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Laparoscopic mesh sacrocolpopexy

An operation for prolapse of the vaginal vault

Urogynaecology and Pelvic Floor Unit

Women's Health

uclh

If you require the services of an interpreter, contact us on 020 3447 4735. We will do our best to meet your needs.

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1 Introduction

Vaginal vault prolapse is a condition that can affect women who have had a hysterectomy. The vaginal vault is the very end of the vagina internally. Vaginal vault prolapse means that the vaginal vault bulges downwards. You may feel that 'something is coming down' in the pelvis, or have symptoms of a lump or bulge in the vagina. Vaginal vault prolapse can sometimes affect how your bladder or bowels work.

This leaflet provides information about an operation called laparoscopic mesh sacrocolpopexy. It is one of the operations that we offer to treat prolapse of the vaginal vault. This leaflet has been made to help you understand why this operation has been recommended and what surgery might involve.

This leaflet contains information from medical research studies and guidance from independent organisations that specialise in this type of surgery. We have tried to simplify this information and make it easy to understand for patients. We hope that this leaflet will help you decide if you want to go ahead with surgery.

We will review this information every two years. This is to make sure that any information from new research studies is included. We may do this sooner if we think important new information becomes available that you need to be aware of.

2 What does laparoscopic mesh sacrocolpopexy mean?

Laparoscopic mesh sacrocolpopexy is an operation that lifts the vagina up into a more normal position. Using keyhole surgery, a soft plastic mesh is wrapped around the vagina. The mesh is then lifted up and fixed to a ligament on the bone at the bottom of the spine. This moves the vagina back into position.

3 How can a laparoscopic mesh sacrocolpopexy help?

If you have symptoms of vaginal vault prolapse, this operation is likely to help you. No operation will work for everybody. Rarely, the vagina will not stay in place and your prolapse will continue to cause problems after surgery. Sometimes, surgery works well initially but the problems start again some time later.

The most reliable medical research studies (called randomised trials) have shown most women are satisfied after surgery.

- Two years after surgery, around 90 out of 100 women will have no further symptoms of vaginal prolapse.
- Seven years after surgery, around 75 out of 100 women will have no further symptoms of vaginal prolapse.

Surgery may help with other problems and many women describe less leakage of urine after surgery. This includes leakage on coughing, sneezing, or activity, which is known as 'stress urinary incontinence'. It may also help with having to suddenly rush to the toilet to pass urine and not making it in time. This is known as 'urinary urgency'.

- Around 60 out of 100 women will describe improvements in stress urinary incontinence after surgery.
- Around 75 out of 100 women will describe improvements in urinary urgency after surgery.

Some women have difficulty emptying their bladder. Around 80 out of 100 women find that this improves after surgery.

Finally, if you have problems with your bowels, they may improve after surgery. In research studies, around 80 out of 100 women reported improvements. You might have better control over your bowels, less trouble emptying your bowels, or even less leakage.

4 What are the risks of laparoscopic mesh sacrocolpopexy?

All treatments and procedures have risks and we will talk to you about the risks of laparoscopic mesh sacrocolpopexy. Problems that occur during or after surgery are called complications. These are undesirable or unwanted effects that happen as a result of surgery. If a complication affects you, it does not mean that something must have gone wrong during the surgery. If you have a complication, you can expect us to explain what has happened, and whether any further treatment is required. We always provide additional care and support for patients who experience problems after an operation.

We will use numbers to explain how often we might expect problems to happen after laparoscopic mesh sacrocolpopexy. For example, a '10 in 100' chance of a problem means that if we performed 100 operations, the problem would happen 10 times. This is the same as a 10 per cent chance.

Problems that may happen straight away

Bleeding during surgery

- Bleeding that might need a blood transfusion: 1 in 100.

Infections after surgery

- Urine infection immediately after surgery: 10 in 100.
- An infection of the small 'keyhole surgery' wounds: 1 in 100.
- Infection inside the pelvis, infection of the mesh or infection of the bone where the mesh is attached: This has been reported in published research studies but we do not know how often this happens. It is likely to be very uncommon.

How are infections treated? Most infections are easily treated with antibiotics. A serious infection might need a second operation and the mesh might have to be removed. Bone infections can be difficult to treat. Life-threatening infections after prolapse surgery are extremely rare.

Damage to other organs during surgery

- Damage to bladder or bowel: 1 in 100.
- Damage to the ureters: We are not certain how often this happens. The risk is probably less than 1 in 100 based on information from similar operations.

The ureters are the tiny tubes that carry urine from the kidneys to the bladder.

If you are affected, the damaged organs will be repaired during the operation. Sometimes a cut on your abdomen called a laparotomy is needed in order to fix things. If your bowel is damaged we cannot safely use mesh. If this happened, we might use stitches to try and repair the prolapse. If this were not possible, you would need to come back for a second operation to fix the prolapse.

How is bladder damage repaired? We use stitches to repair the bladder. A catheter tube is left in the bladder for around two weeks afterwards whilst the bladder heals.

How is bowel damage repaired? Bowel is usually repaired using stitches. Rarely, a small piece of bowel has to be removed. We would not expect this to cause any long-term problems. If the damage is serious, a stoma might be required. This is an opening on the front of your abdomen that diverts your faeces into a bag whilst the bowel heals. The stoma would be a temporary measure whilst the bowel heals. The stoma is usually reversed within a few months.

What happens if my ureters are damaged? Damage to the ureters is repaired with stitches. Tiny plastic tubes, known as stents, are placed inside the ureters whilst they heal. Rarely, it may be necessary to perform a bigger operation to change how the ureters and the bladder are connected to fix things. This is known as a 'ureteric re-implantation'. If this happens, you may need to see a specialist for a regular check up after your surgery. This is to make sure you do not develop any problems after the repair.

Rarely, damage might occur that is not recognised during the operation. If this happened, you might experience no symptoms, or you could become ill after your surgery. You would need extra tests to find out if this was the case. You might need another operation to repair the damage.

Bladder symptoms after surgery

Some women have bladder symptoms as well as prolapse and these symptoms are likely to improve after your surgery. Unfortunately, a small number of women will find that things get worse.

These problems might include:

- New or worsening stress urinary incontinence that patients request further treatment for: 10 in 100.
- New or worsening urinary urgency that patients request further treatment for: 5-10 in 100.
- New or worsening problems with bladder emptying: 1 in 100.

How are bladder symptoms treated? Bladder symptoms after surgery often improve in time. Problems with stress urinary incontinence usually respond to pelvic floor physiotherapy. Further surgery is sometimes needed. Urinary urgency is usually helped by medication or other non-surgical treatments. Difficulty emptying the bladder generally settles down quickly. You might need a catheter tube to be left in the bladder if this happens. In research studies, this problem has not lasted more than a week or two. Although unlikely, it is always possible that the problem could last longer.

Bowel symptoms after surgery

Some women have bowel symptoms as well as prolapse. Most will find that after surgery, things are the same as before. Some women report improvements after their operation. Sadly, a small minority of women might find that things get worse.

These problems might include:

- New problems emptying the bowel, or having to rush to the toilet without warning: 5 in 100.
- New problems with leakage of gas or faeces: 1-2 in 100.

If you already have bowel symptoms, there is a chance they could worsen after surgery. We are not sure how often this happens but we think it might affect up to 10 in 100 women.

How are persistent bowel symptoms treated? If you experience new bowel symptoms after surgery, or existing symptoms get worse, they might get better on their own. Constipation is normally treated with laxatives. If you have other troublesome symptoms, we may ask one of our bowel specialists to see you. They may recommend medication, or other non-surgical treatments.

Pelvic pain or problems with painful sexual intercourse

If you do not have problems with pelvic pain or painful sexual intercourse before surgery, it is unlikely that you will have problems afterwards. The risk of developing problems is low:

- New or worsening pelvic pain: 5 in 100.
- New or worsening painful sexual intercourse: 5-10 in 100.

If you already experience chronic pain in other areas of the body, the risk of pain after surgery might be higher.

What happens if I have persistent pain? You will be checked to see if there is a problem with the operation, or another cause. If no problem is found the pain could be coming from nerves that have been irritated by surgery. If this happens, you will be referred to a specialist in pain medicine and you may be prescribed medication. Painful sex can also be caused by a lack of hormones in the vagina. This can be treated with a hormone cream or tablet. Sometimes a little scarring can develop in the vagina after surgery. This can also cause painful sex. This often improves with time but using vaginal dilators might help. Further vaginal surgery is rarely needed. Despite these treatments, pain can occasionally be a long-term problem.

Problems that may happen later

Your prolapse might come back

Two years after surgery, only 10 in 100 women have symptoms of vaginal prolapse. This includes prolapse of the vaginal vault, and the front and back vaginal walls. One study has suggested that by seven years, up to 25 in 100 women might complain of prolapse again. If this happens, you may need further treatment.

Mesh exposure and erosion

The mesh used in laparoscopic mesh sacrocolpopexy is called polypropylene, which is a type of plastic. This mesh has been used in hernia surgery for many years. The use of mesh can be associated with some specific complications. These include problems with mesh exposure in the vagina and mesh erosion into the bladder or bowel.

Vaginal exposure means that the mesh becomes visible through the vagina. Mesh erosion means that the mesh 'cuts through' into the bladder or bowel. This can sometimes happen many years after the mesh is inserted.

These complications can cause pain, painful sexual intercourse, vaginal discharge, infections, and other bowel and bladder problems. The risk of these problems is:

- Mesh exposure in the vagina: 5 in 100.
- Mesh erosion into bladder or bowel: We are not certain how often this happens but it is uncommon. The risk is probably 1-10 in 1000.

We do not know exactly why problems with exposure or erosion happen. There may be some form of 'foreign body reaction'. This means that your body is reacting to the presence of the mesh. The area then becomes inflamed. At the time of writing, there is no evidence that implanting mesh in the body can cause problems with your general health.

Some doctors implant mesh through a cut in the vagina during prolapse operations. The risk of mesh complications appears to be much higher when it is inserted this way. Laparoscopic mesh sacrocolpopexy is a completely different operation to vaginal mesh prolapse surgery. Putting the mesh in through the abdomen using keyhole surgery reduces the risk of mesh complications.

How is mesh exposure in the vagina treated? Mesh exposure in the vagina soon after surgery often heals on its own. We may recommend a vaginal hormone cream or tablet to help with the healing process. If things do not get better, some women need an operation. This is to trim the mesh and stitch the skin back over the area. Most of the time, the surgery is completed through the vagina. Occasionally, another keyhole operation is needed. If this were a recurrent problem, a larger piece of mesh would need to be removed to fix things.

What if the mesh erodes into the bladder or bowel? Erosion of the mesh into the bladder or bowel would need more major surgery to remove. You may need a laparotomy, which is a cut on your abdomen. If the mesh were in the bladder, the bladder would be cut open to remove it. After surgery, a catheter tube would need to stay in place until the bladder had healed. If the mesh were in the bowel, the bowel would need to be cut open. You may need a segment of bowel removed. A stoma would probably be needed for a few months after surgery. This is an opening on the front of your abdomen that diverts your faeces into a bag whilst the bowel heals. The stoma is usually reversed within a few months. Thankfully, erosion into the bowel or bladder is rare.

Problems that are rare, but serious

- Damage to major blood vessels and life-threatening bleeding: 1 in 1000.

- Blood clots in the legs that can travel to the lungs: 5 in 1000

What happens if I develop a blood clot? After surgery, blood becomes stickier, and clots more easily. Blood clots can form in the legs, break off, and travel through the bloodstream to the lungs. These blood clots stop the lungs working properly, causing breathing difficulties. This condition is known as 'venous thromboembolism'. If this happens, your hospital stay will be prolonged, and you will be given blood-thinning medication for a few months. Thankfully, the condition is only life-threatening for a very small number of affected patients. To reduce the risk of this problem, you will wear special stockings on your legs, and receive a small, daily injection of blood thinning medication in hospital.

Problems with the anaesthetic

You will be given a general anaesthetic for your operation. This means that you will be unconscious and will not feel anything during your surgery. Anaesthetists are doctors who specialise in anaesthetics. Your anaesthetist will give you your anaesthetic medication and gently place a tube through your mouth into your throat. This is to keep your windpipe open so oxygen can get to your lungs.

Some problems are very common after an anaesthetic. They normally settle down very quickly after surgery or are easy to treat. Sore throat or throat pain, feeling sick and vomiting, or shivering after surgery, can affect up to half of patients. Some problems are more likely to affect certain groups of patients. If you are older, overweight, a smoker, or have other medical problems, you are more likely to be affected:

- Chest infection after surgery: 1-10 in 100.
- Permanent nerve damage: 1 in 1000.
- Permanent loss of sight: 1 in 100,000.
- Death as a result of anaesthesia: 1 in 100,000.

Older patients, especially those with dementia, poor eyesight or hearing, can become confused after an operation. It is not known how often this happens.

Damage to the lips and tongue may occur but this is usually minor. Tooth damage is more likely to happen if you have diseased teeth and gums, or have had extensive dental work:

- Damage to the lips and tongue: 5 in 100.
- Damage to teeth: 5 in 10,000.

Some problems can happen to anyone as a result of an anaesthetic:

- The eyeball getting grazed or damaged: 4 in 10,000.
- Being aware of what is happening during surgery despite the anaesthetic: 5 in 100,000.

Life-threatening allergic reaction: 1 in 10,000.

5 What will happen if I choose not to have laparoscopic mesh sacrocolpopexy?

If you decide not to have this operation you could simply carry on as you are. You will continue to have symptoms of prolapse. Whilst these symptoms can be distressing, you are unlikely to come to any harm.

6 What alternatives are available?

The alternatives to laparoscopic mesh sacrocolpopexy are:

- Pelvic floor physiotherapy.
- A vaginal pessary.
- Sacrospinous colpopexy.

Will physiotherapy work? We recommend four months of physiotherapy to see if it works. You will be taught how to strengthen your pelvic floor muscles with an expert physiotherapist. Around 50 in 100 women will report improvements in their symptoms. Half of these women will find that their symptoms go away completely. If you keep doing the exercises, they seem to keep working. If you stop, your problems will come back. If you have a large prolapse, physiotherapy will not work.

What about a pessary? It is a device made of flexible plastic or silicone. Pessaries are inserted into the vagina to stop your prolapse coming down. If you use a pessary, you will need a check up every six months so that your vagina can be examined. Pessaries can sometimes rub on the vaginal walls, or cause a little bleeding or discharge. This affects around 5 in 100 women. Rarely a minor infection can develop. Pessaries can be safely used long term. You can learn to remove and replace the pessary yourself. This is helpful if you only use it at certain times when your symptoms are worse. Some women remove their pessary overnight. Sex is possible with some pessaries still inside. If you learn to remove the pessary yourself, you can take it out before sex.

What is a sacrospinous colpopexy? This operation is performed through the vagina. The vaginal vault is attached to a strong band of tissue in the pelvis called the sacrospinous ligament. A strong stitch is used rather than mesh. Sacrospinous colpopexy seems to be less effective than laparoscopic mesh sacrocolpopexy. In research studies comparing the two operations, more women complained of prolapse again after sacrospinous colpopexy. Painful sex and urinary leakage were also more common after sacrospinous colpopexy. Despite these problems, satisfaction with surgery was still good. If you do not want mesh used, you might prefer sacrospinous colpopexy. If we think that keyhole surgery might be complicated, we sometimes recommend sacrospinous hysteropexy.

Sometimes your doctor may suggest that one treatment might be better than another in your particular case. They will obviously provide you with the reasons why this is so.

7 How should I prepare for laparoscopic mesh sacrocolpopexy?

The Preoperative Assessment Clinic (PAC)

Before your operation, you will be seen in the PAC to make sure that you are fit for your surgery. Specialist nurses and anaesthetists run the clinic. This normally happens a few weeks before your operation. When you come to your appointment, you should bring the following:

- A list of your medical conditions and previous operations.
- A list of your current medications and allergies.

What if the PAC finds a problem? Occasionally, a new health problem is found. Sometimes, an existing problem may need further treatment before surgery. If this happens, your surgery will need to be delayed. Your GP will be asked to arrange any extra tests, treatment, or consultations with other specialists. Whilst we understand how disappointing this might be, the PAC team are there to make sure your surgery is conducted safely. If your operation is delayed, we will arrange another date for you as quickly as possible when you are cleared for surgery. Unfortunately, we are unable to speed up any tests or extra appointments requested by PAC.

Sometimes, certain types of medication need to be stopped before your operation. The team in PAC will tell you if any of your medication needs to be stopped and which ones you should take on the day of your operation. **Please do not stop any medication before your operation unless you are asked**

to do so. Stopping important medication before your surgery may mean that your operation is cancelled or you come to harm.

Some patients may need to take additional medication the day before their surgery to clear their bowels. This is called ‘bowel preparation’. Not all patients require bowel preparation and if is needed, we will discuss it with you before your operation.

The day of your surgery

On the day of surgery, you will come to the Surgical Reception on the First Floor of University College Hospital at 07:00 in the morning. You will receive a letter confirming these details. Your operating surgeons will see you for final checks. Please note that your operating surgeon may not be the same specialist as you saw in clinic. The nurses will then prepare you for your surgery. You may be given an enema to clear out the lower bowel before your operation. You will not need this if you took bowel preparation.

On the day of surgery, you should follow the instructions given to you at the PAC appointment about the following:

- Which medications to take on the morning of surgery.
- When to stop eating and drinking before your surgery.

If you are confused about any of the instructions, you must contact them before your surgery. Their details are at the end of this leaflet.

- Bring your regular medications along with you.
- Pack a bag with clothes and toiletries for your stay.
- Bring the copy of your consent form that we gave you.

Please be aware that your surgeons will be operating through the day until 19:00. They are often unable to leave the operating

theatre between patients. For this reason, they see all patients in the morning, even if surgery is planned for later in the day.

If your surgery is in the afternoon, you may be allowed to drink some water. You might also be able to leave the Surgical Reception for a little while until you are due for surgery. Please do not drink, or leave the Surgical Reception, until instructed to do so. Drinking at the wrong time may mean that your operation is cancelled.

There is a very small chance that your surgery may be cancelled on the day you come in to hospital. This might happen because the hospital is full and there is no bed for you. This is uncommon but obviously very distressing if it occurs.

Whilst beds often become available as the day passes, this is not always the case. If it looks like your surgery will have to be cancelled, we will let you know as early as we can. We will then work with our management team to rearrange your surgery as soon as possible.

Making plans for after your surgery

Please make plans well in advance:

- You will be in hospital for one or two nights. Up to two people can visit you in hospital between 09:00 and 20:00 every day.
- Please ensure that your travel plans are flexible. Remember that your stay might also be extended on medical grounds.
- You will need an escort to help you get home and you will not be able to use public transport to get home alone.
- You will need four weeks off work. If you have a very strenuous job you may need slightly longer to recover.
- You should avoid carrying anything heavier than 5kg during this time.

- You will need friends and family to help with groceries and household chores, particularly in the first week or two.

Unfortunately, we will be unable to extend your hospital stay if you have not made transport arrangements. If you already use hospital transport because of a medical illness, we will be able to help arrange this. Unfortunately, hospital transport is not available for other patients.

8 Asking for your consent

We want to involve you in all the decisions about your care and treatment. If you decide to go ahead with treatment, by law we must ask for your consent and will ask you to sign a consent form. This confirms that you agree to have the procedure and understand what it involves. Staff will explain all the risks, benefits and alternatives before they ask you to sign a consent form. If you are unsure about any aspect of your proposed treatment, please ask to speak with a senior member of staff again. Our contact details are at the end of this leaflet.

9 What happens during a laparoscopic mesh sacrocolpopexy?

The operation takes around two hours and is performed using ‘keyhole surgery’.

- Four or five small cuts are made on the abdomen and special tubes, known as ‘ports’, are placed through these cuts.

- A tiny camera and special operating instruments are inserted through the ports.

- Pictures of the inside of the abdomen are sent from the camera to television screens that the surgeons watch.

- A woven plastic mesh, which feels like strong fabric, is inserted into the pelvis through one of the small ports.

- One end of the mesh is attached to the vagina using stitches.
- The other end is pulled up, lifting the vagina to a more normal position. It is then attached to the bone at the bottom end of the spine using tacks to keep it in place.
- Finally, the mesh is covered using peritoneum, which is the thin, stretchy tissue that lines the inside of your abdomen.
- You will have a drip in your hand and a catheter tube in the bladder. These will normally be removed within 24 hours.

10 What should I expect after laparoscopic mesh sacrocolpopexy?

The first two weeks after surgery

- You will need to rest and take regular painkillers.
- You should take regular medicine, known as a laxative, to keep your bowels opening every day.
- You will spend much of your time at home but you may take short walks. You should avoid anything strenuous and lifting anything heavier than 5kg.
- You should try to shower, rather than have a bath, to allow the keyhole stitches to heal. If you do take a bath, do so in shallow water for a maximum of ten minutes.
- You can remove the plasters from the keyhole scars after three days and then keep the areas clean and dry.

You will receive a telephone clinic appointment through the post. This is normally scheduled for two to three weeks after surgery. The urogynaecology nurses will call you by phone on this day to check on your progress. We will give you a two-week supply of painkillers, laxative medication, and any other drugs

you will need at home. If you need further supplies after you have gone home, you will need to contact your GP.

Weeks two to four after surgery

- You will be able to reduce your regular painkillers, start taking them only if needed, and eventually stop using them.
- You will continue to use your laxatives to keep your bowels opening daily. If you can do this by eating plenty of fruit and fibre, and drinking enough water, you can stop the laxatives.
- You can increase your activity, go out for longer walks, and visit friends and family, provided you take things easy.
- You will continue to avoid lifting anything heavier than 5kg.
- You can start driving again but you should inform your insurance company that you have had surgery. They must be happy for you to drive again. You should only start driving again if you feel safe to do so. You must be able to perform an emergency stop if needed.

Four weeks onwards

- You can get back into your normal routine and return to work. If you have a strenuous job, you may need slightly longer to recover. Please let us know if this is the case.
- If you exercised regularly before your surgery, please discuss this with us before you go home. We might suggest some changes to your usual exercise programme.
- You can start having sexual intercourse after six weeks.
- We will send you a clinic appointment through the post for three months after your surgery. At the appointment, we will ask you how things are and examine you.

What serious problems should I look out for? Serious problems after surgery are rare but they need to be checked urgently. If you develop the following symptoms, you should go to your nearest Accident and Emergency department.

- High fever.
- Repeated vomiting.
- Pain in the abdomen that is getting worse.
- Swelling of the abdomen that is getting worse.
- You are unable to pass urine or pass very little.
- Swelling, redness, or tenderness in the lower legs.
- Difficulty breathing, or chest pain.

If you have to go to hospital, please contact the urogynaecology nursing team afterwards to let them know. Their contact details are below.

What I have other less urgent problems? You should discuss these problems with the urogynaecology nursing team or your GP within 24 hours. Such problems might include:

- Burning when you are passing urine.
- Difficulty passing urine.
- Not opening your bowels for three days.
- Redness around your abdominal wounds.
- A smelly vaginal discharge.

The urogynaecology team will return telephone calls and messages the same day, or the next working day. You should ring them first if you have problems. If you call them on Friday and do not hear back the same day, you should see a GP. At the weekend, you should see a GP or go to Accident and Emergency if there is no other help available.

11 Where can I get more information?

The British Society of Urogynaecology

Website: www.bsug.org.uk/patient-information.php
Email: bsug@rcog.org.uk
Telephone: 020 7772 6211
Fax: 020 7772 6410

The National Institute for Health and Care Excellence

Website: www.nice.org.uk/guidance/ipg282/informationforpublic
Email: nice@nice.org.uk
Telephone: 030 0323 0140
Fax: 030 0323 0748

The International Urogynecological Association

Website:
http://www.iuga.org/general/custom.asp?page=patientinfo
Email at: www.iuga.org/general/?type=CONTACT

UCLH cannot accept responsibility for information provided by other organisations.

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Space for notes and questions

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