Sacrospinous Colpopexy

Prolapse surgery usually involves repair of the anterior (front) and posterior (back) walls of the vagina. Where there has been a major pelvic organ prolapse (bladder, rectum or both) or the uterus or vaginal vault is also involved, repair of the anterior or posterior walls of the vagina alone may not be sufficient to prevent recurrence of a prolapse. A sacrospinous colpopexy will give added support to the top of the vagina. An added advantage is that it helps maintain the length of the vagina.

Procedure
Sacrospinous colpopexy is usually performed under general anaesthesia, but, can be done with a regional block. It is usually done in conjunction with repair of the vaginal walls. The vaginal incision runs in the midline to the top of the vagina.

The sacrospinous ligament is a strong ligament attaching the side of the sacrum to the ischial spine of the pelvis. Two sutures are passed through this ligament and through the upper part of the vagina. The vaginal wall repair is then completed and the incision is closed with dissolvable sutures. Surgery will be covered with antibiotics to decrease the risk of infection and blood thinning agents will be used to decrease the risk of clot formation 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.

Complications
- 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% women. This can be very painful but usually fully subsides by 6 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 forming 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.

Recovery
After the operation you will have an IV drip in your arm for fluids and pain relief. You can expect to stay in hospital between 1 – 3 days. The urinary catheter and/or vaginal pack are removed on the first day. In the early postoperative period you should avoid situations where excessive pressure is placed on the repair i.e. lifting, straining, coughing and constipation.

Maximal repair with scar tissue 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 Stamatiou at 6 weeks for a post-operative review. You can return to work at approximately 2 to 6 weeks depending on your discomfort levels and the type of work. Driving can resume at 2 to 4 weeks and sexual intercourse at 6 to 8 weeks.