Sacrohysteropexy for Uterine Prolapse (Womb Prolapse)

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 not been accurately determined, but most women appear to benefit. 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 Sacrohysteropexy?

A sacrohysteropexy is an operation to pull up a prolapsed (dropped) womb using a strip of synthetic mesh.

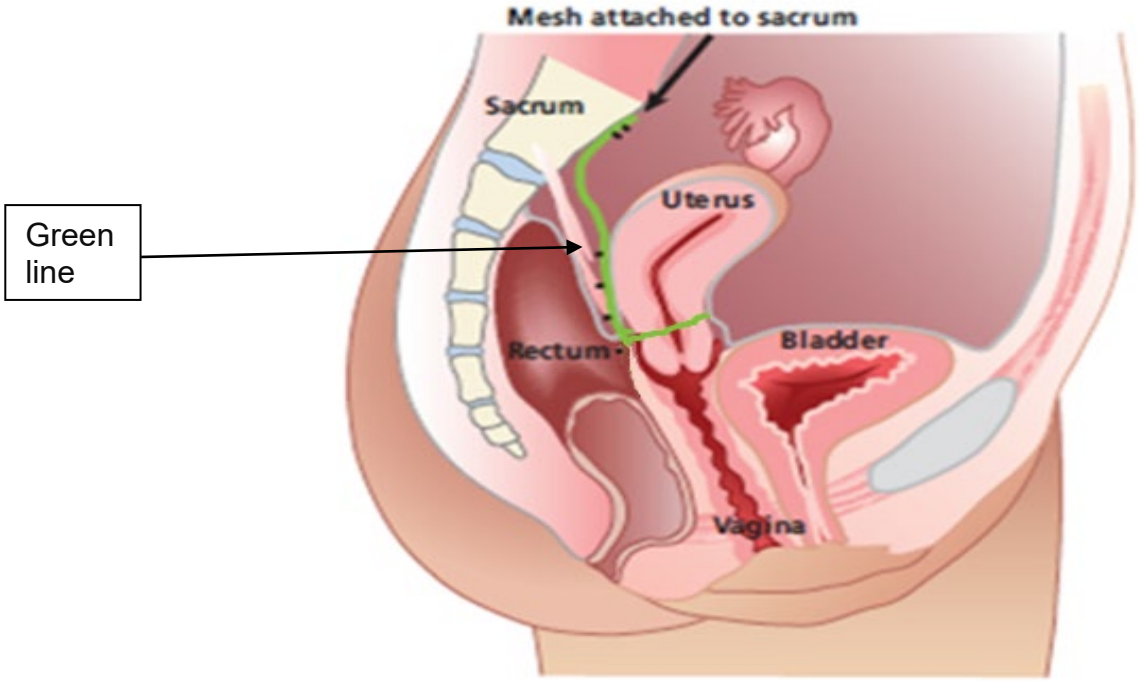


Diagram showing suspension of uterus using mesh (green line) following sacrohysteropexy

What condition does a sacrohysteropexy treat?

The operation is primarily intended to treat prolapse of the womb. It can also help correct a prolapse of the bladder or bowel to some extent if they are also present.
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 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 as an open operation or laparoscopically (key hole). The open entry means a horizontal or bikini incision is made in your lower tummy, and laparoscopically there are 3-4 small cuts on the tummy. To date, studies have not shown any difference in success between the two techniques. However, there is evidence that the laparoscopic (keyhole) operation results in less blood loss, fewer wound infections and a shorter hospital stay. The decision about the way in which the surgery is performed depends on a number of factors and will need to be discussed with your surgeon.
- The womb 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 to the back of the pelvic bone (the sacrum) 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** (see separate leaflet).

Other operations which can be performed at the same time

- The ovaries and fallopian tubes can be removed if necessary and this will be discussed with you before the operation.
- **Vaginal repairs** - Sometimes there is also a prolapse of the front or back wall of the vagina and your doctor may suggest repairing them at the same time as your sacrohysteropexy. 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 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.

Benefits of surgery

- The main aim of the operation is to improve the symptoms of prolapse, e.g. the feeling of a lump or bulge within or protruding out of the vagina, and the dragging sensation. Surgery is successful in the majority of women.
- Some women who have difficulty passing urine before surgery notice this improves after a vaginal hysterectomy, especially if they have a large prolapse.
- Some women report an improvement in overactive bladder symptoms, e.g. less urgency, passing urine less frequently, etc.

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. 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.

Information for Patients

- **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 in your tummy can become infected or occasionally stitches can become loose allowing the wound to open up.

- **Getting another prolapse**
  There is little published evidence of exactly how often prolapse recurs, but it can. It is 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. 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.

- **Damage to bladder**
  This means accidentally making a hole or tear in the bladder. It is an uncommon complication but usually straightforward to repair with stitches if detected at the time of surgery. It can result in a delay in recovery, but usually does not cause any long-term problems. A catheter is usually kept in the bladder for 7-14 days following surgery to allow the bladder to heal. Damage to the bladder is sometimes not detected at the time of surgery and may not be diagnosed for days or weeks after surgery. In this situation, the bladder can take weeks to heal.

- **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 rare.

- **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. If you are struggling with constipation after simple changes in diet and fluid intake, your doctor/GP can prescribe a laxative.

- **Damage to ureter**
  The ureters are tubes which transport urine from the kidneys to your bladder. The right ureter is vulnerable to injury, but this is uncommon. It may require surgery to put it right.

- **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, laughing or sneezing. 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

- **Mesh exposure/erosion**:
  There is a small risk of mesh erosion into the adjacent organs such as bladder and bowel. This is reduced by covering the mesh with peritoneum, which is a membrane lining the inside of your pelvis. Although this complication is uncommon, it may require a repeat operation to trim or remove the mesh and in severe cases may compromise the results of operation. It may also cause pain with sexual intercourse, but this is much less common compared to surgery performed through the vagina.

- Inflammation of sacral bone (osteomyelitis) is serious, but rare.

- 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.

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 a spinal anaesthetic, 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. It is often best to take the painkillers supplied to you on a regular basis aiming to take a painkiller before the pain becomes a problem. If you have had an open operation you may need more pain relief.

- **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.

- **Drain.** If there has been more than average bleeding during the operation a drain (tube) from inside the tummy to outside may be placed beside a wound to let any blood which has collected. This is usually taken out the next 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 two or three 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.
- 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

- 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 3 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 having sex whenever you feel comfortable enough after about 6 weeks. You will need to be gentle and may wish to use lubrication.
- 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 you did not have before your 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 improve an advanced prolapse where the womb is 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 the above to help to 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

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
Sacrohysteropexy - laparoscopic (key hole) or abdominal (open operation) (described in this leaflet)	May also treat a co-existing vaginal prolapse. No cuts or stitches in vagina. Vaginal length is maintained. Womb is still present so pregnancy is possible. Minimal blood loss and shorter length of hospital stay (compared to other options) with laparoscopic approach.	Requires a general anaesthetic (asleep) for laparoscopic or open surgery As mesh is used there is a small risk that the mesh will work its way into surrounding tissues. Only if open surgery: • More painful than the other procedures • Slower return to normal activities • Longer hospital stay
Vaginal Hysterectomy (removal of womb through the vagina)	No cuts in your tummy Womb is removed so no risk of cancer of the cervix or womb in future. Can be done with you awake or asleep	Risk of prolapse of the vault (top) of the vagina in the future

Information for Patients

Manchester repair (removal of only the cervix through the vagina)	No cuts in your tummy The body of the womb is still present so pregnancy is possible, although prolapse might recur during or after pregnancy Can be done with you awake or asleep	Narrowing of opening into the womb can cause pain Pregnancy can be complicated by premature labour
Vaginal Sacrospinous Hysteropexy (stitches to support the womb inserted through vagina)	No cuts in your tummy The womb is still present, so pregnancy is still possible although prolapse might recur during or after pregnancy Can be done with you awake or asleep	Can cause temporary buttock pain Variable long-term success with recurrence of uterine prolapse 14-30%.
Colpocleisis (closure of the vagina using stitches)	High success rates (90-95%) both for prolapse of the uterus and the walls of the vagina. No cuts in your tummy 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 inside the uterus if abnormal bleeding occurs 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.

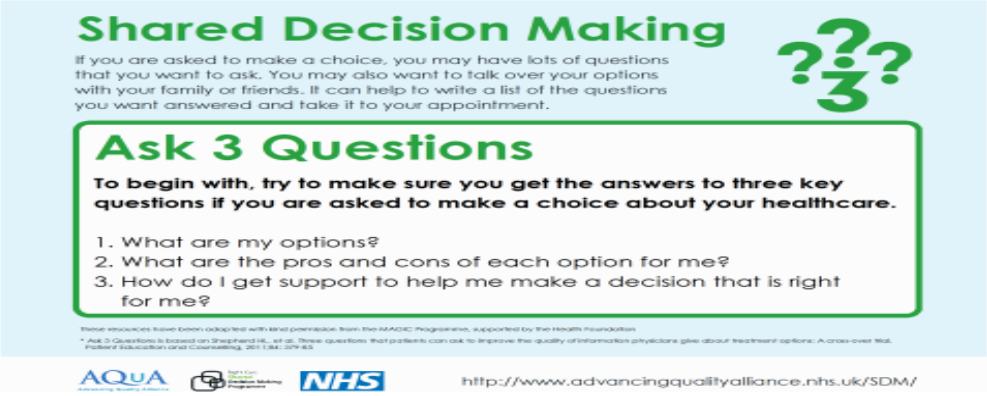
- Ask your GP.
- Ask the Doctor or Nurse at the hospital.
- Look at a website such as

    - 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 (no specific leaflet for sacrohysteropexy) 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 – Sacrocolpopexy (similar operation to sacrohysteropexy) at https://c.ymcdn.com/sites/www.iuga.org/resource/resmgr/brochures/eng_sacrocolpopexy.pdf
    - National Institute for Health and Clinical Excellence (NICE). Information for people who use NHS services. Treating prolapse of the womb with a mesh suspension

sling at https://www.nice.org.uk/guidance/ipg282/resources/treating-prolapse-of-the-womb-with-a-mesh-suspension-sling-pdf-311008861

- National Institute for Health and Clinical Excellence (NICE). Information for the public. Sacrocolpopexy with hysterectomy using mesh to repair uterine prolapse at https://www.nice.org.uk/guidance/ipg577/ifp/chapter/What-has-NICE-said

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)……

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

Information for Patients

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.