

Operations for Prolapse of the Vaginal Apex:

Sacrospinous fixation of the vaginal vault

Sacrospinous fixation of the uterus

Patient Information Leaflet

BSUG Patient Information Sheet Disclaimer

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We will endeavour to update the information sheets at least every two years.

Vaginal Vault / Apex Prolapse

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Describe your expectations from surgery

About this leaflet

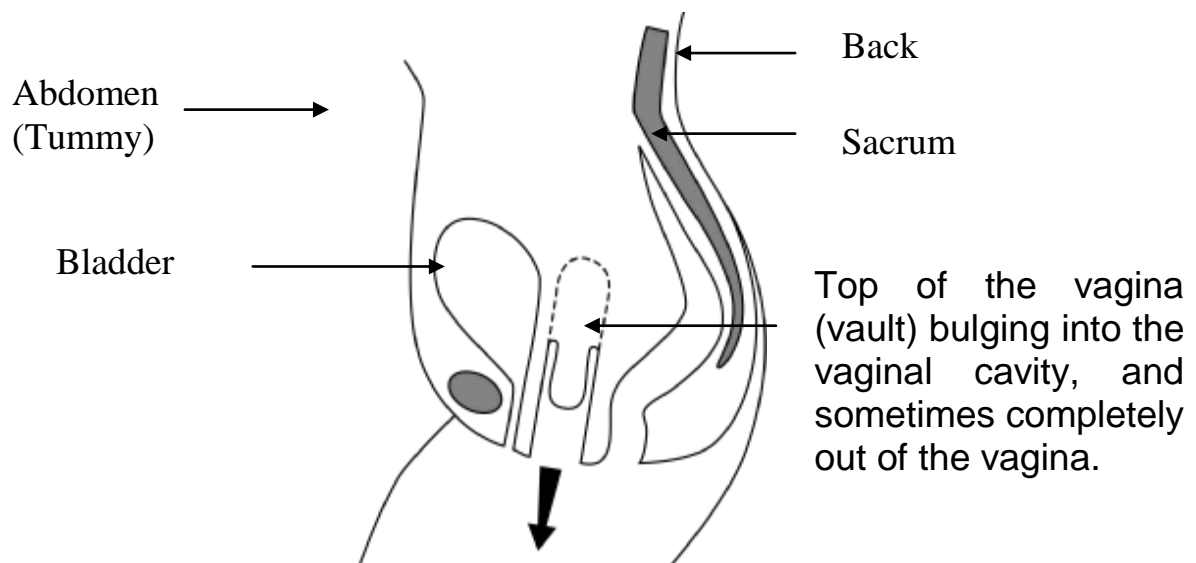
We advise you to take your time to read this leaflet, any questions you have please write them down on the sheet provided (towards the back) and we can discuss them with you at our next meeting. It is your right to know about the operations being proposed, why they are being proposed, what alternatives there are and what the risks are. These should be covered in this leaflet.

This leaflet firstly describes what a Vaginal Vault Prolapse is, it then goes on to describe what alternatives are available within our trust, the risks involved in surgery and finally what operation we can offer.

What is Prolapse of Vaginal Apex

- A prolapse is where the vaginal tissue is weak and bulges downwards into the vagina itself. In severe cases it can even protrude outside the vagina
- The apex is the deepest part of the vagina (top of it) where the uterus (womb) usually is located. If you have had a hysterectomy then the term (Vault) is used to describe the area where your womb would have been attached to the top of the vagina (front passage). A vaginal vault prolapse is a prolapse arising from the vaginal vault (see diagram below).

Figure 1 - a diagram sideways on showing the normal anatomy (dotted line) and a prolapsing vaginal vault (continuous line)



- It is often accompanied by a Posterior Vaginal Wall Prolapse, either a High Posterior Vaginal Wall Prolapse called a Enterocoele, or a Low Posterior Vaginal Wall Prolapse called a Rectocoele, or sometimes both.
- The pelvic floor muscles are a series of muscles that form a sling or hammock across the opening of the pelvis. These muscles, together with their surrounding tissue, are responsible for keeping all of the pelvic organs (bladder, uterus, and rectum) in place and functioning correctly.

- Prolapse occurs when the pelvic floor muscles or the vagina have become weak. This usually occurs after trauma of childbirth but is most noticeable after the menopause when the quality of supporting tissue deteriorates.
- With straining for e.g. on passing a motion, the weakness described above allows the vault of the vagina to bulge downwards and the rectum (back passage) to bulge into the vagina and sometimes bulge out of the vagina.
- Some women have to push the bulge back into the vagina with their fingers in order to empty their bladder or complete a bowel movement.
- Occasionally women find that the bulge causes a dragging or aching sensation.

Alternatives to surgery

- **Do nothing** – if the prolapse (bulge) is not distressing then treatment is not necessarily needed. 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.
- **Pelvic floor exercises (PFE).** The pelvic floor muscle runs from the coccyx at the back to the pubic bone at the front and off to the sides. This muscle supports your pelvic organs (uterus, vagina, bladder and rectum). Any muscle in the body needs exercise to keep it strong so that it functions properly. This is more important if that muscle has been damaged. PFE can strengthen the pelvic floor and therefore give more support to the pelvic organs. These exercises may not get rid of the prolapse but they make you more comfortable. PFE are best taught by an expert who is usually a Physiotherapist. These exercises have little or no risk and even if surgery is required at a later date, they will help your overall chance of being more comfortable.

Types of Pessary

- **Ring pessary** - this is a soft plastic ring or device which is inserted into the vagina and pushes the prolapse back up. This usually gets rid of the dragging sensation and can improve urinary and bowel symptoms. It needs to be changed every 4-6 months and can be very popular; we can show you an example in clinic. Other pessaries may be used if the Ring pessary is not suitable. Some couples feel that the pessary gets in the way during sexual intercourse, but many couples are not bothered by it.
- **Shelf Pessary or Gellhorn** - If you are not sexually active this is a stronger pessary which can be inserted into the vagina and again needs changing every 4-6 months.

General Risks of Surgery

- **Anaesthetic risk.** This is very small unless you have specific medical problems. This will be discussed with you.
- **Haemorrhage.** There is a risk of bleeding with any operation. The risk from blood loss is reduced by knowing your blood group beforehand and then having blood available to give you if needed. It is rare that we have to transfuse patients after their operation.
- **Infection.** There is a risk of infection at any of the wound sites. A significant infection is rare. The risk of infection is reduced by our policy of routinely giving antibiotics with major surgery.
- **Deep Vein Thrombosis (DVT).** This is a clot in the deep veins of the leg. The overall risk is at most 4-5% although the majority of these are without symptoms. Occasionally this clot can migrate to the lungs which can be very serious and in rare circumstances it can be fatal (less than 1% of those who get a clot). DVT can occur more often with major operations around the pelvis and the risk increases with obesity, gross varicose veins, infection, immobility and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood (heparin).

Specific Risks of this Surgery

- **Pain** - there may be short term buttock pain which may occur in approximately 25%, long term buttock pain occurs in around 1% of patients.
- **Damage to local organs** - this can include bowel, bladder, ureters (pipes from kidneys to the bladder) and blood vessels. This is a rare complication but requires that the damaged organ is repaired and this can result in a delay in recovery. It is sometimes not detected at the time of surgery and therefore may require a return to theatre. If the bladder is inadvertently opened during surgery, it will need catheter drainage for 7-14 days following surgery. If the rectum (back passage) is inadvertently damaged at the time of surgery, this will be repaired, however, inserting the mesh may be delayed till a later date. This will require another operation, and in rare circumstances, a temporary colostomy (bag) may be required.
- **Prolapse recurrence:** If you have one prolapse, the risk of having another prolapse sometime during your life is 30%. This is because the vaginal tissue is weak.
- **Painful sexual intercourse.** Once the wound at the top of the vagina has healed, there is nothing to stop you from having sex. The healing usually takes about 6 weeks. Some women find sex is uncomfortable at first but it gets better with time and sometimes improves using a bit of extra lubrication (KY Jelly). Sometimes sex continues to be painful after the healing has finished but this is unusual.
- **Change in sensation with intercourse.** Sometimes the sensation during intercourse may be less and occasionally the orgasm may be less intense.

The Operation - Sacrospinous Fixation

This operation has been performed for a long time and the success rate of the operation is 70-90%, this may decrease with time. You should feel more comfortable following the operation and the sensation of the prolapse, or something coming down should have gone.

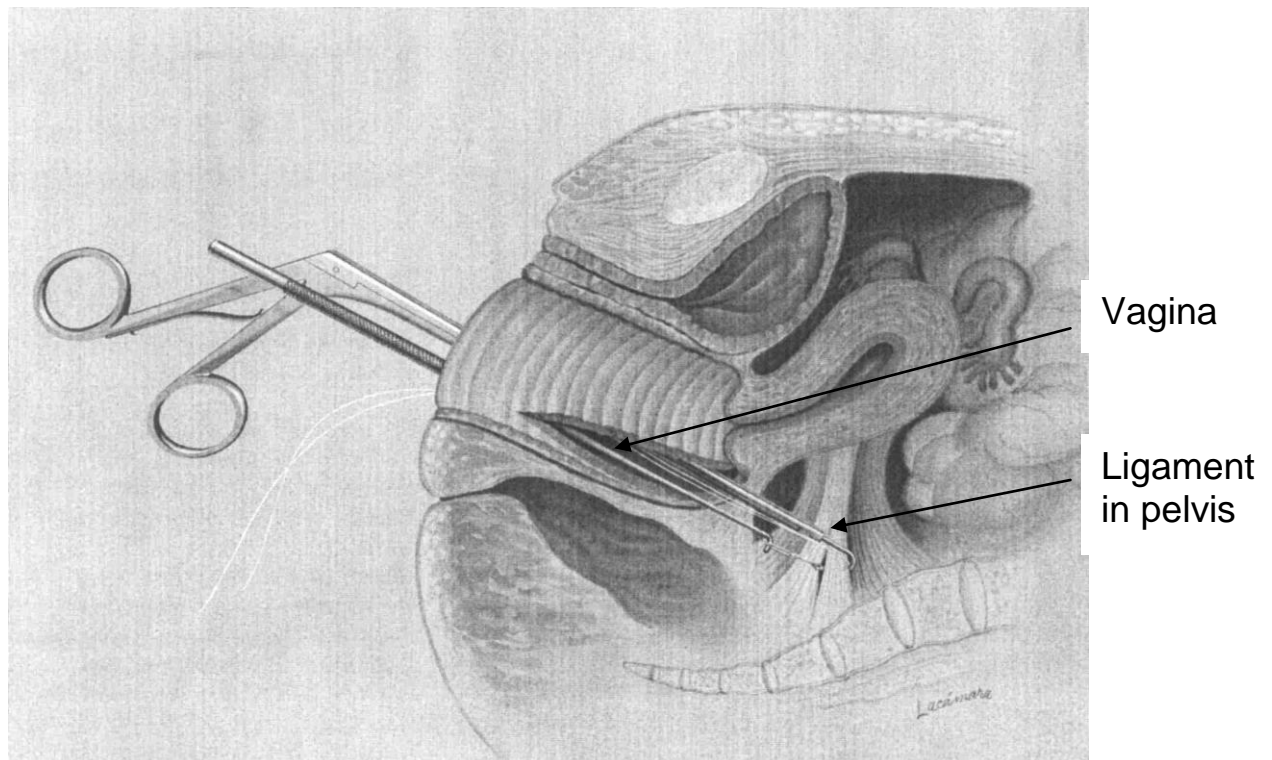
Before the operation

It is recommended that you take a medication to soften your motions for at least three days before the operation. This will help to reduce the risk of you getting constipated after the operation and could mean you get home earlier. Magnesium sulphate, Lactulose or Movicol would be suitable and you can obtain these from your General Practitioner.

How the operation is performed – sacrospinous fixation

- The operation can be done with a spinal or general anaesthetic and you may have a choice in this.
- A spinal anaesthetic involves an injection in the lower back, similar to what we use when women are in labour or for a Caesarean Section. The spinal anaesthetic numbs you from the waist down. This removes any sharp sensation but a pressure sensation will still be felt.
- A general anaesthetic will mean you will be asleep (unconscious) during the entire procedure.
- The legs are placed in stirrups (supported in the air).
- The operation is done through the vagina with special instruments.
- The top of the vagina (if have had a hysterectomy) or the neck of the womb (cervix) is suspended to a ligament in the pelvis called the sacrospinous ligament using suture (stitch) material that dissolves slowly (over 3 months) or permanent sutures.
- Posterior repair may be done at the same time(see leaflet for posterior repair)

Figure 2. Sacrospinous fixation using special instruments (Miya hook) done through the vagina.



After the operation - in hospital

- On return from the operating theatre you will have a fine tube (drip) in one of your arm veins with fluid running through to stop you getting dehydrated.
- You may have a bandage in the vagina, called a 'pack' and a sanitary pad in place. This is to apply pressure to the wound to stop it oozing.
- You may have a tube (catheter) draining the bladder overnight. The catheter may give you the sensation as though you need to pass urine but this is not the case.
- Usually the drip, pack and catheter come out the morning after surgery or sometimes later the same day. This is not generally painful.
- The day after the 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 clots on the legs.

- It is important that the amount of urine is measured the first couple of times you pass urine after the removal of the catheter. An ultrasound scan for your bladder may be done on the ward to make sure that you are emptying your bladder properly. If you are leaving a significant amount of urine in your bladder, you may have to have the catheter re-inserted back into your bladder for a couple of days more.
- You may be given injections to keep your blood thin and reduce the risk of blood clots normally once a day until you go home or longer in some cases.
- The wound is not normally very painful but sometimes you may require tablets or injections for pain relief.
- There will be slight vaginal bleeding like the end of a period after the operation. This may last for a few weeks.
- The nurses will advise you about sick notes, certificates etc. You are usually in hospital for up to 4 days.

After the operation - at home

- Mobilization is very important; using your leg muscles will reduce the risk of clots in the back of the legs (DVT), which can be very dangerous.
- 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. The deep stitches dissolve during the first three months and the body will gradually lay down strong scar tissue over a few months.

Avoiding constipation

- Drink plenty of water / juice

- Eat fruit and green vegetables esp broccoli
 - Plenty of roughage e.g. bran / oats
- Do not use tampons for 6 weeks.
 - There are stitches in the skin wound in the vagina. The parts of the stitches under the skin will melt away by themselves. The surface knots of the stitches may appear on your underwear or pads after about two weeks, this is quite normal. There may be little bleeding again after about two weeks when the surface knots fall off, this is nothing to worry about.
 - At six 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 six weeks. Leave a very heavy or busy job until 12 weeks.
 - You can drive as soon as you can make an emergency stop 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 six weeks.
 - You can start sexual relations whenever you feel comfortable enough after six weeks, so long as you have no blood loss. You will need to be gentle and may wish to use lubrication (KY jelly) as some of the internal knots could cause your partner discomfort. You may, otherwise, wish to defer sexual intercourse until all the stitches have dissolved, typically 3-4 months.
 - Follow up after the operation is usually six weeks to six months. This maybe at the hospital (doctor or nurse), with your GP or by telephone. Sometimes follow up is not required.

Where can I obtain more information?

Bladder & Bowel Foundation

SATRA Innovation Park, Rockingham Road
Kettering, Northants, NN16 9JH

Nurse helpline for medical advice: 0845 345 0165

Counsellor helpline: 0870 770 3246

General enquiries: 01536 533255

Fax: 01536 533240

<mailto:info@bladderandbowelfoundation.org>

<http://www.bladderandbowelfoundation.org>

<http://www.easyhealth.org.uk/>



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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).....
- 4).....
- 5).....
- 6).....
- 7).....
- 8).....

Please describe what your expectations are from surgery.

- 1).....
- 2).....
- 3).....
- 4).....
- 5).....
- 6).....
- 7).....