

Laparoscopic Sacrohysteropexy

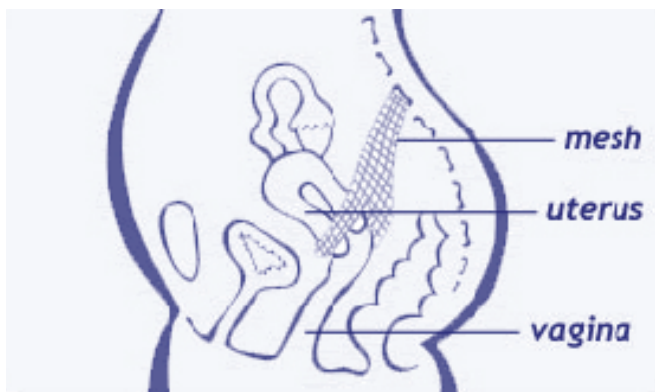
Department of Gynaecology

What is a laparoscopic sacrohysteropexy?

This is an operation carried out to correct uterine prolapse, in patients who do not wish to have hysterectomy. It 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 a laparoscopic sacrohysteropexy?

The operation is intended to support the uterus and correct associated vaginal prolapse. This is achieved by attaching the back of the cervix to the top of the lower back bone. This will improve associated urinary, bowel and/or sexual problems.



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 your 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. It is not unusual to feel anxious; the nursing staff will gladly discuss how you are feeling and talk you through your emotions.

If you have not already completed a quality of life questionnaire, you might be asked to do so before surgery. You will be provided with further copies to complete before your follow up appointment. This will help monitoring your progress before and after surgery. 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.

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 may be made below the left side of the chest wall. Another small cut (1 cm) is made in the hair line at the bikini line. 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.

Through these cuts, the back of the cervix is lifted up and attached to the top of the lower back bone. The attachment is made using synthetic material. At the end, all instruments are removed and all wounds are closed.

A cut is made in the front and/or back walls of vagina to tighten the supporting layer around the bladder and/or bowel. The wounds are closed after that.

What are the risks?

There are risks with any operation but these are small. The main risks associated with a laparoscopic sacroco hysteropexy 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 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.

Uncommon risks:

- Wound infection, which may require antibiotics.
- Bruising and delayed wound healing.
- Urinary tract infection. This may happen as a result of passing a catheter to drain the bladder and is treated with antibiotics.
- Inability to complete the operation through the key-hole, which may necessitate laparotomy (open tummy) approach.
- The synthetic material used to lift the uterus may erode into the vagina, bladder or bowel. This is very rare but may require excision of the eroding mesh. It can also get infected. This is also rare but may require removal of the mesh.
- The bladder and/or bowel rarely get injured during the operation and these are usually repaired at the time. If such injury is not identified and repaired at the time, there is a risk of fistula, but this is extremely rare.
- Pelvic abscess or infection.

- Late onset difficulty passing urine. This may manifest days or even weeks after being able to pass urine smoothly. The management is the same as initial difficulty passing urine, either by using a catheter with a leg bag and/or clean intermittent self catheterisation.
- Deep vein thrombosis and pulmonary embolism (blood clots in the leg veins / lung) can happen after any major operation. You will be asked to wear elastic stockings and given injections to prevent these clots. If you do develop such clots, you will be given more injections.
- Hernia at site of entry.
- Bleeding requiring blood transfusion. Sometimes, bleeding only becomes apparent after surgery and requires returning back to theatre.
- Whilst the operation may improve the sense of bulge, there is small chance that urinary, bowel and/or sexual problems may persist. It is hoped however they will at least improve to some degree.
- Unmasking of stress incontinence of urine (leakage of small drops of urine on coughing and sneezing) that was hidden by the kink of the urethra, associated with prolapse. This will need assessment and will be managed by pelvic floor exercises. If it persists despite these exercises, it may require a small operation to insert a mid-urethral tape sling, like tension-free vaginal tape (TVT) sling, to support the urethra.
- The operation may fail or prolapse may recur with time. The operation however is the most effective and durable method to correct the condition. Recurrence of bulge may be due to development of prolapse in an area of the front passage that was not repaired at the time. It is therefore advisable to support the front and back walls of the vagina at the same time.

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 pump (Patient Controlled Analgesia) 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 will 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, 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 remove the gauze pack from the vagina (front passage), 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 (plastic tube) that drains the bladder (water works) usually come out. 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 (waterworks).

The key to the success in this respect is to forget that you need to pass urine and drink and walk as you would normally do, and this when your bladder (waterworks) is likely to work as normal. You will have 2-4 small dressings on the cuts in your abdomen that 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 and getting up and walking around will help this. You may also find it difficult to open your bowels at first, we will give you mild laxatives to soften your stools and prevent constipation and straining.

What about going home?

You will be seen and assessed by the gynaecology team the following day to check on your recovery and decisions will be made about your care, this information will be shared with you. You may then be able to go home. Please feel free to ask questions about your operation and recovery at any time.

The average length of stay following a laparoscopic sacrohysteropexy 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 few days after surgery. This is like a light period and is red or brown in colour. Sanitary towels, rather than tampons, should be used, to reduce the risk of infection.

Stitches: The cut across your tummy 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 and you will 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. The cuts in the vagina (front passage) are also closed with dissolvable sutures.

Housework:

Weeks 1-2 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 and integration of the mesh into your own body tissues.

Exercise: Exercise is important and it is advisable to go for short walks each day, increasing the distance gradually. You may return to light exercise, such as gentle cycling and swimming after 4-6 weeks. However, you should avoid heavy straining for 3 months. 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 a 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. This will allow the cuts in the vagina (front passage) to heal. 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 three months off work. The hospital doctor will provide a sick certificate for this period.

Driving: It is usually safe to drive after 12 weeks but this will depend on your level of concentration and ability to perform an emergency stop and your car insurance policy.

What about follow up?

You will be invited for follow up, usually 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 frequency volume chart and quality of life will be checked.

Are there any alternatives to having a laparoscopic sacrohysteropexy?

You may decide not to have surgery and want to try vaginal pessaries to control the prolapse without having to have an operation.

Alternative forms of surgery include:

- Abdominal sacrohysteropexy, which is the same operation performed abdominally (through a cut across the tummy).
- Vaginal repair with sacrospinous hysteropexy. In this operation, the prolapse (slipping down) is corrected vaginally (from down below) and the back of the uterus (womb) is fixed to a ligament (band of fibrous tissue) in the pelvis.

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 distention and/or failure to open your bowel.

If you have any problems or questions, please use the telephone numbers below to contact us.

Princess Royal Hospital: 01444 441881 Ext. 4013

Royal Sussex County Hospital: 01273 696955 Ext. 4013

Urogynaecology Unit at Lewes Victoria Hospital: 01273 474153 Ext. 2178

Useful links:

www.bsug.org.uk/userfiles/file/patient-info/Sacrohysteropexy%20for%20Uterine%20Prolapse-%20SHP%20BSUG%20F1.pdf

www.patient.co.uk/doctor/Genitourinary-Prolapse.htm

www.nature.com/nrurol/journal/v7/n11/full/nrurol.2010.164.html
publications.nice.org.uk/insertion-of-mesh-uterine-suspension-sling-including-sacrohysteropexy-for-uterine-prolapse-repair-ipg282

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