



Sacropexy

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INTRODUCTION

Sacropexy is performed to correct an enterocoele, which forms mainly after hysterectomy, but can occur with the uterus in situ. The ligaments are weakened and a hernia forms at the site from which the uterus was removed. It is pushed down by the bowel above and it protrudes through the vagina. Enterocoele is usually accompanied by a rectocoele, which is a weakness of the posterior wall of the vagina and may also be accompanied by a prolapse of the bladder (cystocoele). Enterocoele is a particularly difficult prolapse to correct, as the ligaments attached to the cervix have atrophied and there is no fixed point to attach the vagina to.

PROCEDURE

To repair this defect, a tape is passed from behind near the coccyx bone, up past the rectum to the site of the enterocoele, and then passed down through the other side. This tape is attached to the remains of the weakened pelvic ligaments and supports them. A fibrous reaction occurs around the tape to strengthen and replace the weakened ligament. Unlike other similar procedures, no vaginal pack or catheter is required. There is almost always a weakness of the posterior wall of the vagina, and a repair of this prolapse is almost always necessary at the same time.

ADMISSION TO HOSPITAL

This normally occurs the morning of the operation. You should have nothing to eat or drink from midnight the night before. If the operation is to be in the afternoon, you can have a light breakfast before 6am, eg: toast, tea or coffee. If you develop a cough, cold or fever before the operation, it may need to be postponed. The appropriate anaesthesia will be decided by the anaesthetist and should be discussed with him or

her. The anaesthetist will arrange the appropriate premedication if required. The operation can be performed under local or epidural anaesthesia. If you are currently taking Aspirin, Indocid, Naprosyn or other anti-inflammatory drugs, these should be discontinued ten days before the operation, as these can cause bleeding. Please bring a packet of sanitary pads with you to hospital with your own night attire and toiletries.

RECOVERY

You will wake up in the post-operative recovery room within the theatre complex. You may have an oxygen mask fitted comfortably over your mouth and nose. There may be an intravenous 'drip' needle in your arm. Analgesic medication will be prescribed to prevent any postoperative pain. The pain is usually minimal, as local anaesthetic is injected into the operative area. There may be some nausea and vomiting, although medication to counteract this is routinely given during the operation. If you continue to feel nauseated, notify the nursing staff so that further medication may be administered. The nursing staff will measure the volume of urine passed each time to make sure that there is no retention of urine. In this case, a small "in-out" catheter will be passed to empty the bladder.

The amount of vaginal bleeding will be checked on a regular basis. Once fluids are tolerated, the intravenous 'drip' will be removed. You will normally be discharged home the afternoon of the operation or the next morning. A longer hospital stay can be arranged according to your medical condition or personal circumstances.

DISCHARGE HOME

The operation was designed for patients to return to work and normal activities as soon as possible ie: you can usually drive your car, cook, shop, look after your children within 10-14 days. However, in some patients, recovery may take longer, and return to work takes a variable time, depending on the activities involved. Please remember to be sensible. Most operations that fail, do so because sutures tear out of the vagina due to excessive strain and lifting before the tissue have knitted together. Vaginal intercourse should be avoided for six weeks. Avoid tampons during this time and prevent constipation with orange juice and bran and other fibre products.

It is important to exercise extreme care when getting in and out of a car or getting up from a chair. In particular, the knees should be kept together as much as possible during activity, especially lifting and squatting.

FOLLOW-UP

An initial appointment should be made 1 - 2 weeks after operation, or earlier if there is a problem. The sutures near the coccyx will be removed. There is a further follow-up at 6 weeks. There may be some vaginal bleeding for the first few days after the operation.

RESULTS OF THE OPERATION

The results of any operation cannot be guaranteed and it is possible for the prolapse to recur. This can happen if the sutures tear out before the tissues have knitted together. It is important to realise that the principal reason for your problem is that the ligaments and muscles around the vagina have been damaged and stretched and can no longer function normally. As the tissues are damaged, the absolute success rate for surgery cannot be higher than 85-90%. It is also possible that strengthening the pelvic ligaments in one area may cause extra pressure on other areas, leading to other types of prolapse, requiring further surgery.

COMPLICATIONS

Complications are rare, but it must be understood and accepted that these can occur. Although major complications are not common, they may be disabling and even life threatening and may require further surgery to correct. This can lead to prolonged recovery time and even permanent disability. It is your responsibility to make sure that you understand the proposed surgery and to ask any questions if you are unsure. The complications that can occur include, but are not limited to the following, as it is not possible to list all rare or unexpected complications that may occur:

- ? Infection - there may be a simple infection of the wound requiring antibiotics alone. However a pelvic abscess could develop, requiring drainage.
- ? Haemorrhage - this is rare, but could lead to a haematoma, a pocket of blood behind the sutures, which may need to be drained or which may drain spontaneously.
- ? Injury to Rectum - if the instrument inserting the tape is passed through the rectum this could lead to infection, but as it is only a puncture wound, withdrawing the instrument should not cause any
- ? Deep Venous Thrombosis - a possible complication of any surgery, but much less likely with this type of operation as you are mobilised almost immediately.
- ? Rejection of the Tape - in 5% there will be a tape rejection, which can occur even several months after the operation. This will lead to discharge and bleeding, although there is usually no infection and would require removal of the tape. This can usually be done in the surgery, but could require admission to hospital.
- ? Injury to Bowel - if the bowel is well down in the enterocoele sac, there is a small risk that it could be caught up in the sutures. This could lead to bowel obstruction and/or peritonitis and require further surgery through an abdominal incision.
- ? Vaginal Narrowing - there is a possible risk that the vagina could be narrowed and/or shortened. This could require further surgery to correct, but could be permanent, causing pain with intercourse.