**Robotic Sacrocolpopexy Guide**

**About your surgery**

Sacrocolpopexy is a procedure that uses soft synthetic mesh to support pelvic organs that have slipped out of their normal positions. (This condition is called pelvic organ prolapse.) The mesh is initially held in place by friction from strap-like arms of mesh material woven through the pelvis. Body tissues then grow through the mesh, creating the final support. This minimally invasive surgery takes only one to two hours and can be performed using general or regional (epidural or spinal) anesthesia. Sacrocolpopexy can be performed following a hysterectomy to provide long-term support of the vagina.

The da Vinci Sacrocolpopexy, offers the advantages of laparoscopy but with the control and precision needed for a procedure of this complexity. Part of the da Vinci Sacrocolpopexy is a state-of-the-art surgical procedure that uses very small abdominal incisions and computer technology to convert hand movements into precise micro-movements of the da Vinci instruments.

Unlike vaginal suspension procedures, which are performed by vaginal access, sacrocolpopexy is performed by abdominal or laparoscopic access. Another difference is that vaginal suspension procedures suspend the synthetic mesh from pelvic ligaments, while sacrocolpopexy suspends the mesh from the sacrum-a large, triangular bone at the base of the spine. These differences result in a more accurate repair when using sacrocolpopexy, with lower failure rates and fewer associated complications.

**What risks are associated with sacrocolpopexy?**

Although complications associated with sacrocolpopexy are unlikely, they can include difficulty urinating and possible injury to blood vessels, nerves, bladder and bowel. There is also a small risk of the mesh material becoming exposed in the vaginal canal. These conditions can be repaired with surgery. Temporary leg pain may also occur.

Sacrocolpopexy is not appropriate for pregnant women or for women planning future pregnancies.

**What is the recovery period following sacrocolpopexy?**

Patients usually return home the day after a sacrocolpopexy procedure. Many patients resume most normal daily activities within four day and recover in two to three weeks.

**Before your Surgery**

There are a few important things to do before your surgery to help improve your chance of a smooth recovery.

* If you smoke; please stop. (Your surgeon may be able to prescribe medications to help with this.)
* If you consume alcohol regularly; cut down or stop completely. Ask your doctor for help.
* Stop the use of aspirin products or blood thinning medications 1 week before surgery to reduce bleeding.
	+ Aspirin, Ibuprofen, Coumadin, Plavix, Naproxen, Celebrex. (ask your surgeon for details; you will be given a complete list at your pre-op appointment)
* Herbal supplements and vitamins should be stopped one week before surgery.
* Follow the diet instructions the day before surgery. (see bowel prep instructions)
* Increase fiber and fruit intake to promote regular bowel function before and after surgery
* Begin practicing Kegel exercises to strengthen bladder muscles.
* Let your PCP and/or cardiologist know about the surgery.

**Remember, don’t eat or drink anything after midnight the day of your surgery.** However, it is ok to take your usual morning medications (**EXCEPT** your diabetic meds, blood thinners, or aspirin products) with a sip of water. If you have any questions ask your surgeon.

**During your Hospital Stay**

* When you wake up after your surgery you will be in the recovery room. There, nurses will check your vital signs and get you ready to go to your hospital room.
* Once in your hospital room you will start the recovery process. You will be able to get out of bed to a chair as soon as you feel fully awake. Your nurse will instruct you on breathing exercises to keep your lungs clear and leg exercises to reduce cramps. You will wear stockings and leg massagers to prevent blood clots.
* As you recover your nurse will care for your surgical dressing and administer your medications. You may have a small drain in your abdomen.
* Patients will be out of bed and walking the morning after surgery; and have their first meal shortly thereafter.
* Before you go home your nurse will teach you how to care for your urinary catheter if you need to have one
* Most patients go home 24-48 hours after surgery.
* Your follow up appointment will need to be two to three weeks post op.

**At Home**

* After you are discharged home from the hospital it is important to continue your breathing exercises and to walk three times a day.
* Be cautious not to tug on the urinary catheter and carefully empty your urinary catheter bag when it is full.
* You may ride in a car for short distances. Don’t drive for one to two weeks.
* It is normal to see some bloody mucous come out from around the catheter at times.
* It is OK to use the stairs once or twice a day.
* Do not lift anything heavier than a phonebook for two weeks after surgery.
* You will be sore after surgery and may experience pain when you get up and move around. Still, you are encouraged to take short walks several times a day and stay out of bed as much as possible to avoid blood clots in your legs.
* You may shower 48 hours after surgery. Over time the liquid skin dressing on each incision will begin to peel away. This is normal.
* The urine may become bloody after bowel movements or if you are on your feet for an extended period of time.
* You will see blood and mucous around the catheter at times. This discharge may become heavy if you overexert yourself or after a bowel movement, especially if you become constipated.
* If the urine becomes bloody drink a few glasses of water and rest until the urine clears.
* Vaginal bleeding may be mild to moderate (red to pink color), you may use pads only, NO tampons.
* No strenuous exercise for 2 months.
* No tampons/douche/intercourse for 6 weeks.
* It is important not to become constipated.

**Diet**

* Begin with clear liquids, Gatorade and Popsicles. After a day or two try some, soup, or applesauce.
* After you begin passing gas and have a small bowel movement slowly try some solid foods.
* Most patients report gas pains and bloating for several days after surgery. Take short walks several times a day to relieve gas pains.
* Take a generic brand stool softener daily to prevent constipation.
* Warm prune juice can promote a bowel movement if you are feeling constipated.

**Medications**

Use Advil and Tylenol according to the instructions on the label to help with pain control. If Tylenol is not strong enough then use the narcotic medication prescribed by your surgeon. Limit the use of this as much as possible because it can upset your stomach and causes gas.

***Contact your surgeon if you have:***

* Fever above 101.5° Fahrenheit
* Severe nausea or vomiting
* Heavy bleeding or drainage from the incision
* Persistent bloody urine that won’t clear up
* No urine draining from catheter tube
* Painful swelling in your legs
* Chest pain or shortness of breath
* Problems or questions about your medications

**Post Op Visits**

* Continue to limit your physical activity for a full 2 weeks after surgery.
* After 2 weeks gradually ease back into your normal activities and exercise routine. If you lift heavy objects you may experience pain near your surgery site. Do not over exert yourself. If you experience pain stop what you are doing and ask your doctor.
* For 6 weeks avoid activities that involve riding on moving objects as this can cause irritation.
* Avoid long car trips or air travel for 6 weeks after surgery because of the risk of blood clots forming in your legs. If you must travel (in an emergency) take a full strength aspirin tablet every day and get up from your seat every hour to walk around and flex your leg muscles.
* Laughter is a powerful medicine. Remember to keep a positive attitude during your recovery and take time to let your body heal. Maintain a healthy lifestyle as you recover, it will pay off in the long run.

**BOWEL PREP INSTRUCTIONS**

1. Clear liquids only the day before surgery. (see below)
2. Magnesium Citrate; ½ to 1 bottle at 12 noon the day before the surgery.
3. **Nothing by mouth after midnight the day before surgery**.

**Foods allowed on a clear liquid diet are:**

**Beverages**: Coffee (decaf or regular), tea with lemon juice, carbonated beverages, apple juice, cranberry juice, grape juice or any combination thereof, warm fruit flavored gelatin, fruit flavored drinks and powders.

**Desserts**: Plain gelatin desserts, clear water ices and popsicles.

**Soups**: Fat free clear broths and bouillon.

**Sweets**: Sugar and hard candy.

**Warning**

**No milk or milk products or anything not listed above.**

**REMEMBER: NOTHING TO EAT OR DRINK AT ALL AFTER MIDNIGHT** **OR YOUR PROCEDURE WILL BE CANCELLED BY THE ANESTHESIOLOGIST**

Care for your Urinary Catheter

A urinary catheter is a flexible plastic tube used to drain urine from your bladder when you cannot urinate by yourself. A doctor will place the catheter into the bladder by inserting it through the urethra, the opening that carries urine from the bladder to the outside of the body. Once the catheter is in the bladder, a small balloon is inflated to keep the catheter in place. The catheter allows urine to drain from the bladder into a bag that is usually attached to the thigh.

A catheter may be needed because of certain medical conditions, such as an enlarged prostate, the inability to control the release of urine, or after surgery on the pelvis or urinary tract. Urinary catheters are also used when the lower part of the body is paralyzed.

**Catheter care**

Always wash your hands before and after dealing with your catheter.

* Make sure that urine is flowing out of the catheter into the drainage bag.
* Make sure the tube doesn't get twisted or kinked.
* Check the area around the urethra for inflammation or signs of infection, such as irritated, swollen, red or tender skin at the insertion site or drainage around the catheter.
* Keep the drainage bag below the level of the bladder. Make sure that the drainage bag does not drag and pull on the catheter.
* Unless you've been told otherwise, it's okay to shower with your catheter and drainage bag in place.
* Clean the area around the drainage tube twice a day, using soap and water. Dry with a clean towel afterward.
* Do not tug or pull on the catheter.
* Do not have sexual intercourse while wearing an indwelling catheter.
* You may wrap a small piece of gauze around the area where the catheter comes out of your body. Change the gauze if it feels wet. Use a new piece of gauze each time you clean your catheter.
* At night you may wish to hang the bag on the side of your bed.
* Do not allow the bag to pull on the catheter.

**Living with a catheter**

Try to prevent constipation, and be sure you drink enough fluids. Most adults should drink between 8 and 10 glasses of water, non caffeinated beverages, or fruit juice each day. Include fruits, vegetables, and fiber in your diet each day. Try a stool softener, such as Colace, if your stools are very hard.

**Draining the urine collection bag**

You will need to empty the bag regularly, whenever it is half-full, and at bedtime.

* Wash your hands with soap and water. If you are emptying another person’s collection bag you may wish to wear disposable gloves.
* Unfasten the tube from the drainage bag.
* Fasten the tubing clamp and remove the drainage bag.
* Drain the urine into the toilet. Avoid touching the tubing or drainage cap on the toilet, the collection container, or the floor.
* Replace the drainage cap, close the clamp, and refasten the collection tube to the drainage bag.
* Refasten the collection tube to the drainage bag.
* Wash your hands with soap and water.

**Quick Activity Sheet**

Post Op SCP/TOT/TVT

|  |  |
| --- | --- |
| **ACTIVITY** | **TIME TO ABSTAIN** |
| Tampons | 6 weeks |
| Drive, automatic | \*1 day |
| Drive, manual | \*2 days |
| Making Beds | 1-2 weeks |
| Hanging Wash | 1-2 weeks |
| Stretching/Reaching Overhead | 1-2 weeks  |
| Mopping/Vacuuming | 1-2 weeks |
| Swimming | 2-3 weeks |
| Lifting Over 20 pounds | 6 weeks |
| Sexual Activity | 6 weeks |

\* as long as you are not taking pain medicine

**Information and Consent for**

**PELVIC ORGAN PROLAPSE/INCONTINENCE SURGERY**

We recommend that you read this handout carefully in order to prepare yourself or family members for the proposed procedure. In doing so, you will benefit both the outcome and safety of the procedure. By signing this form you are stating that you have been fully informed and understand the indications, risks, benefits and expected outcomes of this procedure, and have had time to ask questions. *If you still have any questions or concerns, we strongly encourage you to contact our office prior to your procedure so that we may clarify any pertinent issues.*

* ***Prolapse of Pelvic Organ***

Prolapse of the uterus or vagina simply means the “dropping” of these structures to an abnormally low position. This bulge from the vagina may include your uterus, intestines, bladder, rectum, or any combination of the above. Because of the complex nature of this problem it is common for multiple procedures to be performed at the time of this surgery.

* ***Hysterectomy***

Hysterectomy is the surgical removal of the cervix and uterus. This procedure may be accomplished abdominally, vaginally, or a combination of both.

* ***Enterocele***

Enterocele is a hernia of the small intestine into the vagina. The goals of enterocele repairs are to replace the intestines to its normal position and restore the tissue so it will not recur.

* ***Cystocele***

Cystocele means bladder appearing like a balloon prolapsing (“dropping”) into and out of the vagina. To repair this problem we use either your own tissues or synthetic mesh material.

* ***Urinary Incontinence***

Urinary Incontinence is a very common problem that occurs in conjunction with pelvic organ prolapsed. If this is present, it is generally repaired at the same time as your prolapsed surgery. Repair of this problem usually involves placing a piece of mesh material underneath the mid-portion of your urethra by passing it through small incisions either above the pubic bone or next to the labia. After the procedure a telescope called a “cystoscope” may be placed in the bladder to inspect the inside of the bladder.

* ***Vaginal Augmented Repair***

These mesh graft procedures are new minimally invasive techniques to help repair different types of prolapse. These procedures use small specially designed instruments to pass a minimally reactive sterile medical mesh material to reinforce the areas of poor support in the pelvis. This material acts as a scaffold for your tissue to regain and provide stronger support.

* ***Abdominal Sacral Colpopexy***

This surgery uses an abdominal approach to attach a permanent mesh graft from the top of the vagina to the back of the pelvic bone in order to permanently hold the vagina in place.

**Possible Complication of the Procedure**

All surgical procedures, regardless of complexity or time, can be associated with unforeseen problems. They may be immediate or even quite delayed in presentation. While we have discussed these and possibly others in your consultation, we would like you to have a list so that you may ask questions if you are still concerned. Aside from anesthesia complications, it is important that every patient be made aware of all possible outcomes, which may include, but are not limited to:

* **Urinary Tract Infection or Sepsis**: Although we may give you antibiotics prior to and after the operation it is possible for you to get an infection. The most common type is a simple bladder infection (after the catheter is removed) that presents with symptoms of burning urination, urinary frequency and a strong urge to urinate. This will usually resolve with a few days of antibiotics. If the infection enters the bloodstream, you might feel very ill. This type of infection can present with both urinary symptoms and any combination of the following: fevers, shaking chills, weakness or dizziness, nausea and vomiting. You may require a short hospitalization for intravenous antibiotics, fluids, and observation. This problem is more common in diabetics, patients on long-term steroids, or in patients with disorders of the immune system.
* **Wound Infection**: The incision sites can become infected. While it typically resolves with antibiotics and local wound care, occasionally, part or all of the incision may open and require revision and or catheter replacement.
* **Treatment Failure**: Although usually associated with a high success rate, the procedure can fail in the immediate post-operative period, or months to years later.
* **Urinary Retention**: Retention is the inability to urinate and it occurs in fewer than 5% of cases. Usually, a patient is able to urinate normally within one to two weeks following the procedure. However, if retention is prolonged, a catheter may be necessary. You could learn to self-catheterize or simply have a urethral catheter placed back in for a few days at a time. It would periodically be removed to test whether you are able to urinate. We always encourage patients to be patient, because urinary retention usually resolves with time and observation. In rare instances of prolonged retention, a corrective procedure may be required. Factors which may delay the rapid return of voiding include: excessive sling tension, poor bladder function before the surgery, and multiple repaired organs (i.e. a dropped bladder, a dropped uterus, or a prolapsed rectum) during the same surgery. Urodynamic testing may need to be performed for further assessment.
* **Blood Loss/Transfusion**: The vaginal region is quite vascular. Usually blood loss in this procedure is minimal to moderate. In 1-2% of cases, blood loss can be significant enough to necessitate transfusion.
* **Ureteral Injury/Ureteral Kinking**: Enterocele repair procedures often utilize structures within the pelvis that are near or adjacent to the ureters (tubular structures that carry urine from the kidneys to the urinary bladder). When tension is placed on these structures the ureters can be drawn away from their normal position and partially or completely blocked by kinking. It is also possible to inadvertently injure the ureter by placing an instrument across it, a suture around it or cutting it with surgical instruments. Ureteral injury can be quite serious and requires prompt attention.
* **Organ Injury**: during any part of the surgical procedure, any organ in the abdomen or pelvis (liver, spleen, colon, intestine, bladder, stomach, ureter, etc.) can be inadvertently injured. Often the injury is minor and can be treated with relative ease. In other instances, when the injury is major or the repair is complicated, more extensive surgery may be necessary. Treatment depends on the particular organ injured and the severity of the injury.
* **Bowel/Rectal Injury**: It is possible to make a hole in the deeper tissue of the rectum or bowel. In almost all cases, the hole can be repaired, and there are no long-term problems. In severe injuries, we may ask for a consultation from a general surgeon to ensure that no other protective surgical measures should be undertaken.
* **Painful Intercourse and Vaginal Shortening**: After prolapsed surgery, the shape of the vaginal vault can change. In certain cases, the depth of the vagina may be lessened and the angle changed. While usually not a problem, some women may complain of pain or difficulty with intercourse. Sometimes it is temporary, but it can also be permanent.
* **Deep Vein Thrombosis (DVT)/Pulmonary Embolus (PE)**: In any operation (especially longer operations), you can develop a clot in a vein of your leg (DVT). Typically, this presents two to seven days (or longer) after the procedure as pain, swelling, and tenderness to touch in the lower leg (calf). Your ankle and foot can become swollen. **If you notice these signs, you should go directly to an emergency room and also call our office**. Although less likely, this blood clot can move through the veins and block off part of the lung (PE). This would present as shortness of breath and possibly chest pain. We may sometimes as the medical doctors to be involved with the management of either of these problems.
* **Sling Erosion**: It is possible for the sling material to erode through the tissue that surrounds it. If the vaginal tissue breaks down, the sling can often be removed with a minimal procedure. Often, the patient is still continent because scar tissue from the surgery will continue to support the urethra. On the contrary, if the back of the sling erodes into the urethra, the surgical removal is more involved, and the rates of incontinence afterward are higher.
* **Graft/Mesh Erosion**: It is possible for the permanent graft material to erode through the tissue that surrounds it. If the vaginal tissue breaks down, the graft may need to be removed with another operation. Removal of the graft may lead to repeat prolapse formation and in rare cases chronic pain.
* **Bleeding/Hematoma**: When a small blood vessel continues to ooze or bleed after the procedure is over, the area of collected blood is referred to as a hematoma. The body normally re-absorbs this collection over a short period of time, and surgical drainage is rarely necessary.
* **Lower Extremity Weakness/Numbness**: This, too, is a rare event that may arise due to your position on the operating table. It is possible in procedures in which you are in the lithotomy (legs up in the air) for a long period. The problem is usually self-limited, with a return to baseline expected; rarely is it permanent.
* **Chronic Pain**: As with any procedure, a patient can develop chronic pain in an area that has undergone surgery. Typically, the pain disappears overtime, although some feeling of numbness may persist. If persistent, further evaluation may be necessary.

If you would like a copy of the patent labeling from the manufacturer of the product used in your repair, please inform us and we will obtain a copy for you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Physician/Date Patient/Date Witness/Date*