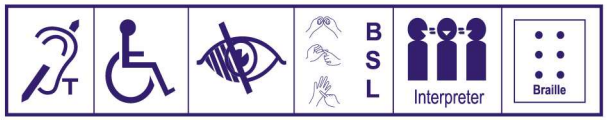
Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust



We can provide interpreters for a variety of languages, information in larger print or other formats (e.g. audio) - please call us on 01932 723553.

To use the Text Relay service, prefix all numbers with 18001.

اگر نیاز به ترجمه دارید، لطفا با شماره 01932 723553 تماس بگیرید.

ਜੇ ਤੁਹਾਨੂੰ ਤਰਜਮੇ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ: 01932 723553

اگرآپ اِس کا اُردو زبان میں ترجمہ چاہتے ہیں، تو براہِ کرم اِس فون نمبر 01932 723553 پر رابطہ کریں

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আপনার অনুবাদের দরকার হলে এখানে যোগাযোগ করুন : 01932 723553

यदि आपको अनुवाद की ज़रूरत है तो कृपया इस नंबर पर फोन करें: 01932 723553

Jeżeli chcemy, aby te informacje w innym języku, proszę zadzwonić 01932 723553

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Ashford and St. Peter's Hospitals
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Sacrocolpopexy

Department of Urogynaecology

Patient Information

Sacrocolpopexy

Introduction

Vaginal vault prolapse occurs when the upper portion of the vagina loses its normal shape and sags or drops down into the vaginal canal or outside of the vagina. It may occur alone or along with prolapse of the front (anterior) or back (posterior) wall of the vagina. Vaginal vault prolapse is usually caused by weakness of the pelvic and vaginal tissues and muscles. It happens in women who have had their uterus removed (i.e. after hysterectomy). Symptoms vary depending on the severity but can include a bulge in the vagina, discomfort; back ache or a dragging sensation; as well as associated problems with the bladder, bowel and/ or sexual intercourse.

What are my options?

No treatment

Whilst vaginal prolapse can be uncomfortable and unpleasant, it is not life-threatening and having no treatment is a perfectly reasonable option, especially if you are not particularly aware of it and it is not causing any problems

Lifestyle strategies

Stopping smoking, losing weight and managing your bowels will all help in alleviating symptoms.

Further Information

We endeavour to provide an excellent service at all times, but should you have any concerns please, in the first instance, raise these with the Matron, Senior Nurse or Manager on duty.
If they cannot resolve your concern, please contact our Patient Experience Team on 01932 723553 or email asp-tr.patient.advice@nhs.net. If you remain concerned, the team can also advise upon how to make a formal complaint.

Department: Kate Anders, Lead Nurse **Department:** Urogynaecology
Version: 2 **Published:** June 2018 **Review:** July 2020

Further information can be found at these websites
http://www.mhra.gov.uk
http://www.nice.org.uk
http://bsug.org.uk
http://rcog.org.uk

MHRA

* All mesh-related adverse events are required to be reported to the medical device watchdog, the Medicines and Healthcare products Regulatory Agency (MHRA)

Summaries of the safety/adverse effects of vaginal meshes for prolapse

The aim of the use of mesh in women having prolapse surgery is to reduce the very high failure rate of traditional prolapse surgery: one in three women will need a second operation at some time in the future.

Operations for uterine or vault prolapse (such as sacrocolopexy & uteropexy) cannot be carried out without the use of a synthetic mesh bridge.

A number of reports of complications associated with meshes have been reported to the MHRA, in a few cases of a particularly severe nature leading to further medical conditions. The most frequent reported adverse events have included pain, sexual problems, mesh exposure and erosion and occasionally injury to nearby organs such as bladder or bowel.

In most cases these extreme adverse advents or problems occur where a synthetic mesh is used for a vaginal wall prolapse (i.e. anterior or posterior) and is inserted vaginally.

The use of mesh for anterior or posterior repair is optional and only absorbable biological meshes are used in this department for vaginal repair – see leaflet V*aginal repair with biological mesh.*

Vaginal oestrogens

These will not cure a prolapse, but if the tissues lack oestrogen (due to the menopause) it can help to reduce the awareness of a prolapse.

Physiotherapy

If a prolapse is mild, supervised physiotherapy (pelvic floor exercises) can help to reduce the symptoms so that surgery can be avoided.

Vaginal Support Pessaries

There are a wide variety of pessaries which hold the prolapse in place. The pessary will need to be changed every 4-6 months but they can avoid the need for surgery altogether or be used temporarily should you wish to defer surgery

Combination of the above

Conservative (non-surgical) treatments can be used alongside each other, and if post-menopausal vaginal oestrogens are often advised alongside surgical options

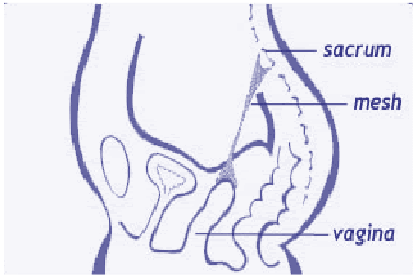
Surgery

Surgical procedures will be offered if clinically indicated. The type of surgery and the need for an abdominal or vaginal surgical approach will depend on the type of prolapse, whether you are sexually active, whether you have had previous vaginal surgery, and how medically fit you are. All procedures, their risks and benefits will be discussed with you and your case reviewed by our multi-disciplinary team (MDT) before a decision, with your input, can be made on which is the right procedure for you.

What is a sacrocolpopexy

A sacrocolpopexy is a repair to the vaginal vault (top of the vagina) with or without additional repair to the vaginal walls. The primary aim of surgery is to restore normal vaginal anatomy, improve vaginal bulge symptoms; and restore or maintain normal bladder, bowel and sexual function.

It involves attaching the highest point of the vagina to a ligament on the back bone using a piece of synthetic "mesh" material. The material is made from non-absorbable polypropylene (prolene) sutures (stitches) which are then woven into a mesh. Mesh implants are permanent implants and are not intended to be removed.



Driving **-** You should avoid driving until you feel comfortable moving around the car and you can perform an emergency stop without experiencing any pain/discomfort and to allow the wounds to heal (up to 4 weeks).

It is your legal responsibility to remain in control of a vehicle at all times and you must ensure you remain covered by your insurance policy to drive after surgery. You only need to notify the DVLA of your surgical recovery if it is likely to affect your driving and persist for more than 3 months.
https://www.gov.uk/guidance/miscellaneous-conditions-assessing-fitness-to-drive#driving-after-surgery

Return to work **-** 4-8 weeks. This will depend on what your work entails and whether it involves heavy manual work.

Follow up

You should be seen in clinic approximately 3 months after the operation by either one of our specialist nurses or doctors

If you have any acute illness, please contact your GP.

If you need to ask for advice then please ring the ward you were admitted to or the Urogynaecology department on 01932 722124 Monday to Friday.

If you have been previously prescribed medication for an underlying overactive bladder, you should continue to take these unless otherwise instructed.

Stitches - All stitches are dissolvable. If you see any stitch material it is better to leave it alone. If it is bothersome it can be trimmed by your GP or nurse. Do NOT pull them

Personal hygiene - It is better to shower than bathe for long periods of time for the first couple of weeks.
Mild vaginal discharge is part of the normal healing process. If it becomes excessive or offensive it may indicate an infection

Bowels - Constipation and straining when opening your bowels, puts unnecessary pressure on the repair and should be avoided in the long term.

Sexual intercourse - avoid penetrative intercourse for 4 - 6 weeks. This will allow time for the vagina to heal and any stitches to dissolve. It may feel superficially tender to start but this should settle down with time

Exercise - avoid vigorous sports *and swimming* for 6- 8 weeks. As a long term rule avoid sit ups or heavy weight training. You can gradually introduce gentle exercise into your daily routine after 4 weeks.
Pelvic floor exercise should resume once you feel comfortable

Lifting - You should avoid heavy lifting as a long term lifestyle change if you have had continence surgery.

Overall, sacrocolpopexy offers 85-90% chance of supporting the vaginal vault.

The risks and complications associated with this procedure are covered in the leaflet but your consultant will discuss these with you and answer any questions you may have.

The surgery can be performed laparoscopically or through a bikini line incision in the tummy known as a laparotomy. This will be dependent on your individual circumstances which your surgeon will discuss with you. Post-surgery recovery is the same.

Additional repair to the vaginal walls can be either the front wall (anterior) and/or the back wall (posterior). Anterior wall and vault prolapse can cause bladder symptoms, including frequency, urgency, incontinence and difficulty with bladder emptying. Urodynamic (bladder function) tests maybe performed prior to surgery to ascertain their impact on your bladder function or predict whether surgery may unmask pre-existing problems if even if you have no current urinary symptoms.

Posterior wall prolapse may cause bowel symptoms, including constipation and difficulty in passing stool. For some women, ano-rectal studies may be performed before surgery to establish your current bowel function and how surgery may affect it.

Other routine investigations may include a pelvic ultrasound to examine a number of structures including the ovaries, if still present. If you are post-menopausal, ovaries can be removed at the time of surgery.

Before the operation

Pre-operative assessment

This is done well in advance of your surgery date to ensure you are fit and well to undergo surgery and will include a review of your medications, urine and blood test and other tests such as an ECG (heart monitoring test) or chest x-ray. It can often be done immediately following your consultation when you are initially added to the waiting list. If not, you will be sent an appointment. Surgery dates are usually offered with about 4-6 weeks' notice. Please notify us of any previous arrangements/ holidays so that we do not offer dates that clash. You should expect to be in hospital for 2-3 days.

Medications

Please *bring all your medications* with you when you attend for your surgery and *only* stop those medications you have been advised to

You will be asked to stop any anticoagulants (blood thinning medications) but we will liaise with your GP/ Haematology department about a regime to reduce and come off these medications. (These include warfarin, heparin, dabigatran, rivaroxaban, apixaban and clopidogrel)

Other medications with similar properties (e.g. Aspirin, ibuprofen and diclofenac) will need to be stopped 2 weeks before the operation.

- ***Stress incontinence. (Common)*** This could be worsening of pre-existing symptoms or a new symptom. Urodynamic tests performed before your surgery will help predict this risk and any additional need for treatment will be discussed with you.

- ***Difficulty emptying your bowel and/or constipation (Common).*** It is important to maintain a healthy diet to avoid constipation but some women find their symptoms are worse following surgery. This usually settles down but must be managed to reduce the risk of recurrent prolapse

- ***Failure or recurrence of prolapse requiring further surgery (Uncommon).*** Any recurrence of symptoms will require re assessment and investigation.

Recovery at home

Medication **-** You may receive some take-home medication including painkillers and/or antibiotics. Please finish the course of any antibiotics as prescribed.

Any topical vaginal oestrogen cream or pessary (vagifem) should be continued as prescribed once you feel comfortable inserting the applicator (usually after 4 weeks) and any bleeding/ discharge has subsided.

discomfort. Lubrications or topical vaginal oestrogens (if post-menopausal) may help reduce these symptoms, but if they persist advice should be sort.

- ***Long term pain in the pelvis, vagina or during sexual intercourse (Rare)*** Persistent pain needs to be investigated as it may indicate an infection or mesh migration. Nerve or musculoskeletal damage may be ongoing requiring referral to physiotherapy, the pain management team, and/or the need for surgical revision

- ***Mesh erosion/ migration into surrounding structures (Rare).*** These complications are dealt with on an individual case by case basis. They can be seen shortly or several years after insertion and can present in a number of ways; unexplained pain, urinary infection, vaginal discharge, infection, bleeding and/or pain during sexual intercourse. Mesh erosion will usually require further surgery and possibly removal of the tape.

- ***Mesh infection (Rare).*** If the mesh becomes chronically infected and does not respond to antibiotics, it will normally be removed

- ***Inflammation of a sacral bone (Rare)*** Any suspected infection is first treated with antibiotics, inflammatory medication and painkillers. In extreme cases surgery may be required

Consent

You will be asked to sign a consent form which confirms you have agreed to the procedure. If you do not understand anything, require any further information or would like someone with you, please let the consenting doctor know **before** you sign.

Eating and drinking

You will be advised when you need to stop eating and drinking prior to the procedure depending on the type of anaesthetic and the time your surgery is scheduled.

Pre-existing bladder problems

If you have any urinary symptoms, urodynamic tests will be performed to ascertain their cause, severity and whether additional surgery is needed.

If you have had previous continence surgery, have difficulty emptying your bladder or pass urine slowly with or without the need to strain, you may need to be taught clean intermittent self-catheterisation (CISC) before going on the waiting list, in case these symptoms are made worse by the surgery.

The anaesthetic and operation

The anaesthetic

The operation is usually done under a general anaesthetic (asleep) but can be done under a spinal anaesthetic (numb from the waist down).

The operation

- The length of the operation can vary from 90-180 minutes depending on any previous pelvic surgery
- Your legs will be held in stirrups. Please let us know if you have any hip or back problems.
- A small bikini cut (or laporoscopic port holes) is made on your abdomen just above your pubic bone.
- The bowel may need to be moved out of the way to gain access to the vagina and back bone
- The highest point of the vagina is located, lifted, and then attached to a ligament on the back bone using the synthetic mesh.
- When the operation is completed any incisions will be stitched together with dissolvable stitches and a small dressing will be applied.

After the operation

- After the surgery, you will be taken to recovery and then on to the ward.

left in for a longer period or you will be taught clean intermittent self-catheterisation (CISC) - or asked to start if taught before surgery.

- ***Long-term difficulty in bladder emptying (Rare).*** This may require long term CISC

- ***Haematoma - collection of blood (Uncommon)****.* This can present as a tender swelling but in most cases will resolve on its own.

<u>After discharge</u>

- ***Vaginal Infection (Common).*** Symptoms include an offensive, greenish vaginal discharge. If you suspect an infection contact your G.P. as you may need antibiotics.

- ***Wound Infection (Uncommon).*** The wound site may appear red and angry-looking with or without the presence of pus. You may need antibiotics.

- ***Vaginal bleeding (Common)*** If the bleeding does not subside, it becomes heavy or associated with pain you should visit your GP as it may indicate an infection

- ***Superficial pain on sexual intercourse (Common).*** If you have had a vaginal repair as well, there will be some scarring on the vaginal wall that can be aggravated by penetrative sexual intercourse causing superficial

bladder) but this is rarer. Any damage is generally dealt with when it is identified at the time of your operation but your recovery may be delayed. Any damage undetected during surgery, may require a return to theatre.

  - Bladder damage may require a catheter (small tube) to be inserted to give time for the injury to heal. You will be sent home with the catheter during this time and an appointment will be made to have the catheter removed 1 to 2 weeks later.
  - Occasionally, further tests such as a cystogram (xray test with dye) may be required to confirm the injury has healed before the catheter is removed.

- ***Injury to the bowel requiring a temporary colostomy (bag) (Rare).*** Faeces may need to be directed away from the injury to allow the bowel to heal and your planned prolapse surgery could be delayed till a later date

<u>After surgery</u>

- ***Temporary difficulty in passing urine (Common)***

  - A catheter is inserted to rest the bladder (initially 1-2 weeks). This will be connected to a drainage bag fastened to your leg. You will be shown how to manage it and allowed home.
  - An appointment will be made to remove the catheter so that you can try again to pass urine.
  - If the problem persists *(Uncommon)* the catheter may be

- You may experience some discomfort/pain for the first 24-48 hours. Painkillers will be provided but please ask if any pain is not relieved by the painkillers you are given
- An intravenous (IV) cannula will be in your arm. This usually stays in place for 1-2 days to administer any IV medication and/or fluids (drip) until you are drinking normally again.
- If there has been more than average bleeding during the operation a drain (tube) maybe placed in the abdomen (tummy) to drain out any blood that has collected. This is removed once it has stopped draining any excess blood, usually in 1-2 days.
- If you have had a spinal anaesthetic you will have a urinary catheter left in the bladder, usually overnight.
- There will be a small dressing covering the wound or laparoscopic port sites.
- Once you are awake/ready you will be able to drink starting with sips and slowly gradually increase your fluid intake to 1.5 to 2 litres a day. Once you are able to tolerate fluids and have normal bowel sounds you will be able to eat normally

What are the risks of surgery?

<u>General surgical risks</u>

- ***Anaesthetic/ cardiovascular problems*** – all anaesthetics carry some risks including chest infection, pulmonary embolus, stroke, heart attacks and very rarely, death. These risks are dependent on the type of anaesthetic you are having and how fit you are before your surgery. Your

surgeon/anaesthetist will discuss your individual risks with you.

- ***Pain & discomfort.*** It is usual to experience some discomfort. Painkillers will be offered on a regular basis but if your discomfort is not well-controlled please advise the staff that are looking after you.

- ***Vaginal Bleeding.*** It is normal to have some vaginal bleeding for 48 hours after surgery. This should tail off and become a brown discharge for a couple of weeks before stopping altogether.

- ***Urinary infection****.* Symptoms include foul smelling urine, frequency, urgency and a burning pain on passing urine. If you suspect an infection, increase you fluid intake and contact your G.P. to arrange to have a sample tested

- ***Generalised Infection****.* Either in the vagina or the wound sites. A swab is often taken and antibiotics will be given if an infection is present.

- ***Venous vein thrombosis (VTE****).* The risk of blood clots in the leg (4-5%) or lung (1%) is increased by immobility, if you are overweight or smoke. This risk will decrease by quick mobilisation after surgery and weight loss/ smoking cessation prior to your operation. You will be required to wear TED stockings

Risks specific to this type of surgery

The terms in the table are designed to give you an idea of relative risks that are reported in medical literature and confirmed /endorsed by the National Institute of Health and Clinical Excellence.

Term	**Number of people**	**Size of group / area**
Very common	1in1 to 1in10	One person in a **family**
Common	1in10 to 1in100	One person in a **street**
Uncommon	1in100 to 1in1000	One person in a **village**
Rare	1in1000 to 1in10 000	One person in a **small town**
Very rare	1in10 000 and above	One person in a **large town**

During surgery

- ***Conversion to open surgery (Uncommon).*** Even when a laparoscopic approach is planned it is sometimes necessary to perform a laparotomy (open surgery) to proceed with the operation safely. This can be due to previous scarring making visibility difficult, bleeding that is difficult to control laparoscopically or damage to local organs.

- ***Damage to local organs (Uncommon).*** This can include bladder and bowel; or the ureters (tubes from kidneys to