Oxford University Hospitals NHS
NHS Foundation Trust

Department of Urogynaecology

Sacrospinous fixation for vaginal vault prolapse

Information for women

You have been given this leaflet as you have been advised to have a sacrospinous fixation procedure for your vaginal vault prolapse. It explains what vaginal vault prolapse is and why you have been recommended to have this operation. It also describes what will happen when you come into hospital, the potential benefits as well as the risks, recovery from the operation and what to expect when you go home.

What is a sacrospinous fixation?

This procedure is performed if you have developed a prolapse at the top of your vagina after a hysterectomy. This is called a vaginal vault prolapse. This is called a vaginal vault prolapse.

A sacrospinous fixation involves stitching the prolapsed top of the vagina to the sacrospinous ligament, which is situated near the tail bone. This supports the vagina, restoring it to its normal position and preventing it from prolapsing again.

The operation is performed either while you are asleep under a general anaesthetic or with a spinal anaesthetic to make your lower body completely numb. We carry out the repair through an incision (cut) on the inside of your vagina.

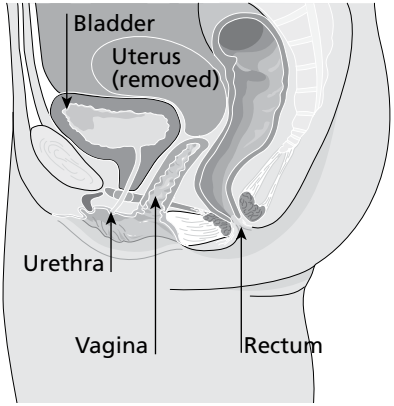
What is a vaginal vault prolapse?

When you have had a hysterectomy (removal of the uterus or 'womb') then the term 'vault', is used to describe where your uterus would have been attached to the top of your vagina.

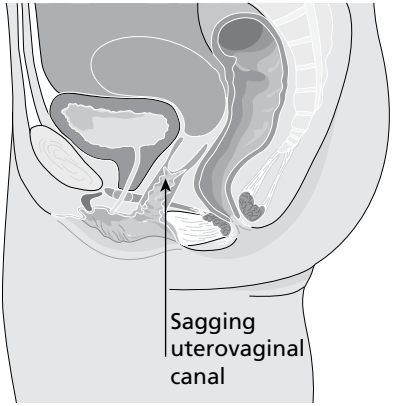
A vaginal vault prolapse is where the top of the vagina slips down into the vagina itself. Vaginal vault prolapse commonly occurs following a hysterectomy, because the uterus usually provides support for the top of the vagina. This condition occurs in up to 40% of women (40 in 100) after a hysterectomy.

In a vaginal vault prolapse, the top of the vagina gradually falls toward the vaginal opening. Eventually, the top of the vagina may protrude out of the body through the vaginal opening, effectively turning the vagina inside out.

Normal anatomy



Vaginal vault prolapse



A vaginal vault prolapse is often accompanied by a weakness and prolapse of walls of the vagina. This may cause a rectocele (a bulge of the back wall of the vagina) or a cystocele (a prolapse of the front wall of the vagina). Sometimes, surgery to correct one of these further prolapses is required at the same time as the sacrospinous fixation procedure. Your surgeon will discuss this with you.

Conditions leading to vaginal prolapse

A prolapse is collapse of the vaginal walls away from their normal positions inside the body. Prolapse occurs over a period of time, to varying degrees, and is usually caused by damage to the supporting muscles of the pelvic floor during childbirth. Being overweight, heavy lifting, chronic constipation and a lack of hormones after the menopause can produce further weakening of these muscles, creating a prolapse. Many women will have a prolapse of some degree after childbirth; it is not unusual and unless you have symptoms you do not need to seek treatment.

If your vault or vaginal prolapse protrudes from your vagina, you may find you have to push the bulge back inside your vagina in order to empty your bladder and help to empty your bowel. Occasionally, you may find that the bulge causes a dragging or aching sensation, which can be particularly worse towards the end of the day.

There are different levels of vault and vaginal prolapse. The symptoms can include:

- a 'dragging' feeling, a lump inside or outside the vagina and a feeling of 'fullness' in the vagina
- low backache
- constipation or straining to open your bowels, and a feeling of not having emptied them properly
- discomfort or pain during intercourse.

Alternative treatments

If the prolapse (bulge) is not troubling you greatly then you do not have to choose to have surgery. However, if the prolapse is outside your vagina and exposed to the air, it can become dry and sore. Even if it is not causing any symptoms, in this situation (if you would prefer not to have surgery) we would recommend supporting it back inside the vagina with a ring or shelf pessary.

We would also recommend that you practice pelvic floor exercises. These can be beneficial, even if you have decided to go ahead with the surgery.

Pelvic floor exercises

Your pelvic floor muscles run from the coccyx at the back of your pubic bone through to the front and off to the sides. These muscles support your pelvic floor organs (uterus, vagina, bladder and rectum).

Any muscle in the body needs exercise to keep it strong, so that it functions properly. Pelvic floor exercises help strengthen the pelvic floor and give more support to the pelvic organs. These exercises may not get rid of the prolapse, but they can make you more comfortable. To help you perform these exercises correctly we can refer you to a Physiotherapist.

These exercises have little or no risk and even if you need surgery at a later date they will help you feel generally more comfortable in the meantime.

Vaginal pessary

There are two types of vaginal pessary:

Ring pessary

This is a ring made of a type of plastic called PVC. It 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. It needs to be changed every 4-6

months (this can be done by your GP or Practice Nurse) and is very popular.

We can show you an example of a ring pessary in clinic, please ask if you would like to see one. Some couples feel it can interfere with intercourse but other couples are not bothered by it. Ring pessaries are not suitable for every woman and do not always stay in place. If this is the case for you, we will need to consider a different type of pessary, such as a shelf pessary.

Shelf pessary

This is a stronger type of pessary but cannot be used if you are sexually active. Again this needs to be changed every 4-6 months, but this normally has to be done in hospital (not by your GP or Practice Nurse).

The benefits of sacrospinous fixation

This operation has been performed for a long time and the success rate is 70 to 80%. You should feel more comfortable after the operation and the sensation of prolapse or something coming down should have gone.

Risks of sacrospinous fixation procedure

Most operations are straightforward and without complications. However, there are risks associated with all operations. You need to be aware of these when deciding whether to have this treatment. The risks of having sacrospinous fixation are:

- Damage to the bladder or one of the tubes (ureters) which drain the kidneys (1 in 200).
- Very rarely, damage to the bowel (1 in 1000).
- Excessive bleeding during the operation (1 in 100).
- Deep vein thrombosis (DVT). This is the formation of a blood clot in a leg vein, which occurs in about 1 in 250 women. We

will give you medication and special stockings to wear to help prevent a blood clot from developing.

- Aching buttock pain. This is due to bruising of the muscles and nerves in the sacrospinous area. This pain occurs in 1 in 4 women after this surgery, but usually gets better after 4 to 6 weeks as healing takes place. However, in 1 in 100 women the pain continues for longer.
- Prolapse returning. If you have one prolapse, the risk of having another prolapse some point during your life is 30%. This is because the vaginal tissue is weak.
- As with all surgery, there is a risk of an infection developing. This could be in the area where you have had surgery (such as the vagina, the area where any cuts have been made, or the pelvic area) or may be related to the surgery (such as a bladder or chest infection). You will be given a dose of antibiotics before surgery to help prevent infection.

Although hysteropexy is a relatively safe operation and serious complications are not very common, it is still major surgery. You and your doctor must weigh up the benefits and risks of surgery, giving consideration to alternative treatments.

Changes in bladder and bowel function

The sacrospinous fixation procedure helps to restore the normal position of the bladder and bowel, to improve how well they work. However, in some women the straightening of vaginal walls when prolapse is repaired can uncover a pre-existing weakness of the bladder neck. This can lead to a new incontinence problem.

Some women also experience worsening constipation following this surgery. This tends to get better over time. It is important to try to avoid being constipated after your surgery, to reduce the chance of the prolapse returning.

Painful sexual intercourse

The healing after this surgery usually takes about six weeks. Some women find sex is uncomfortable at first, but it gets better with time. It may help if you use a lubricant such as Replens, topical oestrogen cream or pessaries, such as Vagifem. Do expect things to feel a little different; after the operation your vagina will be suspended and therefore under slight tension. Sometimes sensation during sex may be less and occasionally orgasm may be less intense.

Anaesthetic risks – general anaesthesia

In modern anaesthesia, serious problems are uncommon. Risk cannot be removed completely, but modern equipment, training and drugs have made general anaesthesia a much safer procedure in recent years. Throughout the whole of life, a person is at least 100 times more likely to suffer serious injury or death in a road traffic accident than as a result of anaesthesia.

Pre-admission clinic

Before your surgery you may be asked to come to a pre-admission clinic appointment. This is to check that you are fit and well for the operation.

A nurse practitioner or doctor will see you at this appointment. We will ask you about your general health, past medical history and any medicines that you are taking. We will organise any investigations you may need (such as blood tests, ECG (heart tracing), chest X-rays). We will tell you about your admission, the operation itself and your care before and after the operation.

At this appointment you will be given information about not eating or drinking (fasting) before your operation.

This is the time to ask any questions you may have or to raise any concerns.

Before you come into hospital

Plan ahead

When you come out of hospital you are going to need extra help at home for the first two weeks. Make sure your family know this too!

Smoking

If you smoke, try to stop completely. This will make your anaesthetic safer, reduce the risk of complications after the operation, and speed up the time it takes for you to recover. Perhaps this is a good opportunity to give up completely. If you are not able to stop completely, even doing so for a few days will be helpful. You will not be able to smoke while you are in hospital.

Driving

We recommend that you do not drive for two to four weeks after the procedure. You will then need to check with your doctor at your follow-up appointment whether you are safe to return to driving. We advise checking with your insurance company that you have insurance cover if you choose to drive earlier than we recommend. It may be helpful to first sit in the car while it is parked, to see if you could do an emergency stop, if needed. You must be able to comfortably and safely perform an emergency stop for your safety and that of others.

Medicines

Some medicines need to be stopped or altered before the operation. You should check this with your GP. If you have been anaemic then your GP will recommend that you take iron supplements before the surgery.

On the day of surgery

You will be given an estimated time for your operation, but this may change, as the operating theatres are also used for emergency surgery.

You will be seen by the anaesthetist and the surgeon (or a senior member of the team). They will confirm with you the purpose of the operation, what will happen during the operation, and the risks associated with it. 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 further questions about anything you are still unsure about.

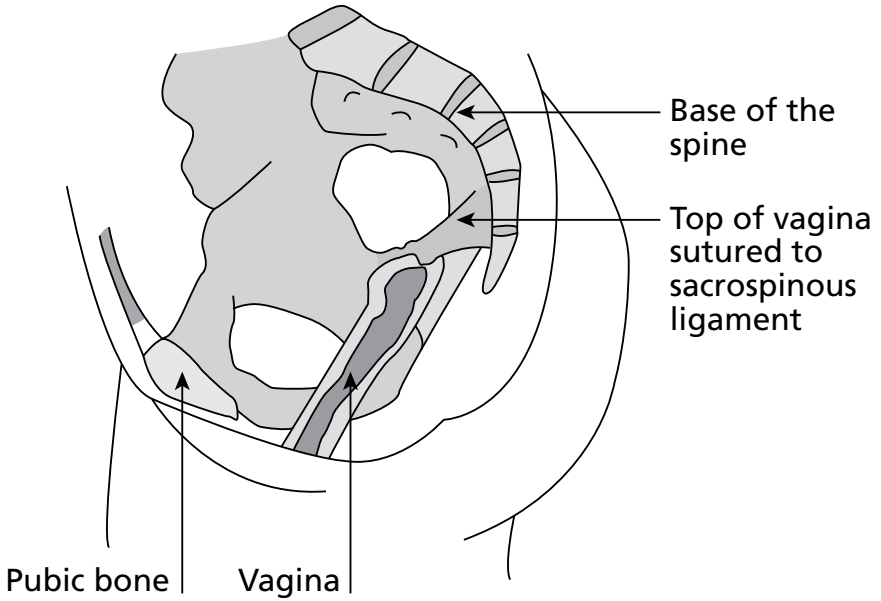
In the anaesthetic room, next to the operating theatre, you will have a narrow tube called a cannula placed in your arm or wrist. It will be attached to a tube which will supply your body with fluids and medicines during and after the operation. This will stay in place until you are drinking normally after the operation.

Before you are given the anaesthetic, we will attach a monitor to your chest with leads. This is connected to a machine called an ECG (electrocardiograph) which measures the activity of your heart.

The operation

A sacrospinous fixation involves making an incision (cut) in the back wall of the vagina. The prolapsed top of the vagina is then stitched to one of the sacrospinous ligaments, which are situated near the tail bone. Two strong dissolvable stitches are put between the ligament and top of the vagina. The effect of this is to support the vagina, restoring it to its normal position and preventing it from prolapsing. The stitches take 4-6 months to dissolve, by which time the tissue has healed and the top of the vagina stays in place.

Diagram of sacrospinous fixation



Vaginal repair

Other types of prolapse may result from stretching and weakening of the walls of the vagina, with bulging of the bladder through the front wall (cystocele) or bowel through the back wall (rectocele). All of these conditions can result in the feeling of something coming down the vagina.

If you are having this additional part of the operation carried out at the same time as the sacrospinous fixation, your surgeon will have explained what will be done. The repair operation tightens the walls of the vagina. All the stitches used are dissolvable.

After the operation

When you return to the ward you are likely to be very sleepy for the rest of the day. There will be a narrow tube called a catheter in your bladder (to drain away urine). This will normally be removed the next day.

Will I have any pain?

You are likely to experience some pain or discomfort for the first few days, but we will offer you painkillers to help ease this. Please let us know as soon as you start to feel any discomfort, rather than waiting until the pain becomes worse.

You may need to have strong painkillers to keep you comfortable. As you recover, you will have the choice of tablets or suppositories to control any pain you may have. You will be encouraged to take painkillers, as being pain-free will speed up your recovery.

Having an anaesthetic, being in pain, and having strong painkillers can sometimes make you feel nauseous or sick. We can easily help with this by giving you anti-sickness medications as injections or tablets.

You may get wind pains a few days after the operation, which can be uncomfortable and make your tummy look distended (swollen). This should not last long and can be relieved with medicines, eating and walking about.

Will I bleed?

After the operation you may have some vaginal bleeding and will need to wear a sanitary pad. We advise you not to use tampons, as these increase the chance of an infection developing. This blood loss should change to a creamy discharge over the next two to three weeks. If you have any new pain, fresh bleeding, or bad smelling discharge after you go home, you should contact your GP.

Will I have stitches?

If you had vaginal repair as well as sacrospinous fixation you will have stitches on the inside of your vagina, which are all dissolvable. As they dissolve, the threads may come away for up to three months, which is quite normal.

How will I cough?

If you need to cough, your stitches won't come undone and you won't damage the repair. You will be wearing a sanitary towel, and coughing will hurt less if you press on your pad firmly to give support between your legs.

Recovery

Recovery is a time consuming process, which can leave you feeling tired, emotionally low or tearful. Your body needs time to build new cells and repair itself. Depending on the surgery you have had, you will need to take 4 to 6 weeks off work to recover.

After a sacrospinous fixation, you are likely to stay in the hospital for one to two days, but this may be longer if needed. When you will be discharged from hospital depends on the reasons for your operation, your general health and how smoothly things go after surgery. Recovery time varies from woman to woman. It is important to remember that everyone's experience is different, and it is best not to compare your own recovery with that of others on the ward.

Whilst you are on the ward you will be visited by a physiotherapist, who can give you advice on exercises, including pelvic floor exercises, and other ways to help your body recover.

Sex after the operation

For many women, this area of their life is improved because there is no longer any discomfort during sexual activities. We advise that you avoid penetrative intercourse for about six weeks, until you've had your check-up with your doctor.

Take your time; feel comfortable and relaxed and don't be rushed. For the first few occasions you might find a lubricating gel is helpful. You can buy this from the chemist and many other shops. Talk to your husband or partner about this, as you will need extra gentleness and understanding.

Weight

The operation itself should not cause you to gain weight. Initially, because you are feeling better, are not able to be as active as usual and may have an increase in appetite, you might put weight on. By paying attention to what you eat and increasing your activity level as you recover, you should be able to avoid any significant weight gain.

Exercise

It is important to continue to exercise; walking is an excellent way of doing this. Gradually increase the length of your walks, but remember to only walk the distance you can achieve comfortably. Cycling and swimming are equally good, but please allow yourself a couple of weeks to recover before returning to these exercises.

Follow-up

We will see you back in clinic again approximately 8 to 12 weeks after your surgery, to assess your recovery. This appointment will be sent to you through the post. Please contact us if this has not arrived within 4 to 6 weeks after your surgery.

Contact us

If you have any questions please telephone either the:

Urogynaecology Nurse Specialists

Tel: **01865 222 767**
(Monday to Friday, 8.00am to 5.00pm)

Or

Gynaecology Ward Nurses

Tel: **01865 222 001/2**
(24 hours)

Further reading and support

The Physiotherapy Department
Women's Centre
John Radcliffe Hospital

Tel: **01865 235 383**
(8.00m to 4.00pm, Monday to Friday)

Women's Health Concern

Women's Health Concern produce information leaflets about hysterectomy, prolapse, and associated health conditions.

Website: www.womens-health-concern.org

Oxford Gynaecology and Pelvic Floor Centre

Oxford Gynaecology and Pelvic Floor Centre provides specialist services for women with gynaecological and pelvic floor problems. Please speak with your doctor about being referred to this service.

Website: www.oxfordgynaecology.com/

NHS Choices

NHS Choices has information about a wide range of health problems and symptoms.

Website: www.nhs.uk/pages/home.aspx

If you have a specific requirement, need an interpreter, a document in Easy Read, another language, large print, Braille or audio version, please call **01865 221 473** or email **PALSJR@ouh.nhs.uk**

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