

Sacrocolpopexy

What is Sacrocolpopexy?

Sacrocolpopexy is a major surgical procedure to treat prolapse of the vault (top) of the vagina in women who have had a previous hysterectomy by fixing it to the sacrum using a graft or mesh. First described in the late 1950's, sacrocolpopexy is highly regarded for its effectiveness and durability in the treatment of vault prolapse.

What is Sacrohysteropexy?

In women with uterine prolapse, a procedure similar to sacrocolpopexy can be done to restore the uterus back to its normal place in the pelvis.

What is Sacrocervicopexy?

Some women who have undergone supracervical (also called subtotal) hysterectomy with the cervix left behind, the prolapse of the top of the vagina with the cervix attached can be restored back to its normal place similar to sacrocolpopexy.

How is the operation performed?

Traditionally, sacrocolpopexy is carried out through a large abdominal incision (**laparotomy**) under general anaesthesia. With advances in minimally invasive surgery, sacrocolpopexy can be carried out through 'keyhole' surgery using **laparoscopic** or **robotic** surgery, delivering benefits of less pain and quicker recovery compared to laparotomy.

What does Sacrocolpopexy/ Sacrohysteropexy/ Sacrocervicopexy involve?

All three procedures involve securement of a **graft** or **mesh** from the top of the vagina, the uterus or cervix to the ligament lying on the front of the sacrum using suture materials or tacking devices.

How successful is Sacrocolpopexy and how does it compare to other surgical options?

Based on **Cochrane**, a non-profit organization formed to facilitate evidence-based choices about health interventions (<http://www.cochranelibrary.com>), sacrocolpopexy delivers superior outcomes to transvaginal procedures such as sacrospinous ligament, uterosacral ligament and transvaginal mesh suspension.

Reported long-term success rate varies from surgeon to surgeon, and ranges from 80 to 100%. At CARE, our long-term follow-up shows success for correction of uterine and vault prolapse over 95%.

What are the potential complications associated with Sacrocolpopexy?

Like every major surgical procedure, sacrocolpopexy does carry inherent risks with:

- General anaesthesia < 1/1000
- Abdominal wall blood vessel injury, hernia, deep vein thrombosis – 1/100 to 1/1000
- Injury risk to adjacent organs including bladder, bowel, blood vessels and nerves in the pelvis – 1/100
- Fistula (an abnormal connecting track) formation – between the rectum and the vagina (recto-vaginal fistula), or between the bladder and vagina (vesico-vaginal fistula) - 1/100 to 1/1000
- Painful sex due to painful scar tissues or vaginal wall strictures, - 1/10 to 1/100
- Urinary incontinence - 1/10 to 1/100
- Graft or mesh complications include:
 - exposure or extrusion through the vaginal epithelium
 - erosion into pelvic viscera (bladder, rectum) with risk of fistula formation
 - infection, recurrent vaginal discharge
 - painful intercourse, pelvic pain which may require additional intervention and may not resolve completely even with mesh removal
 - The reported incidence of mesh complications varies from 2 to 10% of cases.

Factors which may increase the risk for mesh complications include concurrent hysterectomy, sexual activity, time lapse following surgery.

Is there any way to minimise the risk of complications?

Being a complex surgical procedure, sacrocolpopexy does carry inherent risks (mentioned above). In general, the chance of complications can be minimised when the procedure is carried out by surgeons who have appropriate level of training, acceptable surgical skills and good experience. The **American Urogynecologic Society (AUGS)** indicates that 'good experience' means ongoing surgical volume of a minimum of 30 prolapse procedures per year, with at least 5 being sacrocolpopexy (<https://www.augs.org/clinical-practice/guidelines/>).

What is the current use of mesh in sacrocolpopexy?

On 28 November 2017, the **Therapeutic Goods Administration (TGA)** made a decision to remove **transvaginal mesh** products used in the treatment of pelvic organ prolapse via transvaginal implantation. At the same time, the TGA has maintained legal supply of specific meshes for sacrocolpopexy available on the Australian Register of Therapeutic Goods (<https://www.tga.gov.au/alert/tga-actions-after-review-urogynaecological-surgical-mesh-implants>).

What steps should one considers before choosing Sacrocolpopexy?

- Full evaluation of prolapse symptoms, bladder, bowel and sexual function
- Opportunity to try conservative management options such as a vaginal pessary

- Opportunity to ask questions about the sacrocolpopexy procedure
- Consideration and evaluation of likely outcomes, success, and risks associated with non-mesh repair options such as uterosacral or sacrospinous ligament fixation
- Enquiry about the surgeon's level of knowledge, skill and experience.

What can one expect after surgery?

- Indwelling catheter and vaginal pack the night following surgery
- Hospital stay between 2-4 days
- Some degree of abdominal bloating, pelvic and vaginal pain or discomfort
- Gentle walking and gradual resumption of physical exercises
- Avoid sexual activity, heavy housework or lifting for 6 weeks following surgery
- Report any excessive vaginal bleeding, pain, infection to the hospital or surgeon
- Follow-up visit 6 weeks after surgery
- Report any concerns such as bleeding, pain, recurrent prolapse at any unexpected time after surgery or at the annual check.

A/Professor Alan Lam at **CARE (Centre for Advanced Reproductive Endosurgery)** specialises in the assessment and management of pelvic organ prolapse, particularly in laparoscopic and robotic sacrocolpopexy.

For [an appointment at CARE, please ring 9966 9121.](#)