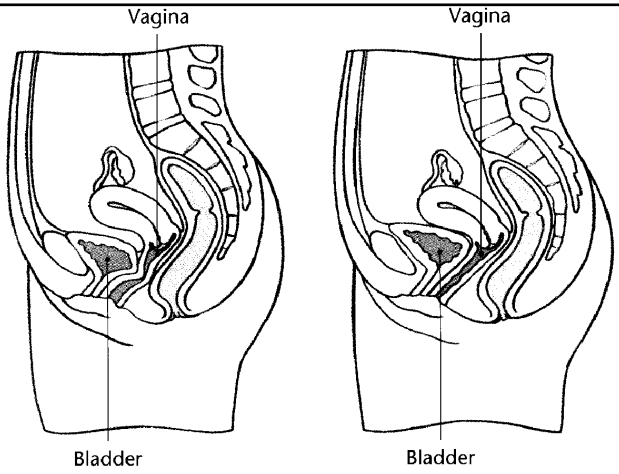
After surgery



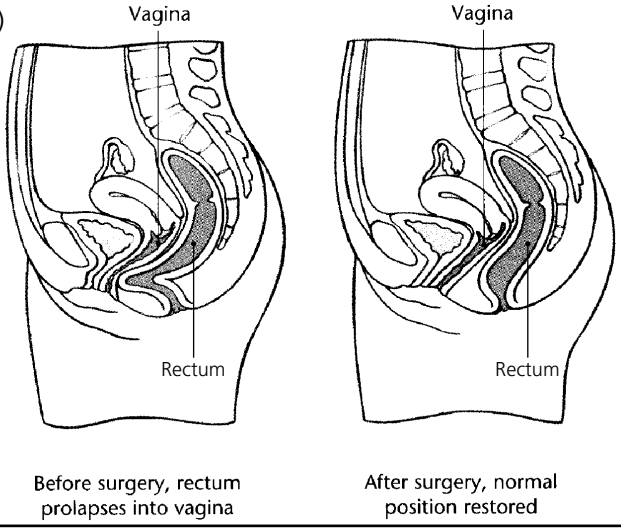
Anterior or posterior repair

If your surgeon has advised that you have additional vaginal repair at the time of your hysteropexy, you will also have one or both of the following procedures to tighten the walls of your vagina and pelvic floor muscles.

Anterior (cystocele) repair



Posterior (rectocele) repair



The vaginal repair operation tightens the walls of the vagina and the pelvic floor muscles. Anterior (cystocele) repair involves making a cut on front wall of the vagina and repairing the wall between the vagina and bladder. Posterior (rectocele) repair involves making a cut on the back wall of the vagina and repairing the wall between the vagina and rectum.

Anterior and posterior repair operations normally take around 20-30 minutes to complete and will remove the vaginal bulge. All the internal stitches used in anterior and posterior repair are dissolvable, but can take up to 3 months to fully dissolve.

After the operation

When you return to the ward you are likely to be very sleepy for the rest of the day. There may be a narrow tube, called a catheter, in your bladder (to drain away urine). The catheter will normally be removed the next day.

Will I have any pain?

You are likely to experience some pain or discomfort for the first few days but we will offer you painkillers to help ease this. Please let us know as soon as you start to feel any discomfort, rather than waiting until the pain becomes worse.

Pain can be controlled in a number or ways. These include: self administration of strong pain relief (patient controlled analgesia – PCA), injections, tablets or suppositories. The wounds following laparoscopic (keyhole) surgery are not normally very painful.

Having an anaesthetic, being in pain, and having strong painkillers can sometimes make you feel nauseous or sick. We can easily help with this by giving you anti-sickness medications as injections or tablets.

You may get wind pains a few days after the operation, which can be uncomfortable and make your tummy look distended (swollen). This should not last long and can be relieved with medicines, eating, and walking about.

Will I bleed?

After the operation you may have some vaginal bleeding and will need to wear a sanitary pad. We advise you not to use tampons as these increase the chance of an infection developing. This blood loss should change to a creamy discharge over the next two to three weeks. If you have any new pain, fresh bleeding or bad smelling discharge after you go home, you should contact your GP.

Will I have stitches?

Some women will have dissolvable stitches in the wounds on their abdomen (tummy) and some women will have glue (dermabond) and no stitches.

Stitches will dissolve on their own in 2-4 weeks. If you have glue, this will loosen from your skin on its own as your wound heals in approximately 7-10 days. Do not pick, scratch or rub it off the wound. Do not soak the glue off in the bath before your wounds have healed.

Please make sure you know what type of skin closure you have before leaving the ward.

If you had anterior or posterior repair as well as hysteropexy, you will have stitches inside your vagina, which are all dissolvable. As they dissolve, the threads may come away for up to three months, which is quite normal.

How will I cough or sneeze?

If you need to cough or sneeze, your stitches won't come undone and you won't damage the repair. You will be wearing a sanitary towel, and it will hurt less if you press on your pad firmly to give support between your legs.

Recovery

Recovery is a time-consuming process, which can leave you feeling tired, emotionally low or tearful. Although the scars from laparoscopic (keyhole) surgery are small, this does not shorten the healing process. Your body needs time to build new cells and repair itself. Depending on the surgery you have had, you will need to take four to six weeks off work to recover.

After a hysteropexy, most women stay in hospital for approximately two days, but this could be longer if needed. When you will be discharged from hospital depends on the reasons for your operation, your general health and how smoothly things go after surgery. Recovery time varies from woman to woman. It is important to remember that everyone's experience is different, and it is best not to compare your own recovery with that of others on the ward.

Whilst you are on the ward you will be visited by a physiotherapist, who can give you advice on exercises, including pelvic floor exercises, and other ways to help your body recover.

Sex after the operation

For many women, this area of their life improves because there is no longer any discomfort during sexual activities. We advise that you avoid penetrative intercourse for about six weeks, until your abdominal wounds are comfortable.

Take your time, feel comfortable and relaxed and don't be rushed. For the first few occasions you might find a lubricating gel is helpful. You can buy this from the chemist and many other shops. Talk to your partner about this, as you will need extra gentleness and understanding.

Painful intercourse

Some women find sex is uncomfortable at first but this gets better with time. Occasionally pain during intercourse can be long-term or permanent. Pain during intercourse is more common if you also had anterior or posterior repair.

Weight

The operation itself should not cause you to gain weight. Initially, as you are not able to be as active as usual and may have an increase in appetite, you might tend to put weight on. By paying attention to what you eat and increasing your activity level as you recover, you should be able to avoid any significant weight gain.

Exercise

It is important to continue to exercise; walking is an excellent way of doing this. Gradually increase the length of your walks, but remember to only walk the distance you can achieve comfortably. Cycling and swimming are equally as good and you can start to do these activities within a couple of weeks of your operation.

Cervical smears

After a hysteropexy you will need to continue to have your usual cervical smear tests.

Follow-up

We will see you back in clinic again approximately 12 weeks after your surgery to assess your recovery. This appointment will be sent to you through the post and should arrive within 3 to 4 weeks.

British Society of Urogynaecology (BSUG) database

In order to better understand the success and risks of surgery for prolapse, the British Society of Urogynaecologists has established a national database. Our centre is a member of this society and enters all our procedures onto this database.

If you are happy for your details to be entered onto this secure database you will be asked to sign a consent form to allow us to do this. The information collected is being used to develop an overall picture of what procedures are being performed throughout the United Kingdom together with complications and outcomes. Individual surgeons can also use it to evaluate their own practice.

How to contact us

If you have any questions or concerns either before or after your surgery, please telephone the:

Urogynaecology Nurse Specialists

Tel: **01865 222 767**

(Monday to Friday, 8.00am to 5.00pm)
We have an answerphone available and will return your call by the end of the next working day.

Or

Gynaecology Ward Nurses

Tel: **01865 222 001** or **01865 222 002**

(24 hours)

Specific enquiries will be referred to the Urogynaecology Nurse Specialists.

Further reading and support

The Physiotherapy Department

Women's Centre
John Radcliffe Hospital

Tel: **01865 235 383**

(Monday to Friday, 8.00am to 4.00pm)

Women's Health Concern

Women's Health Concern produce information leaflets about hysterectomy, prolapse, and associated health conditions.

Website: **www.womens-health-concern.org**

Oxford Gynaecology and Pelvic Floor Centre

Oxford Gynaecology and Pelvic Floor Centre provides specialist services for women with gynaecological and pelvic floor problems. Please speak with your doctor about being referred to this service.

Website: **www.oxfordgynaecology.com/**

British Society of Urogynaecology (BSUG)

This website provides information about urogynaecological conditions and all surgical options for pelvic organ prolapse and urinary incontinence.

You may find the 'Patient decision aid about choice of procedure for prolapse of the uterus (NICE)' particularly useful. This can be found on the 'Information for patients' page.

Website: **www.bsug.org.uk/**

NHS Choices

NHS Choices has information about a wide range of health problems and symptoms.

Website: **www.nhs.uk/Pages/HomePage.aspx**

References:

1. Laparoscopic Hysteropexy– One to four years follow up of women post operation. Rahmanou P, White B, Price N, Jackson S. Int Urogynecol J. January 2015.

If you need an interpreter or would like this information leaflet in another format, such as Easy Read, large print, Braille, audio, electronically or another language, please speak to the department where you are being seen. You will find their contact details on your appointment letter.

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