Patient Information

Patient information and consent to Sacrocolpopexy/Pelvic Floor Repair (PFR)/Sacrospinous Fixation for Prolapse

Key messages for patients

- Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation. You will need to starve for six hours before the operation and drink only clear fluids, water is best for three hours before, the staff will advise you the times for this.

- **Please read this information carefully**, you and your health professional will sign it to document your consent.

- **It is important that you bring the consent form with you when you are admitted for surgery.** You will have an opportunity to ask any questions from the surgeon or anaesthetist when you are admitted. You may sign the consent form either before you come or when you are admitted.

- Please bring with you any medications you use (including patches, creams and herbal remedies) and any information that you have been given relevant to your care in hospital, such as x rays or test results.

- Take your medications as normal on the day of the procedure **unless** you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. **Do not** take any medications used to treat diabetes.

- Please call the urogynaecology nurse specialist on telephone number 01223 245151 and ask for bleep 159216 or 157952 if you have any questions or concerns about this procedure or your appointment.

After the procedure we will scan the consent form into your electronic medical notes and you may take this information leaflet home with you.

Important things you need to know

Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist, unless the urgency of your treatment prevents this.

We will also only carry out the procedure on your consent form unless, in the opinion of the responsible health professional, a further procedure is needed in order to save your life or prevent serious harm to your health. However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form. We are unable to guarantee that a particular person will perform the procedure. However the person undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 2018 and the resultant General Data Protection Regulations (GDPR).

Sacrocolpopexy/PFR/Sacrospinous fixation for prolapse, CF448, V5, August 2018
About sacrocolpopexy/pelvic floor repair (PFR)/sacrospinous fixation

Vaginal surgery for vaginal prolapse (bulge coming down in the vagina) aims to alleviate the symptoms of pelvic organ prolapse and return the tissues and organs to their correct position (see picture left). The pelvic organs that can prolapse include the front wall, back wall and/or top of the vagina.

You have previously had your uterus removed; however, the vaginal vault can prolapse. The prolapse generally occurs due to damage to the supporting structures of the vagina. Weakening of the strong tissue layer (fascia) and the ligaments that hold the vagina can occur during childbirth, as a result of chronic heavy lifting or straining e.g. with constipation, chronic cough, obesity and as part of the ageing process. In some cases there may be a genetic weakness of the supportive tissues. It can cause an uncomfortable dragging sensation or feeling of fullness in the vagina. As a result the vagina is not supported as strongly as previously and thus leading to descent of these tissues.

If the front wall of the vagina is weak it is commonly known as a cystocele. (Left).
NB: you have no uterus

If the back wall of the vagina is weak it is commonly known as a rectocele. (Right).
NB: you have no uterus.

There is a common misconception that stitching the bladder or bowel back into place will improve or cure any bladder problems such as leakage or frequency and urgency and bowel problems such as constipation. However this is not the case. The only benefit of the surgery is to fix the bulge coming down and return the vaginal walls to their original normal position. Any other associated bladder or bowel problems will need separate investigations and management either before or after surgery.
A cystocele may cause a feeling of fullness or dragging in the vagina or an uncomfortable bulge that extends beyond the vaginal opening. It may also cause difficulty passing urine with a slow or intermittent urine stream. While symptoms of urinary frequency and urgency commonly occur in association with prolapse they are seldom cured by prolapse surgery.

A rectocele may cause some difficulty when passing a bowel motion, a feeling of fullness or dragging in the vagina or an uncomfortable bulge that extends beyond the vaginal opening. The perineal body (the supporting tissue between vaginal and anal openings) also helps to support the back wall of the vagina. The perineum is the area that is often damaged when tears or episiotomies occur during childbirth or due to general stretching during childbirth and age related wear and tear. This area may need to be repaired along with the back wall of the vagina to give perineal support and in some cases narrow the vaginal opening.

The surgery
There are three commonly used operations for prolapse when you do not have your uterus – your doctor will discuss with you which procedure may be more suited to you:

*Sacrocolpopexy (laparoscopic/open) attaching the prolapsed vaginal vault to the sacrum (lower part of the bony spine) using a Type 1 polypropylene mesh to support the vaginal vault in the correct position. This can be performed laparoscopically (key-hole) or via an incision in the lower abdomen.

*Sacrospinous colpopexy stitches placed into the strong ligament (sacrospinous ligament) of the pelvis and then into the vaginal vault (top of the vagina).

Pelvic floor repair. This is performed for pelvic organ prolapse. This involves making a cut in the walls of the vagina.

The surgery may involve repairing a cystocele (an anterior repair or colporrhaphy) which is a surgical procedure to repair or reinforce the fascial support layer between the bladder and the vagina.
This may be performed alone or with a repair of a rectocele (posterior repair or colporrhaphy) this repairs or reinforces the fascial support layer between the rectum and the vagina.

A perineorrhaphy is the term used for the operation that repairs the perineal body.

Due to the nature of your condition, the actual operation you will have cannot be fully determined until you are examined under anaesthesia and a laparoscope inserted to assess your abdomen. You may therefore have one or a combination of the procedures described above.

The procedures are performed under a general anaesthetic and you will stay in hospital for one to two nights following your operation. You will also require a period of recovery at home for up to six weeks.

**Intended benefits**

This procedure is performed to alleviate symptoms of prolapse to:

- correct a bulge coming down in the vagina
- improve dragging sensation and discomfort
- improve incomplete emptying of bowels (50% success rate)

**Who will perform my procedure?**

This procedure will be performed by a consultant gynaecologist or a qualified doctor undergoing training, under the supervision of the consultant.

**Preparing for your operation**

You should maintain a sensible diet. Daily exercise in the run up to the operation will improve your recovery. A 30 minute brisk walk, three to four times a week should be sufficient. Swimming is a good alternative. Avoid alcohol and cigarettes in the month before the operation.

Discuss the operation with your GP and ask him/her to review your medications. Medications such as low dose aspirin, non-steroidal anti-inflammatories (such as ibuprofen [Nurofen], diclofenac [Voltarol]) need to be stopped at least seven days before the operation. Blood thinning medications such as warfarin need to be converted to an alternative drug before the operation. Hormone replacement therapy (HRT) or tamoxifen should be stopped four weeks before your surgery and not recommenced until six weeks after your operation. If you are on hypertension (high blood pressure) medication you should arrange to have your blood pressure checked by your GP.

If you have any symptoms of a cold or ‘flu in the days leading up to the operation, you must let your surgeon know as this may necessitate the cancellation of your operation. It may cause some problems to undergo surgery if you have any sort of infection.
In the two days before the operation take plenty of fluids. It is important to avoid dehydration in the days before the operation.

**Before your procedure**

Most patients attend a pre-admission clinic, when you will meet a member of the pre-admission team in addition to the urogynaecology team. At this clinic, we will ask for details of your medical history and carry out any necessary clinical examinations and investigations. Please ask us any questions about the procedure, and feel free to discuss any concerns you might have at any time.

We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy. Please bring all your medications and any packaging (if available) with you. Please tell the staff about all of the medicines you use. It may be possible for you to take your regular medication yourself (self-medicate), please ask your nurse. When you are on the ward your nurse will complete a Self-Administration of Medication (SAM) form in your electronic notes.

If you are not diabetic, you will be provided with nutritional carbohydrate drinks in the pre-admission clinic. These nutritional drinks are to be drunk in the 24 hours leading up to your surgery. These drinks help your wounds heal faster, reduce the risk of infection and help your overall recovery. You will need to starve for six hours before the operation and drink only clear fluids, water is best, for three hours before. The pre-admission staff will tell you what time to do this and also advise you of what time you are to come to the hospital.

This procedure involves the use of general anaesthesia. We explain about the different types of anaesthesia we may use at the end of this leaflet. You will see an anaesthetist before your procedure.

Most women who have this type of procedure will need to stay in hospital for one or two nights. Sometimes we can predict whether you will need to stay for longer than usual - your doctor will discuss this with you before you decide to have the procedure.

You will be given some thromboembolic (TED) stockings to wear before the surgery; you should wear these until you have returned to your normal activities after the operation.

**Hair removal before an operation**

For most operations, you do not need to have the hair around the site of the operation removed. However, sometimes the healthcare team need to see or reach your skin and if this is necessary they will use an electric hair clipper with a single-use disposable head, on the day of the surgery. Please do **not** shave the hair yourself or use a razor to remove hair, as this can increase the risk of infection. Your healthcare team will be happy to discuss this with you.
During the procedure

- Before your procedure, you will be given the necessary anaesthetic - see below for details of this and the role of the anaesthetist in your care.
- You will be given antibiotics whilst you are asleep; this is administered intravenously (into the vein) by the anaesthetist. This is given as a preventative measure against possible infection. It is therefore important that you tell a member of staff if you are allergic to any antibiotics.
- Four small incisions are made in the abdomen (tummy) for the laparoscopic approach or a lower transverse incision (a horizontal cut lower on the tummy) is made for the open approach. A piece of synthetic mesh is attached to the vagina and the other end of this mesh is then attached to the lower part of the bony spine to support the top of the vagina. Additionally a repair of the front and back vaginal wall may be performed, if necessary, at the same time. If it is not possible to perform an abdominal procedure, the top of the vagina may be attached with stitches to a ligament near your spine.
- At the end of the procedure a urinary catheter will be placed in the bladder so that you do not have to get up to pass urine. A pack (like a bandage) will be placed in the vagina overnight. This helps to reduce swelling and bleeding in the vagina after the surgery. The pack is removed early the following morning by the nursing staff on the ward. Whilst you have the pack you will stay on bed-rest and the nurses will look after you.

After the procedure

Once your surgery is completed you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure, oxygen levels too and check for any vaginal bleeding. You may be given oxygen via a facemask, fluids via your drip and appropriate pain relief until you are comfortable enough to return to your ward.

You will be given appropriate pain relief, generally this may be in the form of a Patient Controlled Analgesia System (PCAS) see Patient Information Leaflet: Analgesia: Patient controlled

After certain major operations you may be transferred to the intensive care unit (ICU/ITU), high dependency unit (HDU), intermediate dependency area (IDA) or fast track/overnight intensive recovery (OIR). These are areas where you will be monitored much more closely because of the nature of your operation or because of certain pre-existing health problems that you may have. If your surgeon or anaesthetist believes you should go to one of these areas after your operation, they will tell you and explain to you what you should expect.

**If there is not a bed in the necessary unit on the day of your operation, your operation may be postponed as it is important that you have the correct level of care after major surgery.**
Eating and drinking. Usually following surgery you will be able to drink fluids when you are ready. If you feel hungry, you can usually have something light to eat soon after the operation.

Getting about after the procedure. We will help you to become as mobile as you were before the procedure as soon as possible after it. This helps improve your recovery and reduces the risk of certain complications from lying in bed. If you have a vaginal pack you will have to stay in bed for two hours after the pack is removed and then the nursing staff will give you assistance to get out of bed.

Leaving hospital. Generally most people who have had this operation will be able to leave hospital after one or two nights. However, the actual time that you stay in hospital will depend on your general health, how quickly you are recovering from the procedure and your doctor’s opinion.

Resuming normal activities including work. Usually you can resume normal activities including beginning gentle work within two weeks after your operation. Often you will want to wait a little longer before resuming more vigorous activity. If you have a physical job or are on your feet for long periods of time you will need a “Fitness for work” certificate which we can give to you before you leave the ward. Generally this is for six weeks but you may require twelve weeks off. If you have not told your employer the reason for your absence and you do not wish for them to know we will respect your confidentiality and will discuss with you what you wish writing on the certificate.

Special measures after the procedure:
- **Trial of urinary voiding (without catheter – TWOC).** The catheter into your bladder will be removed early the following morning unless your surgeon requests differently. Once it is removed and you get the sensation to void (pass urine), please inform the nursing staff so that they can provide a bed-pan liner for the toilet; do not strain to void. The voided amount will be measured, following which the nurse will scan your bladder using a bladder scanner (like that used during pregnancy and not painful). The scanner will be placed on your lower abdomen and used to measure how much urine is left in the bladder. If the bladder scanner shows you are able to empty your bladder sufficiently you can continue to drink to thirst. If, however you are unable to empty the bladder sufficiently you may have the catheter replaced and you will go home with this and return to Daphne Ward in one week for a further TWOC. Alternatively you will be taught how to empty the bladder yourself using a technique called clean intermittent self-catheterisation (CISC). The nursing staff will teach you how to do this and give you all the information and equipment you will need to manage at home.
- **Vaginal bleeding.** You may have some vaginal bleeding after the operation. This will gradually decrease over the next few weeks. You may experience a heavy bleed (as much as a period) at about ten days after the operation.
This is normal and will usually settle within a few hours. A vaginal discharge can persist for up to four to six weeks. This may be quite heavy but does not mean that there is an infection. You should use sanitary towels and not tampons for the bleeding/discharge. If the discharge lasts much longer than six weeks, becomes heavier or offensive, or you have flu-like symptoms, then please contact us on the numbers below or see your GP.

- **Pain:** You may have period-like pains for a few days, this is normal. Simple painkillers that you can buy over the counter such as paracetamol and ibuprofen should help this. You may get buttock pain if the procedure is done vaginally.

- **Bowels.** It is important to avoid constipation after surgery. We recommend you drink plenty of fluids and eat lots of fresh fruit and vegetables. You will be prescribed laxatives and also given some on discharge to help with this.

- **Hygiene:** As previously mentioned please use sanitary towels and do not use tampons. You are able to shower or bath following the procedure but do not have the water temperature too hot as this may make you feel faint and dizzy. If you have mobility concerns and find getting in and out of a bath difficult we suggest you shower only until you feel able to not only get in the bath but have the upper body strength to get yourself out.

- **Menopause:** If you still have your ovaries and have not been through the menopause this surgery may make no difference to when you will go through your menopause.

- **Pelvic Floor Exercises:** It is important that you continue with the physiotherapy advice you have been given prior to, or following your procedure. This advice is summarised in the “Fit following surgery” leaflet which you will be given on the ward by the physiotherapist.

- **Housework.** Do not lift anything heavy. This means that you will not be able to do housework for a few weeks. We generally advise complete rest for the first two weeks. After this you may gradually increase the amount you do. If you look after your house, start with gently dusting – but not moving everything around, increase to cleaning bathrooms etc, but remember you will not be able to lift a vacuum for approximately eight weeks or to lift buckets of water to wash floors either. You will not be able to lift heavy washing baskets or hang out washing for a few weeks. You will be able to do some ironing after two weeks but you will not be able to put the ironing board up or down.

- **Cooking.** You will be able to make yourself light meals when you come home but you should not lift anything heavier than a kettle of water for approximately four weeks. You will therefore not be able to do things like straining saucepans, lifting heavy dishes in and out of the oven and you will not be able to lift shopping bags or push supermarket trolleys.

- **Sexual Intercourse.** We recommend you wait for four to six weeks before you have any penetrative sexual intercourse; this is to ensure you have healed internally. You may find your vagina is drier than before the surgery it is advisable to use a commercial lubricant for the first time (Vielle, Durex or Sylk); this can be purchased from most supermarkets or pharmacies.
Sexual intercourse may feel different for both yourself and your partner after the surgery as you both may have become accustomed to your prolapse; this has now been repaired. You may find different positions more comfortable.

- **Driving:** You need to be pain free and able to respond to any emergency situation that you may encounter, especially being able to brake quickly without having any pain. It is best to check this by sitting in the car with the engine off. This may be four weeks after your operation. If in doubt check with your GP and your insurance company.

- **Emotionally:** Some women become weepy about three days post surgery; this does not last very long.

Maintaining a normal weight and stopping smoking will help with the long term success of this procedure.

You should continue to wear your thromboembolic stockings (TEDS) until you have resumed normal activities. You will be prescribed anti-clotting injections for one week following your surgery to reduce the risk of a blood clot. You will be shown how to give these to yourself by the nurses on the ward before you go home.

**When to seek advice:**
You should see your GP or contact us on the numbers listed below if you develop any of the following:

- urinary burning, frequency or urgency,
- Have an offensive vaginal discharge
- A fever
- Pain that is not controlled by over the counter (OTC) medications

**Check-ups and results:** When you are discharged from the ward either an appointment will be made for you to be seen in the urogynaecology clinic approximately three months after your surgery or you will have a telephone follow up again in approximately three months. You will be asked to complete a questionnaire so that we can assess how the operation has helped with your symptoms.

**Significant, unavoidable or frequently occurring risks of this procedure**
If you have a pre-existing medical condition, are obese, or have had previous surgery the quoted risks for serious or frequent complications will be increased.
The table below is designed to help you understand the risks associated with this type of surgery (based on the Royal College of Obstetricians and Gynaecologists [RCOG] Clinical Governance Advice, Presenting Information on Risk). This is further explained in the following patient information leaflet available from the RCOG: Understanding how risk is discussed in healthcare. Information for you.

<table>
<thead>
<tr>
<th>Term</th>
<th>Equivalent numerical ratio</th>
<th>Colloquial equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very common</td>
<td>1/1 to 1/10</td>
<td>A person in family</td>
</tr>
<tr>
<td>Common</td>
<td>1/10 to 1/100</td>
<td>A person in street</td>
</tr>
<tr>
<td>Uncommon</td>
<td>1/100 to 1/1000</td>
<td>A person in village</td>
</tr>
<tr>
<td>Rare</td>
<td>1/1000 to 1/10 000</td>
<td>A person in small town</td>
</tr>
<tr>
<td>Very rare</td>
<td>Less than 1/10 000</td>
<td>A person in large town</td>
</tr>
</tbody>
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Serious risks include:

- Damage to bladder/urinary tract, 1-2 women in 100 (uncommon).
- Damage to bowel, 1-2 women in 100 (uncommon).
- Excessive bleeding requiring transfusion or return to theatre, 2 women in 100 (uncommon).
- Failure to achieve desired results recurrence of prolapse, 10-12 women in 100 (common).
- Although venous thrombosis (common) and pulmonary embolism (uncommon) may contribute to mortality, the overall risk of death within 6 weeks is 37 women in every 100 000 (rare).
- Herniation of bowel through the laparoscopic port site (uncommon).
- Erosion of mesh through vagina 5-9 women in 100 which may require further surgery (common).
- Mesh can also erode into bowel or bladder. (uncommon)

Frequent risks include:

- Urinary infection, retention and/or frequency. (common)
- New or continuing bladder dysfunction including incontinence (leaking of urine)
- 10-15 women in 100 (common).
- Altered bowel function including worsening constipation. (common)
- Postoperative pain and difficulty and/or pain with intercourse, 2-3 women in every 100 (common)
- Buttock pain, 3-6 women in 100 (common)
- Wound infection (common).

Alternative procedures that are available

- Physiotherapy may improve some symptoms in some patients. This may not be a sustained (long-term) improvement. Even if physiotherapy fails to improve your symptoms it will improve the outcome of surgery.
A vaginal pessary (a device that is placed into the vagina to hold the organs in the right place) may help control the symptoms caused by your prolapse. There are many different types of pessary but the most commonly used are ring, falk and shelf pessaries (see Management of pelvic organ prolapse with ring pessary). These are fitted in the out-patients clinic and if placed correctly you will not be able to feel the pessary. It may take more than one visit to fit the correct size pessary for you. Once inserted, they need to be changed every few months. Pessary changes may be performed by your GP, at the outpatient clinic or you may be taught to do this yourself. Ring pessaries do not prevent intercourse however they are not suitable for some patients and may fall out. Over time some patients will develop vaginal discharge or bleeding and the pessary will need to be removed.

If you decide not to proceed with surgery your problem may remain the same or get worse. There is no sure way of predicting this. Life style modifications may help your symptoms. These changes may help whether you have an operation or not:

- adjusting your daily routines to help you cope better
- weight loss if you are overweight
- managing a chronic cough if you have one
- giving up smoking
- Trying medication for your bladder if it is a problem.

Your GP or your gynaecologist may be able to help you achieve some of these.

An alternative to this surgery is a decision not to have surgery. We will discuss with you the implications of deciding not to have surgery.

**Information and support**

- Urogynaecology Clinical Nurse Specialists
  Contact via Switchboard 01223 245151 and ask for Bleep 159216 or 157952
  Available Monday to Friday 08.00 – 16.00
  Email: urogynaenurses@addenbrookes.nhs.uk

- Clinic 24 (The Emergency Gynaecology Unit and Early Pregnancy Unit)
  Telephone: 01223 217636
  Open 08:00 – 20:00 Monday to Friday
  08:30 – 14:00 at weekends
  Closed Bank holidays

- Daphne Ward - Inpatient Gynaecology ward
  Telephone: 01223 348544
  At all other times
There is currently a lot of controversy in the literature about the use of synthetic materials (mesh/tape) in vaginal reconstructive surgery and incontinence surgery.

Mesh is used in mid-urethral sling operations via the retropubic approach for incontinence surgery. It is also used for pelvic organ prolapse surgery in the form of sacrocolpopexy and sacrohysteropexy. No transvaginal procedures are employed at Addenbrookes Hospital.

Further information on mesh can be viewed at:

Further support:
Additional information is available from the following organisations:

- International Urogynaecological Association
  www.iuga.org
  https://www.yourpelvicfloor.org/media/sacrocolpopexy-english-1.pdf
  https://www.yourpelvicfloor.org/media/Pelvic_Organ_Prolapse.pdf

- Royal College of Obstetricians and Gynaecologists
  www.rcog.org.uk
  http://www.rcog.org.uk/files/rcog-corp/PelvicFloorRecoveringWell0710.pdf

- Bladder and Bowel Community.
  08453450165
  www.bladderandbowel.org

Anaesthesia

Anaesthesia means ‘loss of sensation’. There are three types of anaesthesia: general, regional and local. **The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness.** Sometimes different types of anaesthesia are used together.

Before your operation

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery.
To inform this decision, he/she will need to know about:

- Your general health, including previous and current health problems
- Whether you or anyone in your family has had problems with anaesthetics
- Any medicines or drugs you use
- Whether you smoke
- Whether you have had any abnormal reactions to any drugs or have any other allergies
- Your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.

**Pre-medication**

You may be prescribed a ‘premed’ prior to your operation. This is a drug or combination of drugs which may be used to make you sleepy and relaxed before surgery, provide pain relief, reduce the risk of you being sick, or have effects specific for the procedure that you are going to have or for any medical conditions that you may have. *Not all patients will be given a premed or will require one and the anaesthetist will often use drugs in the operating theatre to produce the same effects.*

**Moving to the operating room or theatre**

You will usually change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and **before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting.**

Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted. If a regional anaesthetic is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

**General anaesthesia**

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement.
Regional anaesthesia
Regional anaesthesia includes epidurals, spinals, caudals or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic. Regional anaesthesia may also be used to provide pain relief after your surgery for hours or even days. Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.

Local anaesthesia
In local anaesthesia the local anaesthetic drug is injected into the skin and tissues at the site of the operation. The area of numbness will be restricted. Some sensation of pressure may be present, but there should be no pain. Local anaesthesia is used for minor operations such as stitching a cut, but may also be injected around the surgical site to help with pain relief. Usually a local anaesthetic will be given by the doctor doing the operation.

What will I feel like afterwards?
How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

You may have fewer of these effects after local or regional anaesthesia although when the effects of the anaesthesia wear off you may need pain relieving medicines.

What are the risks of anaesthesia?
In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.

Very common (1 in 10 people) and common side effects (1 in 100 people)
Feeling sick and vomiting after surgery
Sore throat
Dizziness, blurred vision
Headache
Bladder problems
Damage to lips or tongue (usually minor)
Itching
Aches, pains and backache
Pain during injection of drugs
Bruising and soreness
Confusion or memory loss

**Uncommon side effects and complications (1 in 1000 people)**
- Chest infection
- Muscle pains
- Slow breathing (depressed respiration)
- Damage to teeth
- An existing medical condition getting worse
- Awareness (becoming conscious during your operation)

**Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications**
- Damage to the eyes
- Heart attack or stroke
- Serious allergy to drugs
- Nerve damage
- Death
- Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK.

For more information about anaesthesia, please visit the Royal College of Anaesthetists’ website: [www.rcoa.ac.uk](http://www.rcoa.ac.uk)
Information about important questions on the consent form

1 Creutzfeldt Jakob Disease (‘CJD’)
We must take special measures with hospital instruments if there is a possibility you have been at risk of CJD or variant CJD disease. We therefore ask all patients undergoing any surgical procedure if they have been told that they are at increased risk of either of these forms of CJD. This helps prevent the spread of CJD to the wider public. A positive answer will not stop your procedure taking place, but enables us to plan your operation to minimise any risk of transmission to other patients.

2 Photography, Audio or Visual Recordings
As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment, they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

3 Students in training
Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

4 Use of Tissue
As a leading bio-medical research centre and teaching hospital, we may be able to use tissue not needed for your treatment or diagnosis to carry out research, for quality control or to train medical staff for the future. Any such research, or storage or disposal of tissue, will be carried out in accordance with ethical, legal and professional standards. In order to carry out such research we need your consent. Any research will only be carried out if it has received ethical approval from a Research Ethics Committee. You do not have to agree and if you prefer not to, this will not in any way affect the care and treatment we provide. The leaflet ‘Donating tissue or cells for research’ gives more detailed information. Please ask for a copy.

If you wish to withdraw your consent on the use of tissue (including blood) for research, please contact our Patient Advice and Liaison Service (PALS), on 01223 216756.
Privacy & dignity

Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

We are a smoke-free site: smoking will not be allowed anywhere on the hospital site. For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

Other formats:

If you would like this information in another language or audio, please contact Interpreting services on telephone: 01223 348043, or email: interpreting@addenbrookes.nhs.uk For Large Print information please contact the patient information team: patient.information@addenbrookes.nhs.uk.
Sacrocolpopexy/pelvic floor repair (PFR)/Sacrospinous fixation for prolapse

Consultant or other responsible health professional

Name and job title: 

☐ Any special needs of the patient (e.g. help with communication)?

Please use ‘Procedure completed’ stamp here on completion:

B Statement of health professional (details of treatment, risks and benefits)

I confirm I am a health professional with an appropriate knowledge of the proposed procedure, as specified in the hospital's consent policy. I have explained the procedure to the patient. In particular, I have explained:

  a) the intended benefits of the procedure (please state)
     - to correct a bulge coming down in the vagina
     - to improve dragging sensation and discomfort
     - to improve incomplete emptying of bowels (50% success rate)

  b) the possible risks involved. Addenbrooke's always ensures any risks are minimised. However all procedures carry some risk and I have set out below any significant, unavoidable or frequently occurring risks including those specific to the patient.
     Serious risks include: Damage to bladder/urinary tract / Damage to bowel / Excessive bleeding requiring transfusion or return to theatre / Failure to achieve desired results recurrence of prolapse / Although venous thrombosis (common) and pulmonary embolism (uncommon) may contribute to mortality, the overall risk of death within six weeks is 37 women in every 100 000 (rare)/ Herniation of bowel through the laparoscopic port site / Erosion of mesh through vagina / Mesh can also erode into bowel or bladder.
     Frequent risks include: Urinary infection, retention and/or frequency / New or continuing bladder dysfunction including incontinence (leaking of urine) / Altered bowel function including worsening constipation / Postoperative pain and difficulty and/or pain with intercourse / Buttock pain / Wound infection.

  c) what the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:
Consent Form

Sacrocolpopexy/pelvic floor repair (PFR) / Sacrospinous fixation for prolapse

d) any extra procedures that might become necessary during the procedure such as:
☐ Blood transfusion  ☐ Other procedure (please state)

2 The following information leaflet has been provided:

Sacrocolpopexy / pelvic floor repair (PFR)/ sacrospinous fixation

Version, reference and date: CF448; Version 5; August 2018

or ☐ I have offered the patient information about the procedure but this has been declined.

3 This procedure will involve:
☐ General and/or regional anaesthesia  ☐ Local anaesthesia  ☐ Sedation  ☐ None

Signed (Health professional): .......................................................... Date: D.D./M.M./Y.Y.Y.Y.

Name (PRINT): ........................................................................ Time (24hr): H.H.:M.M.

Designation: ................................................................................ Contact/bleep no:

C Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

Important: please read the patient information about this procedure and then put a tick in the relevant boxes for the following questions:

1 Creutzfeldt Jakob disease (CJD)
Have you ever been notified that you are at risk of CJD or variant CJD for public health purposes? If yes, please inform your health professional.

☐ Yes ☐ No

2 Photography, Audio or Visual Recording
 a) I agree to the use of any of the above type of recordings for the purpose of diagnosis and treatment.

☐ Yes ☐ No

 b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting.

☐ Yes ☐ No

3 Students in training
I agree to the involvement of medical and other students as part of their formal training.

☐ Yes ☐ No
Consent Form

Sacrocolpopexy/pelvic floor repair (PFR) /Sacrospinous fixation for prolapse

4 Use of Tissue
   a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research. □ Yes □ No
   
   b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records. □ Yes □ No

I have listed below any procedures that I do not wish to be carried out without further discussion.

I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): .......................................................... Date: __/__/_______
Name of patient (PRINT): ...........................................

If signing for a child or young person; delete if not applicable.
I confirm I am a person with parental responsibility for the patient named on this form.
Signed: ........................................................................ Date: __/__/_______
Relationship to patient:

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.
Signed (Witness): .......................................................... Date: __/__/_______
Name of witness (PRINT): ...........................................
Address: 

Patient safety – at the heart of all we do

Addenbrooke’s Hospital | Rosie Hospital

Sacrocolpopexy/PFR/Sacrospinous fixation for prolapse, CF448, V5, August 2018
Sacrocolpopexy/pelvic floor repair (PFR)/Sacrospinous fixation for prolapse

D Confirmation of consent

Confirmation of consent (where the treatment/procedure has been discussed in advance)
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): .............................................. Date: ...D.D./M.M./Y.Y.Y.Y.

Name (PRINT): ................................................................. Job title: ..........................................................

Please initial to confirm all sections have been completed:

E Interpreter’s statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): .......................................................... Date: ...D.D./M.M./Y.Y.Y.Y.

Name (PRINT): ........................................................................................................

Or, please note the language line reference ID number:

F Withdrawal of patient consent

☐ The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): ............................................................. Date: ...D.D./M.M./Y.Y.Y.Y.

Signed (Health professional): .............................................. Date: ...D.D./M.M./Y.Y.Y.Y.

Name (PRINT): ................................................................. Job title: .................................