



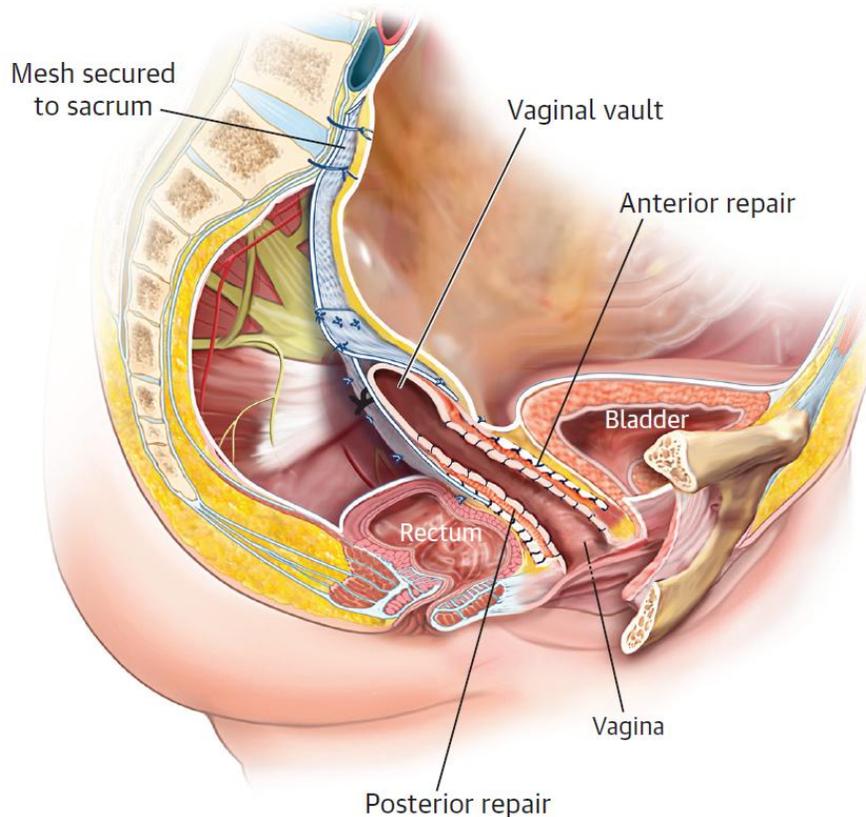
## Sacral Colpopexy

**Aim:** To correct upper genital tract prolapse.

**Indication:** Usually reserved for recurrent prolapse of the upper vagina (recurrent cystocele, vault or enterocele) or complete vaginal prolapse.

**Surgical technique:**

- Usually performed under general anaesthesia
- Performed through laparotomy (an incision on the lower abdomen) or laparoscopy (keyhole)
- The bladder and rectum are freed from the vagina and permanent mesh supports the front and back wall of the vagina
- The mesh is secured to the sacrum (upper tailbone)
- Peritoneum (lining of the abdominal cavity) is closed over the mesh
- A cystoscopy is performed to ensure the bladder or ureters have not been damaged during the surgery
- Other repairs are performed as required at the same time, including paravaginal repair, perineoplasty, colposuspension or rectopexy.



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*Shows mesh suspending the vagina from the sacrum at sacral colpopexy*



## INFORMATION SHEET

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

- Failure to correct prolapse in 10%
- Urinary urgency or urge incontinence in 5%
- The development of urinary incontinence that was not present prior to surgery in 1–5%
- Urinary tract or wound infections in 2–5%
- Voiding difficulty that necessitates prolonged catheter use in less than 1%
- Blood loss requiring transfusion in less than 1%
- Clotting in the legs or lungs in less than 1%
- Damage to the urinary system (bladder or ureter) or bowel in less than 1% that may require further surgery
- Mesh erosion/rejection in 2–3% that may require further surgery
- Persistent painful intercourse can occur in 1–5%, especially if a posterior vaginal repair is performed. Confidence and comfort during intercourse is likely to be increased as a result of the prolapse being repaired.

Antibiotics are given in theatre to reduce 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 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 2 and 3 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, such as lifting, straining, coughing and constipation. Driving can normally be commenced 2–3 weeks after discharge. Maximal fibrosis (scarring) 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 gynaecologist at 6 weeks for a review and sexual activity can usually be safely resumed at 6–8 weeks. 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. Any concerns should be raised with your doctor.

Avoiding heavy lifting (more than 15kg), weight gain, constipation and weight-bearing exercises can minimise failure of the procedure in the long term. If you have any questions about this information, you should speak to your doctor before your operation.

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

**Disclaimer:** This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.