













## 4. Evidence & Care Pathways

### 4.1 Sacrocolpopexy compared to other prolapse surgery

Overall, sacrocolpopexy is associated with lower risk of recurrent prolapse symptoms, recurrent prolapse on examination, repeat surgery for prolapse, postoperative stress urinary incontinence, and dyspareunia when compared broadly with vaginal prolapse repairs with or without mesh augmentation.<sup>1,22</sup>

Compared with sacrospinous ligament suspension, sacrocolpopexy has a higher anatomical success rate, less stress urinary incontinence, and less postoperative dyspareunia, but has greater surgical morbidity<sup>21</sup> including

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Mesh exposure was nearly six times lower (1.5% vs 8.5%) when the uterus was preserved compared with concomitant hysterectomy during sacrocolpopexy.<sup>32</sup> Concurrent subtotal hysterectomy together with sacrocolpopexy had been advocated to reduce mesh exposure rates,<sup>29</sup> although powered morcellation [detailed in the RANZCOG statement [C-Gyn 33: Tissue extraction at minimally invasive procedures](#)] is often required during laparoscopic/robotic routes. A recent RCT with follow up to 24 postoperative months showed no difference in anatomical outcomes between subtotal hysterectomy/sacrocolpopexy and total hysterectomy/sacrocolpopexy, but showed more mesh exposures in the total hysterectomy group.<sup>33</sup>

## Recommendation 2

Compared with open sacrocolpopexy, laparoscopic sacrocolpopexy has less blood loss, longer operating time, shorter hospital stay with no clinically significant difference in objective or subjective cure rates.<sup>1, 22</sup>

Evidence based recommendation I (A)

## 5. Discussion and recommendations

### 5.1 Informed patient consent

The consent process should adhere to the principles of shared decision-making and include wide-ranging discussion of issues such as the following.

1. Informed consent should be recorded, supported by explicit information that should include specifically a discussion around the use of mesh.
2. Women with asymptomatic prolapse do not necessarily require surgical management. The decision to operate should be based upon symptomatic bother from the prolapse as defined by the patient. There are little longitudinal data in the literature on the natural history of untreated asymptomatic prolapse to inform a decision for surgery in this situation.
3. Alternatives to surgical management, including options such as pelvic floor muscle training for mild prolapse and vaginal support pessaries.
4. Other alternative surgical treatments including obliterative vaginal procedures (colpocleisis), conventional vaginal native tissue repair such as sacrospinous fixation or uterosacral vault suspension, or other abdominal procedures including abdominal uterosacral vault suspension.
5. Surgeons performing sacrocolpopexy should have current experience in treating women with pelvic organ prolapse which includes commonly recommending conservative treatments and commonly performing a variety of prolapse surgeries. Surgeons should reserve sacrocolpopexy for women with the most severe prolapse, women with recurrent prolapse following prior vaginal surgery, or women with significant risk factors for prolapse recurrence using vaginal approaches.
6. Patients considering sacrocolpopexy should be provided sufficient information regarding the broad nature and effects of sacrocolpopexy. The RANZCOG patient information pamphlet on [pelvic organ prolapse](#) provides broad information, including treatment options for prolapse. The International Urogynaecological Association (IUGA) & Urogynaecological Society of Australasia (UGSA) has patient information pamphlet on sacrocolpopexy. Information is also available from ACSQHC and NZ Ministry of Health respectively.











## 6. References

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