Prolapse repair by sacrocolpopexy — laparoscopy

01 What is it?

The pelvic organs (bladder, uterus, rectum) rest on the pelvic floor, a set of muscles and ligaments that acts like a hammock. A prolapse, or "organ descent", occurs when these organs are no longer supported and bulge into the vagina, sometimes beyond the vulva. It can affect the bladder (cystocele), the uterus (hysterocele) and the rectum (rectocele), alone or in combination.

This sheet complements, without replacing it, your discussion with your gynaecologist: if you are in doubt or have a question, see them again before the operation.

Sacrocolpopexy puts these organs back in place and reinforces their support with a synthetic implant (a "mesh"), attached to a very strong ligament located in front of the spine, at the level of the promontory. It is performed by laparoscopy (keyhole surgery), through small incisions in the abdomen.

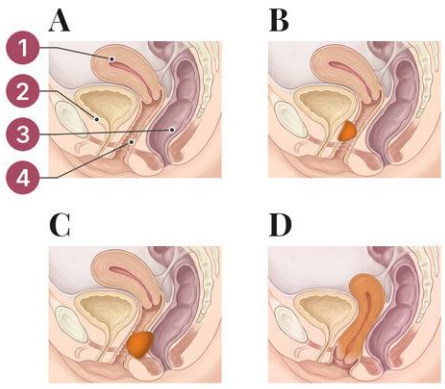


FIGURE 1 — Prolapse: normal position, then descent of the bladder (cystocele), of the rectum (rectocele) and of the uterus (hysterocele) (diagram, side view).

A — The pelvic organs rest on the pelvic floor

1 Uterus

2 Bladder

3 Rectum

4 Vagina

B — The bladder bulges into the vagina: cystocele

C — The rectum bulges into the vagina: rectocele

D — The uterus bulges into the vagina: hysterocele

In orange: the organ that bulges into the vagina.

Side view: the abdomen is on the left of the image, the back on the right.

Diagram Wagram Clinic, 2026.

This sheet is based on the patient information sheet of the CNGOF and the SCGP "Prolapsus génital : traitement chirurgical par promontofixation cœlioscopique robot assistée ou pas" (2025), adapted to the practice of the clinic.

02 Why this procedure?

The prolapse forms a "lump" that causes a feeling of heaviness, pressure or discomfort, can limit physical activity and affect your sex life, more often for psychological reasons (apprehension, self-image) than physical ones.

A prolapse is not a disease: it is neither dangerous nor painful, and causes no complications in the great majority of cases. If it worsens to the point of coming out of the vagina, it can block the emptying of the bladder, cause

the kidneys to dilate with kidney failure, or cause ulceration of the vagina and the cervix.

The operation is offered to you when the symptoms become troublesome or affect your quality of life, or in the event of a complication. It is never urgent and can be planned calmly.

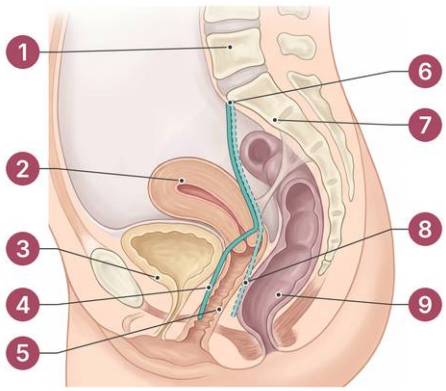


FIGURE 2 — Sacrocolpopexy: the mesh or meshes attached in front of the sacrum, at the level of the promontory (diagram, side view).

1. Spine
2. Uterus
3. Bladder
4. Front mesh: between the bladder and the front wall of the vagina
5. Vagina
6. Attached to the ligament in front of the sacrum, at the level of the promontory
7. Sacrum
8. Back mesh (possible): between the rectum and the back wall of the vagina
9. Rectum

In blue-green: the meshes. Dashed: the second mesh, which may be added.

Side view: the abdomen is on the left of the image, the back on the right.

Diagram Wagram Clinic, 2026.

03 How does the procedure take place?

The operation is performed under general anaesthetic, by laparoscopy, with or without robotic assistance, through 3 or 4 small incisions in the abdomen. You lie flat on your back; a urinary catheter is inserted at the start of the operation.

- A mesh is attached between the bladder and the front wall of the vagina.
- A second mesh may be attached between the rectum and the back wall of the vagina, and sometimes to the rectum itself (rectopexy).
- The mesh or meshes are then attached to the ligament located in front of the sacrum.

If there is a difficulty or a complication, it may be necessary to open the abdomen. A rectal examination may be carried out during the operation to check that the rectum has not been injured.

The operation takes about 3 hours.

04 What the procedure does not guarantee

The result is usually good in the long term, but it cannot be guaranteed.

The prolapse can come back, in up to 15 to 20% of cases in the long term. Several factors contribute to this (ageing, excess weight, chronic cough, fragility of the vaginal lining after the menopause, constipation) and the risk varies from one patient to another. A recurrence does not necessarily bring back the symptoms; it can be treated medically or by a further operation.

Once the organs have been put back in place, leaks of urine on exertion that were masked by the prolapse may appear, in about 10% of cases; how they are managed is discussed at the consultation after the operation.

05 Risks and complications

In the majority of cases, the operation goes ahead without complication. The anaesthetic has its own risks, which are explained by the anaesthetist. Like any surgery, it carries a risk of infection, of bleeding with a haematoma and sometimes a transfusion, of phlebitis or pulmonary embolism, and of allergy.

During the operation, the following may occur: accidental opening of the bladder (more frequent if you have already had surgery; it may interrupt

the operation, and the urinary catheter is then kept in for longer), of the rectum (exceptional, repaired immediately) or of the vagina (more frequent if the uterus has already been removed; it is closed with dissolvable stitches), an injury to the ureter (repaired with a temporary internal stent) or to a blood vessel (which may make it necessary to open the abdomen). These injuries may prevent the mesh from being placed.

After the operation:

- Pain is usually moderate. Pain in the buttocks usually subsides on its own within two weeks; persistent pain is exceptional.
- Leaks of urine on exertion may appear and later require an additional operation. Frequent or urgent needs to pass urine are not rare and may persist if they were present before. Significant difficulty passing urine may make it necessary to reinsert a catheter or to teach you to catheterise yourself, temporarily. A urinary infection is possible and is treated with antibiotics.
- Digestive problems may appear or worsen, and resolve with treatment. A blockage of the bowel (obstruction) caused by adhesions is rare; it often requires a further operation.
- Bleeding or a haematoma is rare and exceptionally requires a further operation or a transfusion.
- The operation usually improves your sex life; rarely, pain or a lack of lubrication makes intercourse uncomfortable, and treatment may be prescribed.
- A fistula (an abnormal connection between two hollow organs) is exceptional, especially after several operations; it is usually treated surgically.
- The mesh may become exposed through the wall of the vagina, sometimes years after it was placed: often without symptoms, it can cause unpleasant discharge, bleeding or infection, and require an operation to remove it partly or entirely. Exceptionally, it migrates towards the bladder or the rectum and must be removed.
- An infection of the attachment on the spine (spondylodiscitis) is rare; it requires removal of the mesh and prolonged antibiotic treatment.

06 Alternatives

- Doing nothing: possible for a minor prolapse, without symptoms or without complications; however, it does not improve on its own.
- Pelvic floor rehabilitation: effective only for mild prolapses.
- The pessary: this is the alternative to surgery. Placed in the vagina, it holds the prolapse back, temporarily or permanently; it does not cure it but relieves the symptoms.

07 Contraindications

If you have a urinary infection, the operation is postponed until your urine is sterile again.

Smoking multiplies the risk of infection by 3 and healing problems by 5. Stopping 6 to 8 weeks before the operation significantly reduces these risks; do not start again during your recovery. If you smoke, talk to your doctor, your surgeon and your anaesthetist, or call Tabac-Info-Service on 3989.

08 Before the procedure

Additional tests may be useful to plan the operation; a urine test may be requested.

An anaesthetic consultation takes place a few days before the operation.

Compression stockings may be prescribed for you, to be worn during the operation and until you are walking normally again, to prevent phlebitis.

09 After the procedure and your instructions

The urinary catheter is usually removed before you wake up, otherwise at the time set by your surgeon; afterwards, some leaks of urine, especially on exertion, are possible and are usually temporary.

Wind usually returns within 48 hours. Avoid straining at all costs when opening your bowels:

a varied diet, rich in fruit and vegetables, and drinking plenty of fluids are usually enough; a treatment to regulate your bowels may be prescribed. Several days without a bowel movement is not a cause for concern.

Some vaginal discharge or light bleeding is normal while healing takes place. A little blood in the urine is possible for a few days: drink plenty of fluids and pass urine regularly.

Your hospital stay is 2 days.

In the shower, wash the scars with your usual soap and pat them dry. Dissolvable stitches or glue come away on their own within 2 to 6 weeks; non-dissolvable stitches or staples are removed by a nurse at home, on prescription.

For the first few weeks: no exertion, sport or heavy lifting. For four weeks: no penetrative sex, and for about six weeks: no tampons or baths. Avoid strenuous effort for two months. Time off work suited to your job may be prescribed.

A follow-up consultation takes place 3 to 4 weeks after the operation; your surgeon will then tell you when to resume all your activities, in particular sport and sexual activity.

10 When to seek medical advice without delay

- No wind, nausea or vomiting: seek urgent medical attention.
- Unexplained fever, severe or persistent pain: contact your doctor.
- Difficulty passing urine that is getting worse (needing to push, urine coming out drop by drop), burning that persists or cloudy urine, blood in the urine that persists or increases: seek medical advice.
- Red, hot or swollen scar: show it to your surgeon, not urgently.

11 Your questions for Dr Gatri

This information sheet probably cannot answer all your questions. In any case, do not hesitate to ask your doctor any question that comes to mind, either orally or in writing.