



LAPAROSCOPIC SACROCOLPOPEXY

Pelvic prolapse is the descent of various pelvic organs into and out of the vagina. The normal supporting structures weaken, a result of a number of factors, allowing the bladder (cystocele), rectum (rectocele), small bowel (enterocele), or uterus to herniate. This results in the sensation of “something coming down”, dragging discomfort, lower back pain, incontinence, difficulties voiding urine or passing bowel motion, and discomfort with sexual intercourse.

There are a number of different surgical techniques for repair, each of which may be combined with anti-incontinence surgery when this is indicated. Vaginal repair of pelvic organ prolapse has a failure rate (recurrence of pelvic organ prolapse) of up to 70% of patients. Therefore, where possible and in particular for multicompartament and more severe prolapse, **abdominal** rather than vaginal procedures are more reliable. Sacrocolpopexy involves re-suspending the uterus / vaginal vault to the apex of the sacrum, high in the pelvis, and reinforcing both front and back walls of the vagina, commonly using permanent synthetic mesh. Polypropylene surgical mesh use in pelvic organ prolapse surgery has been controversial and its use is now restricted in New Zealand and many parts of the world.

The FDA in the USA has reviewed mesh-related complications and endorsed continued use of polypropylene surgical mesh for sacrocolpopexy. However, there remain concerns around mesh use even for this procedure.

It may be possible to achieve this repair using native tissues, but this requires a reasonably significant wound, often on the side of the thigh, to harvest the donor fascia for the reconstruction.

There is a choice between an open or laparoscopic approach for sacrocolpopexy. Laparoscopy (key-hole surgery) is associated with less pain, fewer complications and superior recovery, compared to open surgery. Internally, the surgery is very similar to the older open operation, and achieves similar results in terms of cure of the underlying condition. 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). Fascia for use as the mesh-substitute may be harvested via a 10cm incision on the lateral side of the thigh.

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.
- continue ciprofloxacin 500mg antibiotic twice daily for 1 week after the surgery
- 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 prolapse occurs in up to 15% of patients. This compares to a recurrence rate after vaginal repairs of <70%.

Cystocele repair may unmask urinary incontinence or rarely cause voiding difficulty and irritative urinary symptoms.

Sexual difficulty and difficulties passing bowel motion are uncommon but have been reported.

With surgical mesh, there is risk of the mesh being infected, rejected, or eroding into the vagina, and needing to be removed. It has generally been possible to achieve complete removal of surgical mesh used for laparoscopic sacrocolpopexy.

There is no risk of mesh-related complications if only native tissues are used for the reconstruction.

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
- Ureteric obstruction / injury, bladder or rectal injury. Rectal injury may require a temporary ileostomy/colostomy to achieve repair.
- 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://nznrisk.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