

Laparoscopic Sacrocoldpopexy

Department of Gynaecology

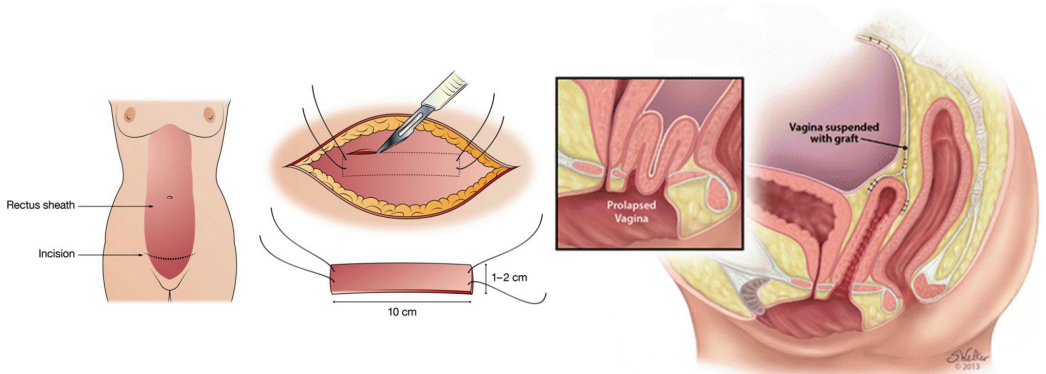
What is laparoscopic sacrocolpopexy?

This is an operation carried out using key hole surgery under general anaesthesia to correct prolapse of the vaginal vault. This condition refers to slipping down of the top of the front passage in patients who had a hysterectomy, removal of the womb. Usually, there is associated prolapse of the front and back walls of the vagina, which is dealt with at the same time. The condition can cause sense of bulge, discomfort, urinary and bowel problems and sexual difficulties.

Why do I need laparoscopic sacrocolpopexy?

The operation is intended to support the vaginal vault and correct associated vaginal prolapse. Hopefully this will improve urinary, bowel and/or sexual problems.

This is achieved by attaching the vaginal vault to the top of the lower back bone (sacrum). Traditionally, mesh was used for this attachment. Although this used was never paused, during the mesh and tape pause that started in 2017, the concern about the use of mesh cannot be ignored. A strip of one of the layers of the abdominal (tummy) wall is used instead. As this is part of one's own body, and not a foreign material, there are no concerns about its use.



What can I expect before the operation?

At your pre-op assessment and on your admission day the nurse will go through your hospital stay and explain your operation. Please do let us know about any concerns you have or if there is any information you think we should know about that will make your stay with us more comfortable.

You will need to make arrangements for your family, children or any other commitments that you have prior to coming in to hospital and to cover the length of your recovery.

You will see an anaesthetist and the doctor performing the surgery before you go to theatre. If you have not already completed a quality of life questionnaire, you might be asked to do so before surgery. Likewise, if you have not already signed the consent form on booking, the doctor will go through it with you before you go to theatre.

You will be asked for permission to enter your data on the national database for continence and prolapse surgery. This is a quality control measure to compare the safety and effectiveness of such procedures at the hospital against other units in the country. You will be given a frequency volume chart and quality of life questionnaires to complete and bring with you as you attend for follow up after surgery. This will enable assessing the benefit of surgery for you.

What does the operation involve?

The operation is done through a key-hole approach. A small cut (1 cm) is made in the umbilicus (belly button), to introduce the laparoscope (tummy camera). If you had previous operation(s), this cut may be made below the left side of the chest wall. Another cut (4 cm) is made in the hair line at the bikini line. Through this cut, the strip from the tummy wall is obtained. Two additional small cuts (1/2 cm) are made,

one on either side of your tummy. These cuts enable introducing instruments to do the operation.

Through these cuts, the vaginal vault is located and lifted up by attaching it to the top of the lower back bone (sacrum). At the end of the operation, all instruments are removed and all wounds are closed.

What are the risks?

There are risks with any operation but these are small.

The main risks associated with a laparoscopic sacrocolpopexy are:

Common risks:

- Postoperative pain particularly shoulder tip pain. This is caused by the gas used to distend your abdomen being trapped under the muscle that separates the chest from the abdomen. Pain from this muscle is referred to the shoulder. This pain is usually mild and responds to pain killers. It often disappears within a day or two.
- Initial difficulty in passing urine. This is usually managed by leaving the catheter to drain the bladder for longer and you can go home with a leg bag for few days. Less commonly, patients may need intermittent self catheterisation for a short period of time.

Uncommon risks:

- Wound infection, which may require antibiotics.
- Bruising and delayed wound healing.
- Urinary tract infection. This may happen as a result of passing a catheter to drain the bladder and is treated with antibiotics.
- Inability to complete the operation through the key-hole, which may necessitate laparotomy (open tummy) approach.
- The bladder and/or bowel rarely get injured during the operation and these are usually repaired at the time. If such injury is not identified and repaired at the time, there is a risk of fistula, but this is extremely rare.

- Pelvic abscess or infection.
- Late onset difficulty passing urine. This may manifest days or even weeks after being able to pass urine smoothly. The management is the same as initial difficulty passing urine, either by using a catheter with a leg bag and/or clean intermittent self catheterisation.
- Deep vein thrombosis and pulmonary embolism (blood clots in the leg veins / lung) can happen after any major operation. You will be asked to wear elastic stockings and given injections to prevent these clots. If you do develop such clots, you will be given more injections.
- Hernia at site of entry.
- Bleeding requiring blood transfusion. Sometimes, bleeding only becomes apparent after surgery and requires returning back to theatre.
- Whilst the operation may improve the sense of bulge, there is small chance that urinary, bowel and/or sexual problems may persist. It is hoped however they will at least improve to some degree.
- Unmasking of stress incontinence of urine (leakage of small drops of urine on coughing and sneezing) that was hidden by the kink of the urethra, associated with prolapse. This will need assessment and will be managed by pelvic floor exercises. If it persists despite these exercises, it may require an operation to improve continence.
- The operation may fail or prolapse may recur with time. The operation however is the most effective and durable method to correct the condition. Recurrence of bulge may be due to development of prolapse in an area of the front passage that was not repaired at the time. It is therefore advisable to support the front and back walls of the vagina at the same time.

In order for you to make an informed choice about your surgery please ask one of the doctors or nurses if you have any questions about the operation before signing the consent form.

What can I expect after the operation?

As you come round from the anaesthetic, you may experience episodes of pain and/or nausea. Please let the nursing staff know and they will assess you and take appropriate action.

You may have a PCA (Patient Controlled Analgesia) pump to control your pain. This is not common and will be discussed with you before the operation by the anaesthetist. The nurses will assess you regularly to ensure that the PCA is effective. We will use a pain score to assess your pain 0-10; 0 = No Pain, 10 = Very Strong Pain.

Your nurse will be checking your blood pressure, pulse, breathing and temperature and monitor the laparoscopic ports and any vaginal bleeding. S/he will also ask you to move from side to side and to do leg and breathing exercises once you are able, this will help prevent any pressure damage, a DVT (deep vein thrombosis) or chest infection.

The first 12 hours after the operation

You will have a drip attached but will be able to eat and drink once you are fully awake. Your drip will then be discontinued.

You may also have a catheter to drain the bladder. You can expect pain and discomfort in your lower abdomen for the first few days after the operation. You may experience shoulder tip pain from the gas trapped under your rib cage. This is the gas used to distend your tummy during the operation and is common following laparoscopic (key hole) surgery. You will be given pain killers to alleviate this.

Day 1 after the operation

The nursing staff will assist with washing as necessary and encourage early mobilisation. We would normally expect you to sit out of bed and begin to walk around the day after your operation. The drip, drain and catheter are usually removed. You will be asked to pass urine in a jug and will have a scan to measure how much urine is left in the bladder. It helps to forget that you need to pass urine and drink and walk as you would normally do, and this when your bladder is likely to work as normal.

You will have 2-4 small dressings on the cuts in your abdomen. These will be removed the day after your operation and you will be able to shower. You may experience trapped wind which can cause discomfort. Peppermint water, getting up and walking around will help this. You may also find it difficult to open your bowels at first. You can have mild laxatives to soften your stools and prevent constipation and straining.

What about going home?

You will be seen and assessed by the gynaecology team the following day to check on your recovery and decisions will be made about your care. This information will be shared with you.

Please feel free to ask questions about your operation and recovery at any time.

The average length of stay following a laparoscopic sacrocolpopexy is 1-2 days. As you physically recover from your operation, the nursing team will discuss your convalescence. To ensure you have a good recovery you should take note of the following:

Rest: During the first two weeks at home it is common to feel tired, exhausted and emotional. You should relax during the day gradually increasing the number of things you do each day. Avoid crossing your legs when you are lying down.

Vaginal bleeding: You might have some vaginal discharge/bleeding for 1-2 days after surgery, but this should settle quickly.

Stitches: The wounds will be closed by stitches which are usually dissolvable. If after 7 days you notice the stitches have not dissolved then they will need to be removed. This is normally done by your practice nurse, but you need to make an appointment. We advise that you shower daily and keep the wound clean and dry. There is no need to cover the wound with a dressing.

Housework:

Weeks 1-2: we recommend that you do light activities around the house and avoid any heavy lifting (not more than 1.5kgs in each hand).

Weeks 3-4: we recommend that you gradually introduce lighter household chores, dusting, washing up, making beds and ironing. You may begin to prepare food and cook remembering not to lift any heavy items.

Weeks 4-6: by this time you should resume normal daily activities, but refrain from straining and heavy lifting for 3 months to ensure good healing.

Exercise: Exercise is important and it is advisable to go for short walks each day, increasing the distance gradually. You will be able to manage the stairs on your arrival home. You may return to light exercise, like gentle swimming and cycling after 4-6 weeks.

We encourage you to do pelvic floor exercises. You will be given a physiotherapy booklet titled 'Fit for Life' to guide you.

Diet: A well balanced nutritious diet with high fibre content is essential to avoid constipation. Your bowels may take some time to return to normal after your operation and you may need to take laxatives. You should include at least 5 portions of fruit and vegetables per day. You should aim to drink at least 2 litres of water per day.

Sex: You should usually allow 4-6 weeks after the operation before having sex for the vagina to heal in its new supported position. If you experience dryness, you may try a vaginal lubricant from your local pharmacy. If after this time you are experiencing pain or any problems with intercourse then you should see your GP.

Returning to work: This will depend on the nature of your work. If you work in an office base environment, you will need 4–6 weeks off work. If your work involves lifting and exertion, you will need 3 months off work. The hospital doctor will provide a sick note for this period.

Driving: It is usually safe to drive after 12 weeks but this will depend on your level of concentration, ability to perform an emergency stop and your car insurance policy.

What about follow up?

You will be invited for follow up, usually about 12 weeks after surgery.

If you have problems before this, you can either contact your doctor or contact the hospital to bring the appointment forwards. During this follow up appointment, your symptoms will be reviewed and you will be examined to assess wound healing.

The frequency volume chart and quality of life will be checked.

Are there any alternatives to having a laparoscopic sacrocolpopexy?

You may decide not to have surgery and want to try vaginal pessaries to control the prolapse without having to have an operation.

Alternative forms of surgery include:

- Abdominal sacrocolpopexy, which is the same operation performed abdominally (through a cut across the tummy).
- Vaginal repair with sacrospinous fixation. In this operation, the prolapse is corrected vaginally (from down below) and the vaginal vault is fixed to a ligament (band of fibrous tissue) in the pelvis.

These can be discussed with your doctor.

Who can I contact with any concerns or questions?

You should contact your doctor or the hospital if you notice increased temperature, wound swelling and/or pain, smelling discharge either from the wounds on your tummy or the front passage, blood in urine or motion, abdominal distension and/or failure to open your bowel.

If you have any problems or questions, please use the telephone numbers below to contact us.

Princess Royal Hospital, Horsted Keynes Ward:
01444 441881 Ext. 5686

Royal Sussex County Hospital, Level 11:
01273 523191 Ext. 4013

Urogynaecology Unit at Lewes Victoria Hospital:
01273 474153 Ext. 2178

Useful links:

www.bsug.org.uk/userfiles/file/patient-info/Sacrocolpepexy%20for%20Vault%20Prolapse-%20SCP%20BSUG%20F1.pdf

www.iuga.org/resource/resmgr/Brochures/eng_sacrocolpopexy.pdf

www.rcog.org.uk/files/rcog-corp/uploaded-files/GT46Posthysterectomy-VaginalProlapse2007.pdf

www.patient.co.uk/doctor/Genitourinary-Prolapse.htm

publications.nice.org.uk/sacrocolpopexy-using-mesh-for-vaginal-vault-prolapse-repair-ipg283

This leaflet is intended for patients receiving care in Brighton & Hove or Haywards Heath

This patient information leaflet was prepared by Dr. Sharif Ismail, Consultant Subspecialist Urogynaecologist

This information leaflet has been approved at the Clinical Governance and Safety and Quality Meetings of the Department of Obstetrics and Gynaecology as well as Brighton and Sussex University Hospitals NHS Trust Carer and Patient Information Group (CPIG).

Ratified April 2017 Women's Safety and Quality Committee

© University Hospitals Sussex NHS Foundation Trust

Disclaimer

The information in this leaflet is for guidance purposes only and is in no way intended to replace professional clinical advice by a qualified practitioner.

Reference no.526.5

Publish Date: May 2021 Review Date: May 2024

