NHS
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Laparoscopic Utero-sacral Suspension

Department of Gynaecology

Patient Information

What is a laparoscopic utero-sacral suspension?

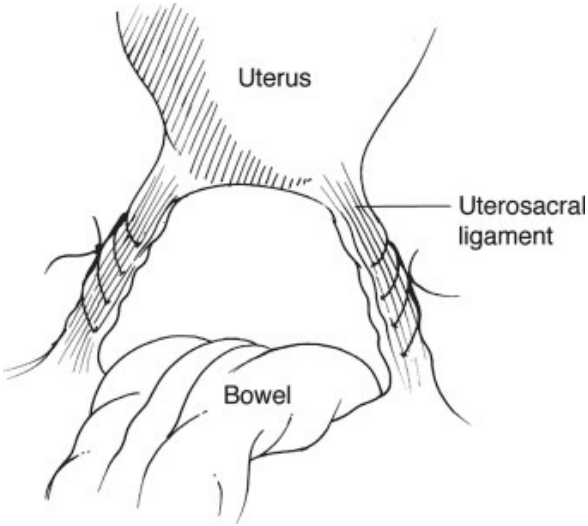
Laparoscopic uterosacral suspension is an operation done through key hole to correct uterine prolapse, in patients who do not wish to have hysterectomy. Uterine prolapse is a condition where the uterus (womb) slips down from its usual location. This is usually associated with vaginal wall prolapse (slipping down).

The prolapse can lead to sense of bulge or pressure. It can also affect bladder and bowel function. Sex can be affected as well.

The operation can be carried out using key-hole approach under general anaesthesia. Associated prolapse of the vagina is dealt with at the same time.

Why do I need this kind of surgery?

The operation is intended to support the uterus and correct associated vaginal prolapse. This is achieved by shortening the utero-sacral ligaments.



The utero-sacral ligaments support the back of the cervix (neck of the womb). The slipping down of the uterus (womb) could be caused by weakness of these ligaments, which lead to them becoming slack (redundant). Shortening these ligaments will elevate the prolapsed uterus. This will improve associated urinary, bowel and/or sexual problems.

Why do I need a laparoscopic utero-sacral suspension?

Laparoscopic utero-sacral suspension is offered to you to help improve the prolapse, whilst keeping the uterus.

Surgery is an alternative to non-surgical measures like weight loss, avoiding straining, having pelvic floor muscle training and trying vaginal pessaries. These options will have been discussed with you before surgery is considered.

The operation entails preserving the uterus (womb), rather than removing it. It is one of several operations that can be used to preserve the uterus (womb). These operations vary and can be performed vaginally (from down below), open (through cut across the tummy) or through the laparoscope (key-hole). All the options will be discussed with you.

Laparoscopic utero-sacral suspension is an established key-hole operation. However, it is less commonly performed than laparoscopic sacro-hysteropexy, which is another key hole operation that provides support to the womb (uterus) with mesh or strip of the tummy wall (rectus sheath).

The latest guideline from the National Institute of Health and Care Excellence (NICE) includes sacro-hysteropexy but does not include utero-sacral suspension. The choice you make is entirely yours and this information is to enable you to make the choice with full knowledge of all relevant points.

What can I expect before the operation?

At your pre-op assessment and on your admission day the nurse will go through your hospital stay and explain the operation. Please do let us know about any concerns you have or if there is any information you think we should know about that will make your stay with us more comfortable.

You will need to make arrangements for your family, children or any other commitments that you have prior to coming in to hospital and to cover the length of your recovery.

You will see an anaesthetist and the doctor performing the surgery before you go to theatre. If you have not already completed a quality of life questionnaire, you might be asked to do so before surgery. Likewise, if you have not already signed the consent form on booking, the doctor will go through it with you before you go to theatre.

You will be asked for permission to enter your data on the national database for continence and prolapse surgery. This is a quality control measure to compare the safety and effectiveness of such procedures at the hospital against other units in the country. You will be given quality of life questionnaires to complete and bring with you as you attend for follow up after surgery. This will enable assessing the benefit of surgery for you.

What does the operation involve?

The operation is done through a key-hole approach. A small cut (1 cm) is made in the umbilicus (belly button), to introduce the laparoscope (tummy camera). If you had previous operation(s), this cut for may be made below the left side of the chest wall. Two additional small cuts (1/2 cm) are made, one on either side of your tummy. These cuts enable introducing instruments to do the operation.

What are the risks?

There are risks with any operation but these are small. The main risks associated with a laparoscopic colposuspension are:

Common risks:

- Postoperative pain particularly shoulder tip pain. This is caused by the gas used to distend your abdomen being trapped under the muscle that separates the chest from the abdomen. Pain from this muscle is referred to the shoulder. This pain is usually mild and responds to pain killers. It often disappears within a day or two.

- Initial difficulty in passing urine. This is usually managed by leaving the catheter (plastic tube) to drain the bladder for longer and you can go home with a leg bag for few days. Less commonly, patients may need intermittent self-catheterisation for a short period of time.

- Urinary tract infection, which may need antibiotics.

Uncommon risks:

- Damage to the ureter, bladder and/or bowel, which will be repaired at time.

- Overactive bladder symptoms, such as frequency and urgency of passing urine may happen. These can be managed with medication.

- Unmasking of weakness of the neck of the bladder, manifesting as stress incontinence of urine. This is initially managed with pelvic floor muscle training, resorting to surgery if pelvic floor muscle training does not help.

- Inability to complete the operation through the key-hole, which may necessitate laparotomy (open tummy) approach.
- Failure or recurrence of prolapse. This might be managed by vaginal pessary or repeat surgery.
- Venous thrombosis and pulmonary embolism (clot in leg/lung). These are prevented by elastic stockings and anticoagulants (injections that thin the blood to prevent a clot).
- Hernia at site of entry.
- Haemorrhage requiring blood transfusion.
- Return to theatre because i.e. because of bleeding.
- Wound infection, which may need antibiotics.
- Wound bruising and delayed wound healing.

In order for you to make an informed choice about your surgery please ask one of the doctors or nurses if you have any questions about the operation before signing the consent form.

What can I expect after the operation?

As you come round from the anaesthetic you may experience episodes of pain and/or nausea. Please let the nursing staff know and they will assess you and take appropriate action. You may have a PCA (Patient Controlled Analgesia) pump to control your pain. This is not common and will be discussed with you before the operation by the anaesthetist. The nurses will assess you regularly to ensure that the PCA is effective. We use a pain score to assess your pain

0-10: 0 = No Pain, 10 = Very Strong Pain.

Your nurse will be checking your blood pressure, pulse, breathing and temperature and monitor the laparoscopic ports and any vaginal bleeding. S/he will also ask you to move from side to side and to do leg and breathing exercises once you are able, this will help prevent any pressure damage, a DVT (deep vein thrombosis) or chest infection.

The first 12 hours after the operation

You will have a drip attached but will be able to eat and drink once you are fully awake. Your drip will then be discontinued. You may also have a catheter to drain the bladder. You can expect pain and discomfort in your lower abdomen for the first few days after the operation. You may experience shoulder tip pain from the gas trapped under your rib cage. This is the gas used to distend your tummy during the operation and is common following laparoscopic (key hole) surgery. You will be given pain killers to alleviate this.

Day 1 after the operation

The nursing staff will assist with washing as necessary and encourage early mobilisation. We would normally expect you to sit out of bed and begin to walk around the day after your operation. The drip, drain and catheter are usually removed. You will be asked to pass urine in a jug and will have a scan to measure how much urine is left in the bladder. It helps to forget that you need to pass urine and drink and walk as you would normally do, and this when your bladder is likely to work as normal.

You will have 2-4 small dressings on the cuts in your abdomen. These will be removed the day after your operation and you will be able to shower. You may experience trapped wind which can cause discomfort. Peppermint water, getting up and walking around will help this.
You may also find it difficult to open your bowels at first. You can have mild laxatives to soften your stools and prevent constipation and straining.

What about going home?

You will be seen and assessed the following day to check on your recovery and decisions will be made about your care. This information will be shared with you. Please feel free to ask questions about your operation and recovery at any time.

The average length of stay following a laparoscopic utero-sacral suspension is 1-2 days. As you physically recover from your operation, the nursing team will discuss your convalescence. To ensure you have a good recovery you should take note of the following:

Rest:
During the first two weeks at home it is common to feel tired, exhausted and emotional. You should relax during the day gradually increasing the number of things you do each day. Avoid crossing your legs when you are lying down.

Vaginal bleeding:
You might have some vaginal discharge/bleeding for 1-2 days after surgery, but this should settle quickly.

Stitches:
The wounds will be closed by stitches which are usually dissolvable. If after 7 days you notice the stitches have not dissolved then they will need to be removed.

This is normally done by your Practice Nurse, but you need to make an appointment. We advise that you shower daily and keep the wound clean and dry. There is no need to cover the wound with a dressing.

Housework:

Weeks1-2: We recommend that you do light activities around the house and avoid any heavy lifting (not more than 1.5kgs in each hand).

Weeks 3-4: We recommend that you gradually introduce lighter household chores, dusting, washing up, making beds and ironing. You may begin to prepare food and cook remembering not to lift any heavy items.

Weeks 4-6: By this time you should resume normal daily activities, but refrain from straining and heavy lifting for 3 months to ensure good healing.

Exercise:

Exercise is important and it is advisable to go for short walks each day, increasing the distance gradually. You will be able to manage the stairs on your arrival home.

We encourage you to do pelvic floor exercises. You will be given a physiotherapy booklet titled ‘Fit for Life’ to guide you.

Diet:

A well balanced nutritious diet with high fibre content is essential to avoid constipation. Your bowels may take some time to return to normal after your operation and you may need to take laxatives.

You should include at least 5 portions of fruit and vegetables per day. You should aim to drink at least 2 litres of water per day.

Sex:

You should usually allow 4-6 weeks after the operation before having sex for the vagina to heal in its new supported position.

If you experience dryness, you may try a vaginal lubricant from your local pharmacy. If after this time you are experiencing pain or any problems with intercourse then you should see your GP.

Returning to work:

This will depend on the nature of your work. If you work in an office base environment, you will need 4–6 weeks off work. If your work involves lifting and exertion, you will need 3 months off work.
You will be provided with a sick note for this period.

Driving:

It is usually safe to drive after 6 weeks but this will depend on your level of concentration, ability to perform an emergency stop and your car insurance policy.

What about follow up?

You will be invited for follow up, usually at Lewes Victoria Hospital about 12 weeks after surgery. If you have problems before this you can either contact your doctor or contact the hospital to bring the appointment forwards.

During this follow up appointment, your symptoms will be reviewed and you will be examined to assess wound healing. The quality of life will be checked.

Are there any alternatives to having a laparoscopic utero-sacral suspension?

You may decide not to have surgery. You will have had the option of pelvic floor muscle training with a specialist physiotherapist before surgery is considered. Weight loss, avoidance or reduction of straining / lifting, attention to bowel habit and vaginal pessaries should have been discussed with you.

Alternative procedures include:

- Sacrospinous fixation of the uterus. This operation is done vaginally (from down below).

- Sacrohysteropexy, where the cervix (neck of the womb) is suspended to the top of the sacrum (bone at the back of the pelvis).

  This operation can be done using a strip from the abdominal (tummy) wall, rather than mesh, in view of the concern about using mesh.

  The operation can be done through a cut across the tummy (open surgery) or through the laparoscope (key hole).

These can be discussed with your doctor.

Who can I contact with any concerns or questions?

You should contact your doctor or the hospital if you notice increased temperature, wound swelling and/or pain, smelling discharge either from the wound or the front passage, blood in urine or motion, abdominal distension and/or failure to open your bowel.

If you have any problems or questions, you can contact
The Urogynaecology Unit at Lewes Victoria Hospital
on 01273 474 153 Ext. 2178

The Gynaecology Ward at the Princess Royal Hospital
on 01444 441 881 Ext. 5686

The Gynaecology Ward at the Royal Sussex County Hospital
on 01273 696 955 Ext. 4013

References/useful links

https://www.yourpelvicfloor.org/media/Uterosacral_Ligament_Suspension_RV1-1.pdf

This leaflet is intended for patients receiving care in Brighton & Hove or Haywards Heath

This patient information leaflet was prepared by Dr. Sharif Ismail, Consultant Subspecialist Urogynaecologist

This information leaflet has been approved at the Clinical Governance and Safety and Quality Meetings of the Department of Obstetrics and Gynaecology as well as Brighton and Sussex University Hospitals NHS Trust Carer and Patient Information Group (CPIG).

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