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).

This can be done using a sling made of your own tissue or using an artificial mesh

A strip of mesh or the autologous fascial sling 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).

You need to bear in mind that the surgical treatment may correct your prolapse however it may or may not address all of your symptoms. The decision should be made after a thorough discussion.

Use of Mesh: Mesh has been developed to make repairs stronger (because repairs without mesh may fail or may not last long). Using mesh vaginally (fitting mesh through a cut in the vagina) is no longer permitted. However, using mesh abdominally (fitting mesh through a cut in the abdomen or 'tummy' for operations such as the Sacrocolpopexy and Sacrohysteropexy) is not new and these operations have a long record of safety and success.
This means that mesh fitted during these procedures is safe and much less likely to cause complications. Mesh can be made of plastic (synthetic) or animal tissues (biomesh).
Traditionally plastic mesh has been used for Sacrocolpopexy and Sacrohysteropexy.
The mesh remains permanently inside your body

Autologous sling- A sling is created measuring about 14-16 cm x 2-3 cm wide from the sheath of your rectus muscle (Autologous rectus sheath sling) or from sheath of muscle from your thigh (fascia lata graft) .

The operation is done under general anaesthesia and can be done thru open surgery or laparoscopic surgery(key hole). A cathter is left in situ usually for 24 hrs

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. 80-90 % uccess rate is reported with the use of mesh over a period of 3-5 years however, there is lack of long term evidence on the success rate of sacrocolpopexy using your own tissue but has been reported as 70-90% at the end of 1 year and seems durable over short to medium term.

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 will be given a minimum of 1 week notice to attend this clinic
- You will be given minimum of 2 weeks **notice** of your surgery date.
- You will usually be seen by your Surgeon either 1-3 weeks before the operation to sign your **consent** and discuss details of the operation or the consent will be taken in pre-assessment clinic or during consultation at Gynae clinic.
- **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

Women will have their postoperative check done either in the community with a telephone call from one of our nurses or secretary or via a Gynaecological outpatient appointment. (usually 3 months after the operation).If the check is done via telephone the nurse or the secretary 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, previous multiple abdominal surgeries 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 life saving 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, Warfarin, Hormones, etc).

There is small risk of infection. An infection can occur in the wound, urine or sometimes in the chest following anaesthesia. The risk of infection is reduced by routine administration of antibiotic during the procedure however, if it still happens it can be treated with antibiotics.

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 (1 in 200), the bowel (1 in 1000) 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). A bladder injury will need a catheter to drain the bladder for 7-14 days following surgery. Injury to the rectum (back passage) may require a temporary colostomy (bag) in rare circumstances and inserting the mesh may be delayed till a later date

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. It is advisable to avoid constipation to prevent recurrence of symptoms

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) or after learning to use the catheters themselves to empty the bladder (Intermittent self catheterisation)

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). It is difficult to define the risk but it is said to be in order of 10%

Failure to cure symptoms- Even if the operation cures the bulge it may fail to cure your prolapse.

Mesh Complications- 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). Infection of mesh can happen which is usually treated with antibiotics however , rarely may need removal. Other complication is inflammation of the sacral bone (osteomyelitis) which is rare but serious.
Unfortunately problems due to plastic mesh can sometimes be difficult to treat.

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.

Complication	**Very common (up to 1 in 10)**	**Common (1 in 100 to 1 in 1000)**	**Uncommom (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**
Stress urinary incontinence	**X**		
Urge urinary incontinence	**X**		
constipation	**X**		
Sexual dysfunction		**X**	
Chronic pain		**X**	
Mesh erosion		**X**	
Recurrence of same problem in future*	**X**		

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 brochures' (remember to 'select language')

Pelvic organ prolapse Sacrocolpopexy

British Society of Urogynaecology (BSUG)
http://www.bsug.org.uk
Go to 'Guidelines and Information' / 'Patient Information'

Sacrocolpopexy for vault prolapse Sacrohysteropexy for uterine prolapse

MHRA- The Medicines and Healthcare products Regulatory Agency (MHRA) is a government body for the regulation of medicines and medical devices and equipment used in healthcare and the investigation of harmful incidents. Side effects and complications of mesh such as pain, mesh erosion can be reported to your clinician or to MHRA directly through yellow card scheme. You can access yellow card scheme via following link "https://yellowcard.**mhra**.gov.uk"

Useful contacts

Re-scheduling of surgery **Jean Newton**
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