Sacrospinous fixation of the Vaginal Vault

Sacrospinous fixation of the Uterus

Gynaecology

Introduction

This leaflet will provide information for woman who have a vaginal apex (vault) prolapse and are considering sacrospinous fixation (an operation to repair the prolapse).

What is prolapse of the vaginal apex?

A prolapse is herniation (coming down) of the vaginal walls and pelvic organs away from their normal positions inside the body. In severe cases, it can protrude outside the vagina.

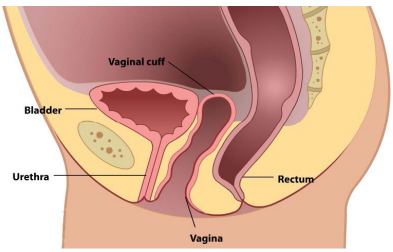
An apical vaginal prolapse is a prolapse from the top of the vagina. The apex is the deepest part of the vagina where the uterus (womb) is usually located.

A vaginal vault prolapse is a prolapse arising from the top of the vagina (vault) where the uterus (womb) was situated.

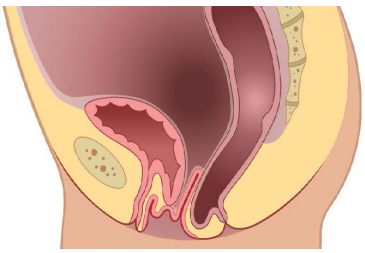
A uterine prolapse is when the uterus comes down into the lower part or the opening of the vagina. In severe cases, it may completely protrude outside of the body.

A vaginal apex prolapse is often accompanied by a weakness and prolapse of walls of the vagina such as a rectocele (a bulge of the back wall of the vagina) or a cystocele (prolapse of the front wall of the vagina).

Normal vaginal vault



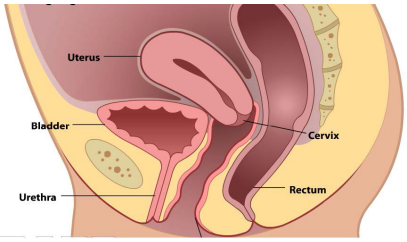
Vault prolapse



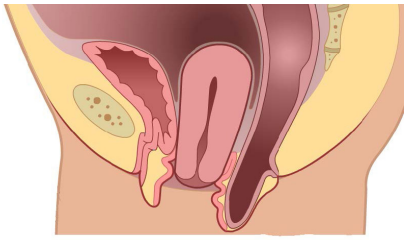
The prevention of infection is a major priority in all healthcare and everyone has a part to play.

- **Please decontaminate your hands frequently for 20 seconds using soap and water or alcohol gel if available**
- **If you have symptoms of diarrhoea and/or vomiting, cough or other respiratory symptoms, a temperature or any loss of taste or smell please do not visit the hospital or any other care facility and seek advice from 111**
- **Keep the environment clean and tidy**
- **Let's work together to keep infections out of our hospitals and care homes.**

Normal anatomy



Uterine prolapse



What conditions lead to prolapse?

Prolapse occurs over a period of time, to varying degrees, and it is usually caused by weakening or injury to the supporting muscles and ligaments of the pelvic floor. This can be as a result of childbirth, abnormally weak collagen type, being overweight, heavy lifting, chronic constipation, smoking and a lack of hormones after the menopause. There are usually multiple factors in the development of prolapse. Many women will have a prolapse of some degree after childbirth; it is not unusual and unless you have symptoms, you do not need to seek treatment.

What are the symptoms of prolapse?

Symptoms may vary depending on type and severity of prolapse. Usually, symptoms are worse towards the end of the day. In general, the symptoms can include:

- Dragging feeling, heaviness or lump down below
- Difficulty opening bowel or bladder
- Difficulty with intercourse or having a loose sensation

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

Pain is not usually a symptom of prolapse. Some women with prolapse may not have any symptoms in which case, no treatment is required.

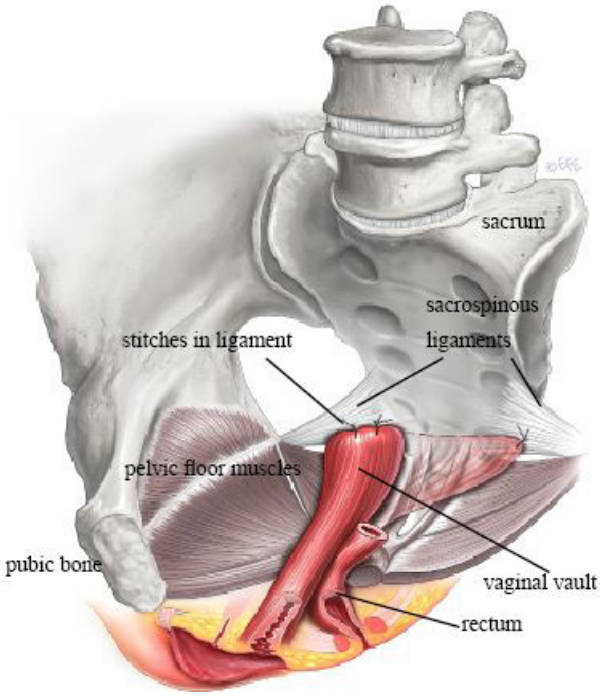
What is a sacrospinous fixation?

A sacrospinous fixation is an operation designed to restore support to the uterus or vaginal vault (in a woman who has had a hysterectomy). Through a cut in the vagina, stitches are placed into a strong ligament (sacrospinous ligament) in the pelvis and then to the cervix or vaginal vault.

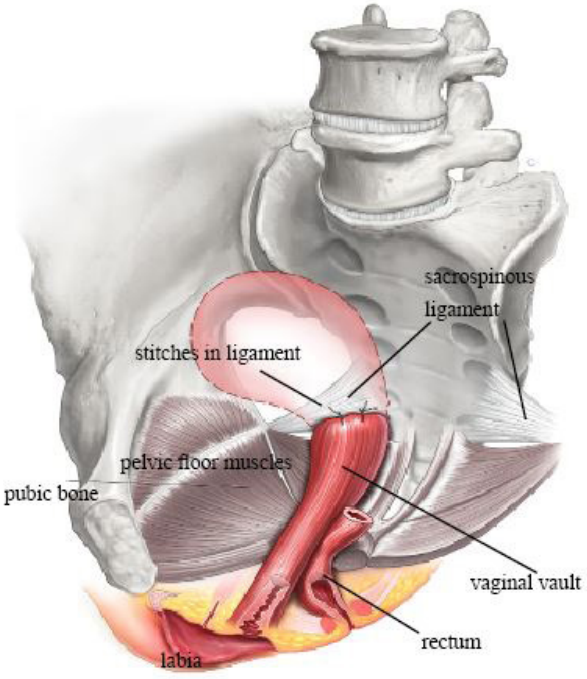
The stitches can be either permanent or slowly absorbed over time. Eventually, they are replaced by scar tissue that then supports the vagina or uterus. This procedure is often combined with a vaginal hysterectomy and / or surgery to treat prolapse of the bladder, bowel or stress urinary incontinence.

Following the sacrospinous fixation, further repair may be required to correct these kinds of prolapse at the lower part of vagina during your operation. The repair operation tightens the walls of the vagina and the pelvic floor muscles. All the stitches used are dissolvable.

Sacrospinous fixation with stitches in both sacrospinous ligaments



Sacrospinous fixation with stitches into right ligament shown with uterus present



Consent

We must seek your consent for any procedure or treatment beforehand. Your doctor will explain the risks, benefits and alternatives where relevant before they ask for your consent. If you are unsure about any aspect of the procedure or treatment proposed please do not hesitate to ask for more information.

What are the benefits of sacrospinous fixation?

The quoted success rates for sacrospinous fixation are between 80 to 90%. However, there is a chance that the prolapse might come back in the future, or another part of the vagina may prolapse, for which you would need further surgery. You should feel more comfortable following the operation and the sensation of the prolapse, or something coming down should have gone. This operation is done through the vagina, thus it avoids having a cut in your tummy and has a quick recovery rate. It can be also done under spinal anaesthesia (injection into your back).

What are the risks of sacrospinous fixation?

Sacrospinous fixation is considered major surgery and as with all surgery, there are associated risks that you need to be aware of when deciding on the right treatment for you. You and your doctor must discuss these and the benefits of surgery, while also considering any alternative treatments.

The risks are:

General risks of surgery

- **Anaesthetic risk.** This is very small; however, you should be aware that all operations carry a risk of death. Deaths caused by anaesthetics are very rare. There is probably 1 death for every 100,000 anaesthetics given in the UK, (Royal College of Anaesthetics 2017). However, the risk does increase depending on your general health and medical conditions. Each specific procedure carries an individual risk depending on many factors such as age, size and current health etc, and these will be discussed with your doctor
- **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 this operation. Please let your doctor know if you are taking an anticlotting drug such as warfarin or aspirin. The risk of excessive bleeding during the operation is about 1 in 100 women
- **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 (1/10 to 1/100 i.e. Common). 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 risk of surgery

- **Pain.** There may be short term buttock pain which may occur in approximately 25% of patients, long term buttock pain occurs in around 1% of patients. You may need to take painkillers, but the pain usually lasts for no more than a few weeks. In a few cases, the pain may be severe, in which case removal of the stitch(es) may have to be considered
- **Damage to local organs.** This can include bowel, bladder, ureters (pipes from kidneys to the bladder) and blood vessels. This is a rare complication. As the damaged organ has to be repaired, this can result in a delay in recovery. It is sometimes not detected at the time of surgery and, therefore, it 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. 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
- **Painful sexual intercourse.** Once the wound at the top of the vagina has healed, there is nothing to stop you from having sex. The healing usually takes about 6 weeks. Some women find sex is uncomfortable at first but it gets better with time and sometimes improves using a bit of extra lubrication (KY Jelly). Sometimes, sex continues to be painful after the healing has finished, but this is unusual
- **Change in sensation with intercourse.** Sometimes the sensation during intercourse may be less and occasionally, the orgasm may be less intense
- **Overactive bladder symptoms** (urinary urgency and frequency with or without incontinence) usually improve after the operation, but occasionally can start or worsen after the operation
- **Stress incontinence.** Having a large prolapse sometimes causes some kinking of the tube through which you pass urine (urethra). This can be enough to stop urine leaks on coughing, laughing or sneezing. By correcting the prolapse this kink gets straightened out and the leaks are no longer stopped. The risk is reported to be in the order of 1 in 10
- **Bladder emptying or voiding problems** generally improve after surgery for prolapse but there may be problems emptying the bladder in the first few days. There can be persistence of voiding problems in 1 in 10 women
- **A change in the way your bowel works.** 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

What are the alternative non-surgical treatments?

Do nothing

If the prolapse (bulge) is not troubling you greatly, then surgery may not be necessary. If, however, the prolapse is outside the vagina and exposed to the air, it can become dried out and eventually become ulcerated

Even if it is not causing symptoms, in this situation, we would recommend supporting it back inside the vagina with a vaginal pessary (see below)

Pelvic Floor Exercises (PFE)

The pelvic floor muscles form a bowl at the bottom of your pelvis. These muscles support your pelvic floor organs (uterus, vagina, bladder and rectum). Every muscle in the body needs exercising to keep it strong so that it functions properly. PFE help strengthen the pelvic floor muscles and, therefore, give more support to the pelvic organs. These exercises may not get rid of the prolapse completely but they can make you more comfortable and are best taught by an expert (usually a physiotherapist). These exercises have little or no risk and even if surgery is required at a later date they can help to strengthen the area before surgery. Please discuss a referral for physiotherapy with your surgeon.

Vaginal pessary

Ring pessary

This is a ring made of PVC which 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. The ring pessary is very popular and needs to be changed every 6 to 12 months (by your GP or Practice Nurse). We can show you an example of one in clinic, please ask. Ring pessaries are not always suitable and do not always stay in place. Some couples feel it can interfere with intercourse. If a ring is not suitable, we will need to consider a different type of pessary, for example, a shelf pessary.

Shelf pessary / Gel Horn pessary

This is a different shaped pessary which cannot be used if you are sexually active. It needs to be

changed every 6 to 12 months and is usually done in hospital by an experienced specialist.

We have a leaflet about pessaries; please ask in clinic if you would like one.

The choice about which treatment is best for you will be made together with your doctor. This will be based on the risks and benefits of the treatment and individual circumstances.

What are the alternative surgical treatments?

For uterine prolapse:
Sacrohysteropexy – (laparoscopic or open): This is an operation to suspend a prolapsed womb using a strip of synthetic mesh to lift it and hold it in place. Mesh provides strong and continuing support to the uterus so uncommon for prolapse to recur. In this procedure, no cuts or stitches in vagina are required and the vaginal length is maintained. The Uterus is still present so pregnancy is possible. As mesh is used there is a small risk that the mesh will work its way into surrounding tissues.

Vaginal Hysterectomy (removal of uterus via the vagina): No abdominal incision is required. As the Uterus is removed there is no risk of cancer of cervix or uterus in future.

There is a small risk of prolapse of the vault (top) of the vagina in the future.

Manchester repair (removal of cervix only via the vagina). The procedure is done through the vagina. The main body of uterus is not removed so pregnancy is possible although, can be complicated by premature labour.

Colpocleisis (closing of vagina). This procedure has high success rates (90-95%) both for prolapse of the uterus and the walls of the vagina. No abdominal incision is required, and this can be done with you awake or asleep. Sexual intercourse will never be possible after this operation. And it is not possible to take a smear or to investigate inside the uterus if abnormal bleeding occurs

For vaginal vault prolapse
Sacrocolpopexy - laparoscopic (key hole) or abdominal (open operation). An operation to treat a prolapse of the vaginal vault using a strip of synthetic mesh to lift the top of the vagina and hold it in place. Mesh provides strong and continuing support to the top of the vagina so uncommon for prolapse to recur. It may also treat a coexisting vaginal prolapse. No cuts or stitches in vagina is required and the vaginal length maintained. As mesh is used there is a small risk that the mesh will work its way into surrounding tissues.

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Consent

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What should I expect before the operation?

Before admission for surgery, you will be asked to attend a pre-admission clinic to ensure that you are fit and well for your surgery. A nurse practitioner or a doctor will ask about your general health, past medical history and any medication that you are taking. Any necessary investigations will be organised, such as blood tests, ECG (heart trace) and chest X-rays.

You will receive information about your admission, hospital stay, operation and pre and post-operative care. You will also be given the opportunity to ask any further questions that you may have.

You are advised that you should not go on a long haul flight (more than 4 hours) in the six weeks prior to your surgery due to increased risk of clots in your legs.

Plan ahead – when you come out of hospital you are going to need extra help at home for the first two weeks. Make sure your family knows this.

If you smoke, try to stop completely. This will make your anaesthetic safer, reduce the risk of complications after operation, and speed up the recovery time. If you are unable to stop completely, even doing so for few days will be helpful.

Some medicines need to be stopped or altered before the operation. You should check with your GP and bring your list of medications with you when you come to the pre-admission clinic. If you are on a contraceptive pill, you should stop it at least four weeks before the operation and you should use another method of contraception.

What will happen on the day of my surgery?

On the day of your operation, you must have nothing to eat or drink for a specified time prior to your operation. You will be advised as to what time you need to stop eating and drinking.

Before your operation can take place, a doctor will see you to reconfirm your written consent, which will have already been obtained at a previous appointment. You will have the opportunity to ask any questions not covered during your pre-admission clinic appointment.

You are requested to have a bath or shower before you come into hospital. Prior to your surgery you will be asked to put on a theatre gown.

You will be asked to remove all items of clothing including underwear, jewellery (except wedding rings) including all piercings, nail varnish, false nails, make up, contact lenses, hearing aids, dentures, wigs and any false limbs.

You will be requested to wear a pair of elasticated stockings (TEDS). The stockings help to prevent clots (thrombosis) in your legs. You will need to keep these on until you are discharged from hospital. The nurses will advise you how long you will need to continue to wear the stockings following your discharge from hospital.

You will be escorted to theatre by a member of the team. If a pre-medication (pre-med) has not been given, you may have the option of walking to theatre, otherwise a theatre trolley will be arranged to collect you from the ward.

You will be taken to the anaesthetic room where you will be asked few questions. If you are having general anaesthesia, you will be given an injection into a vein usually in the back of your hand. Once you are asleep, you will be taken into theatre.

You will wake up in recovery area once your operation is finished. A nurse will then escort you back to your bed on the ward.

What will happen after the operation?

When you wake up from the anaesthetic, you will have a drip in your hand to give you fluids. The surgeon may place a vaginal pack (swabs inside the vagina) to stop any bleeding into the tissues. There will also be a tube in the bladder (catheter) to avoid urinary retention. The pack and catheter is usually removed on the day after surgery.

Will I have any pain following surgery?

Most people experience some pain or discomfort for the first few days and you will be offered pain relief to help ease it.

Initially, you may need to have pain relief by injection to keep you comfortable. After this, you will have the choice of tablets or suppositories.

You will be encouraged to take regular pain relief, as being pain-free will speed up your recovery. The anaesthetist will discuss pain relief with you before your operation.

Having an anaesthetic, being in pain, and having strong pain relief can sometimes make you feel nauseous or sick. This can be relieved by injections or tablets.

Many women get wind pains a few days after the operation, which can be uncomfortable and make the tummy look distended (swollen). This should not last long and can be relieved by medicines, eating and walking about.

You should avoid constipation and once you are eating and drinking again you can do this by:-

- Drinking plenty of water or juice
- Eating fruit and green vegetables, especially broccoli
- Eating plenty of roughage, such as bran or oats

Will there be any bleeding?

After the operation, you may have some vaginal bleeding and you will need to wear a sanitary pad. We advise that you do not use tampons. Your vaginal loss should change to a creamy discharge over the next 2 to 3 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 any stitches?

You will have vaginal stitches, which are dissolvable. Threads may come away for up to three months, which is quite normal.

Will I be able to cough?

If you need to cough, your stitches will not come undone. You will be wearing a sanitary towel, and coughing will hurt less if you press on your pad firmly to give support between your legs.

When can I return to my usual routine?

Recovery is a time-consuming process, which can leave you feeling tired, emotionally low or tearful. The body needs time and help to build new cells and repair itself.

Depending on what surgery you have had, you will need to take 4 to 6 weeks off work to recover. This also depends on the nature of your work.

After a sacrospinous fixation, most women stay in hospital for approximately 2 days, but it could be longer, if necessary. Your date of discharge depends on the reasons for your operation, your general health and how smoothly things go after surgery.

It is important to remember that everyone's experience is different; recovery time varies from woman to woman and it is, therefore, best not to compare your own recovery with that of others on the ward.

When can I drive again?

You can drive as soon as you can make an emergency stop without discomfort. This is generally after 2 weeks, but you must also check with your insurance company, as some of them insist that you should wait for six weeks.

When can I exercise again?

It is important to continue to exercise. Walking is recommended as an ideal form of exercise. Gradually increase the length of your walks, but remember to only walk the distance you can achieve comfortably. Cycling and swimming are equally good.

You are encouraged to do pelvic floor exercises within 1-2 weeks after the operation.

Will I have a follow up appointment?

We will arrange follow-up after surgery to assess your recovery either as an outpatient clinic

appointment or a symptom questionnaire. The clinic appointment will be posted to you.

When can I resume sex after the operation?

For many women, following recovery, this aspect of their life is improved because there is no longer any discomfort. We advise that you avoid penetrative intercourse for about 6 weeks, until after your follow-up appointment.

Take time, feel comfortable, do not be rushed and for the first few times you might find a lubricating gel is helpful. You can buy this from the chemist. Talk to your husband or partner about this, as you will need them to be extra gentle and understanding.

Will I gain weight?

The operation itself should not cause you to gain weight. Initially, because you are feeling better, reduced levels of activity and an increased appetite, might lead to weight gain if you are not careful. By paying attention to what you eat and increasing your activity level as you recover, weight gain need not be a problem.

What happens if I feel unwell after I go home?

You may expect some minor bleeding, especially some old, brownish blood for two weeks.

You should contact your GP or the Gynaecology Ward (01902 694034 24 hours a day 7 days a week) if you notice any of the following:

- Increased temperature
- Wound swelling
- Worsening pain
- Bad smelling discharge either from the wounds on your tummy or the front passage
- Blood in your urine or bowel motions
- Abdominal distension
- Failure to open your bowels

Further Information

Patient.co.uk

Website: www.patient.co.uk/doctor/genitourinary-prolapse-pr

Useful support advice and literature is available:

PALS (patient advice and liaison service) 01902 695362

HNSDirect - 08454647

Gynaecology Ward on extension (01902 694034)

Bladder & Bowel Foundation
SATRA Innovation Park,
Rockingham Road Kettering,
Northants, NN16 9JH
Nurse helpline for medical advice: 0845 345 0165
Counsellor helpline: 0870 770 3246
General enquiries: 01536 533255
Fax: 01536 533240
email info@bladderandbowelfoundation.org
http://www.bladderandbowelfoundation.org

Sacrocolpopexy:
http://www.nice.org.uk/guidance/index.jsp?action=download&o=42 887

Hysterectomy and Sacrocolpopexy:
http://www.nice.org.uk/guidance/index.jsp?action=download&o=42 894
http://www.easyhealth.org.uk/

English

If you need information in another way like easy read or a different language please let us know.

If you need an interpreter or assistance please let us know.

Lithuanian

Jeigu norėtumėte, kad informacija jums būtų pateikta kitu būdu, pavyzdžiui, supaprastinta forma ar kita kalba, prašome mums apie tai pranešti.

Jeigu jums reikia vertėjo ar kitos pagalbos, prašome mums apie tai pranešti.

Polish

Jeżeli chcieliby Państwo otrzymać te informacje w innej postaci, na przykład w wersji łatwej do czytania lub w innym języku, prosimy powiedzieć nam o tym.

Prosimy poinformować nas również, jeżeli potrzebowaliby Państwo usługi tłumaczenia ustnego lub innej pomocy.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਪੜ੍ਹਨ ਵਿਚ ਆਸਾਨ ਰੂਪ ਜਾਂ ਕਿਸੇ ਦੂਜੀ ਭਾਸ਼ਾ ਵਿਚ, ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

ਜੇ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ ਦੀ ਜਾਂ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

Romanian

Dacă aveți nevoie de informații în alt format, ca de exemplu caractere ușor de citit sau altă limbă, vă rugăm să ne informați.

Dacă aveți nevoie de un interpret sau de asistență, vă rugăm să ne informați.

Traditional Chinese

如果您需要以其他方式了解信息，如易读或其他语种，请告诉我们。

如果您需要口译人员或帮助，请告诉我们。

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