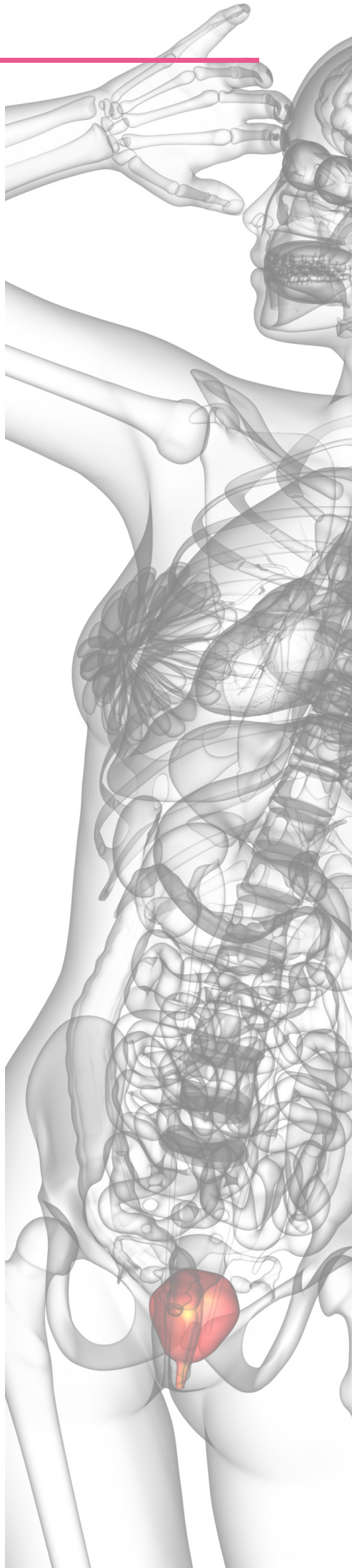
Sacrospinous Hysteropexy

THE UROGYNAECOLOGICAL SOCIETY OF AUSTRALASIA



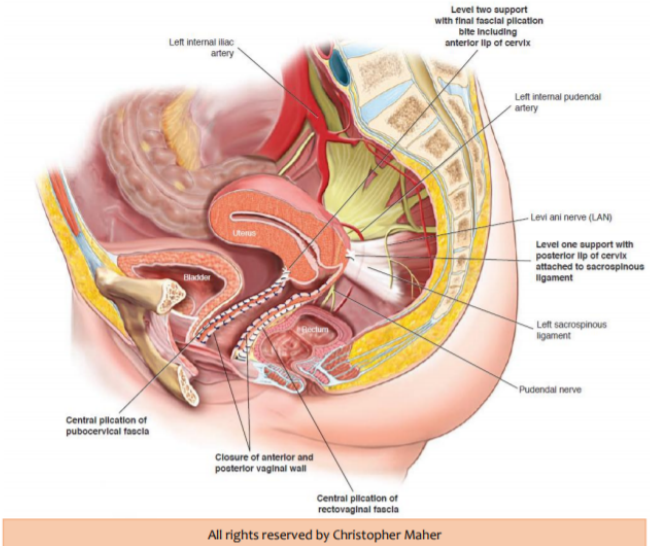
Aim

Hysteropexy is a surgical procedure performed to treat prolapse of the uterus, and often of the vaginal wall as well, in women who would rather avoid a hysterectomy. A hysteropexy avoids removing your uterus. Some women chose to this as it helps them feel more intact and to maintain their personal identity. Often women are anxious that a hysterectomy may change sensitivity during sexual intercourse; however, studies have not demonstrated a difference in sexual function. Early studies demonstrate hysteropexy and hysterectomy to be equally effective.

Although keeping your uterus allows you to have a pregnancy, you are advised to complete your family before having prolapse surgery as a pregnancy may damage the repair resulting in the prolapse returning. Therefore, if a pregnancy does occur, a caesarean section may be advised to reduce the risk of prolapse. Having a hysteropexy may also affect your ability to become pregnant, but not much is known about this effect.

Surgical technique

A cut is made in either the front or back wall of the vagina and the sacrospinous ligament identified. Sutures (stitches) are inserted in the ligament and then attached to the cervix so that the uterus is suspended back in its normal position. Either permanent or dissolving sutures are used, around which scar tissue forms to help maintain the effect of the operation. As shown in the diagram below, an anterior and/or posterior vaginal repair is commonly performed at the same time for the management of bladder (cystocele) or bowel (rectocele). If required, a continence operation can be performed at the same time and a cystoscopy may be performed to ensure there has been no damage to the bladder or ureters during the operation.



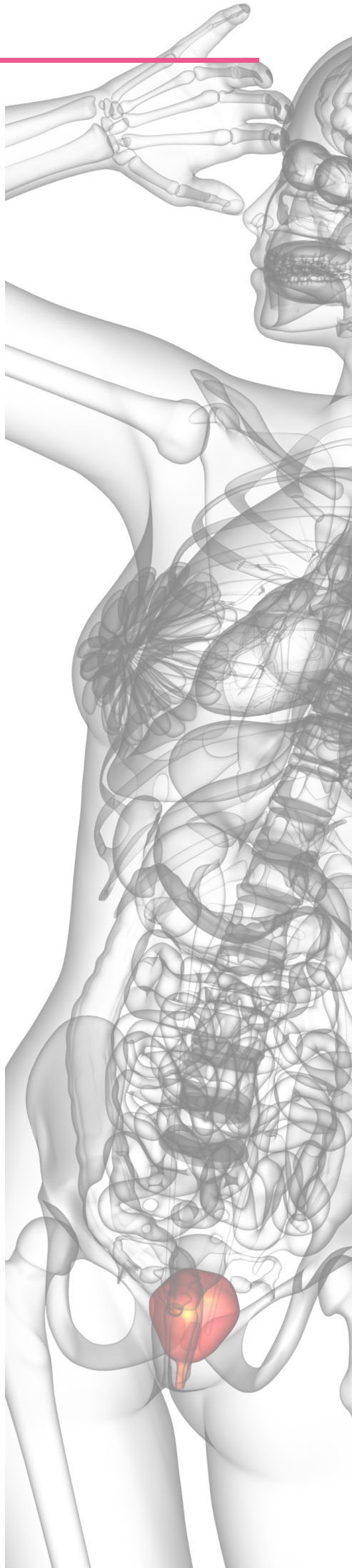
Pelvic floor muscles form a hammock running from the pubic bone to the sacrum and support the urethra, vagina and bowel

Sacrospinous Hysteropexy

THE UROGYNAECOLOGICAL SOCIETY OF AUSTRALASIA

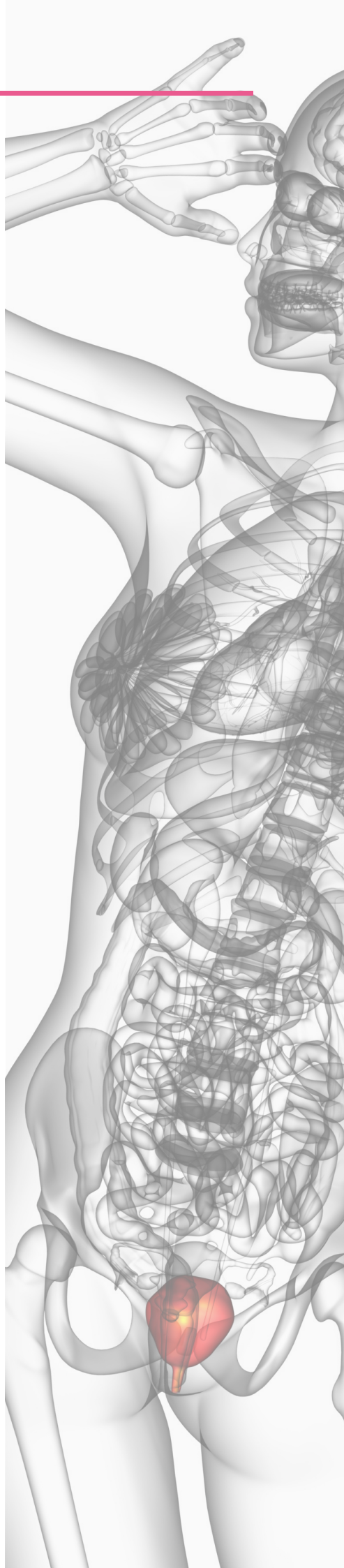
Serious complications are rare with this type of surgery. However, no surgery is without risk and the main potential complications are listed below:

- As with all surgery, there is a risk of bleeding requiring a blood transfusion (1%), infection (2–5%), or clotting to legs (less than 1%)
- There is a risk of damage to the bowel or bladder requiring further surgery (less than 1%)
- 1-in-9 women will have buttock pain from the sacrospinous sutures after the procedure, but this settles without further intervention in most cases (90%)
- Painful sexual intercourse may occur (1–5%)
- Approximately 10-15% of women will require subsequent prolapse surgery
- Urinary incontinence that was not present prior to surgery may develop (1–5%)
- Problems emptying your bladder completely requiring prolonged catheter use (less than 1%)
- Hip pain may occur due to your position during the surgery. This usually improves with physiotherapy and pain relief, but can sometimes be difficult to treat. coughing/sneezing to prevent stress urinary incontinence).



SACROSPINOUS HYSTEROPEXY

THE UROGYNAECOLOGICAL SOCIETY OF AUSTRALASIA



In Hospital

You can expect a 2-4 day stay in hospital. Antibiotics are given in theatre to reduce the risk of infection. Blood-thinning injections will be given to reduce the risk of clots to your lungs and legs and you will be given special stockings to wear. After the operation, you will have a pack in the vagina for the first night, to reduce any bleeding, and a catheter in your bladder for the first 24–48 hours. After removing the catheter, the nurses will check that you are emptying your bladder completely. Dissolvable sutures are used to close the vaginal skin. These usually dissolve between 4–6 weeks after surgery and you may find fragments of wiping them when.

Recovery

During the first week at home you will be able to resume personal care, but you should avoid lifting, coughing, straining and constipation as these put pressure on the repair. Laxatives will often be given to you in hospital and you may need to continue using them to keep your stool soft at home. Any pain and discomfort will usually be controlled with paracetamol and anti-inflammatories; rarely is other stronger pain relief required. Bladder infections are quite common after prolapse surgery. If you experience any pain with voiding or any frequency you should see your local doctor. You may drive short distances after the first 2–3 weeks Sexual activity can be resumed after 6 weeks. Generally, you can return to work after 6 weeks; however, this will vary depending on your work and should be discussed with your gynaecologist. Scarring from the procedure occurs 3 months after surgery and this helps reduce the risk of prolapse recurring; therefore, it is important to be extra careful during this period. In the long term, it is important to continue avoiding heavy lifting (more than 15kg), constipation, weight gain and weight-bearing exercises to reduce the risk of the prolapse returning. Ongoing routine Pap smears will be required until 70 years of age.

For more detailed postoperative recovery information, see separate information sheet – *Recovery after vaginal prolapse surgery.*

This statement has been developed by the Urogynaecological Society of Australasia (UGSA).