INFORMATION SHEET & CONSENT FORM

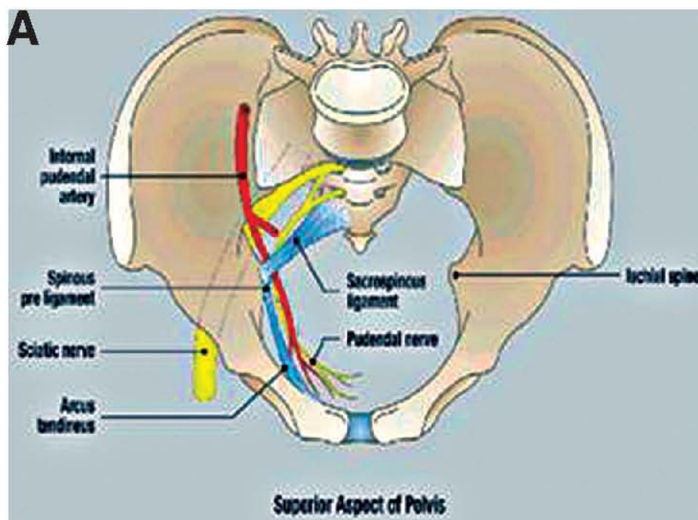
Sacrospinous / Uterosacral Colpopexy

AIM: This surgery offers support to the upper vagina minimising risk of recurrent prolapse at this site.

INDICATION: Upper vaginal prolapse (uterine or vault prolapse, enteroceles). This procedure can be used in reconstructive vaginal surgery where increased vaginal length is required.

Procedure

- The procedure can be preformed under regional or general anaesthesia.
- A routine posterior vaginal incision is made and extended to the top of the vagina.
- Using sharp dissection the vagina is freed from the underlying tissue and rectum until the pelvic floor (puborectalis) muscle is seen
- Using sharp and blunt dissection the sacrospinous ligament running from the ischial spine to the sacral bone is palpated and identified (A).
- Two sutures are placed through the strong ligament and secured to the top of the vagina. This results in increased support to the upper vagina. There is no shortening of the vagina.
- Alternatively sutures are taken through the uterosacral ligaments and attached to the top of the vagina (B).
- Other fascial defects in the vagina are repaired and the vaginal skin is closed.



Surgery will be covered with antibiotics to decrease the risk of infection and blood thinning agents will be used to decrease the risk of clots forming in the postoperative phase. For the first 24hrs 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.

- The sacrospinous fixation is highly effective at controlling upper vaginal prolapse with a failure rate of only 5-10%.
- Buttock pain on the side that the sacrospinous sutures have been passed occurs in 5-10% of women. This can be very painful but usually fully subsides by 8 weeks.
- Bleeding requiring transfusion <1%.
- Damage to the surrounding organs (bladder, rectum or ureter) occurs rarely and is usually repaired in surgery.
- Small risk of clots developing in the legs or lungs after surgery. (<1%)
- Urinary tract infection occurs in 1 - 5%.
- 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.

IN HOSPITAL & RECOVERY

You can expect to stay in hospital between 3 - 4 days. The vaginal pack, is removed on the first day and the bladder catheter after the first few days or when your bladder empties appropriately. In the early postoperative period you should avoid situations where excessive pressure is placed on the repair ie lifting, straining, coughing and constipation. Maximal healing 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. Vaginal spotting or discharge is not uncommon in the first 10 days but should be reported to your doctor if heavy or persistent. You will see Dr. O'Reilly or his team 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.

Avoiding heavy lifting (>15Kg), Weight gain and smoking can minimise failure of the procedure in the longterm. If you have any questions about this information, you should speak to the doctor or his team before your operation.

CONSENT

I ……………………………………………………. of ………………………………………………………..

……………………………………………………………………have read and understand the information.

I hereby consent to have this procedure performed.

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(patient signature) (Date) (Doctors Signature)