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Urogynaecologist & Reconstructive Pelvic Surgeon

INFORMATION SHEET AND CONSENT FORM

Laparoscopic sacral colpopexy and cystoscopy

- **Paravaginal repair**
- **Posterior vaginal wall repair**

Indications:

- Recurrent pelvic organ prolapse (after uterus has been removed)

Surgical Technique:

- The operation is performed under general anaesthetic (you are asleep) and antibiotics are given through a drip
- The surgery is performed through 4 keyhole incisions
- Because this surgery can only be performed on women who have previously had a hysterectomy, there are often adhesions between bowel and other tissues which need to be divided before the surgery can be done. If the adhesions are too dense, the keyhole surgery may be abandoned and a vaginal approach used to complete your prolapse surgery.
- After dissection of your bladder and bowel away from your vagina, a permanent mesh is sutured to the outside of your vagina.
- Although this is not without complication, this use of mesh is not associated with the same complication profile as transvagianlly placed mesh. Please read the UGSA and IUGA information given to you closely to make sure that you understand the risk/benefit profile and also the alternative native tissue repair options.
- The mesh is then tacked to a strong ligament near your sacrum and peritoneum closed over the mesh
- Strong permanent sutures between the vaginal and a ligament near your pubic bone will be used to support your lower anterior wall if necessary and a vaginal posterior wall repair will be performed if necessary
- A camera is used to make sure there is no injury to your bladder or ureters

Complications:

- Recurrent symptomatic prolapse 5-10-%
- Serious complications are rare however your symptoms must be severe enough to accept the risks listed below
- Large blood loss requiring blood transfusion
- Intraoperative injury to bowel, ureters, bladder or other organs requiring reoperation or prolonged hospital stay, this are usually picked up at the time of surgery but can reveal themselves up to 2 weeks after surgery
- Return to theatre for pain or bleeding
- New urinary symptoms like urgency or slow urine flow 5%

- Painful sex 5%
- 5% wound infection requiring antibiotics
- Urinary tract infection 5%
- Clot in legs or lung <1%
- Mesh exposure 2%, often requiring reoperation

In Hospital and Recovery:

- Hospital stay is usually 2-3 nights
- When you wake up from your operation you will have bladder catheter and a pack in your vagina. These will be removed the following day and we will assess whether you are emptying your bladder properly. If you are not, the nurses will teach you to self-catheterise and you may go home doing this while your bladder function recovers which is most often within 2 weeks. The risk of this is around 5%.
- You will be given pain medicine to manage post-operative pain and you should take aperients to avoid constipation
- A small amount of vaginal bleeding is to be expected for 2 weeks
- It is crucial to avoid constipation, heavy lifting, running or any other stress to your pelvic floor over the first 3 months postoperatively while healing takes place. Sexual intercourse should wait until after review at 6 weeks.
- Time off work is usually 4-6 weeks depending on your occupation
- After discharge, worsening pain or urinary symptoms like burning or pain are not normal and you should see your local doctor.
- Dr Mowat will review you around the 6-week mark, but if you have any concerns before this, please ring the rooms
- As a long-term lifestyle measure we recommend avoiding lifting over 15 kgs, excessive exercise, weight gain, constipation and smoking to optimise the chance of a long-lasting repair.