LAPAROSCOPIC COLPOSUSPENSION

Stress incontinence (SI) is leakage that occurs with cough, sneeze or strain. It results from weakness of the valve mechanism of the bladder, usually secondary to childbirth and aging.
All patients should have attempted a course of pelvic floor exercises prior to surgery.
Colposuspension re-supports the bladder neck, using the front wall of the vagina to create a hammock, and so uses only your own tissues. The vaginal vault is lifted towards, and secured to, a ligament over the pubic bone using sutures. It is a reliable anti-incontinence operation for typical SI, with initial success rates of 85%, maintained to 70% at 10 years. The surgery may simultaneously address associated cystocoele. However, there is a risk of recotocoele and other pelvic organ prolapse following this procedure.
The procedure is performed abdominally (or from above). There is a choice between an open or laparoscopic approach. Laparoscopy is associated with less pain, less blood loss and superior recovery when compared to the open procedure, and allows an earlier return to normal function. The scars are small and cosmetically superior. It follows the same principles as open surgery and achieves similar early results in terms of cure of the underlying condition. However, there is some data suggesting that the long-term success may be less than with the open approach, although this remains controversial.
In general, laparoscopy has longer operating times than open surgery but this does not equate to more complications. In common with all laparoscopic surgery, hospital stay is short and recovery is quicker than the open procedure with few or no wound-related problems.
The procedure is performed under general anaesthetic and surgery performed using a camera and telescope system through the ports (keyholes).

WHAT TO DO BEFORE YOUR PROCEDURE:

- ensure laboratory tests are done > 48 hours prior to surgery, unless advised otherwise
- discontinue aspirin and other anticoagulants 1 week prior, other medications may also need to be stopped
- nothing to eat or drink from 6 hours prior to procedure - see Admission Booklet regarding diet restrictions
- microlax enema morning of the procedure for afternoon procedures, evening prior for morning procedures
- you will be admitted to hospital on the day of surgery.
- you do not need to shave prior to surgery

WHAT HAPPENS IN HOSPITAL AFTER YOUR PROCEDURE:

- day 1: urethral catheter and vaginal pack will be removed
- your hospital stay is commonly 1-3 days

WHAT HAPPENS AFTER YOU LEAVE HOSPITAL:

- recovery is reasonably quick, with return to normal activities including driving after 10 days.
- withhold aspirin and other anticoagulants for 1 week but reinstate other usual medications.
- the Steristrip (tape) dressings should be left on the wounds for 4 weeks. If the Steristrips come off, the wounds should be left exposed without further dressings applied
- post-operative constipation is a common problem and may be minimised with good fluid intake, dietary fibre and laxatives.
- you may not drive for 24 hours post procedure and see Admission Booklet regarding further restrictions following general anaesthetic

- avoid heavy lifting for 2 weeks; thereafter resume normal activity including sexual intercourse
- fatigue continues for several weeks after surgery. You are encouraged to return to normal activities early, accepting the fatigue, which although limiting, will resolve progressively and completely.

WHAT CAN GO WRONG:

Although most cases proceed without particular difficulty and have excellent outcomes,

- recurrent incontinence and voiding difficulties occur in up to 15% of patients;
- all patients report slower voiding and some describe altered sensation of voiding and desire to void;
- urine retention, needing to self-catheterise intermittently is uncommon (1%) in patients with normal pre-operative voiding;
- new irritative urinary symptoms of frequency-urgency-nocturia and vaginal prolapse each occur in some 5% of patients.

Other surgical complications occur overall in 5% of patients. The list below details complications recognised as common or serious, but this does not include the rare and extraordinary. Risk of death is approximately 0.03% in generally healthy patients.

AT THE TIME OF AND EARLY AFTER SURGERY:

- Failed procedure and conversion to open procedure <1%
- Bleeding requiring blood transfusion in < 1%
- Infection may require antibiotic treatment <3%
- Temporary shoulder pain is common after laparoscopy
- Damage to other organs, including bowels, spleen, liver and gall bladder, nerves and lymphatics, and CO2 gas embolism
- Numbness or tingling in legs, genitalia and perineum is usually temporary
- Clots (DVT, PE), gas embolism
- Risk of death may be estimated using the nzRISK https://nzrisk.com on-line pre-operative calculator. It has been developed and validated for patients in New Zealand over the age of 18, to help patients and doctors balance benefits and risks of treatment.

LATER POTENTIAL COMPLICATIONS :

- Port site hernia
- Adhesions