Sacrospinous colpopexy
An operation for prolapse of the vaginal vault

Urogynaecology and Pelvic Floor Unit
Women’s Health
If you require the services of an interpreter, contact us on 020 3447 9411. 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 sacrospinous colpopexy. We offer this procedure to treat vaginal vault prolapse after hysterectomy. 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 sacrospinous colpopexy mean?

Sacrospinous colpopexy is an operation used to repair prolapse of the vaginal vault. The vaginal vault is stitched to a strong band of tissue in the pelvis called the sacrospinous ligament. Attaching the vaginal vault to this ligament should stop it bulging down. This should make you feel better.

Sacrospinous colpopexy is often combined with surgery for prolapse of the front or back walls of the vagina. This is because prolapse of the vaginal vault and the vaginal walls frequently happens at the same time.
The following descriptions should help you to understand the difference between the vaginal vault and the vaginal walls:

- The vaginal vault can be felt if a finger is placed inside the vagina and pushed towards the spine as far as it will go. The vault is the very end of the vagina internally.

- The front wall of the vagina can be felt if a finger is placed in the vagina and pointed towards the head. The bladder is directly above the front wall of the vagina.

- The back wall of the vagina can be felt if a finger is placed in the vagina and pointed towards the feet. The lower bowel is directly below the back wall of the vagina.

We have offered you a sacrospinous colpopexy operation because you have vaginal vault prolapse. If you also have prolapse of the front or back vaginal walls, these areas may need repairing at the same time.

Before you have your surgery, we will do our best to tell you which parts of your vagina we plan to operate on. Sometimes, we cannot be certain which areas will need fixing until you are asleep for the operation. If this is the case, we will talk to you about surgery in all of the areas that might need it.

### 3 How can a sacrospinous colpopexy help?

If you have symptoms of vaginal vault prolapse, sacrospinous colpopexy is likely to help you. Unfortunately, no operation will work for everybody and sometimes the surgery will not be successful. For some women, surgery works well initially but the problem comes back again later.

The most reliable medical research studies (called randomised trials) have shown that two years after surgery, most women are satisfied:
• Around 80 out of 100 women who have a sacrospinous colpopexy will have no symptoms of prolapse.

Other types of research have continued to monitor patients for up to five years after surgery. These studies have suggested that sacrospinous colpopexy seems to keep working during this time. We cannot be sure how effective the operation is more than five years after surgery.

Because the bladder and bowel are so close to the vagina, vaginal surgery can affect how the bladder and bowel work. This means that bladder and bowel problems may get better after sacrospinous colpopexy.

It is difficult to be sure how often bladder and bowel symptoms improve after sacrospinous colpopexy. This is because:

• Research studies have not looked in detail at how often sacrospinous colpopexy makes these symptoms better.

• Sacrospinous colpopexy is often combined with surgery for prolapse in other parts of the vagina. This makes it difficult to decide if sacrospinous colpopexy makes things better, or whether the other surgery is helping.

In most research studies, sacrospinous colpopexy is combined with a repair of the back vaginal wall. This is because prolapse of the vaginal vault and back vaginal wall often happen at the same time. Two of these research studies looked at how bowel symptoms changed after surgery. Around 70 out of 100 women described better bowel control and less trouble with leakage.

If you need a sacrospinous colpopexy and a repair of the back wall of the vagina, your bowels symptoms are likely to improve. Benefits might include better control, less leakage, and less difficulty emptying your bowels. These improvements might be because of the sacrospinous colpopexy, or the vaginal wall repair.
If you only need a sacrospinous colpopexy, without a vaginal repair, any bowel symptoms you have might still improve. Unfortunately, there is not enough research on this subject for us to be sure.

Some women are affected by bladder symptoms as well as prolapse. ‘Stress urinary incontinence’ means urine leakage on coughing, sneezing, or physical activity. ‘Urinary urgency’ describes having to suddenly rush to the toilet to pass urine. Some women also have trouble emptying their bladder.

It is very difficult to be sure how often these bladder symptoms improve after sacrospinous colpopexy. This is because sacrospinous colpopexy is often combined with other operations at the same time, including:

- Surgery for prolapse of the front wall of the vagina.
- Operations on the bladder to treat urinary leakage.

These procedures make it very difficult to know if sacrospinous colpopexy improves bladder symptoms on its own.

One research study has suggested that urinary urgency and difficult bladder emptying might improve after sacrospinous colpopexy. Based on this study, we might expect the following improvements:

- Urinary urgency might improve in 40 out of 100 women.
- Difficult bladder emptying might improve for 80 out of 100 women.

The majority of women in this study had a repair of the front wall of the vagina as well as a sacrospinous colpopexy. If you have a sacrospinous colpopexy on its own, we cannot be sure it will have the same effect.
4 What are the risks of sacrospinous colpopexy?

All treatments and procedures have risks and we will talk to you about the risks of sacrospinous colpopexy. 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 sacrospinous colpopexy. 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

Heavy bleeding that might need a blood transfusion: 1 in 100.

How is serious bleeding dealt with during surgery?
Damage to major blood vessels is uncommon but can cause serious bleeding. Your surgeon may use a vaginal pack to help stop heavy bleeding. This is a rolled-up bandage that is packed tightly in the vagina. This presses on the bleeding blood vessel. If this did not work, you would probably need a procedure called ‘embolisation’.
What is embolisation? Embolisation is a procedure that blocks off a bleeding blood vessel from the inside. First, a tiny tube is inserted through the skin into a large blood vessel in your groin. Using X-rays pictures, the tube is guided to the bleeding vessel at the operation site. A special substance is then passed down the tube to block off the blood vessel. If the bleeding were this serious, you would require a major blood transfusion. Very heavy bleeding can rarely be life threatening.

Please ensure to tell you doctor if you would not accept a blood transfusion on religious or other grounds. This is extremely important.

Infections after surgery

- Urine infection immediately after surgery: 10 in 100.
- An infection of the vaginal wounds: 1-5 in 100.

How are infections treated? Most infections are easily treated with antibiotics. Serious infections after vaginal prolapse surgery are extremely rare.

Damage to other organs during surgery

Because the bowel and bladder are very close to the vagina, they can be damaged during surgery. The ureters can also be damaged. These are the tiny tubes inside your body that carry urine from the kidneys to the bladder. Thankfully, the risk of damage is low:

- Damage to bowel, bladder or ureters: 1-2 in 100.
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 you have had previous vaginal surgery the risk of damage may be higher.

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.

**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. 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.

**Bladder and bowel symptoms after surgery**

Some women have bladder and bowel symptoms as well as vaginal vault prolapse. Although these symptoms might improve
after sacrospinous colpopexy, sometimes they can get worse. In addition, there is a small risk that you could be troubled by new symptoms after surgery that were not there before.

If you already have bladder symptoms, we do not know how likely they are to worsen after sacrospinous colpopexy. It is possible that your symptoms could be made worse by surgery. Unfortunately, there is not enough research information to be sure how often this happens.

Some women experience new bladder symptoms after surgery. Only one small study has looked at how often these problems might happen so we cannot be sure about the risks. Based on this research, we might expect the following problems after surgery:

- New stress urinary incontinence: 20 in 100.
- New urinary urgency: 5 in 100.
- New difficulties emptying the bladder: 1-2 in 100.

**How are bladder symptoms treated?** Bladder symptoms after surgery commonly improve in time. Problems with stress urinary incontinence may respond to pelvic floor physiotherapy. Sometimes, further surgery is needed. Urinary urgency is usually helped by medication or other non-surgical treatments. Difficulty emptying the bladder usually settles down within a week or two. If this happened, you might need a catheter tube to be left in the bladder until things improved. Long-term problems have not been reported in research studies but could still happen. If you were affected, you might need to learn self-catheterisation. Self-catheterisation means passing a small catheter tube through the urethra yourself to empty the bladder.
If you already have bowel symptoms, we do not know how likely they are to worsen after sacrospinous colpopexy. It is possible that your symptoms could be made worse by surgery, although the risks are likely to be small.

Some women develop new bowel symptoms after vaginal surgery for prolapse. Only two research studies have tried to work out how often new symptoms develop after sacrospinous colpopexy. One study suggested that around 5 in 100 women develop new problems with leakage of gas or faeces after surgery. Another found no new problems after sacrospinous colpopexy. New difficulties with bowel emptying after surgery are a possibility. We are not sure how often this happens.

In both of these studies, a repair of the back wall of the vagina was undertaken at the same time as the sacrospinous colpopexy. This makes it difficult to say which of the two procedures cause these problems. However, these results are similar to what we see after a repair of the back wall of the vagina on its own.

After a repair of the back vaginal wall on its own, we would expect the following new symptoms:

- New problems emptying the bowel, or having to rush to the toilet without warning difficult bowel emptying: 5 in 100.
- New problems with leakage of gas: 5-10 in 100.
- New problems with leakage of faeces: 1-2 in 100.

This information is useful, as it gives us an idea of what might happen to bowel symptoms after a combined procedure. If you have a sacrospinous colpopexy and a repair of the back wall of the vagina we might expect similar results. However, we cannot be sure that a combined operation will have the same effects.
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.

Painful sexual intercourse

New problems with painful sexual intercourse after sacrospinous colpopexy have been reported. The risk of problems might depend on whether you have vaginal wall surgery at the same time. It also might depend on which part of the vaginal wall is repaired. We think that a repair of the back wall of the vagina might be more likely to cause problems.

- New problems with painful sexual intercourse: 5-15 in 100.

Does painful sexual intercourse after surgery get better? Symptoms often get better with time. If you have problems, you will be checked to see if there is a problem with the operation, or another cause. Scarring in the vagina can sometimes cause pain. This often improves as time passes but using vaginal dilators might help. Further vaginal surgery is rarely needed. Painful sex can also be caused by a lack of hormones in the vagina. This can be treated with a hormone cream or tablet. 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. Sometimes, pain can be a long-term problem.
If you already have problems with uncomfortable sexual intercourse, they could improve after surgery. This is because repairing the prolapse might make things easier. We are not sure how often this happens.

Unfortunately, there is also a chance that any problems you have with painful sex could worsen. We are not sure how often this happens but it has been reported.

**Symptoms caused by nerve damage**

Some nerves are very close to the sacrospinous ligament. This is the ligament that the vaginal vault is attached to during surgery. Damage to these nerves can cause pain. Often this is felt in the right buttock and the back of the thigh.

Some women also complain of pins and needles in the buttock, pelvis and leg. Loss of sensation, and even muscle weakness, can also occur. These problems normally settle down in time and most problems will be better within few months. Long-term problems are rare.

- Nerve pain immediately after surgery: 10-15 in 100.
- Nerve pain lasting more than six months: 1 in 100.
- Pins and needles, numbness or weakness: 1 in 100.

**How are symptoms caused by nerve damage treated?**

Most symptoms caused by nerve damage just get better with time. Things usually improve within a few weeks, although sometimes, it can take a few months. If you have pain that does not go away, you will be referred to a specialist in pain medicine. You may be prescribed medication or offered other treatments. Sometimes, pain or other nerve symptoms can be a long-term problem.
If you already experience chronic pain in other areas of the body, the risk of pain symptoms after surgery is higher.

Problems that may happen later

Your prolapse could continue to trouble you

Some women find that their prolapse comes back soon after surgery. This could be a problem just a few weeks after your operation. In others, things are better at first, but the prolapse comes back later. Two years after surgery, around 20 in 100 women continue to have symptoms of prolapse.

If you have continuing symptoms, your vaginal vault prolapse could have come back. This happens because the sacrospinous colpopexy has been unsuccessful. If this is not the case, you could have developed new problems with prolapse of the vaginal walls. This can happen even if you had vaginal wall surgery at the same time as your sacrospinous colpopexy. Persisting problems with prolapse might need further treatment.

Problems that are rare, but serious

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

Can surgery help with nerve damage? Rarely, a patient experiences severe nerve symptoms. If severe symptoms do not improve quickly, we might offer removal of the stitches in the sacrospinous ligament. This can be a difficult operation and there is no guarantee that things will improve afterwards, although it can help some patients.
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 sacrospinous colpopexy?

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?

After reading this leaflet, you may decide that you want to look at other options. We provide a separate leaflet on the available treatments for prolapse and we should have given you this to read. Please ask for this leaflet if you do not already have it.
The alternatives to sacrospinous colpopexy are:

- Pelvic floor physiotherapy.
- A vaginal pessary.
- Laparoscopic mesh sacrocolpopexy

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.

**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 laparoscopic mesh sacrocolpopexy? This is another operation for vaginal vault prolapse. Using keyhole surgery, a soft plastic mesh is wrapped around the vagina. The mesh is then lifted up and fixed to bone at the bottom of the spine. This moves the vagina back into a more normal position. After laparoscopic mesh sacrocolpopexy, persistent prolapse seems to be less common. The operation appears to cause less new problems with urine leakage and painful sexual intercourse. Despite these differences, satisfaction rates after sacrospinous colpopexy and laparoscopic mesh sacrocolpopexy appear to be similar. The operation uses a mesh implant and you should talk to us about the use of mesh in prolapse surgery.

7 How should I prepare for sacrospinous colpopexy?

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.

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.

**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.

**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 six 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 for the first six weeks after surgery.

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 sacrospinous colpopexy?

The operation takes around two hours.

A cut is made in the vaginal skin. This is normally on the back wall of the vagina.
• If you are also having a repair of the back wall of the vagina, the cut might extend on to the perineum. This is the skin between the vagina and the anus.

• Two strong stitches are then placed through the sacrospinous ligament.

• If you are having a repair of the back wall of the vagina, it is completed at this stage. The prolapse is repaired using internal stitches.

• The strong stitches in the sacrospinous ligament are then passed through the vaginal vault. This is the very end of the vagina internally. The stitches are then pulled tight. This lifts up the vaginal vault and attaches it to the sacrospinous ligament.

• The cut in the vaginal skin is then closed up using stitches.

• If you need a repair of the front vaginal wall, it is performed at this stage. A cut is made in the vaginal skin over the front wall of the vagina.

• Internal stitches are used to repair the prolapse of the front vaginal wall. The vaginal skin is then closed using more stitches.

• We might insert a ‘vaginal pack’ at the end of your surgery. This is a rolled up bandage placed inside the vagina to help stop any bleeding. The pack is usually removed within 24 hours.

• If you have a pack inside it does not mean that you have had serious bleeding. Vaginal packs can be used to stop heavy bleeding, but they are also used for minor bleeding, which is common.

• You will have a drip in your hand and a catheter tube in the bladder. These will normally be removed within 24 hours.
All of the stitches used will dissolve and do not need to be removed. The internal stitches might take a few months to dissolve. The stitches in the vaginal skin usually dissolve in a few weeks.

10 What should I expect after sacrospinous colpopexy?

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 can expect some vaginal bleeding and discharge.
- You will wear a sanitary pad and change it regularly.
- You can shower as often as you like. You can gently wash around the vaginal opening in the shower. You can direct the shower spray around the vaginal entrance to clear away any discharge or blood. You can use soap or shower gel on the outside of the vagina but not on the inside.
- If you do take a bath, do so in shallow water for a maximum of ten minutes.
- In the first two weeks, we think it is a good idea to gently wash around the vagina twice a day. This is in addition to your daily shower or bath.
- 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 six 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.

- Your vaginal bleeding and discharge will eventually stop.

- If you have a period, please use pads rather than tampons.

**Six weeks onwards**

- You can get back into your normal routine. You can return to work if you do not have a strenuous job. If your job requires heavy lifting, you might need longer off work.
• 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.

• 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. This is to make sure that the operation has worked and that you do not have any problems.

**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.

- Heavy vaginal bleeding or passing large blood clots.
- Severe pain in the vagina or abdomen.
- High fever or repeated vomiting.
- 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:

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

The urogynaecology team will usually 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 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.
12 References


13 Contact details

**Urogynaecology nursing team**
(For medical problems and questions only)
Direct line: 020 3447 6547
Mobile: 07951 674140
Fax: 020 3447 6590
Email: urogynaecology@uclh.nhs.uk

**Gynaecology outpatient appointments**
(Contact for outpatient clinic appointments only)
Direct line: 020 3447 9411
Fax: 020 3447 6590

**Preoperative Assessment Clinic (PAC)**
(Contact for questions about PAC only)
Direct line: 020 3447 3167
Fax: 020 3383 3415

**Gynaecology Admissions**
(Contact for surgery dates and scheduling only)
Direct line: 020 3447 2504

**Urogynaecology secretary**
Direct line: 020 3447 2516
Fax: 020 3447 9775

**University College Hospital**
Switchboard: 020 3456 7890
Website: www.uclh.nhs.uk
14 How to find us

The Urogynaecology and Pelvic Floor Unit
Clinic 2, Lower Ground Floor
Elizabeth Garrett Anderson (EGA) Wing
University College Hospital
25 Grafton Way
London
WC1E 6DB
Space for notes and questions