Gloucestershire Hospitals NHS Foundation Trust

Patient Information

Sacrospinous fixation and pelvic floor repair

Introduction

This leaflet provides you with basic information about vaginal vault prolapse and how it is repaired with a procedure called pelvic floor repair and sacrospinous fixation.

Sacrospinous fixation is a vaginal procedure performed for women who have developed vaginal vault prolapse after a hysterectomy.

What is a vaginal vault prolapse?

A prolapse occurs when one or more of the pelvic organs, (uterus, bladder, and bowel), the pelvic floor muscles, vaginal walls, or their attachments (ligaments) become weak. This causes the pelvic organs and/or vaginal walls to bulge downwards (herniate) into the vagina or in more severe cases, outside the vagina.

When you have had a hysterectomy (removal of the uterus) then the term ‘vault’, is used to describe where your uterus (womb) would have been attached to the top of the vagina (front passage). A vaginal vault prolapse is where the top of the vagina slips down into the vagina. Eventually, it may protrude out of the body through the vaginal opening, effectively turning the vagina inside out.

A vaginal vault prolapse is often accompanied by a weakness and prolapse of the walls of the vagina such as rectocele (a bulge of the back wall of the vagina) or a cystocele (prolapse of the front wall of the vagina). This will mean that further vaginal surgery is needed but will be performed at the same time.

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About sacrospinous fixation and pelvic floor repair

Sacrospinous fixation is an operation to help correct a vaginal vault prolapse. Strong stitches are placed between the vaginal vault and ligaments at the back of the pelvis. This operation may sometimes be performed at the same time of vaginal hysterectomy. There is no mesh used with this operation.

Pelvic floor repair is an operation to help women with a prolapse of the vaginal wall (either front or back or both). This involves a cut in the vagina using strong stiches to strengthen the tissues on either the front wall of the vagina near the bladder or the back wall of the vagina near the rectum. With this procedure the bladder and the bowel are held in a better position.

What conditions lead to vaginal prolapse?

Prolapse happens over a period of time. It is usually caused by the weakening or injury to the supporting muscles and ligaments of the pelvic floor.

This can be as a result of childbirth, connective tissue weakness, being overweight, heavy lifting, chronic constipation, smoking, a lack of hormones after the menopause or a combination of these. Many women will have a prolapse of some degree after childbirth; it is not unusual and unless you have symptoms you will not need treatment. Hysterectomy can also further weaken/remove the supporting structures.

What are the symptoms of prolapse?

Symptoms may vary depending on the type and degree of prolapse. Usually, symptoms are worse at the end of the day. In general, the symptoms can include:

- A dragging feeling, heaviness or lump in the vagina
- Difficulty in opening your bowel or bladder
- Difficulty with intercourse or having a loose sensation in the vagina

Pain is not usually a symptom of prolapse. Some women with prolapse may not have any symptoms, in which case, no treatment is required.

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What are the alternative non-surgical treatments?

Do nothing

If the prolapse (bulge) is not troubling you greatly then surgery may not be necessary. If, however the prolapse is outside the vagina and exposed to the air, it can become dried out and eventually become ulcerated. Even if it is not causing symptoms, in this situation we would recommend supporting it back inside the vagina with a vaginal pessary (see below).

Pelvic Floor Exercises (PFE)

The pelvic floor muscles form a bowl at the bottom of your pelvis. These muscles support your pelvic floor organs (uterus, vagina, bladder and rectum). Every muscle in the body needs exercising to keep it strong so that it functions properly.

PFE help strengthen the pelvic floor muscles and therefore give more support to the pelvic organs.

These exercises may not get rid of the prolapse completely but they can make you more comfortable and are best taught by an expert (usually a physiotherapist). These exercises have little or no risk and even if surgery is required at a later date, they can help to strengthen the area before surgery. Please discuss with your surgeon for a referral to a physiotherapist.

Vaginal pessaries

- **Ring pessary**
  This is a ring made of PVC which is inserted inside the vagina to push the prolapse back up. This usually gets rid of the dragging sensation and can sometimes improve bladder and bowel symptoms. The ring pessary is very popular and needs to be changed every 6 months. This can be done by your GP or practice nurse. We can show you an example of a ring pessary in clinic, please ask.
- **Shelf pessary**
  This is a different shape pessary which cannot be used if you are sexually active. The shelf needs to be checked every 6 months and is usually inserted in hospital by a specialist nurse or doctor.

- **Gellhorn pessary**
  This pessary is made of silicone which is softer than the shelf pessary. The Gellhorn pessary is not suitable for sexually active women. This pessary will also need to be checked every 6 months by a hospital specialist nurse or doctor.

What are the benefits of Sacrospinous fixation?

This procedure has been performed for many years and the success rate of the operation is 70 in every 100 women at 2 years after surgery.

The surgery will provide support to the vaginal vault and strengthen the vaginal wall. The stitch around the ligament helps to hold up the vagina and reduce your prolapse. The stitch will dissolve over several months, but in that time, it will be replaced by your own scar tissue and as a result hold your vagina in place. With this operation you will notice some improvement of your prolapse symptoms. In some patients the function of the bladder and bowel may also get better.

Are there any risks with this operation?

Sacrospinous fixation with pelvic floor repair is considered major surgery and as with all surgeries, there are associated risks that you need to be aware of when deciding on the right treatment for you. The risks are:

- **Bleeding/haematoma** - sometimes, it is difficult to control bleeding from the veins around the ligament. It is very rare but if it does happen then you might need a blood transfusion.
- **Thrombosis** – any period of inactivity will make it more likely that you develop a blood clot in the leg (Deep Venous Thrombosis, DVT). This is a potentially dangerous condition but the risks of this happening are reduced by you wearing anti-embolic stockings. Daily injections to thin your blood will also reduce this risk.

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- **Wound infection** - we will give you antibiotics during the operation to reduce the risk of infection. Despite this, some people may still develop an infection. This will usually clear with a full course of antibiotics but you may need to be stay in hospital for longer than expected.
- **Cystitis** - sometimes you can get a burning sensation when passing urine this is usually from a bladder infection. This might happen while you are in hospital or after you have gone home. If the doctor thinks you have a bladder infection you will be advised to take a course of antibiotics to clear it. If it happens after you have gone home, please contact your GP for advice.

The following complications are particular problems of these kinds of operations:

- **Urinary retention/voiding difficulty** (the inability to pass urine) - if this happens, the urine can be drained using a catheter until you are able to void (pass urine) independently, usually within 24 to 48 hours.
  If it persists you will be taught Intermittent Self Catheterisation (ISC), a procedure where you empty your bladder using a small tube or catheter.
- **Painful sexual intercourse** - some women have problems with sexual relations after any vaginal surgery. This is because the vagina becomes very tight. While every effort is made to stop this from happening, it is sometimes unavoidable.
- **Damage to surrounding organs** - this can include damage to the bowel, urinary tract and blood vessels. This is rare but will need a repair and can result in a longer recovery period. Damage to the bladder or ureters is very low, less than 2 in every 1,000 operations. Sometimes damage is not detected at the time of surgery and therefore a return to the operating theatre is needed. If the rectum is damaged a temporary colostomy may be needed but this is rare.

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- **Buttock pain** - about 1 in every 4 women who have sacrospinous fixation will get pain in their buttock for the first few weeks following surgery. This will get better by itself but you will be given pain relief to help. Long term buttock pain happens in around 1 in every 100 patients.
- **Urinary incontinence** - unfortunately a small percentage of women develop stress incontinence after this operation. You may find that you need physiotherapy treatment or even surgery at a later date.
- **Recurrence of prolapse** – if you have had a prolapse there is risk of having another one. This is due to a weakness of the vaginal tissue and means that the repair may not work; 30 women out of 100 may still have prolapse symptoms 2 years after surgery.
- **Pelvic pain** – which can be related to adhesions around the pelvis. Adhesions are bands of scar tissue that can make your tissues or organs inside your body stick together. They often form after you have had an operation inside your tummy (abdomen) or pelvis. Most of the time, adhesions do not cause problems, so you might not even know you have them. Others may develop chronic pelvic pain.
- **Changes in bladder and bowel function**
  Sacrospinous fixation with pelvic floor repair can help to restore the normal position of the bladder and bowel and therefore improve their function. However, in some women the straightening of the vaginal walls when prolapse is repaired can reveal a pre-existing weakness of the bladder neck and lead to a new incontinence problem. If you already have incontinence, this can persist, sometimes get worse or improve after the operation.

What will happen before the operation?

Before your admission for surgery, you will be asked to attend a pre-admission clinic to check that you are fit and well for surgery.

You will be seen by a nurse practitioner or doctor who will ask you about your general health, past medical history and any medication that you are taking. Any necessary investigations such as blood tests, ECG, chest X-ray will be arranged.

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You will also receive information about your admission, the operation and your hospital care. You will be given the opportunity to ask any questions that you may have.

Please take a bath or shower before you come in to the hospital for your surgery. Shaving the pubic hair is not necessary however it is advisable that you trim your pubic hair.

Before your operation you will be given a questionnaire to complete. Your answers to the questionnaire will help us to understand your symptoms and how they affect you on a daily basis. Six months following the surgery we will send you a further questionnaire. The results of this will be compared with the pre-operation questionnaire to see if the operation has improved your symptoms.

Let your doctor and pre-operation assessment nurse know about all the medication you take and follow their advice. This includes all blood thinning medications as well as herbal and complimentary remedies.

What happens on the day of the operation?

You will be seen by an anaesthetist and a surgeon (or a senior member of the team) who will explain what will happen during the operation. The purpose of the operation and any risks associated with the surgery will be explained to you. You will then be asked to sign a consent form if you have not already done so. You will also have an opportunity to ask any questions not covered during your appointment at the Pre-admission Clinic.

The operation is usually performed under a general anaesthetic (while you are asleep). Sometimes spinal anaesthetics or epidural anaesthetics may be used.

Spinal and epidural anesthesia are medicines that are given through an injection in or around the spine. This numbs the nerves that supply the tummy, hips, bottom and legs. Once the nerves are completely numb you will not feel any pain from the operation. You will also not be able to move your legs. Spinal and epidural anesthesia is recommended for patients with severe respiratory disease as it avoids potential respiratory risks.

You may be given antibiotics during the operation to reduce the risk of infection.

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Your gynaecologist may place a pack (like a large tampon) in your vagina. A catheter (tube) may also be placed in your bladder to help you to pass urine. The pack and catheter are usually removed the day after surgery.

You will be given anti-embolic stockings to wear. These will help to reduce the possibility of blood clots and will need to be worn throughout your hospital stay. You may also be given injections to keep your blood thin and reduce the risk of blood clots. These are normally given once a day until you go home.

What will happen to me after the operation?

After the operation you will be transferred to the recovery area and then to the ward. A drip (thin tube) will be inserted in to a vein in your hand to allow fluids to be given. You will also have a catheter (tube) inserted into your bladder to allow urine to drain. Sometimes the surgeon will leave a pack (like a large tampon) inside the vagina to stop any bleeding into the tissues. The drip, the pack in your vagina and the catheter are usually removed the day after the operation.

Once the catheter is removed it is important that the amount of urine you pass is measured. You will be asked to urinate into a disposable bedpan or bowl. The volume of urine will be measured. A bladder scan will then be performed to check if any urine is left in your bladder. If there is a significant amount of urine you will be taught how to do Intermittent Self Catheterisation (ISC).

This is a procedure to help drain the urine by passing a small tube into your bladder.

Alternatively, a catheter will be inserted into your bladder, this could sometimes stay in place for a few days.

You will be encouraged to get out of bed and take short walks on the first day after your operation. This will help to reduce the risk of blood clots or any other complications.

You will have some pain or discomfort following the operation but we will try to reduce this by giving you pain relief either by injection, tablets or suppositories.

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When can I return to my usual routine?

Recovery is a time-consuming process which can leave you feeling tired, emotionally low or tearful. Although the scars are in the vagina, this does not shorten the healing process. The body needs time and help to build new cells and repair itself.

Depending on the surgery you have had and the nature of your work, you will need to take at least 6 weeks off work to recover. If you require a sick note, please ask.

We advise you to avoid heavy lifting, heavy household chores, driving and sport for at least 6 weeks to allow the wounds to heal.

Sex after the operation

Healing usually takes about 6 to 8 weeks, so penetrative intercourse is not advised during this period.

Some women find penetrative intercourse uncomfortable at first but it gets better with time and may improve if you use a lubricant, such as vaginal moisturisers or topical vaginal oestrogen cream or pessaries.

Do expect things to feel a little different after the operation as the vagina will be suspended and therefore under slight tension. Sometimes, sensation during sex may be reduced and you may find it more difficult to achieve orgasm.

Weight and exercise

Reduced levels of activity and an increase in appetite may add to you putting on extra weight. It is important to continue to exercise following surgery. After 6 weeks you can gradually build up your level of activity, and after
3 months you should be able to return to your usual level of activity.

You should try to avoid any unnecessary heavy lifting to reduce the risk of the prolapse recurring.

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Contact information

If you have any problems or concerns after going home, please contact your GP or if out of normal working hours NHS 111 for advice.

Alternatively, you can contact the hospital, either the ward you were discharged from or an Advanced Urogynaecology Practitioner.

Advanced Urogynaecology Practitioner
Women's Centre
Gloucestershire Royal Hospital
Tel: 0300 422 6246
Tel: 0300 422 6278 (answerphone)
Monday to Friday, 8:00am to 4:00pm

Gloucestershire Domestic Abuse Support Service (GDASS)
This is a county-wide service offering a variety of support programmes for women and men over 16 years old who are experiencing domestic abuse.
Tel: 01452 726 570
Monday to Friday, 9:00am to 5:00pm

Domestic Violence Helpline
Tel: 0808 2000 247 (24 hours)
Email: support@gdass.org.uk
Website: www.gdass.org.uk

Further information

NICE
Patient decision aid about choice of procedure for prolapse of the vaginal vault.
Website:
https://www.nice.org.uk/guidance/ng123/resources/patient-decision-aid-pdf-6725286114

British Society of Urogynaecology
Email: bsug@rcog.org.uk
Website: https://bsug.org.uk/pages/information-for-patients/111

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Bladder & Bowel UK
Helpline: 0161 214 4591
Monday to Friday, 9:00am to 4:30pm
Email: bbuk@disabledliving.co.uk
Website: www.bbuk.org.uk

Patient.info
Website: http://patient.info/health/genitourinary-prolapse-leaflet

International Urogynecological Association (IUGA)
Your Pelvic Floor
Website: https://www.yourpelvicfloor.org

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Making a choice