



PATIENT INFORMATION LEAFLET

AN OPERATION FOR PROLAPSE – LAPAROSCOPIC SACROHYSTEROPEXY

Uterine prolapse is a bulge or lump in the vagina caused by weakness of the tissues that support the uterus (womb). It can be accompanied by prolapse of the vaginal walls.

You are being offered a laparoscopic sacrohysteropexy operation as you have a uterine prolapse which bothers you and treatment with a vaginal pessary has not been successful or has not been something that you previously wished to try.

WHAT IS A LAPAROSCOPIC SACROHYSTEROPEXY?

A laparoscopic sacrohysteropexy operation involves supporting the uterus using a piece of permanent artificial mesh material. One end of the mesh is sewn onto the neck of the womb (cervix) and the other is attached to the sacrum bone using staples. The operation is performed using keyhole surgery (laparoscopy), which means that you will have 2-3 smaller cuts on your tummy rather than one larger cut.

WHAT ARE THE BENEFITS?

A laparoscopic sacrohysteropexy treats a uterine prolapse without removing the uterus. Some people prefer this if they do not wish to have a hysterectomy.

We would advise delaying an operation for prolapse until you have completed your family. Pregnancy puts a lot of strain on any repair and is likely to increase the chance of the repair failing and the prolapse coming back. Having an operation can potentially affect your ability to become pregnant and we do not know much yet about the effect a laparoscopic sacrohysteropexy has on a developing pregnancy.

However, laparoscopic sacrohysteropexy is an option for those who request surgery for uterine prolapse and wish to consider having another baby as it does not involve removing the womb like other operations for prolapse.

At the follow up appointment after surgery, most women who have had a laparoscopic sacrohysteropexy feel it has been a success in treating their uterine prolapse.

We do not yet have good quality research to inform us about the long-term success of laparoscopic sacrohysteropexy. Our tissues continue to stretch and give way over time. This can result in further

prolapse developing. After a similar operation performed for women who have had a hysterectomy, we have found that approximately 35% (1 in 3) have some prolapse that can be measured on examination 5 years after the operation. However, many of these cases did not have any bothersome symptoms or need anything doing about it.

WHAT ARE THE ALTERNATIVE TREATMENTS?

The alternatives to laparoscopic sacrohysteropexy are:

Do nothing: Prolapse is not a dangerous or harmful condition. If it is not bothering you, you could decide to do nothing about it. If the prolapse is very large, we may suggest checking it is not stopping your bladder from emptying properly before you make your final decision not to have treatment. We would also suggest having your prolapse treated if it is rubbing on your underwear and getting sore.

Vaginal Pessary: If you have not already tried a pessary, we would encourage you to do so. There is a large range of plastic pessaries available to support the prolapse. These are worn inside the vagina and, once in place, you should not be able to feel them. They are fitted by a nurse or doctor who will advise you on the type and size of pessary that might suit you best. We usually suggest you have the pessary changed every 6 months. Some GP surgeries will change pessaries for you.

Pessaries are good at treating the symptoms of prolapse. 70% (7 in 10) who use a pessary find it successfully treats their symptoms. However, not everyone finds a pessary to suit them. The main disadvantage of a pessary is that it needs to be changed. Sometimes the pessary can rub the vaginal walls causing bleeding or discharge. This can be treated with an appropriate cream.

A vaginal pessary can be used in pregnancy if you decide to have another baby.

A Different Operation: There are many different operations used to treat prolapse. Deciding which operation to have depends on many factors including:

- The type of prolapse you have.
- Whether you want to keep your womb.
- What treatments you have had in the past.
- Any medical problems you may have.

It is not possible to list all the possible operations in this leaflet. If you decide you want a different operation for your prolapse, your doctor will explain the options open to you.

WHAT WILL HAPPEN BEFORE THE OPERATION?

If you have not already done so, you will be asked to complete an electronic questionnaire to help us identify your troublesome symptoms. You will also be asked to fill in a bladder diary to give us some information on how your bladder is working.

An ultrasound scan might be organised to check the uterus looks normal. If you are having smear tests, you should have had a normal result within the last three years.

Most people requesting a laparoscopic sacrohysteropexy will not need any other tests. However, if you are having a lot of problems with your bladder or bowels, the doctor may suggest extra bladder or bowel tests. They will explain why they have suggested the test, what it involves and give you a leaflet explaining them in more detail.

Shortly before you come in for your operation, you will be asked to attend a pre-operative

appointment with a nurse.

It is important that we arrange this for you as it gives us an opportunity to make sure we can reduce your risk from surgery as much as possible. It will not be possible to go ahead with your operation until these checks are done.

Routine tests, such as blood tests and a heart tracing may be done at this appointment. You may need other tests depending on what medical problems you have. Please bring a list of all your medications, and any allergies you might have, with you when you attend.

Before you come into hospital for your operation, you should make sure you have a supply of simple pain relief, such as Paracetamol, as this will not be supplied for you to take home.

HOW IS THE OPERATION PERFORMED?

Before you go to theatre for your operation, you will be given some elasticated stockings to wear. These reduce the risk of a clot in the leg, known as a deep vein thrombosis (DVT).

The operation is performed with a general (asleep) anaesthetic. The anaesthetist will discuss this with you. During the operation, a camera is inserted into your abdomen through a small cut near or in your tummy button (umbilicus). The surgeon will also make 2 or 3 small cuts on your tummy to pass instruments inside to perform the operation. To make a space to work in, your tummy is filled with carbon dioxide gas. This gas sits in the space outside the intestine and is removed at the end of the operation.

A strip of artificial mesh material is stitched onto the cervix with dissolvable stitches (sometimes this is done through the vagina before the start of the laparoscopic part of the operation). The other end of the mesh is stapled to the sacrum bone. The mesh is then covered over with the lining of the abdomen known as the peritoneum. Once the gas has been let out, any cuts in the skin are closed with dissolvable stitches. The operation takes between 1 and 2 hours to complete.

A dose of antibiotics will be given during the operation to reduce the risk of infection. A catheter tube is inserted along the urethra into your bladder and left in place until the following morning.

WHAT WILL HAPPEN AFTER THE OPERATION?

The catheter tube will be removed the morning after your operation. Most people find they only need simple pain relief such as Paracetamol. Once you are eating, drinking and passing urine normally, you will be able to go home. Most people go home the day after their operation. We will give you fibre powders to take home to help your bowels move without the need to strain.

WHAT HAPPENS AFTER I GET HOME?

It is normal to feel more tired than usual after an operation and this may last several weeks. It is important to take rest and allow your body to heal. However, we would advise gentle exercise, initially around the home, to help prevent a DVT. Try to avoid strenuous exercise that leaves you short of breath, heavy lifting or straining on the toilet as this can put a strain on the repair.

You can drive as soon as you can make an emergency stop without it hurting. This usually takes 4 weeks. If you work, you may need a certificate for your employer. This can be supplied (on request)

before you go home from hospital.

We would like to see you in the out-patient clinic 6 months after your operation to check it has healed well and see what effect it has had on your symptoms. We will ask you to repeat the electronic questionnaire as part of this follow up appointment.

If you are intending to have another baby, we would suggest waiting until after your follow up appointment before getting pregnant. This will allow the repair to heal before the growing pregnancy puts strain on it.

WHAT ARE THE RISKS OF SURGERY FOR PROLAPSE?

Unfortunately, all operations carry some risk. It is important that you are aware of these risks and consider them when making a decision whether or not to have surgery for your prolapse. There are some general risks that are present for any operation. These include:

Anaesthetic Risks: The risk from having an anaesthetic is usually small unless you have certain medical problems.

Bleeding: The risk of serious blood loss is very small, and it is rare that we have to give a blood transfusion after prolapse operations. However, your risk of bleeding may be higher if you are taking an anti-clotting drug such as Warfarin. It is very important that you share with us any religious objection you may have to receiving blood in a life-threatening emergency.

Infection: There is a risk of infection at the wound site or in your bladder, which is reduced by giving you a dose of antibiotics during the operation. The risk of a serious infection is very small.

Deep Vein Thrombosis (DVT): This is a clot in the deep veins of the legs. The risk of a DVT is about 4 in 100 and many cause no symptoms. In a very small number of cases, bits of the clot can break off and get stuck in the lungs causing a serious condition (pulmonary embolism). The risk of a DVT is higher in women who smoke or who are overweight. The risk can be reduced by wearing special stockings and sometimes using injections to thin the blood.

Pain, including pain on intercourse: Mild pain for a few days or weeks after the operation is normal as the wounds from surgery heal. Some women also have increased back or hip pain after the operation as we need to position you with your legs in stirrups to perform the operation. Rarely, more severe or long-lasting pain can develop after surgery, even when the operation has otherwise been successful. There are many reasons for this, and it is not always possible to resolve it.

Worsening or persisting problems with your bladder or bowels: People with prolapse may also have problems with their bladder or bowels. Fixing the prolapse does not always make these problems better. Some problems, such as bladder leakage on coughing, laughing and sneezing, may get worse.

Damage to the bladder or bowel: During the operation, the surgeon will make cuts and place stitches very close to the bladder and bowel. Rarely, the surgeon may make a hole in them by accident. Usually this can be repaired straight way and the operation finished as normal. However, it may affect your recovery and your surgeon will want to explain what has happened when they see you on the ward the next day.

ARE THERE ANY OTHER RISKS?

Risks specific to a laparoscopic sacrohysteropexy, rather than other operations for prolapse include:

Failure to treat the prolapse: No operation for prolapse has a cure rate of 100%. Some who have a laparoscopic sacrohysteropexy will feel the surgery has not helped the prolapse symptoms. A prolapse can come back after this operation. Occasionally the neck of the womb (cervix) can lengthen after this operation. This can feel as if the prolapse symptoms have come back.

Laparotomy: This means making a larger cut in your abdomen to perform an operation. Usually these are along the bikini line, low down on the tummy. Although we intend to complete the operation with a keyhole (laparoscopic) technique, a laparotomy is needed in rare circumstances, either to complete the operation or to repair an injury to a blood vessel, the bladder or bowel.

Needing a hysterectomy: Some women who have a laparoscopic sacrohysteropexy need a hysterectomy at a later date. This may be because they have further problems with uterine prolapse or because they develop other unrelated problems, such as very heavy periods or abnormal smears, which can only be treated by removing the uterus. As we have fastened the uterus in with mesh, this may make the hysterectomy more complicated. Cutting the mesh to get the uterus out may cause prolapse of the top of the vagina to develop later.


Mesh complications: This operation involves inserting permanent artificial material into your body. This has the advantage of providing lifelong strength to the repair. However, artificial meshes used in prolapse surgery can cause problems. They can work their way through the vagina, or less commonly the bladder or bowel, over time. This is called erosion and can occur many years after the mesh was put in. Rarely, the mesh can become infected. These mesh complications can require further operations to treat them. The risk of mesh erosion into the vagina may be increased if the mesh is attached to the cervix using a cut in the vagina.

We have been using this particular type of mesh for several years and have, so far, had found the risk of such problems to be extremely low. However, we would advise you to read our leaflet about the use of mesh in prolapse repair and consider these risks when making your decision with regard to surgery.

If you require any further information or clarification of terminology, please do not hesitate to talk to one of the doctors or nurses, who will be happy to discuss your concerns with you.

CONTACT DETAILS

 **Warrell Unit Nurses: (during office hours only):** (0161) 701 6150 or 701 6776

 **For urgent out of hours enquiries:** Emergency Gynaecology Unit (0161) 291 2561
24 hours; 7 days. *EGU is based at Wythenshawe Hospital on Ward F16*