Sacrospinous fixation (SSF) for prolapse of the uterus (womb) or prolapse of the vaginal vault (top of vagina)

About this leaflet

The information provided in this leaflet should be used as a guide. There may be some variation in how each gynaecologist performs the procedure, the care procedures on the ward immediately after your operation and the advice given to you when you get home. 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/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.

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	Unit in which one adverse event would be expected
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 10,000	A person in small town
Very rare	less than 1 in 10,000	A person in large town

What is a sacrospinous fixation (SSF)?

A sacrospinous fixation is an operation to attach the top of the vagina or the cervix (neck of the womb) to a pelvic ligament (sacrospinous ligament) with a stitch. There are no cuts in the abdomen (tummy).

Information for Patients

What condition does a sacrospinous fixation (SSF) treat?

The operation is primarily intended to treat prolapse of the womb or the vault (top) of the vagina (if you have had a hysterectomy). It can also help correct prolapse of the bladder or bowel to some extent if they are also present.

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 into or out of the vagina. Pelvic organs include the womb, bladder and bowel.

A prolapse may arise in the front wall of vagina (cystocoele), back wall of the vagina (rectoenterocoele or rectocoele), the womb or the vault (top) of the vagina after hysterectomy.

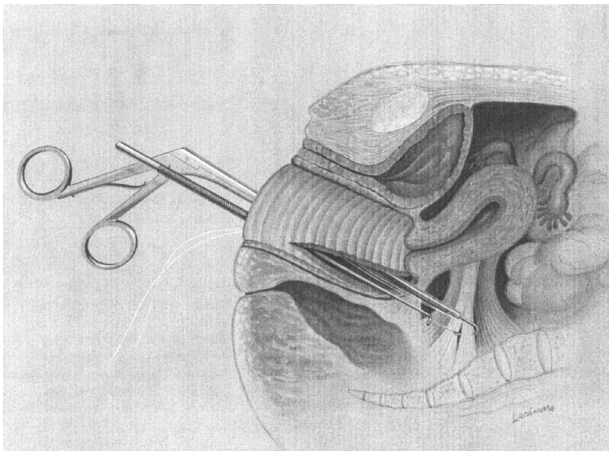
Many women have a prolapse in more than one place at the same time.
You should keep in mind that even though surgical treatment may repair your prolapse, it may or may not relieve all your symptoms.

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 and as well as personal factors.

How is a sacrospinous fixation done?

The operation is done under general anaesthetic (asleep during the entire procedure) or a spinal anaesthetic (awake but numb from the waist down).

The top of the vagina is stitched to a ligament (sacrospinous ligament) at the back of the pelvis, so there are no cuts in your tummy. In most cases, the stitch is placed through the ligament on the right side. Occasionally, if extra support is required, a stitch is placed through the left ligament as well.



Drawing showing sacrospinous fixation using special instruments (Miya hook) done through the vagina

Other operations which can be performed at the same time

Your doctor may suggest that a sacrospinous fixation is all that is required to help your prolapse. Sometimes, additional operations are done at the same time and your doctor should advise you regarding these before your operation.

- **Vaginal repairs** - Sometimes the front or back walls of the vagina sag so much that your doctor may suggest repairing them at the same time as your sacrospinous fixation, which 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.

- **Continence Surgery** - sometimes an operation to treat any bothersome urinary leakage can be performed at the same time as your sacrospinous fixation. Some gynaecologists prefer to do this as a separate procedure at a later date.

Benefits of Surgery

- Relief of prolapse symptoms.
- Some women report an improvement in passing urine especially if this was a problem before surgery.
- Some women report an improvement in overactive bladder symptoms, e.g. less urgency, passing urine less frequently.

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. An anterior repair can be performed with you asleep (a general anaesthetic) or awake (a spinal anaesthetic) whereby you are awake but numb from the waist down. This will be discussed with you. 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 but it would be very rare for this to be a large amount. Please let your doctor know if you are taking a blood-thinning tablet such as warfarin, aspirin, clopidogrel, apixaban, rivaroxaban, dabigatran, etc., 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, vaginal 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. Chest infection may also occur because of the anaesthetic. 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 wearing compression stockings and injections to thin the blood. Stop taking any hormones such as hormone replacement therapy (HRT) and some types of birth-control pills 4 weeks before surgery. These can usually be restarted 4 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.** The wound within the vagina can become infected or less commonly, stitches can become loose allowing the wound to open up. Do not douche the vagina or use tampons. Wait 6 weeks before resuming sexual activity.

- **Damage to bowel.** This is a rare complication which means accidentally making a hole or tear in the bowel (rectum). Minor damage can be repaired with stitches if detected at the time of surgery without any long-term consequences. Sometimes the injury is not detected at the time of surgery and may require another operation and temporary colostomy (bag) but this is very rare.

- **Getting another prolapse**. There is little published evidence of exactly how often prolapse recurs, but it can. This is because the vaginal tissue is weak. Sometimes even though another prolapse develops it is not bothersome enough to require further treatment. 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.

- **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.

- **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.** A prolapse of the anterior vaginal wall sometimes causes some kinking of the tube through which you pass urine (urethra). This can be enough to stop urine leaks on coughing, sneezing or exercise. By correcting the prolapse, this kink gets straightened out, and if there is an underlying weakness in the tissues, leakage of urine can occur. It is difficult to define an exact risk but it is reported to be in the order of 10% (1 in 10). Doing pelvic floor exercises regularly can help to prevent stress incontinence.

- **Painful sexual intercourse.** The healing usually takes about 6 weeks and after this time it is safe to have intercourse. Some women find sex is uncomfortable at first, but it gets better with time. You will need to be gentle and may wish to use lubrication initially. Occasionally pain on intercourse can be long-term or permanent.

- **Buttock pain** – approximately 1 in 10 women will get pain in the right buttock (as the stitch is usually put through the right sacrospinous ligament). Occasionally, a stitch may be placed through both ligaments, in which case the pain may occur in either buttock. 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.

Information for Patients

After the operation - in hospital

- **Pain relief.** Pain can be controlled in a number of ways depending on the preference of your anaesthetist and/or gynaecologist. Options are self-administration of pain relief (patient controlled analgesia - PCA), drugs in a drip, tablets or suppositories. It is usually 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.

- **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.

- **Pack**. Some gynaecologists insert a length of gauze into the vagina at the end of the operation. It acts as pressure bandage and is usually removed the following day.

- **Vaginal bleeding.** There may be slight vaginal bleeding like the end of a period after the operation.

- **Eating and drinking.** You can drink fluids soon after the operation and will be encouraged to start eating as soon as tolerated.

- **Preventing deep vein thrombosis (DVT).** The same day or the day after your 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 DVT. You may be given a daily injection to keep your blood thin and reduce the risk of DVT until you go home or longer in some cases.

- **Going home.** You are usually in hospital for one or two days. If you require a sick note or certificate please ask.

After the operation – at home

- Mobilisation is very important; using your leg muscles will reduce the risk of DVT.
- Bath or shower as normal.
- Do not use tampons for 6 weeks and avoid douching the vagina
- The stitches under the skin will dissolve. The surface knots of the stitches may appear on your underwear or pads after about 2 weeks; this is quite normal. There may be a little bleeding again after about 2 weeks when the surface knots fall off; this is nothing to worry about.
- 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.
- **Avoiding constipation:**

  Drink plenty of water / juice
  Eat fruit and green vegetables especially broccoli
  Plenty of roughage e.g. bran / oats

Information for Patients

- Any constant cough is to be treated promptly. Please see your GP as soon as possible.
- 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, a busy job in 12 weeks. Avoiding all unnecessary heavy lifting will possibly reduce the risk of the prolapse recurring.
- You can drive as soon as you can operate the pedals and look over your shoulder 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 6 weeks.
- The healing usually takes about 6 weeks and after this, it is safe to have intercourse. Some women find sex is uncomfortable at first but it gets better with time. Sometimes the internal knots could cause your partner discomfort until they dissolve away. You will need to be gentle and may wish to use lubrication initially. Occasionally pain on intercourse can be long-term or permanent.
- You usually have a follow up appointment anything between 6 weeks and 6 months after the operation.

- See link: https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/recovering-well/pelvic-floor-repair-operation.pdf

What to report to your doctor after surgery

- Heavy vaginal bleeding
- Smelly vaginal discharge
- Severe pain
- High fever
- Pain or discomfort passing urine or blood in the urine
- Leakage of urine which you did not have before the operation
- Difficulty opening your bowels
- Warm, painful, swollen leg
- Chest pain or difficulty breathing

ALTERNATIVE TREATMENTS

Non-surgical

- **Do nothing.** If the prolapse is not too bothersome treatment may not be necessary. If, however, the prolapse permanently protrudes through the opening to the vagina and is exposed to the air, 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. Weight reduction in overweight women and avoiding risk factors such as smoking (leading to chronic cough), heavy weight lifting jobs and constipation may help with symptom control. The prolapse may become worse with time but it can then be treated.

- **Pelvic floor exercises (PFE).** The pelvic floor muscles support the pelvic organs. Strong muscles can help to prevent a prolapse dropping further. PFE are unlikely to provide significant improvement for a severe prolapse protruding outside the vagina. A women's health physiotherapist can explain how to perform these exercises with the correct technique. It is important that you try these to help manage the symptoms of your prolapse and to prevent it

becoming worse. It is also very important to continue with your pelvic floor exercises even if you have opted for other treatment options.

- **Pessary.** A vaginal device, a pessary (see image below), may be placed in the vagina to support the vaginal walls and uterus. A pessary is usually used continuously and changed by a doctor or nurse every 4 to 12 months depending upon the type used and how well it suits you.

  Alternatively, if you prefer, you may be taught to replace the pessary yourself. It is possible to lead a normal life with continuation of activities such as bathing, cycling, swimming and in some cases, sexual intercourse.

  Ongoing care is often at the GP practice, but some women will need to be kept under review in the gynaecology clinic. Pessaries are very safe and many women to choose to use one long term rather than have an operation. On occasions their use has to be discontinued due to bleeding, discharge, sexual difficulties or change in bladder function but these all stop quickly after removal. Sometimes it will take several visits to the clinic to determine the best size for you. A pessary is not suitable for all women.

Surgical Options

The following table lists the different operations that can be considered to treat **uterine prolapse**. Further information on the operations is available in separate leaflets. All operations are not available in all hospitals. Your consultant may recommend a particular operation depending on his or her preference and expertise, or your individual needs.

Surgical Treatment	Advantages	Disadvantages
Vaginal Sacrospinous Hysteropexy - stitches to support womb inserted through vagina) (described in this leaflet)	No cut in your tummy May also treat a co-existing vaginal prolapse Vaginal length maintained Pregnancy still possible although prolapse might recur during or after pregnancy Can be done with you awake or asleep	Can cause temporary buttock pain
Sacrohysteropexy - abdominal open operation	May also treat a co-existing vaginal prolapse. No cuts or stitches in vagina. Vaginal length maintained. Pregnancy still possible although prolapse might recur during or	Requires a general anaesthetic (asleep) As mesh is used there is a small risk that the mesh will work its way into surrounding tissues.

	after pregnancy	
Vaginal Hysterectomy - removal of uterus via the vagina	No abdominal incision Can be done with you awake or asleep	Risk of prolapse of the vault (top) of the vagina in the future
Manchester repair - removal of only the cervix through the vagina	No abdominal incision Can be done with you awake or asleep	Not effective for advanced prolapse
Colpocleisis - closure of the vagina with stitches	No abdominal incision Can be done with you awake or asleep	Sexual intercourse will never be possible after this operation. Not possible to take a smear Difficult to investigate abnormal bleeding from the womb Urinary incontinence in the future may be more difficult to treat

The following table lists the different operations that can be considered to treat **vaginal vault prolapse** (after a previous hysterectomy). Further information on the operations is available in separate leaflets. All operations are not available in all hospitals. Your consultant may recommend a particular operation depending on his or her preference and expertise, or your individual needs.

Surgical Treatment	Advantages	Disadvantages
Vaginal Sacrospinous Fixation - stitches to support top of the vagina inserted through vagina (described in this leaflet)	No cut in your tummy Can be done with you awake or asleep Vaginal length maintained	Can cause temporary buttock pain Not possible if vagina is short
Sacrocolpopexy - abdominal open operation	May also treat a co-existing vaginal prolapse. No cuts or stitches in vagina. Vaginal length maintained.	Requires a general anaesthetic (asleep) As mesh is used there is a small risk that the mesh will work its way into surrounding tissues.
Colpocleisis - closure of vagina with stitches	No abdominal incision. Can be done with you awake or asleep	Sexual intercourse will never be possible after this operation. Urinary incontinence in the future may be more difficult to treat

More information

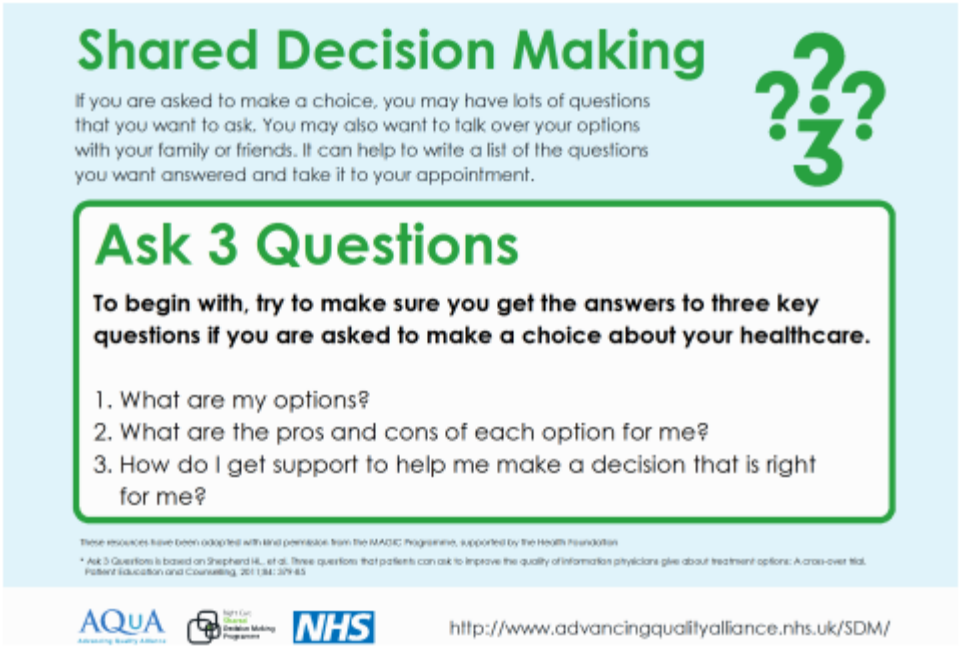
If you would like to know more about uterine prolapse and the treatments available for it, you may try the following sources of information.

- Ask your GP.
- Ask the Doctor or Nurse at the hospital.
- Look at a website such as

Information for Patients

- NHS choices at http://www.nhs.uk/pages/home.aspx
- Patient UK at http://patient.info/health
- Royal College of Obstetricians and Gynaecologists Recovering Well leaflet at https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/recovering-well/pelvic-floor-repair-operation.pdf
- Royal College of Obstetricians and Gynaecologists patient information leaflet – Pelvic organ prolapse at https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/gynaecology/pi-pelvic-organ-prolapse.pdf
- International Urogynaecology Association (IUGA) patient information leaflet Sacrospinous fixation / iliococcygeus suspension at http://c.ymcdn.com/sites/www.iuga.org/resource/resmgr/brochures/eng_sacrospinousfix.pdf
- Patient information leaflets for your own hospital and others (usually available on line)

Making a decision - 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)……

Please describe what your expectations are from surgery.

1)……

2)……

3)……

Information for Patients

Our commitment to confidentiality

We keep personal and clinical information about you to ensure you receive appropriate care and treatment. Everyone working in the NHS has a legal duty to keep information about you confidential.

We will share information with other parts of the NHS to support your healthcare needs, and we will inform your GP of your progress unless you ask us not to. If we need to share information that identifies you with other organisations we will ask for your consent. You can help us by pointing out any information in your records which is wrong or needs updating.

Additional Sources of Information:

Go online and view NHS Choices website for more information about a wide range of health topics http://www.nhs.uk/Pages/HomePage.aspx

You may want to visit one of our Health Information Centres located in:

- Main Entrance at Birmingham Heartlands Hospital Tel: 0121 424 2280
- Treatment Centre at Good Hope Hospital Tel: 0121 424 9946
- Clinic Entrance Solihull Hospital Tel: 0121 424 5616
  or contact us by email: healthinfo.centre@heartofengland.nhs.uk.

Dear Patient

We welcome your views on what you thought of this patient information leaflet, also any suggestions on how you feel we can improve through our feedback link below:

- Patient Information Feedback email:
  patientinformationleafletfeedback@heartofengland.nhs.uk

If you wish to make any other comments this can be done through the links listed below:

- Patient Opinion: www.patientopinion.org.uk
- I want great care: www.iwantgreatcare.org (Here you can leave feedback about your doctor)

Be helpful and respectful: think about what people might want to know about our patient information and this hospital and how your experiences might benefit others. Remember your words must be polite and respectful, and you cannot name individuals on the sites.

If you have any questions you may want to ask about your condition or your treatment or if there is anything you do not understand and you wish to know more about please write them down and your doctor will be more than happy to try and answer them for you.

If you require this information in another format, such as a different language, large print, braille or audio version please ask a member of staff or email patientexperience@uhb.nhs.uk.