Sacral Colpopexy

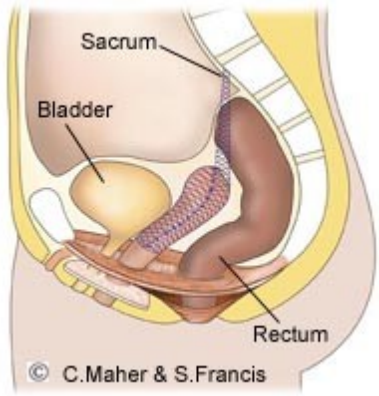
AIM
To correct upper genital tract prolapse

Indication
Usually reserved for recurrent prolapse of the upper vagina, massive vaginal eversion or severe prolapse of the cervix where the uterine function is to be preserved.

Surgical Technique

- Usually performed under general anaesthesia
- Performed through an incision on the lower abdomen
- The bladder and rectum are freed from the vagina and permanent mesh supports the front and back wall of the vagina or cervix *(See picture below)*
- This mesh is secured to the sacrum (upper tailbone)
- Peritoneum (lining of the abdominal cavity) is closed over the mesh
- Other repairs can be performed as required at the same time including perineoplasty, colposuspension or rectopexy.
- Bowel preparation may be required prior to the surgery

Diagrammatic representation of the surgery is shown below



Complications

- failure to correct prolapse in 10%
- urinary urgency or urge incontinence in 5%
- Urinary tract or wound infections in 2-5% of patients.
- Voiding difficulty that necessitates the use of prolonged catheter use <1% of patients
- Blood loss requiring transfusion < 1%
- Clotting in the legs or lungs < 1%
- Damage to the urinary system in <1%
- Mesh rejection in 1%.
- Painful intercourse can occur in 1% especially if a posterior vaginal repair is performed. Confidence and comfort during coitus is likely to be increased as a result of the prolapse being repaired.

Surgery will be covered with antibiotics to decrease the risk of infection and blood thinning agents may be used to decrease the risk of clots forming in the postoperative phase.

For the first 24 hours postoperatively a vaginal pack is often inserted into the vagina to decrease the risk of bleeding and a catheter is used to drain the bladder.

In hospital and recovery

You can expect to stay in hospital between 3-4 days. The vaginal pack, if used is removed on the first day and the bladder catheter after the first few days. In the early postoperative period you should avoid situations where excessive pressure is placed on the repair ie lifting, straining, coughing and constipation. Maximal fibrosis around the repair occurs at 3 months and care needs to be taken during this time. If you develop urinary burning, frequency or urgency you should see your local doctor. You will see your specialist at 6 weeks for a review and sexual activity can usually be safely resumed at this time. You can return to work at approximately 4-6 weeks depending on the amount of strain that will be placed on the repair at your work and on how you feel.