Sacrospinous fixation (SSF) for prolapse of the uterus (womb) or prolapse of the vaginal vault (top of vagina)

Patient Information Leaflet

British Society of Urogynaecology
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About this leaflet

You should use the information provided in this leaflet as a guide. The way each gynaecologist does this procedure may vary slightly as will care in the hospital after your procedure and the advice given to you when you get home. You should ask your gynaecologist about any concerns that you may have.

You should take your time to read this leaflet. A page is provided at the end of the leaflet for you to write down any questions you may have. It is your right to know about your planned operation or procedure, why it has been recommended, what the alternatives are and what the risks and benefits are. These should be covered in this leaflet. You may also want to ask about your gynaecologist's experience and results of treating your condition.

Benefits and risks

There are not many studies about the success and the risks of most of the procedures carried out to treat prolapse and incontinence, so it is often difficult to state them clearly. In this leaflet, we may refer to risks as common, rare and so on, or we may give an approximate level of risk. You can find more information about risk in a leaflet 'Understanding how risk is discussed in healthcare' published by the Royal College of Obstetricians and Gynaecologists.

https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pi-understanding-risk.pdf

The following table is taken from that leaflet

Risk table

Verbal description[a]	Risk	Risk description[b]
Very common	1 in 1 to 1 in 10	A person in family
Common	1 in 10 to 1 in 100	A person in street
Uncommon	1 in 100 to 1 in 1000	A person in village
Rare	1 in 1000 to 1 in 10000	A person in small town
Very rare	Less than 1 in 10000	A person in large town

[a] EU-assigned frequency
[b] Unit in which one adverse event would be expected

British Society of Urogynaecology (BSUG) database

To understand the success and risks of surgery for prolapse and incontinence the British Society of Urogynaecology has set up a national database. We ask all members of the society to enter onto the database all procedures they carry out and how the patients fare after surgery. They may ask you before your operation if you agree to them entering the details of your procedure on this database. We then use this anonymised information to develop a picture of what procedures are being performed throughout the UK, as well as complications and patient satisfaction. Individual surgeons can also use it to see how they compare with others.

What is a sacrospinous fixation (SSF)?

A sacrospinous fixation is an operation to attach the top of the vagina or the cervix (neck of the womb) to a pelvic ligament (sacrospinous ligament) with a stitch. There are no cuts in the abdomen (tummy). When used to support the cervix and uterus it is sometimes called a sacrospinous hysteropexy.

What condition does a sacrospinous fixation (SSF) treat?

The operation is primarily intended to treat prolapse of the uterus (womb) or the vault (top) of the vagina (if you have had a hysterectomy). It can also help correct prolapse of the vaginal walls to some extent.

Prolapse occurs when the pelvic floor muscles, their attachments or the vaginal tissue become weak. This weakness allows one or more pelvic organ to bulge downwards into or out of the vagina. Pelvic organs include the uterus (womb), bladder and bowel.

A prolapse may arise because of weakness in the walls of the vagina (vaginal wall prolapse) or weakness in the ligaments that support the top of the vagina (apical prolapse).

There are different words used to describe these.

- A bulge because of weakness in the front wall of the vagina may be called an anterior compartment prolapse or a cystocoele. Sometimes it is described as a bladder prolapse because the bladder drops down into the bulge.
- A bulge because of weakness in the back wall of the vagina may be called a posterior compartment prolapse or a rectoenterocoele/rectocoele. Sometimes it is described as a bowel prolapse because the bowel drops down into the bulge. This must not be confused with a rectal prolapse when the bowel drops down through the back passage.
- A bulge because of weakness in the ligaments at the top of the vagina allows the uterus (womb) to drop down. This may be called a uterine prolapse or an apical compartment prolapse. If you have already had a hysterectomy (removal of your womb), the weakness in the ligaments at the top of the vagina allows the vault (top) of the vagina to drop down. This may be called a vault prolapse or also an apical compartment prolapse.

Many women have a prolapse in more than one part of the vagina at the same time. The decision to offer you this procedure will only be made after a thorough discussion between you and your doctor. This decision usually depends on the nature and extent of your prolapse and as well as personal factors.

You should keep in mind that even if an operation cures your prolapse, it may or may not relieve all your symptoms. You should consider alternative options before

considering surgery (see Page 12) and may wish to try these before making a final decision about having surgery.

Although pregnancy might be possible following a sacrospinous hysteropexy, a pregnancy increases the chance that the prolapse will recur even if delivery is by caesarean section. It is best, therefore, only to consider surgery once you feel your family is complete.

You will only be offered an operation when you have had a thorough discussion with your doctor about the type of prolapse you have, the extent (grade or stage) of your prolapse and how much your prolapse bothers you as well as your personal preferences.

How is a sacrospinous fixation done?

The operation is done under general anaesthetic (asleep during the entire procedure) or a spinal anaesthetic (awake but numb from the waist down).

The top of the vagina (if you have had a hysterectomy) or the cervix is stitched to some strong tissue (sacrospinous ligament) at the back of the pelvis, so there are no cuts in your tummy. In most cases the stitch is placed through the ligament on the right side. Occasionally, if extra support is required, a stitch is placed through the left ligament as well. Some surgeons use dissolving stitches and others use permanent stitches.

Other operations which may be performed at the same time.

Your doctor may suggest that a sacrospinous fixation is all that is required to cure your prolapse. Sometimes, additional operations are done at the same time (see below) and your doctor should advise you regarding these before your operation.

- **Vaginal wall repair.** Sometimes there is also a prolapse of the front (anterior) or back (posterior) walls of the vagina and your doctor may suggest repairing them at the same time as your operation for uterine prolapse. This is quite common. This may alter the risks of the operation, for example, painful intercourse (sex) is more likely if a repair is done, although it is still uncommon. You should, therefore, discuss this with your doctor who may have an extra information leaflet for you about vaginal wall repairs.
- **Continence Surgery.** Sometimes an operation to treat urinary leakage can be done at the same time as your operation for uterine prolapse. Some gynaecologists prefer to do this later as a separate procedure. You should also refer to an information leaflet about the planned additional procedure.

Benefits

- Relief of prolapse symptoms.
- Some women report an improvement in passing urine especially if this was a problem before surgery.
- Some women report an improvement in overactive bladder symptoms, e.g. less urgency, passing urine less frequently.

Risks

General Risks of Surgery

- **Anaesthetic risk.** This is very small unless you have specific medical problems, such as with your heart, or breathing. If you smoke or are overweight, this also increases risk. A sacrospinous fixation can be done with you asleep (a general anaesthetic) or awake but numb from the waist down (a spinal anaesthetic). This will be discussed with you.
    - **What can I do?** Make the anaesthetist aware of all medical conditions such as problems with your heart or breathing. Bring a list of your medications. Try to stop smoking before your operation. Lose weight if you are overweight and increase your activity.
- **Bleeding.** There is a risk of bleeding with any operation. It is uncommon that we have to give a blood transfusion after a sacrospinous fixation. Rarely bleeding can occur some hours or even days after the operation meaning that you need to be taken back to the operating theatre for further surgery.
    - **What can I do?** Please let your doctor know if you are taking a blood-thinning medicine such as warfarin, aspirin, clopidogrel or rivaroxaban as you may be asked to stop them before your operation.
- **Infection** There is a small risk of infection with any operation (about 5 to 13 cases in 100 operations). If it occurs, an infection can be a wound infection, or a urinary infection, and is usually treated with antibiotics. The risk of infection is reduced by routinely giving you a dose of antibiotic during your operation. You might also get a chest infection because of the anaesthetic.
- **What can I do?** Treat any infections you are aware of before surgery. After surgery, regular deep breathing exercises can help prevent chest infections; the nurses will guide you how to do this.
- **Deep Vein Thrombosis (DVT).** This is a clot (thrombus) in the deep veins of your leg. Occasionally the clot can travel to the lungs (pulmonary embolism - PE) which can be very serious and in rare circumstances it can be fatal (less than 1 in 100 of those who get a clot). The risk increases if you are overweight, have severe varicose veins, infection, are not very mobile, are taking hormones and if you have other medical problems. The risk is significantly reduced by wearing

special compression stockings and having injections to thin your blood for a period of time following your surgery (you will be advised of the duration before the surgery).

- **What can I do?** You should consider stopping taking any hormone tablets such as hormone replacement therapy (HRT) and some types of birth-control pills 4 weeks before surgery. Stopping these hormones will not be a threat to your life and the risk of continuing to take them may be greater than the benefit you will get from taking them. You can usually restart these 4 weeks after surgery when the risk of thrombosis (blood clots) has reduced. The risk is greatest for hormones taken as tablets. The risk from hormone replacement given through the skin using patches, gels and pessaries is very low but not completely absent. If you decide to continue taking hormone medication you will need thromboprophylaxis (measures to prevent thrombosis) during and after the operation.
- Do not arrange surgery the day after a long car journey or flight.
- As soon as you are awake start moving your legs around. Keep mobile once you are at home and continue to wear your compression stockings during times when you are less mobile.

- **Wound complications.** Wounds can become infected or occasionally stitches can become loose allowing the wound to open up or tighten causing discomfort. The wound is within the vagina for this operation.
  - **What can I do?** Keep the surrounding area clean and dry carefully after washing using a clean towel or a hairdryer on a cool setting. Do not douche the vagina or use tampons. It is also better not to sit in a bath but to have showers instead.

General risks of prolapse surgery

- **Getting another prolapse** Although this operation is successful in treating uterine and vaginal vault prolapse, it does not always stop you from getting a prolapse of the vaginal walls in the future or a further prolapse of your uterus or vaginal vault. There is very little published evidence of exactly how often prolapse recurs. Recurrence of the same prolapse probably occurs in about 1 in 10 cases and it is generally believed that about 3 in 10 women who have an operation for prolapse will eventually require treatment for another prolapse. This is because the tissues are weak. Sometimes even though another prolapse develops it is not bothersome enough for you to require further treatment. Sometimes it is possible to treat it without surgery (Page 12)
  - **What can I do?** Doing your pelvic floor exercises, keeping your weight normal for your height (normal BMI), avoiding unnecessary heavy lifting, and not straining on the toilet or during exercise, may help prevent a further prolapse, although even if you are very careful it does not always prevent it.

- **Failure to cure** symptoms. Even if the operation cures your prolapse it may fail to improve your symptoms.
- **Overactive bladder symptoms** (urinary urgency and frequency with or without incontinence) usually improve after the operation, but occasionally can start or worsen after the operation.
    - **What can I do?** If you experience this, please let your doctor know so that treatment can be arranged.
- **Stress incontinence.** Having a prolapse sometimes causes some kinking of the tube through which you pass urine (urethra). This can be enough to stop urine leaks on coughing, laughing or sneezing (stress incontinence). By correcting the prolapse this kink gets straightened out and the leaks are no longer stopped. It is difficult to define an exact risk but it is thought to be about 10% (1 in 10). You may be offered a special bladder test called a urodynamic test before surgery which may give an idea of how likely you are to develop stress incontinence after the operation.
    - **What can I do?** Doing pelvic floor exercises regularly can help to prevent stress incontinence.
- **Bladder emptying or voiding problems** generally improve after surgery for prolapse but as is the case for any surgery in the pelvic area there may be problems with voiding (emptying your bladder) after the operation. There can be persistence of voiding problems for many months in 1 in 10 women but very few women will have ongoing difficulty or be unable to void long term.
    - **What can I do?**
        - If you have trouble passing urine, you may wish to lean forwards or even stand slightly to allow better emptying of your bladder. Make sure that you have your legs apart rather than having your knees together when sitting on the toilet. Waiting for a few minutes after the initial void and trying again may help. This is known as the 'double voiding' technique.
        - Learn clean intermittent self-catheterisation (CISC). CISC involves emptying out the urine using a fine catheter tube. You pass this along the urethra (water pipe) into the bladder so the urine can drain into the toilet. Once the urine is out, you remove the catheter and throw it away. You use a new catheter each time and they are available on prescription, like tablets, from your doctor. Although passing a catheter might sound unpleasant, most women find it is easy to do and it gives you more control and freedom than using a permanent catheter. The normal feeling of wanting to pass urine is not altered so you know when to empty your bladder. The catheters are very small and can easily be hidden in a handbag.
- **A change in the way your bowel works** Some women experience worsening constipation following surgery. This may resolve with time. It is important to try to

avoid being constipated following your surgery as this may reduce your risk of developing another prolapse.

- **What can I do?** If you are struggling with constipation after simple changes in diet and fluid intake, your doctor may prescribe some laxatives.

- **Painful sexual intercourse.** You need to wait at least 6 weeks (sometimes longer) to allow the vaginal wounds to heal. Some women find sex is uncomfortable at first, but it gets better with time. Occasionally, pain with intercourse can be long-term or permanent.
- **Altered sensation during intercourse:** Sometimes the sensation during intercourse may be less. On the other hand, repair of your prolapse may improve it.

Specific risks of sacrospinous fixation

These risks are in addition to the general risks mentioned above.

- **Damage to the bladder or bowel** can occur because these are immediately next to the vagina. The risk is greater if you have had pelvic surgery or pelvic infection in the past. It is usually possible to repair the damage straight away, but it may slow down your recovery. A bladder injury may need a catheter to drain the bladder for 7-14 days following surgery. A bowel injury may require a temporary colostomy (bag to collect faeces).
- **Buttock pain** – approximately 1 in 10 women will get pain in the right buttock (as the stitch is usually put through the right sacrospinous ligament). Occasionally, a stitch may be placed through both ligaments, in which case the pain may occur in either or both buttocks. You may need to take painkillers, but the pain usually lasts for no more than a few weeks although occasionally it can last a few months. In a few cases, the pain may be severe, in which case removal of the stitch(es) may have to be considered.
- **Stitch complications** – if permanent stitches are used these can work their way through the walls of the vagina causing vaginal discharge or bleeding and discomfort during intercourse.

Before the operation -Pre-opassessment

Usually, you are seen in a preoperative clinic some weeks before your planned operation. At that visit you will be seen by a nurse and possibly also a doctor. You will be asked about your general health and any medications you take. Your blood pressure will be checked and you may have tests to assess your heart and breathing. Blood tests will be taken to check you for anaemia and other things according to your medical condition.

Swabs may be taken from your nose and groin to make sure that you do not carry MRSA (bacteria that are very resistant to antibiotics and may cause problems after your operation).

You may be asked to sign a consent form if this has not been done already.

You may be given some medication to take the day before surgery to help clear your bowels, this is called 'Bowel Prep'.

After the operation –in hospital

- **Pain relief**. Pain can be controlled in a number of ways depending on the preference of your anaesthetist and/or gynaecologist. Options are an epidural, injection of local anaesthetic into the tissues during the operation, self-administration of pain relief (patient controlled analgesia - PCA), drugs in a drip, tablets or suppositories. It is often best to take the pain killers supplied to you on a regular basis aiming to take a pain killer before the pain becomes a problem.
- **Drip.** You may have a fluid drip into a vein in your arm or leg after the operation; this is to keep you hydrated until you are drinking normally. The drip is usually removed within 24 hours.
- **Catheter.** You may have a tube (catheter) draining the bladder. The catheter may give you the sensation as though you need to pass urine but this is not the case. It is usually removed the morning after surgery or sometimes later the same day.
- **Drain.** If there has been more than average bleeding during the operation a drain (tube) from inside your tummy to outside may be placed beside a wound to let out any blood which has collected. This is usually taken out the next day.
- **Pack** You may have a length of gauze in your vagina at the end of the operation. It acts as pressure bandage and is usually removed the following day
- **Vaginal bleeding.** There may be slight vaginal bleeding like the end of a period after the operation.
- **Eating and drinking.** You can drink fluids soon after the operation and will be encouraged to start eating as soon as tolerated.
- **Preventing DVT (deep vein thrombosis).** The same day or the day after your operation, you will be encouraged to get out of bed and take short walks around the ward. This improves general wellbeing and reduces the risk of blood clots in your legs. You may be given a daily injection to keep your blood thin and reduce the risk of blood clots until you go home or longer in some cases.
- **Going home.** You are usually in hospital for one or two days. If you require a sick note or certificate please ask.

After the operation – at home

- Mobilisation is very important; using your leg muscles will reduce the risk of blood clots in the back of the legs (DVT).
- Shower as normal.
- Do not use tampons for 6 weeks and avoid douching the vagina
- You are likely to feel tired and may need to rest in the daytime from time to time for a month or more. This will gradually improve.
- It is important to avoid stretching the tissues around the operation particularly in the first weeks after surgery. Therefore, avoid constipation and heavy lifting. The deep stitches dissolve during the first 3 months and your body will gradually lay down strong scar tissue over a few months.
- Avoiding constipation

  Drink plenty of water / juice

  Eat fruit and green vegetables especially broccoli

  Plenty of roughage e.g. bran / oats
- Any constant cough is to be treated promptly. Please see your GP as soon as possible.
- After 6 weeks gradually build up your level of activity.
- After 3 months, you should be able to return completely to your usual level of activity.
- You should be able to return to a light job after about 6 weeks, a busy job in 12 weeks. Avoiding all unnecessary heavy lifting will possibly reduce the risk of the prolapse recurring.
- You can drive as soon as you can operate the pedals, perform an emergency stop and look over your shoulder without discomfort, generally after 3 weeks, but you must check this with your insurance company, as some of them insist that you wait longer.
- You can start having sex whenever you feel comfortable enough after about 6 weeks. Stitches in the vagina which have not dissolved may cause you or your partner some discomfort until they fully dissolve. You will need to be gentle and may wish to use lubrication.
- You usually have a follow up appointment anywhere between 6 weeks and 6 months after the operation. This varies between hospitals and may be at the

hospital (doctor or nurse), with your GP or by telephone. Sometimes follow up is not required.

- See link: https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/recovering-well/pelvic-floor-repair-operation.pdf

What to seek advice about after surgery

- Heavy vaginal bleeding
- Smelly vaginal discharge
- Severe pain
- High fever
- Pain or discomfort passing urine or blood in the urine
- Difficulty opening your bowels.
- Warm, painful, swollen leg
- Chest pain or difficulty breathing

Treatment Alternatives

Non-surgical

- **Do nothing.** If your prolapse is not too bothersome then you may not necessarily need treatment. If, however, your prolapse permanently protrudes through the opening of your vagina and is exposed to the air, the skin on the prolapse may become dry and eventually crack and bleed or get infected. This is why even if a prolapse which is coming outside the opening of the vagina is not causing symptoms it is probably best to push it back with a ring pessary (see below) or have an operation to repair it. Losing weight if you are overweight and avoiding risk factors such as smoking (leading to long term cough), jobs or exercise involving lifting heavy weights or high impact and constipation may help control your symptoms. Your prolapse may become worse with time but it can then be treated.
- **Pelvic floor muscle exercises (PFME).** The pelvic floor muscles support your pelvic organs. Strong muscles can help to prevent your prolapse dropping further. PFEs are unlikely however to provide significant improvement for a severe prolapse which is protruding outside the vagina. A pelvic floor specialist physiotherapist can explain how to perform these exercises with the correct technique. It is important that you try the above to help to manage the symptoms of your prolapse and to prevent it becoming worse. It is also very important to continue with your pelvic floor exercises even if you have opted for other treatment options.
- **Pessary.** A vaginal device, a pessary (see image below), may be placed in the vagina to support your vaginal walls and uterus. A pessary is usually used continuously and changed by a doctor or nurse every four to twelve months depending upon the type used and how well it suits you. Alternatively, if you prefer, you may be taught to replace the pessary yourself. It is possible to lead a normal life with continuation of activities such as bathing, cycling, swimming and, in some cases, sexual intercourse. Ongoing care is often at the GP practice but some women will need to be kept under review in the Gynaecology clinic. Pessaries are very safe and many women to choose to use one long term rather than have an operation. On occasions you have to stop using a pessary due to bleeding, discharge, sexual difficulties or a change in bladder function but these all stop quickly after it is removed. Sometimes it will take several visits to the clinic to determine the best size for you and a pessary is not suitable for everyone.

Surgical

The following table lists the different operations that can be considered to treat **uterine prolapse**. Further information on the operations is available in separate leaflets. All operations are not available in all hospitals. Your consultant may recommend a particular operation depending on his or her preference and expertise, or your individual needs.

Surgical Treatment	Advantages	Disadvantages
Vaginal Sacrospinous Hysteropexy (stitches to support womb inserted through vagina) (described in this leaflet)	No abdominal incision(s) Pregnancy still possible although prolapse might recur during or after pregnancy Can be done with you awake or asleep	Can cause temporary buttock pain Variable long-term success with recurrence of uterine prolapse 14-30%.
Sacrohysteropexy - laparoscopic (key hole) or open (usually through a bikini line cut). The prolapsed womb's position is restored by attaching it to the inside of the sacrum with a permanent mesh	Abdominal mesh provides strong and continuing support to the uterus reducing the chance of the prolapse re-occurring. No cuts or stitches in vagina. Vaginal length maintained. Uterus still present so pregnancy is possible. Likely to be a quicker recovery following an uncomplicated laparoscopic approach but possibly a longer procedure time.	Requires a general anaesthetic (asleep). As mesh is used there is a small risk that the mesh will work its way into surrounding tissues. **If performed as an open operation** • More painful than the other procedures • Slower return to normal activities • Longer hospital stay
Vaginal Hysterectomy Removal of uterus via the vagina	No abdominal cut(s) Uterus removed so no risk of cancer of cervix or uterus in future. Can be done with you awake or asleep	Risk of prolapse of the vault (top) of the vagina in the future
Manchester repair (removal of cervix only via the vagina)	No abdominal cuts(s) Main body of uterus still present so pregnancy is possible. Can be done with you awake or asleep	Rarely stenosis (narrowing) of cervix causes pain Pregnancy can be complicated by premature labour
Colpocleisis Closing of vagina	High success rates both for prolapse of the uterus and the walls of the vagina. No abdominal cut(s) Can be done with you awake or asleep	Sexual intercourse will **not** be possible after this operation. Not possible to take a smear Difficult to investigate inside the uterus if abnormal bleeding occurs afterwards

The following table lists the different operations that can be considered to treat **vaginal vault prolapse** (after a previous hysterectomy). Further information on the operations is available in separate leaflets. All operations are not available in all hospitals. Your consultant may recommend a particular operation depending on his or her preference and expertise, or your individual needs.

Surgical Treatment	Advantages	Disadvantages
Vaginal Sacrospinous Fixation (stitches to support top of the vagina inserted through vagina) **Described in this leaflet**	No abdominal incision(s) Can be done with you awake or asleep	Can cause temporary buttock pain Variable long-term success with recurrence of prolapse in 14-30%.
Sacrocolpopexy - laparoscopic (key hole) or abdominal (open operation)	Abdominal Mesh provides strong and continuing support to the top of the vagina so uncommon for prolapse to recur. No cuts or stitches in vagina. Vaginal length maintained. Likely to be a quicker recovery following an uncomplicated laparoscopic approach but possibly a longer procedure time.	Requires a general anaesthetic (asleep). As mesh is used there is a small risk that the mesh will work its way into surrounding tissues. **If performed as an open operation** • More painful than the other procedures • Slower return to normal activities • Longer hospital stay
Colpocleisis (closing of vagina)	High success rates both for prolapse of the uterus and the walls of the vagina No abdominal incision(s) Can be done with you awake or asleep	Sexual intercourse will **not** be possible after this operation.

More information

If you would like to know more about uterine prolapse and the treatments available for it, you may try the following sources of information.

- Ask your GP
- Ask the Doctor or Nurse at the hospital
- Look at a website such as
    - NHS choices at http://www.nhs.uk/pages/home.aspx
    - Patient UK at http://patient.info/health
    - Royal College of Obstetricians and Gynaecologists Recovering Well leaflet at
      https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/recovering-well/pelvic-floor-repair-operation.pdf
    - Royal College of Obstetricians and Gynaecologists patient information leaflet – Pelvic organ prolapse at
      https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/gynaecology/pi-pelvic-organ-prolapse.pdf
    - International Urogynaecology Association (IUGA) patient information leaflet Sacrospinous fixation / iliococcygeus suspension at
      https://www.yourpelvicfloor.org/media/Sacrospinous_Fixation_RV1.pdf
    - National Institute for Health and Clinical Excellence (NICE). Patient Decision Aid (PDA) for **uterine prolapse** at
      https://www.nice.org.uk/guidance/ng123/resources/surgery-for-uterine-prolapse-patient-decision-aid-pdf-6725286112
      and for **vaginal vault prolapse** at
      https://www.nice.org.uk/guidance/ng123/resources/surgery-for-vaginal-vault-prolapse-patient-decision-aid-pdf-6725286114
    - Pelvic obstetric and gynaecological physiotherapy website at www.thepogp.co.uk
    - Patient information leaflets for your own hospital and others (usually available online)

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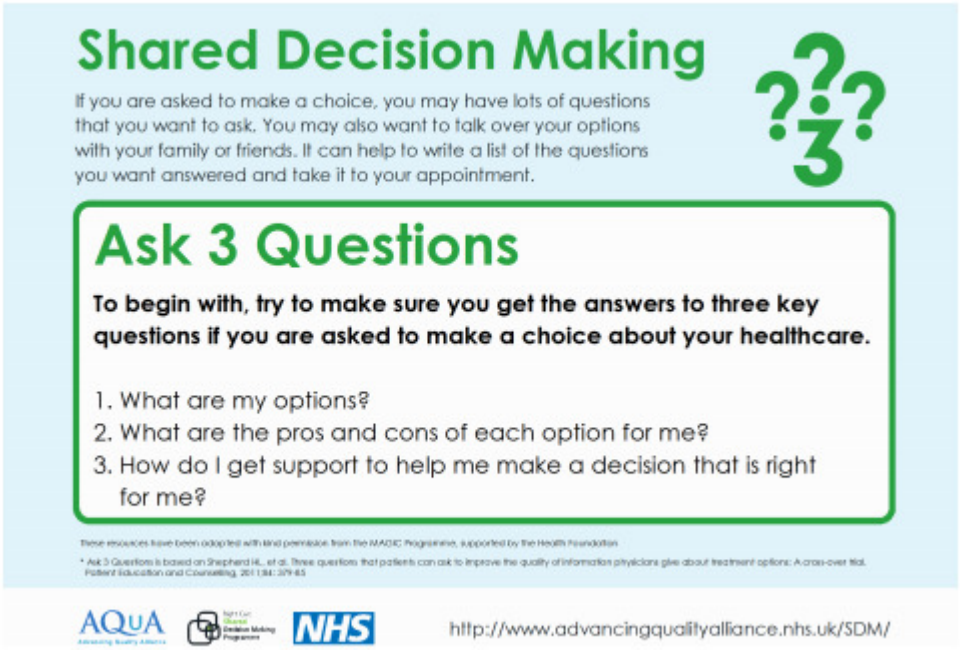
Miss Farah Lone, Consultant Urogynaecologist, Royal Cornwall Hospitals for the photograph of vaginal pessaries

Making a decision -things I need to know before I have my operation.



Please list below any questions you may have, having read this leaflet.

1)……

2)……

3)……

Please describe what your expectations are from surgery.

1)……

2)……

3)……