Sacropexy, Sacrohysteropexy, CESA /VASA

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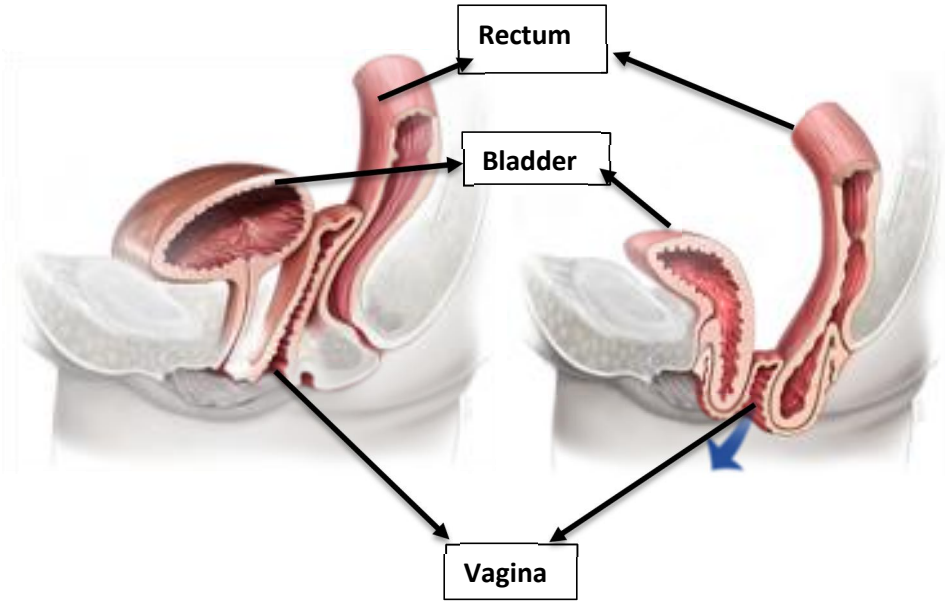
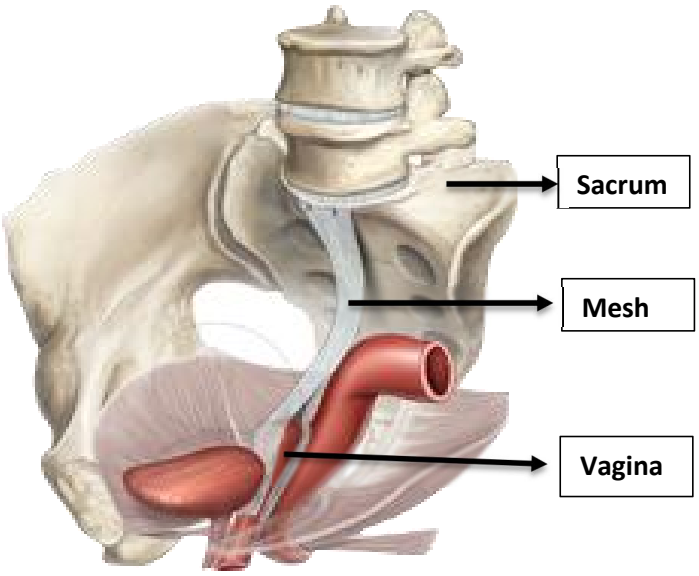
What is sacropexy

Sacropexy is an abdominal operation for Apical prolapse using a permanent mesh (usually polypropylene). Apex means the top of the vagina in patients who have had a hysterectomy or the cervix in patients who still have a uterus. If patients have significant prolapse of other areas- a vaginal approach may also be needed. In this procedure the top of the vagina or the cervix is attached to the sacrum using a permanent mesh. The vaginal aspect of the mesh may be attached to the front and/or back of the vagina as well. The procedure is performed through a cut in the tummy (open sacropexy) or as a key hole procedure (laparoscopic sacropexy). In patients with a uterus- a subtotal hysterectomy may be required although it can be performed without a hysterectomy (Hysteropexy).

No prolapse* **With Prolapse***



Completed sacropexy*



*Modified from IUGA

How is the surgery performed?
This surgery is performed under general anaesthesia or sometimes using a combination of spinal and general anaesthesia. You will be given antibiotics and catheterised at the beginning of the procedure. It can be done as an open procedure or as a key- hole procedure. If it is an open procedure you will have a bikini line cut on your tummy. If it is a key- hole procedure- you will have 4 tiny incisions (1cm size) on your tummy. The surgeon attaches the mesh to the vagina or the cervix (after performing a subtotal hysterectomy) and the tail or arms of the mesh are either stitched using permanent a stitch or stapled to the sacrum using titanium screws.

What are the advantages of sacropexy?
Studies have shown that sacropexy has a success rate of 80-90% over 3-5 years. No success rates are yet available for longer than this.
Sacropexy also had less dyspareunia (painful sexual intercourse) rates than vagina repairs.

What are the alternatives to Sacropexy?
It is important that you have considered the following options.

Do nothing
Prolapse is not a dangerous or harmful condition. If it is not bothering you, you could decide to do nothing about it. We would also suggest thinking about having your prolapse treated if it is rubbing on your underwear and causing bleeding or if it is too large as it is likely to cause problems like difficulty in passing urine.

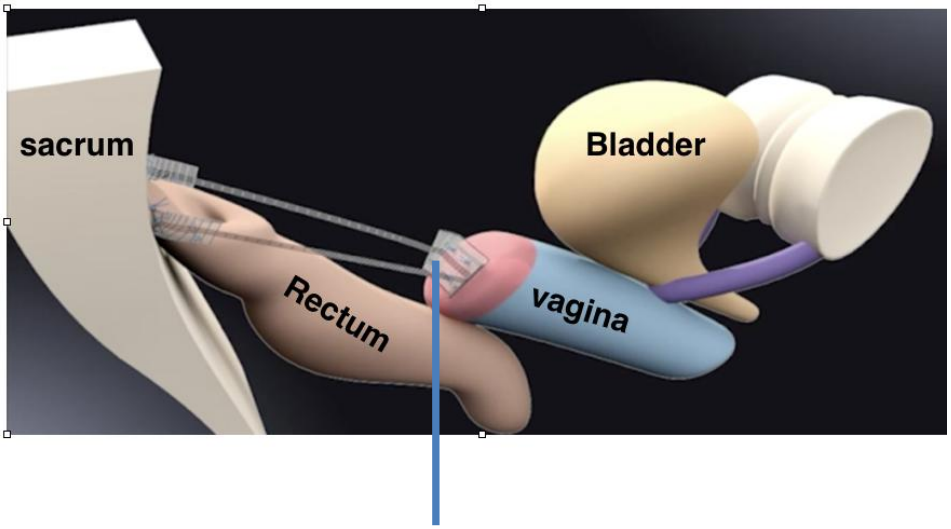
Pessary
There are many types of pessaries available which will suit different types of prolapses. They are also commonly known as ring pessaries although many of them are not ring shaped. They are made of soft plastic and needs to be changed every four months usually at your GP surgery.
Some patients find it uncomfortable and sometimes it can cause discharge and bleeding.

Other types of surgery
There are different types of surgeries available to correct prolapse. Most of them are vaginal repairs. Sacrospinous fixation is a type of vaginal surgery used to correct the apex in patients with apical prolapse. Deciding which operation is most suitable for you depends on several factors including- the type of prolapse, previous prolapse surgeries, medical co morbidities, BMI (body mass index) and previous abdominal surgeries. It is not within the scope of this leaflet to describe the other procedures but your doctor can discuss these options with you.

What is CESA/ VASA?

This is a new type of sacropexy using a permanent ribbon or tape made of PVDF (polyvinylidene fluoride). This procedure is also only for apical correction. If patients have significant prolapse of other compartments- a vaginal approach may also be needed. The tape has two arms and an apex. The apex is attached to the vault or cervix and the two arms are attached to the sacrum on the left and right side. This is a smaller mesh than a standard sacropexy and is also believed to be anatomically similar to the natural uterine support systems (uterosacral ligaments). Although we believe that the results are similar to that of a standard sacropexy, there are no studies available comparing the two methods of sacropexies.

CESA- stands for cervical sacropexy- a subtotal hysterectomy is required and the mesh is attached to the cervical stump.
VASA- stands for vaginal sacropexy- This is for patients who have had a hysterectomy.



Mesh with two arms attached to sacrum on either side of rectum

Before your operation
If you smoke try to give up as soon as possible as smokers are much more likely to develop chest infections, and coughing after the operation can affect the healing which in turn can increase the risk that your prolapse could recur.
If you are overweight reduce your weight as this will make the operation easier and reduce the risk of complications.
We may suggest you use some vaginal estrogen treatment for a few months up to surgery – this strengthens the tissues and they heal better.
Before your operation you will have a chance to ask questions of a nurse, your surgeon and your anaesthetist. You may see them either at the preoperative assessment appointment or when you are admitted to the unit.

Following your operation
Once you come back to the ward you will be allowed to eat and drink if you are able to tolerate orally. Catheter will be removed the following day and the staff will help you mobilise. After a laparoscopic procedure- you might be able to go home the next day provided you are well. After on open procedure you might have to stay in for 2-3 nights.

Your recovery and Care at home
Once you are at home- it is normal to feel tired after a major surgery. It is important to drink plenty of fluids and mobilise to prevent any DVTs. We will provide you with laxatives to avoid any constipation. Try to avoid strenuous exercise that leaves you short of breath, heavy lifting or straining on the toilet as this can put a strain on the repair. You should be able to drive after 2 weeks following a laparoscopic procedure and at about 4 weeks after an open procedure provided you can make an emergency stop and wear a seat belt comfortably. You should also check you're your insurance company before you start driving. You should be able to go back to work by about 6 weeks and also resume sexual intercourse by this time. Sometimes it may take up to 3 months to feel completely normal and pain free.

What to Report to your doctor after surgery
If you have any of the following you should contact your doctor.

- Heavy vaginal bleeding,
- Smelly vaginal discharge,
- Severe Pain, High Fever,
- Pain on passing urine,
- Blood in urine,
- Chest pain or breathing difficulty,
- Painful and swollen leg,
- Difficulty in opening bowel.

Risks and complications

Unfortunately, all operations carry some risks. It is important that you are aware of these risks and consider them when making a decision whether or not to have surgery for your prolapse. There are general risks associated with any surgery and those specific to the use of mesh and sacropexy.

General surgical risks

Anaesthetic Risks: The risk from having an anaesthetic is usually small unless you have certain medical problems.

Bleeding: The risk of serious blood loss is very small and it is rare that we have to give a blood transfusion after prolapse operations. However, your risk of bleeding may be higher if you are taking an anti-clotting medication, such as Warfarin. It is very important that you share with us any religious objection you may have to receiving blood in a life threatening emergency. In some cases a repeat operation may be necessary to stop the bleeding.

Infection: There is a risk of infection at the wound site or in your bladder, which is reduced by giving you a dose of antibiotics during the operation. The risk of a serious infection is very small.

Deep Vein Thrombosis (DVT): This is a clot in the deep veins of the legs. The risk of a DVT is about 4 in 100 and many cause no symptoms. In a very small number of cases, bits of the clot can break off and get stuck in the lungs causing a serious condition (pulmonary embolism). The risk of a DVT is higher in women who smoke or who are overweight. The risk can be reduced by wearing special stockings and using injections to thin the blood.

Damage to the bladder or bowel:
Bowel, bladder and ureteric injuries are rare. The risk of bladder injury is 1 in 200; of bowel and ureteric injury is about 1 in 1000. These organs are very close to the uterus and vagina and sometimes they can be injured during surgery. If the injury is recognised it can be repaired straight way. Sometime this may require a surgeon's help and conversion to an open procedure if it was a key hole procedure. Injury to rectum or bowel may sometimes require a temporary bag (colostomy) in some patients to allow the bowel to heal. It will not be possible to proceed with sacropexy in such cases. Very rarely we may have to abandon the sacropexy due to higher risk of mesh infection.

Pain, including pain on intercourse: Mild pain for a few days or weeks after the operation is normal as the wounds from surgery heal. Some women also have increased back or hip pain after the operation as we need to position you with your legs in stirrups to perform the operation. Rarely, more severe or long- lasting pain can develop after surgery, even when the operation has otherwise been successful. There are many reasons for this and it is not always possible to resolve it.

Painful sexual intercourse
This is less common than after vaginal surgery. Once abdominal incisions have

healed you can resume sexual activity. This is usually possible in 6 weeks. Some women find intercourse uncomfortable at first but it gets better with time. Occasionally pain on intercourse can be long term or permanent

Worsening or persisting problems with your bladder or bowels:
Preexisting bladder symptoms like urgency, difficulty in emptying and poor flow usually improves after surgery. Some women may develop new (de novo) urgency or stress incontinence symptoms due to change in the anatomical position of bladder. Constipation is common after surgery and usually resolves after a few weeks. We usually advice patients to take laxatives for at least 2 weeks following surgery.

Mesh complications:
These are permanent meshes. The risks are overall minimal but they can be significant and it is important that you are aware of these risks before making a decision.

Erosion
They can work their way through the vagina (5% if it is attached to vagina- in vault prolapse; 1% or less if attached to cervix following subtotal hysterectomy). Less commonly the mesh can work its way into the bladder or bowel, over time. This can occur many years after the mesh was put in. This often requires surgery to remove the mesh. Vaginal erosion are treated my excising the vaginal part of exposed mesh which can usually be done as a day case procedure.

Infection of mesh
Rarely, the mesh can become infected. In this case further surgery will be required to remove the mesh. There are also case reports of osteomyelitis (infection of bone). This is very rare.

Risk of bowel obstruction
This is about 1-2% and may require further surgery if it's not settling with conservative management. Usual symptoms are sickness and abdominal pain. This can happen weeks to years after the initial surgery. If surgery is required, it will be usually an open procedure and will involve bowel surgeons. There is a possibility of having a temporary bag (colostomy) in such cases.

Risk of recurrence of prolapse
Although recurrence risks are greatly reduced by using a mesh, over time the tissues can stretch and prolapse can recur. Most of these are not symptomatic and do not require any treatment.
Recurrence of same prolapse is about 1 in 10 cases. About 3 in 10 may require treatment for prolapse of another compartment (anterior or posterior).

Specific risk of laparoscopic procedure
Although we intend to complete the operation using a keyhole (laparoscopic) technique, a laparotomy is needed in rare circumstances, either to complete the operation or to repair an injury to a blood vessel, the bladder or bowel. This means making a cut in your tummy- usually a bikini line incision.

If you have any more questions- please list them below to ask at the time of your next consultation.

1.

2.

3.

FURTHER INFORMATION

NICE guideline -Sacrocolpopexy with hysterectomy
https://www.nice.org.uk/guidance/ipg583

NICE guideline -*Sacrocolpopexy for vaginal vault*
https://www.nice.org.uk/guidance/ipg577

The British Society of Urogynaecology – patient information leaflet on sacrohysteropexy and sacrocolpopexy
http://bsug.org.uk/pages/information-for-patients/111

International Urogynaecological Association – patient information leaflet on sacropexy
http://www.iuga.org/?page=patientleaflets

REPORTING OF MESH COMPLICATION

MHRA reporting of adverse incidents involving medical device
https://www.gov.uk/report-problem-medicine-medical-device

Author- Mr Elias Kovoor, MD MRCOG- April 2018