

# Sacrohysteropexy for uterine prolapse

Patient Information

Women  
and Children -  
Obstetrics and  
Gynaecology

## Sacrohysteropexy for uterine prolapse

### Contents

- About this leaflet
- What is uterine prolapse
- Alternatives to surgery
- General risks of surgery
- Specific risks of this surgery
- The operation – Sacrohysteropexy
  - Before the operation
  - How is the operation performed
  - After the operation - in hospital
  - After the operation - at home
- British Society of Urogynaecology Database
- Useful references
- Any questions – write them here ‘Things I need to know before I have my operation’.
- Describe your expectations from surgery

### About this leaflet

We advise you to take your time to read this leaflet, any questions you have 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,

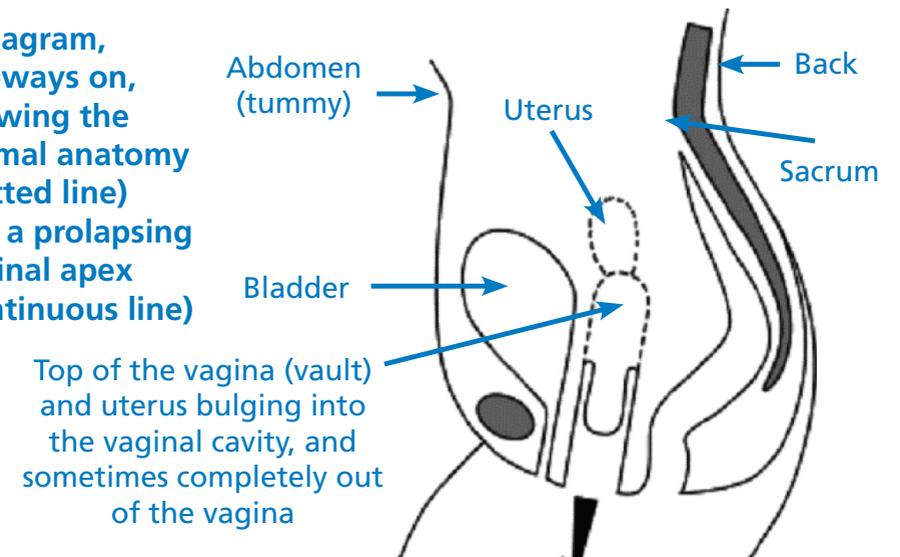
what alternatives there are and what the risks are. These should be covered in this leaflet.

This leaflet firstly describes what an apical vaginal prolapse is, it then goes on to describe what alternatives are available within our trust, the risks involved in surgery and finally 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 (see diagram below).

**A diagram, sideways on, showing the normal anatomy (dotted line) and a prolapsing vaginal apex (continuous line)**



Top of the vagina (vault) and uterus bulging into the vaginal cavity, and sometimes completely out of the vagina

- 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 (see below) 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 continence nurse advisor or women's health physiotherapist. These exercises have 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 six to nine months, or earlier if there is any bleeding or discharge, 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 four to six 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 four or five percent 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 one percent 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 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 seven to 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** 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. In rare circumstances the vagina may become too narrow so that intercourse cannot take place. Corrective surgery may be complex but could be an option in the circumstance.

## 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 theoretical benefits in leaving the womb behind if it is still present:

1. reducing operating time
2. reducing the risk of damage to local organs
3. reducing the risk of bleeding
4. the cervix is a much tougher tissue to place surgical sutures into 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 key-hole 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.

## How the operation is performed

- The operation is done under general anaesthetic.
- A general anaesthetic will mean you will be asleep (unconscious) during the entire procedure.
- The legs are placed in stirrups (supported in the air)
- A horizontal (side ways) 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.

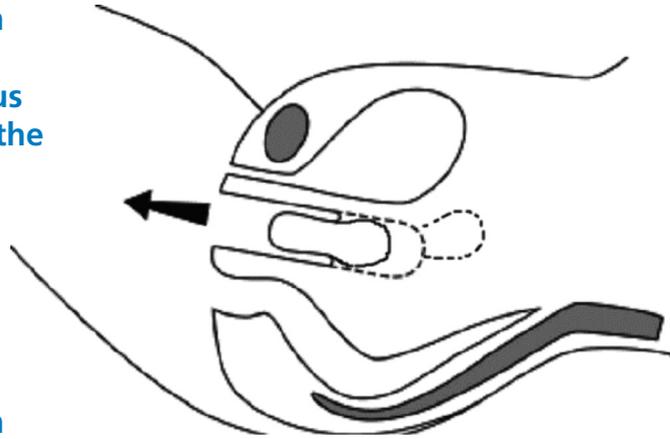


Figure 3. Diagram showing sideward view of the uterus and vagina protruding outside the vagina.

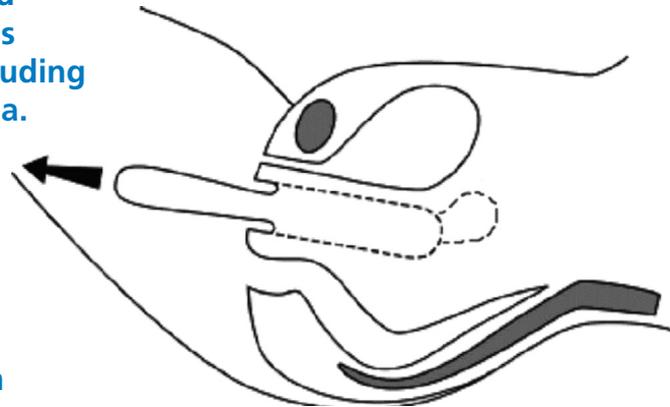
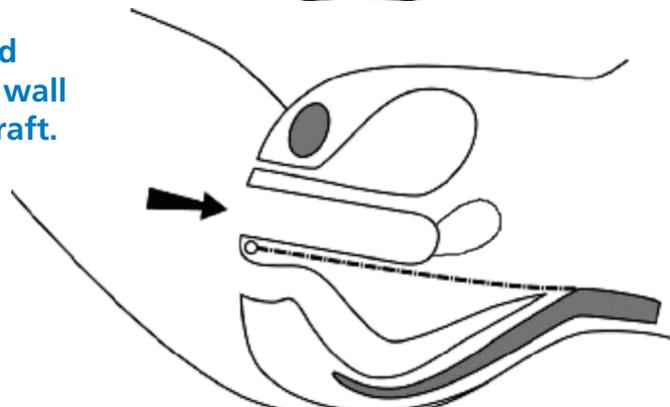


Figure 4. Diagram showing uterus (vaginal apex) and posterior vaginal wall supported by a graft.



## 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. 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 may be in hospital for up to four 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.

### Avoiding constipation

- Drink plenty of water / juice
- Eat fruit and green vegetables esp broccoli
- Plenty of roughage e.g. bran / oats
- Do not use tampons for six weeks.
- There are stitches in the skin wound in the vagina. Any stitches under the skin will dissolve by themselves. The surface knots of the stitches may appear on your underwear or pads after about two weeks, this is quite normal. There may be little bleeding again after about two weeks when the surface knots fall off, this is nothing to worry about.

- At six weeks gradually build up your level of activity.
- After three 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 six weeks. Leave a very heavy or busy job until twelve weeks.
- You can drive as soon as you can make an emergency stop without discomfort, generally after three weeks, but you must check this with your insurance company, as some of them insist that you should wait for six weeks.
- You can start sexual relations whenever you feel comfortable enough after six weeks, so 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 six weeks to six 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.

## Information about the British Society of Urogynaecology Surgical Database (Surgical Register)

The British Society of Urogynaecology (“**BSUG**”) is a national group of gynaecologists with a special interest and expertise in the treatment of incontinence and prolapse. BSUG has developed a database of clinical and surgical data for the purposes of publishing **anonymous** statistical information for research purposes and to enable individual NHS Trusts and consultants to audit information about operations to ensure that the procedures performed at their hospitals are as safe and effective as possible.

The patient information held in the BSUG database comprises name, hospital number and date of birth, together with clinical and surgical information (“**patient identifiable data**”). Because this information is confidential to each patient and is that patient’s personal data within the meaning of the Data Protection Act 1998, we do not disclose patient identifiable data to BSUG without written consent.

If you agree to allow us to enter your patient identifiable data into the BSUG database, please sign in the relevant section on the operation consent form.

### The benefits the BSUG database may bring to you:

- Improving patient awareness of the outcomes of incontinence and prolapse surgery.
- Finding out how long the different operative procedures last.
- Helping to identify individual patients who have received an implant and where there may be a need for urgent clinical review

The BSUG database will also be used to bring additional long-term benefits by:

- Providing feedback to gynaecological surgeons and teams to help maintain high clinical standards
- Promoting open publication about the performance of implants used in operations.
- Providing feedback on implant performance to regulatory authorities
- Providing feedback to suppliers about the performance of their implants
- Monitoring and comparing the performance of hospitals

### Data collection – its security and confidentiality

The **BSUG database** uses an electronic system for data collection. The data is sent securely to a protected database, avoiding the need to send paper records through the post, to ensure your data receives maximum protection.

Your personal information is confidential and cannot be used outside of the BSUG database. Strict procedures are in place to protect your information and keep it confidential; it will only be available to you and your surgeon. If you wish, you can obtain access to a copy of your own record in accordance with the Data Protection Act 1998.

## BSUG database Consent

### I consent to:

1. the processing of my patient identifiable data for the research and auditing purposes described in this information sheet.
2. the disclosure by BSUGs of my patient identifiable data to its IT service provider or any future IT service provider, where such IT service provider has:
  - (a) agreed to adopt appropriate technical and organisation measures to protect the security of my patient identifiable data and only to process it in accordance with BSUGDL's instructions;
  - (b) been instructed NOT to store my patient identifiable data on a server which is located outside of the United Kingdom; and
  - (c) been informed of the existence of my legal right to confidence in respect of my patient identifiable data.
3. the disclosure of my patient identifiable data to the consultant team (and the NHS Trust employing that consultant team) who disclosed it to BSUG.
4. the disclosure of my patient identifiable data to BSUG or any legal entity which is wholly owned by BSUG, for processing in accordance with the consents in this section.

## Your participation is voluntary

The form asks for your consent for your personal information to be recorded by the **BSUG database**. Your participation in the BSUG database is entirely voluntary. You can request access to view your entry on the BSUG database from your consultant team. If you agree and then change your mind, you may revoke this permission at any time by sending a written notice to your consultant OR to the address below. If you do not agree, your data will not be entered.

BSUG Database Limited  
c/o BSUG ,  
Royal College of Obstetricians & Gynaecologists  
27 Sussex Place  
Regents Park  
London  
NW1 4RG

**If you consent to the above please sign in the relevant section on the operation consent form.**

## Things I need to know before I have my operation

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

1. ....
2. ....
3. ....
4. ....
5. ....
6. ....
7. ....

Please describe what your expectations are from surgery.

1. ....
2. ....
3. ....
4. ....

5. ....
6. ....
7. ....

## Useful references

You may find the address and websites useful to obtain more information. We can however bear no responsibility for the information they provide:

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

### Also:

- <http://www.ics.org/Documents/Documents.aspx?DocumentID=2172>
- <http://www.iuga.org/?patientinfo>
- <https://www.rcog.org.uk/en/patients/patient-leaflets/?q=&subject=Urogynaecology&orderby=title>

## Comments, compliments, concerns or complaints

South Tees Hospitals NHS Foundation Trust is concerned about the quality of care you receive and strives to maintain high standards of health care.

However we do appreciate that there may be an occasion where you, or your family, feel dissatisfied with the standard of service you receive. Please do not hesitate to tell us about your concerns as this helps us to learn from your experience and to improve services for future patients.

## Patient Advice and Liaison Service (PALS)

This service aims to advise and support patients, families and carers and help sort out problems quickly on your behalf.

This service is available, and based, at The James Cook University Hospital but also covers the Friarage Hospital in Northallerton, our community hospitals and community health services. Please ask a member of staff for further information.

Author: Urogynaecology Team, Department of Obstetrics & Gynaecology

---

**The James Cook University Hospital**

**Marion Road, Middlesbrough, TS4 3BW. Tel: 01642 850850**

Version 2, Issue Date: November 2014, Revision Date: November 2016