There may be students and observers present during your consultation as part of their ongoing training. Please let the staff know if you do not wish any students to be present during your attendance.

Please ask a member of staff if you would like a chaperone present during your procedure.

Southport Hospital
Town Lane,
Kew,
Southport,
Merseyside,
PR8 6PN
Telephone:
01704 547 471

Ormskirk Hospital
Dicconson Way,
Wigan Road,
Ormskirk,
Lancashire,
L39 2AZ
Telephone:

www.MerseyWestLancs.nhs.uk

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Sacrohysteropexy for uterine prolapse/womb prolapse

Patient information

If you need this leaflet in a different language or accessible format please speak to a member of staff who can arrange it for you.

اگر به این بروشور به زبان دیگر یا در قالب دسترس‌پذیر نیاز دارید،
لطفاً با یکی از کارکنان صحبت کنید تا آن را برای شما تهیه کند.

Jeśli niniejsza ulotka ma być dostępna w innym języku lub formacie,
proszę skontaktować się z członkiem personelu, który ją dla Państwa przygotuje.

Dacă aveți nevoie de această broșură într-o altă limbă sau într-un format accesibil,
vă rog să discutați cu un membru al personalului să se ocupe
de acest lucru pentru dumneavoastră

如果您需要本传单的其他语言版本或无障碍格式，请联系工作人员为您安排。

إذا احتجت إلى هذه النشرة بلغة أُخرى، أو بتنسيق
يسهل الوصول إليه، يرجى التحدث إلى أحد الموظفين لترتيب ذلك لك.

Author: Specialist nurse
Department: Gynaecology
Document Number: MWL2463
Version: 001
Review Date: 31/01/2028

The information provided in this leaflet should be used as a guide.

You should ask your gynaecologist about any concerns that you may have. You should take your time to read this leaflet.

A page is provided at the end of the leaflet for you to write down any questions you may have.

It is your right to know about your planned operation or procedure, why it has been recommended, what the alternatives are and what the risks and benefits are. These should be covered in this leaflet. You may also wish to ask about your gynaecologist's personal experience and results of treating your condition.

Please list below any questions you may have after reading this leaflet.

1)……

2)……

3)……

Please describe what you expect from treatment.

1)……

2)……

3)……

Drip

This is to keep you hydrated until you are drinking normally. The drip is usually removed within 24 hours.

Catheter

You may have a tube (catheter) draining the bladder. The catheter may give you the sensation as though you need to pass urine, but this is not the case. It is usually removed the morning after surgery or sometimes later the same day.

Benefits and risks

The success and the risks of most operations carried out to treat prolapse and incontinence have been poorly studied and so it is often not possible to define them clearly. In this leaflet risks may be referred to as common, rare etc. or an approximate level of risk may be given.

Further information about risk is explained in a leaflet published by the Royal College of Obstetricians and Gynaecologists “Understanding how risk is discussed in healthcare”.

https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pi-understanding-risk.pdf

The following table is taken from that leaflet

Risk table

Verbal description[a]	Risk	Risk description[b]
Very common	1 in 1 to 1 in 10	A person in family
Common	1 in 10 to 1 in 100	A person in street
Uncommon	1 in 100 to 1 in 1000	A person in village
Rare	1 in 1000 to 1 in 10000	A person in small town
Very rare	Less than 1 in 10000	A person in large town

[a] EU-assigned frequency
[b] Unit in which one adverse event would be expected

British Society of Urogynaecology (BSUG) database

In order to understand better the success and risks of surgery for prolapse and incontinence, the British Society of Urogynaecology (BSUG) has established a national database.

All members of the society are asked to enter all procedures that they carry out onto the database and you may be asked to consent to this for your operation.

The data collected is being used to develop an overall picture of what procedures are being performed throughout the United Kingdom together with complications and outcomes.

Individual surgeons can also use it to evaluate their own practice.

Before the operation - pre-op assessment

Usually you are seen in a preoperative clinic some weeks before your planned operation. At that visit you will be seen by a nurse and possibly also a doctor. You will be asked about your general health and any medications you take. You may have tests to assess your heart and breathing.

Blood tests will be taken to check you for anaemia and other things according to your medical condition. Swabs may be taken from your nose and groin, to make sure that you do not carry MRSA (bacteria that are very resistant to antibiotics and may cause problems after your operation). You may be asked to sign a consent form if this has not been done already.

After the operation - in hospital

Pain relief

Pain can be controlled in a number of ways on the preference of your anaesthetist and/or gynaecologist. Options are an epidural, injection of local anaesthetic into the tissues during the operation, self-administration of pain relief (Patient Controlled Analgesia - PCA), drugs in a drip, tablets or suppositories.

The wounds following laparoscopic (keyhole) surgery are not normally very painful, but sometimes you may require tablets or injections for pain relief. It is often best to take the pain-killers supplied to you on a regular basis, aiming to take a pain-killer before the pain becomes a problem. If you have had an open operation you may need more pain relief.

Infection of mesh

The mesh and/or the tissues attached to it may get infected, but this is uncommon. This is usually treated by antibiotics and in rare cases, by removing the mesh.

Inflammation of sacral bone (Osteomyelitis) is serious, but rare. Sometimes even if it is planned, a laparoscopic approach is not possible and conversion to a laparotomy (open surgery) may be required or you may be advised to have an open surgery from the outset.

Occasionally, it is not possible to perform the operation, due to scar tissue from previous surgery or infection.

Further pregnancies may reduce the benefits derived from surgery and cause recurrence of prolapse symptoms. Delivery in future pregnancies will be via a planned caesarean section.

If you need a hysterectomy in the future and the mesh has been wrapped around the cervix, it may make the hysterectomy difficult.

What condition does a Sacrohysteropexy treat?

The operation is primarily intended to treat prolapse of the uterus. It can also help correct a prolapse of the bladder or bowel to some extent, if they are also present along with prolapse of the uterus.

A prolapse is a bulge within the vagina (front passage) caused by a weakness in the supporting tissues and muscles around the vagina, so that one or more pelvic organs bulges downwards into or out of the vagina.

Pelvic organs include the uterus, bladder and bowel. A prolapse may arise in the front wall of the vagina (anterior compartment/cystocoele), back wall of the vagina (posterior compartment/rectoenterocoele/rectocoele), the uterus or the vault (top) of the vagina after a hysterectomy (apical compartment).

Many women have a prolapse in more than one compartment at the same time.

You should keep in mind that even though surgical treatment may repair your prolapse, it may or may not relieve all your symptoms.

The decision to offer you this procedure will only be made after a thorough discussion between you and your doctor. This decision usually depends on the nature and extent of your prolapse as well as personal factors.

How is a Sacrohysteropexy done?

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

The operation of Sacrohysteropexy can be done through an open operation or laparoscopically (key hole). The open operation means a horizontal or bikini incision is made in the lower abdomen (tummy), a laparoscopically involves three to four small incisions on the tummy.

To date, studies have not shown any difference between the two techniques for successful repair of the prolapse. However, there is evidence that the laparoscopic (key hole) operation results in less blood loss, fewer wound infections and a shorter hospital stay.

The uterus is suspended by stitching one end of a strip of synthetic mesh to the back, or around the lower part of the uterus with the other end being stitched or stapled (titanium staples) to a prominent part of the back bone (the sacral promontory) internally.

The mesh remains permanently in the body. A urinary catheter is often left in place, usually overnight. Some gynaecologists prefer to remove the body of the womb leaving the cervix, to which the mesh is attached. This operation is called a Sacrocervicopexy.

Other operations which may be performed at the same time

The ovaries and fallopian tubes can be removed with your prior consent and this will be discussed with you before the operation.

Specific risks of Sacrohysteropexy

Damage to local organs

This can include bowel, bladder, ureters (tubes from kidneys to the bladder) and blood vessels. The risk of bladder injury is about 1 in 200 procedures and bowel injury is about 1 in 1000. Damage to the ureters is even less common. The damaged organ is repaired at the same time and this may delay your recovery.

Sometimes, it is not detected at the time of surgery and therefore, may occasionally require a return to theatre.
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.

Mesh exposure/erosion

There is a small risk of mesh erosion into the adjacent organs such as bladder and bowel. Although this is uncommon, this may require a repeat operation to trim the mesh and in severe cases may compromise the results of operation. It may also cause pain with sexual intercourse, but this is less common than for the alternative surgery performed through the vagina.

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 can I do?

If you are struggling with constipation after simple changes in diet and fluid intake, your doctor/GP may prescribe some laxatives.

Painful sexual intercourse

Once the abdominal wounds are comfortable, there is nothing to stop you from having sex. The healing usually takes about six weeks.

Some women find sex is uncomfortable at first, but it gets better with time. Occasionally, pain on intercourse can be long-term or permanent. Pain on intercourse is less common after this surgery than after vaginal surgery.

Altered sensation during intercourse

Sometimes the sensation during intercourse may be less and occasionally orgasm may be less intense. On the other hand repair of your prolapse may improve it.

Vaginal repairs

Sometimes there is also a prolapse of the front and your doctor may suggest repairing it at the same time as your Sacrohysteropexy. This is quite common.

This may alter the risks of the operation. For example, painful intercourse (sex) is more likely if a repair is done, although it is still uncommon. You should, therefore, discuss this with your doctor who may have an extra information leaflet for you about vaginal wall repairs.

Continence surgery

Sometimes an operation to treat any bothersome urinary leakage can be performed at the same time as your Sacrohysteropexy. Some gynaecologists prefer to do this as a separate procedure at a later date. You should also refer to an information leaflet about the planned additional procedure.

Leaflets of vaginal repairs and continence surgery are Available. Please ask a member of the hospital team and we will be happy to provide them.

Benefits

Improvement in symptoms of uterine prolapse

Common symptoms are a lump/bulge within or protruding out of the vagina and a dragging sensation.

Initial success rates of about 70% were reported, but more recently reported success rates over three to five years are 90%. No success rates are yet available for longer than this.

The degree of success of a Sacrohysteropexy depends on many factors. Studies are underway to evaluate further the procedure and to compare it with other surgical options.

The success rates of Sacrohysteropexy and vaginal hysterectomy or treating the prolapse appear to be similar.

If a Sacrohysteropexy is done laparoscopically (key hole surgery), there are advantages such as minimal blood loss and shorter length of hospital stay.

This operation also gives a woman the option to preserve the uterus, for future fertility purposes or by choice.

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. It is difficult to define an exact risk but it is reported to be in the order of 10% (1 in 10).

What can I do?

Doing pelvic floor exercises regularly can help to prevent stress incontinence.

Bladder emptying or voiding problems

Generally improves after surgery for prolapse, but there may be problems emptying the bladder in the first few days. Your doctor may wish to do bladder tests (urodynamics) prior to surgery, to predict post-operative voiding difficulties. There can be persistence of voiding problems in 1 in 10 women.

What can I do?

If you experience difficulty passing urine, you may wish to lean forwards or even stand slightly, to allow better emptying of your bladder. Make sure that you have your legs apart than having your knees together when sitting on the toilet, waiting for two minutes after the initial void and trying again may help. This is known as the double void technique.

Recurrence of the same prolapse probably occurs in about 1 in 10 cases. It is generally believed that about 3 in 10 women who have an operation for prolapse will eventually require treatment for another prolapse. This is because the vaginal tissue is weak. Sometimes even though another prolapse develops, it is not bothersome enough to require further treatment.

What can I do?

Keeping your weight normal for your height (normal BMI), avoiding unnecessary heavy lifting and not straining on the toilet, may help prevent a further prolapse. Although even if you are very careful it does not always prevent it.

Failure to cure symptoms

Even if the operation cures your prolapse, it may fail to improve your symptoms.

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.

What can I do?

If you experience this, please let your doctor know so that treatment can be arranged.

Risks

General risks of surgery

Anaesthetic risk

This is very small unless you have specific medical conditions, such as a problem with your heart, or breathing. Smoking and being overweight also increase any risks. Sacrohysteropexy is performed with you asleep and this will be discussed with you.

What can I do?

Make the anaesthetist aware of medical conditions, such as problems with your heart or breathing. Bring a list of your medications. Try to stop smoking before your operation. Lose weight if you are overweight and increase your activity.

Bleeding

There is a risk of bleeding with any operation. It is rare that we have to transfuse patients after their operation.

What can I do?

Please let your doctor know if you are taking a blood-thinning tablet such as warfarin, aspirin, clopidogrel or rivaroxaban as you may be asked to stop them before your operation.

Infection

There is a small risk of infection with any operation (about 5 to 13 cases in 100 operations). If it occurs, an infection can be a wound infection or a urinary infection and is usually treated with antibiotics. The risk of infection is reduced by routinely giving you a dose of antibiotic during your operation. A chest infection may also occur because of the anaesthetic.

What can I do?

Treat any infections you are aware of before surgery. After surgery, regular deep breathing exercises can help prevent chest infections; the nurses will guide you how to do this.

Deep Vein Thrombosis (DVT)

This is a clot in the deep veins of the leg. Occasionally this clot can travel to the lungs (pulmonary embolism), which can be very serious and in rare circumstances it can be fatal (less than 1 in 100 of those who get a clot). The risk increases with obesity, severe varicose veins, infection, immobility and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood.

What can I do?

Stop taking any hormones such as Hormone Replacement Therapy (HRT) and some types of birth-control pills four weeks before surgery. These can usually be restarted four weeks following surgery when the risk of blood clots has reduced.

.

Do not arrange surgery the day after a long car journey or flight. As soon as you are awake, start moving your legs around. Keep mobile once you are at home and continue to wear your compression stockings during times when you are less mobile.

Wound complications

Wounds can become infected or occasionally stitches can become loose, allowing the wound to open up or tighten causing discomfort. There are no wounds within the vagina for this operation, but there may be if there has been an additional vaginal operation at the same time.

What can I do?

Keep any wounds clean, dry external wounds carefully. After washing use a clean towel or a hairdryer on a cool setting. If there are vaginal wounds from a vaginal repair, do not douche the vagina or use tampons.

General risks of prolapse surgery

Getting another prolapse

Although this operation is very successful in treating uterine prolapse, it does not always stop you from getting a prolapse of the vaginal walls in the future. There is very little evidence published of exactly how often prolapse recurs.