

INFORMATION FOR PATIENTS

Sacrohysteropexy for uterine prolapse

We advise you to take your time to read this leaflet. If you have any questions please write them down on the sheet provided (towards the back) and we can discuss them with you at our next meeting. It is your right to know about the operations being proposed, why they are being proposed, what alternatives there are and what the risks are. These should be covered in this leaflet.

This leaflet describes what an apical vaginal prolapse is, what alternatives are available within our Trust, the risks involved in surgery and what operation we can offer.

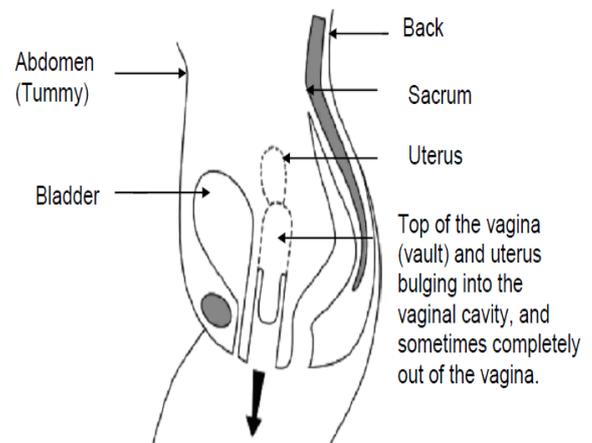
What is prolapse of the uterus/ vaginal apex?

A prolapse is where the vaginal tissue is weak and bulges downwards into the vagina itself.

In severe cases it can even protrude outside the vagina. Apical vaginal prolapse is a prolapse arising from the top of the vagina. The apex is the deepest part of the vagina (top of it/ roof) where the uterus (womb) usually is located.

If you have had a hysterectomy then the term 'vault' is used to describe the area where your womb would have been attached to the top of the vagina.

Figure 1: A diagram, sideways on, showing the normal anatomy (dotted line) and a prolapsing vaginal apex (continuous line).



It is often accompanied by a posterior vaginal wall prolapse, either a high posterior vaginal wall prolapse called an enterocele, or a low posterior vaginal wall prolapse called a rectocele, or sometimes both.

The pelvic floor muscles are a series of muscles that form a sling or hammock across the opening of the pelvis.

These muscles, together with their surrounding tissue, are responsible for keeping all of the pelvic organs (bladder, uterus, and rectum) in place and functioning correctly.

Prolapse occurs when the pelvic floor muscles or the vagina have become weak. This usually occurs after the trauma of childbirth but is most noticeable after the menopause when the strength of supporting tissue deteriorates.

With straining, for example, on passing a motion, the weakness described above allows the apex of the vagina to bulge downwards and the rectum (back passage) to bulge into the vagina and sometimes bulge out of the vagina.

Some women have to push the bulge back into the vagina with their fingers in order to empty their bladder or complete a bowel movement. Some women find that the bulge causes a dragging or aching sensation.

Alternatives to surgery

Do nothing

If the prolapse (bulge) is not distressing then treatment is not necessarily needed. If, however, the prolapse permanently protrudes through the opening to the vagina and is exposed, it may become dried out and eventually ulcerate. Even if it is not causing symptoms in this situation it is probably best to push it back with a ring pessary or have an operation to repair it.

Pelvic floor exercises (PFE)

The pelvic floor muscle runs from the coccyx at the back to the pubic bone at the front and off to the sides. This muscle supports your pelvic organs (uterus, vagina, bladder and rectum). Any muscle in the body needs exercise to keep it strong so that it functions properly. This is more important if that muscle has been damaged.

PFE can strengthen the pelvic floor and therefore give more support to the pelvic organs. These exercises may not get rid of the prolapse but they make you more comfortable. PFE are best taught by an expert who is usually a physiotherapist. These exercises have little or no risk and even if surgery is required at a later date, they will help your overall chance of being more comfortable.

Types of pessary

Ring pessary

This is a soft plastic ring or device which is inserted into the vagina and pushes the prolapse back up. This usually gets rid of the dragging sensation and can improve urinary and bowel symptoms. It needs to be changed every 4-6 months and can be very popular; we can show you an example in clinic. Other pessaries may be used if the ring pessary is not suitable. Some couples feel that the pessary gets in the way during sexual intercourse, but many couples are not bothered by it.

Shelf pessary or gellhorn

If you are not sexually active this is a stronger pessary which can be inserted into the vagina and again needs changing every 4-6 months.

General risks of surgery

Anaesthetic risk

This is very small unless you have specific medical problems. This will be discussed with you.

Haemorrhage

There is a risk of bleeding with any operation. The risk from blood loss is reduced by knowing your blood group beforehand and then having blood available to give you if needed. It is rare that we have to transfuse patients after their operation.

Infection

There is a risk of infection at any of the wound sites. A significant infection is rare. The risk of infection is reduced by our policy of routinely giving antibiotics with major surgery.

Deep vein thrombosis (DVT)

This is a clot in the deep veins of the leg. The overall risk is at most 4-5% although the majority of these are without symptoms. Occasionally this clot can migrate to the lungs which can be very serious and in rare circumstances it can be fatal (less than 1% of those who get a clot).

DVT can occur more often with major operations around the pelvis and the risk increases with obesity, gross varicose veins, infection, immobility and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood (heparin).

Specific risks of this surgery

Damage to local organs

This can include bowel, bladder, ureters (pipes from kidneys to the bladder) and blood vessels. This is a rare complication but requires that the damaged organ is repaired and this can result in a delay in recovery. It is sometimes not detected at the time of surgery and therefore may require a return to theatre.

If the bladder is inadvertently opened during surgery, it will need catheter drainage for 7-14 days following surgery.

If the rectum (back passage) is inadvertently damaged at the time of surgery, this will be repaired, however, inserting the mesh may be delayed till a later date. This will require another operation, and in rare circumstances, a temporary colostomy (bag) may be required.

Prolapse recurrence

If you have one prolapse, the risk of having another prolapse sometime during your life is 30%. This is because the vaginal tissue is weak. The operation may not work and it may fail to alleviate your symptoms.

Pain

General pelvic discomfort, this usually settles with time, and tenderness on intercourse due to vaginal tethering or mesh erosion. Occasionally pain on intercourse can be permanent.

Mesh exposure/extrusion

This occurs when the plastic mesh pokes through the vagina (incidence of around 10%). This may require a repeat operation to trim the mesh and in severe cases may compromise the operation.

Infection of mesh

The mesh and/ or the tissues attached to it (vagina and back bone) may get infected. This is usually treated by antibiotics and in rare cases, by removing the mesh.

Change in bladder and bowel function

Changing the axis of the vagina might interfere with the voiding/continence mechanism leading to voiding dysfunction, or worsening or new urinary incontinence. If you experience this, please let us know as this can be treated. Some patients experience worsening constipation following surgery. This may resolve with time. It is important to try to avoid being constipated following surgery to reduce prolapse recurrence.

Reduced sensation during intercourse

Sometimes the sensation during intercourse may be less and occasionally the orgasm may be less intense.

The operation - sacrohysteropexy

In this operation the cervix (neck of the womb) is lifted upwards toward a prominent part of the back bone (the sacral promontory) using a piece of synthetic mesh. These kinds of operations using a plastic mesh to pull up the vagina toward the backbone have been performed for a long time and are generally successful (90%).

More recently we have been performing the same operation in women who still have a uterus, and pulling the cervix/ uterus up toward the backbone. There are some benefits in leaving the womb behind if it is still present:

1. Reduced operating time.
2. Reduced risk of damage to local organs.
3. Reduced risk of bleeding.

The cervix is a much tougher tissue to place surgical sutures than the vagina so the operation may be more robust. As we have only started leaving the uterus behind during these operations more recently we cannot be sure at this moment of the long term results. It can involve a cut on the abdomen (tummy) and or can be done through keyhole surgery.

Before the operation

It is recommended that you take a medication to soften your motions for at least three days before the operation. This will help to reduce the risk of you getting constipated after the operation and could mean you get home earlier. Magnesium sulphate, Lactulose or Movicol would be suitable and you can obtain these from your GP or local pharmacy.

How the operation is performed – sacrohysteropexy

The operation is done under general anaesthetic. A general anaesthetic will mean you will be asleep (unconscious) during the entire procedure.

During the operation:

- The legs are placed in stirrups (supported in the air). A horizontal (sideways) or a vertical (up and down) incision is made in the lower abdomen (tummy).
- The operation can sometimes be done via keyhole surgery which may mean quicker recovery.
- The prolapse is pushed up from below.
- A synthetic mesh is sutured (stitched) to the back of the cervix and the other end is sutured or stapled (titanium staples) to a prominent part of the back bone (the sacral promontory) internally.
- The mesh remains permanently in the body. This effectively suspends the vagina via the graft to a sturdy bone.
- A urinary catheter is left in place overnight.

Figure 2: Diagram of sideward view showing the uterus collapsing down the vaginal canal.

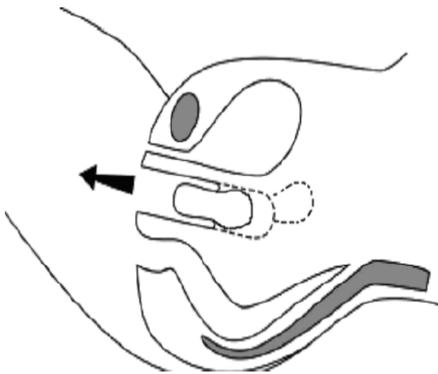


Figure 3: Diagram showing sideward view of the uterus and vagina protruding outside the vagina.

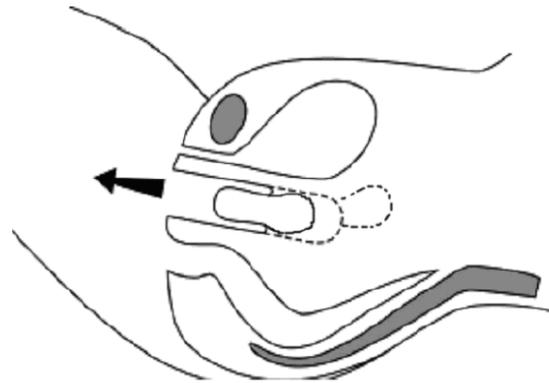
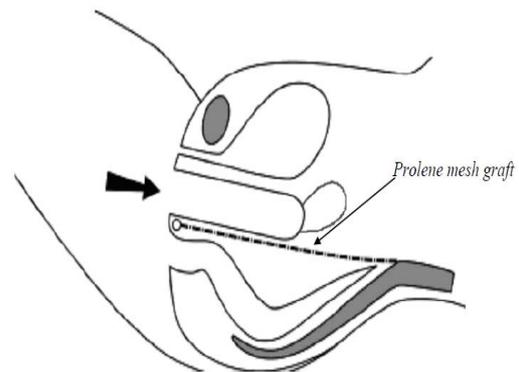


Figure 4: Diagram showing uterus (vaginal apex) and posterior vaginal wall supported by a graft.



After the operation - in hospital

On return from the operating theatre you will have a fine tube (drip) in one of your arm veins with fluid running through to stop you getting dehydrated.

You may have a bandage in the vagina, called a 'pack' and a sanitary pad in place. This is to apply pressure to the wound to stop it oozing.

You may have a tube (catheter) draining the bladder overnight. The catheter may give you the sensation as though you need to pass urine but this is not the case.

Usually the drip, pack and catheter come out the morning after surgery or sometimes later the same day. This is not generally painful.

The day after the operation you will be encouraged to get out of bed and take short walks around the ward. This improves general wellbeing and reduces the risk of clots on the legs.

It is important that the amount of urine is measured the first couple of times you pass urine after the removal of the catheter. An ultrasound scan for your bladder may be done on the ward to make sure that you are emptying your bladder properly. If you are leaving a significant amount of urine in your bladder, you may have to have the catheter re-inserted back into your bladder for a couple of days more.

You may be given injections to keep your blood thin and reduce the risk of blood clots normally once a day until you go home or longer in some cases

The wound is not normally very painful but sometimes you may require tablets or injections for pain relief.

There will be slight vaginal bleeding like the end of a period after the operation. This may last for a few weeks.

The nurses will advise you about sick notes, certificates etc. You are usually in hospital for up to 4 days.

After the operation - at home

When you arrive home you must continue to move around and not be totally bedbound.

You are likely to feel tired and may need to rest in the daytime from time to time for a month or more, this will gradually improve.

It is important to avoid stretching the repair particularly in the first weeks after surgery. Therefore, avoid constipation and heavy lifting. The deep stitches dissolve during the first three months and the body will gradually lay down strong scar tissue over a few months.

Avoid constipation by:

- Drinking plenty of water/juice.
- Eating fruit and green vegetables, especially broccoli.
- Eating plenty of roughage e.g. bran/oats.

Do not use tampons for 6 weeks.

There are stitches in the skin wound in the vagina. Any stitches under the skin will melt away by themselves. The surface knots of the stitches may appear on your underwear or pads after about 2 weeks; this is quite normal. There may be little bleeding again after about 2 weeks when the surface knots fall off, this is nothing to worry about.

At 6 weeks gradually build up your level of activity.

After 3 months, you should be able to return completely to your usual level of activity. You should be able to return to a light job after about 6 weeks. Leave a very heavy or busy job until 12 weeks.

You can drive as soon as you can make an emergency stop without discomfort, generally after three weeks. However, you must check this with your insurance company, as some of them insist that you should wait for 6 weeks.

You can start sexual relations whenever you feel comfortable enough after 6 weeks, as long as you have no blood loss. You will need to be gentle and may wish to use lubrication (KY jelly).

Follow up after the operation is usually 6 weeks to 6 months. This maybe at the hospital (doctor or nurse), with your GP or by telephone. Sometimes follow up is not required. As you would still retain your uterus and cervix you should continue to attend routine cervical smears until 65 years old.

For further information

Bladder & Bowel UK
<http://www.bladderandboweluk.co.uk/>
Telephone: 0161 607 8219

Things I need to know before I have my operation

Please list below any questions you may have, having read this leaflet.

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Please describe what your expectations are from surgery

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Important

Please do not use recording equipment in our hospitals – including cameras, videos or audio recordings on mobile phones. Smart home devices such as Alexa, Echo, Google Home and Siri, record conversations and do not support privacy and dignity for other patients, colleagues or visitors, so please don't bring them to hospital.

Respect for people during your visit

We are an inclusive employer and we are proud of our highly skilled colleagues, who have a range of diverse backgrounds. We also care for a diverse group of patients. We do not tolerate physical or verbal abuse or any form of discrimination towards our staff or patients. This includes, but is not limited to, racism, homophobia, anti-religion and sexism. We will robustly manage any such incidents and, where appropriate, will involve the police.

Further sources of information

NHS Choices: www.nhs.uk/conditions

Our website: www.sfh-tr.nhs.uk

Patient Experience Team (PET)

PET is available to help with any of your compliments, concerns or complaints, and will ensure a prompt and efficient service.

King's Mill Hospital: 01623 672222

Newark Hospital: 01636 685692

Email: sfh-tr.PET@nhs.net

If you would like this information in an alternative format, for example large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know. You can call the Patient Experience Team on 01623 672222 or email sfh-tr.PET@nhs.net.

This document is intended for information purposes only and should not replace advice that your relevant health professional would give you. External websites may be referred to in specific cases. Any external websites are provided for your information and convenience. We cannot accept responsibility for the information found on them. If you require a full list of references for this leaflet, please email sfh-tr.patientinformation@nhs.net or telephone 01623 622515, extension 6927.

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