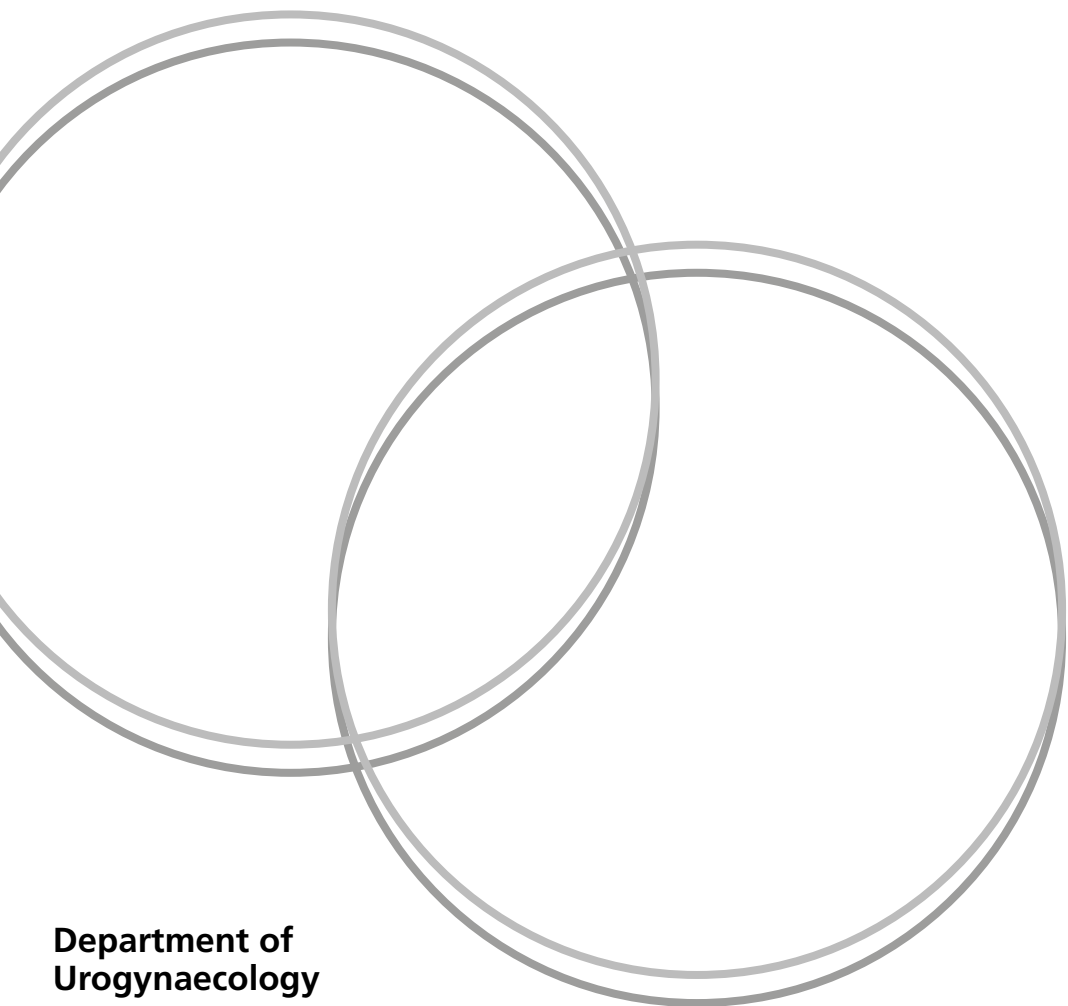




Oxford University Hospitals
NHS Foundation Trust

Laparoscopic sacrocolpopexy for vaginal vault prolapse

Information for women



Department of
Urogynaecology

You have been given this leaflet as you have been advised to have sacrocolpopexy for your vaginal vault prolapse. This leaflet explains what vaginal vault prolapse is and why you have been recommended to have this operation. It also describes what will happen when you come into hospital, the potential benefits as well as the risks, recovery from the operation and what to expect when you go home.

What is a laparoscopic sacrocolpopexy?

This procedure is performed if you have developed a prolapse at the top of your vagina after a hysterectomy. This is called a vaginal vault prolapse.

A piece of mesh is stitched along the back wall, the top and, if necessary, the front wall of the vagina. The mesh is in turn secured to the ligament over the lower backbone (sacrum). The effect of this is to support the vagina and prevent it from prolapsing down, restoring it to its normal position in your body. Eventually, new connective tissue grows into the mesh, which forms a new strong ligament. The mesh will remain permanently in your body.

The operation is performed while you are asleep under a general anaesthetic, using small cuts on your tummy, called keyhole surgery (laparoscopically).

You should bear in mind that even though surgical treatment will repair your prolapse, it may or may not relieve all of your symptoms.

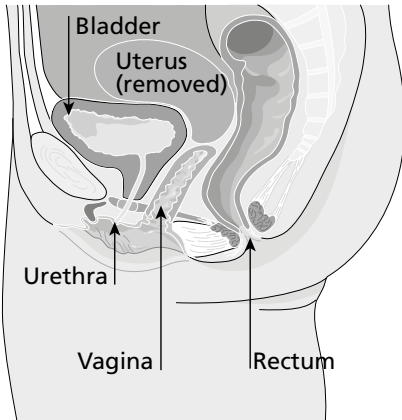
What is a vaginal vault prolapse?

When you have had a hysterectomy (removal of the uterus 'womb') the term 'vault', is used to describe where your uterus would have been attached to the top of your vagina.

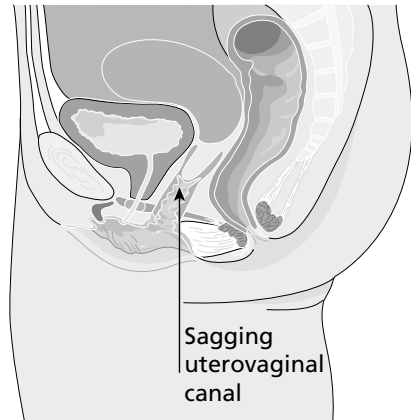
A vaginal vault prolapse is where the top of the vagina slips down into the vagina itself. Vaginal vault prolapse commonly occurs following a hysterectomy, because the uterus usually provides support for the top of the vagina. This condition occurs in up to 40% of women (40 in 100) after a hysterectomy.

In a vaginal vault prolapse, the top of the vagina gradually falls toward the vaginal opening. Eventually, the top of the vagina may protrude out of the body through the vaginal opening, effectively turning the vagina inside out.

Normal anatomy



Vaginal vault prolapse



A vaginal vault prolapse is often accompanied by a weakness and prolapse of the walls of the vagina. This may cause a rectocele (a bulge of the back wall of the vagina) or a cystocele (a prolapse of the front wall of the vagina). Sometimes, surgery to correct one of these further prolapses is required at the same time as the sacrocolpopexy procedure. Your surgeon will discuss this with you.

Conditions leading to vaginal prolapse

A vaginal prolapse is a bulge within the vagina caused by a weakness in the supporting tissues and muscles around the vagina. This can happen when one or more pelvic organs push into the vagina when the muscles are weak.

Pelvis organs include the uterus (womb), bladder and bowel. Many women have more than one 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 at the menopause can weaken these muscles further, creating a prolapse. You do not need to seek treatment unless you have symptoms.

If your vault or vaginal prolapse protrudes from your vagina, you may find you have to push the bulge back inside your vagina in order to empty your bladder and help to empty your bowel. Occasionally, you may find that the bulge causes a dragging or aching sensation, which can be particularly worse towards the end of the day.

There are different levels of vault and vaginal prolapse. The symptoms can include:

- a 'dragging' feeling and a feeling of 'fullness' in the vagina
- a lump inside or outside of 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.

Alternative treatments

If the prolapse (bulge) is not troubling you greatly then it is not necessary to have surgery. However, if the prolapse is outside your vagina and exposed to the air, it can become dry and sore. Even if it is not causing any symptoms, in this situation, if you would prefer not to have surgery, we would recommend supporting it back inside the vagina with a ring or shelf pessary (see below). We would also recommend that you practice pelvic floor exercises. These can be beneficial, even if you have decided to go ahead with the surgery.

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 laparoscopic sacrocolpopexy

This operation has been performed for a long time and the success rate is 90%. You should feel more comfortable after the operation and the sensation of prolapse or something 'coming down' should have gone.

Laparoscopic sacrocolpopexy only uses small cuts (incisions) and small instruments. This reduces the risk of damage to the 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.

Risks of laparoscopic sacrocolpopexy

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 sacrocolpopexy are shown below:

- Damage to the bladder or one of the tubes (ureters) which drain the kidneys (1 in 200).
- Rarely, damage to the bowel (1 in 1000).
- Damage to blood vessels and excessive bleeding during the operation (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 vaginal vault 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. If another prolapse develops, it is generally not bothersome enough to 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 (1 to 2 in 100). If this was to happen you may need a repeat operation to trim the mesh.
- As with all surgery, there is a risk of an infection developing. This could be in the area where you have had surgery (such as the vagina, the area where any cuts have been made, or the pelvic area) or may be related to the surgery (such as a bladder or chest infection). 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.

Although sacrocolpopexy 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

- Overactive bladder symptoms (urinary urgency and frequency, with or without urge incontinence) usually improves after this operation but occasionally can be a new symptom or worsen.
- Stress incontinence. Having a large prolapse can sometimes cause kinking of the pipe through which you pass urine (urethra). 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. This happens in about 1 in 10 women. If you have stress incontinence before sacrocolpopexy, then stress incontinence can be made worse after surgery.
- Bladder emptying. 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.

Painful sexual intercourse

The healing after this surgery usually takes about six weeks. Some women find sex is uncomfortable at first, but it gets better with time. It may help if you use a lubricant gel, topical oestrogen cream, or pessaries. Do expect things to feel a little different; after the operation your vagina will be suspended and therefore under slight tension. Sometimes sensation during sex may be less and occasionally orgasm may be less intense. Occasionally pain on intercourse can be long-term or permanent.

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 you may have or to raise any concerns.

Before you come into hospital

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 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. If you have been anaemic then your GP will recommend that you take iron supplements before the surgery.

On the day of 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 which will measure the activity of your heart (electrocardiogram or ECG).

The operation

Once you are unconscious under the general anaesthetic, the surgeon will make three 5mm incisions (cuts) on your abdomen. 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.

A piece of mesh will be stitched along the back wall, the top and, if necessary, the front wall of your vagina. The mesh is then secured to the ligament over your lower backbone (sacrum). This supports your vagina and prevents it from prolapsing down, restoring it to its normal position within your body. After a few months, new connective tissue grows into the mesh which forms a new strong ligament which will remain permanently in place. The stitches used to secure the mesh are dissolvable.

When the procedure is finished, the surgeon will close all the cuts on your skin with dissolvable stitches or glue (dermabond). These will gradually disappear after two to three weeks.

Diagram of pre sacrocolpopexy

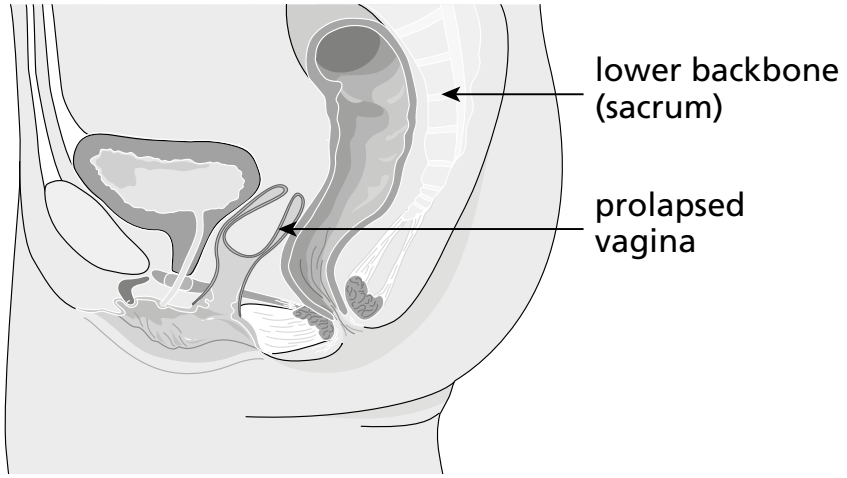
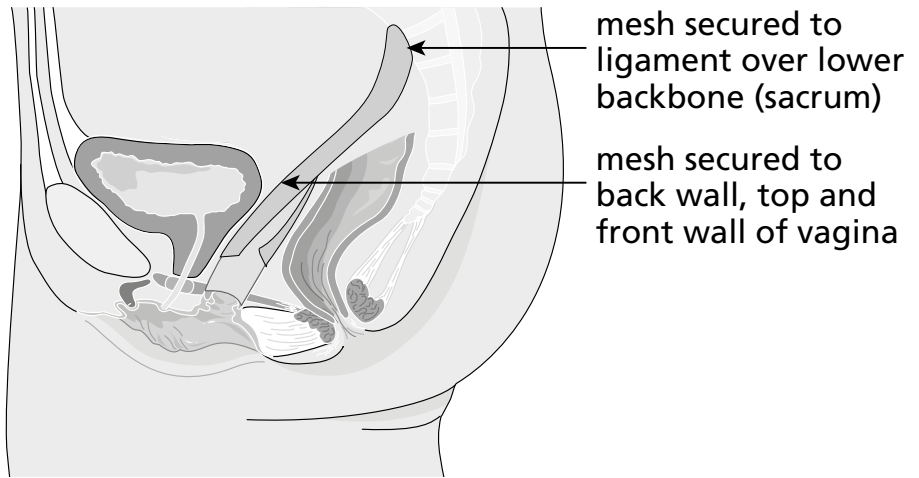


Diagram of post sacrocolpopexy



Vaginal repair

Other types of prolapse may result from stretching and weakening of the walls of the vagina, with bulging of the bladder through the front wall (cystocele) or bowel through the back wall (rectocele). All of these conditions can result in the feeling of something 'coming down' the vagina.

The vaginal repair operation tightens the walls of the vagina and the pelvic floor muscles. It involves making a cut on the back and/or front wall of the vagina and repairing the wall between the rectum and vagina or bladder and vagina to cure the vaginal bulge.

The operation normally takes around 20-30 minutes to complete and may be carried out at the same time as the sacrocolpopexy. All the stitches used in vaginal 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 will be a narrow tube, called a catheter, in your bladder (to drain away urine). This 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 of 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 sacrocolpopexy, 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 sacrocolpopexy, you are likely to stay in the hospital for approximately 1-2 nights. 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 less common after laparoscopic surgery than vaginal surgery.

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, but please allow yourself a couple of weeks to recover before returning to these exercises.

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.

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 222002

(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/

NHS Choices

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

Website: www.nhs.uk/pages/home.aspx

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.

Making a difference across our hospitals

charity@ouh.nhs.uk | 01865 743 444 | hospitalcharity.co.uk

OXFORD HOSPITALS CHARITY (REGISTERED CHARITY NUMBER 1175809)



Authors: Natalia Price and Simon Jackson, Consultant Urogynaecologists
Beverly White, Urogynaecology Nurse Specialist

Approved by SUWON Patient Information Coordinator and Lead

March 2020

Review: March 2023

Oxford University Hospitals NHS Foundation Trust

www.ouh.nhs.uk/information

