



Abdominal retroperitoneal colpopexy with mersilene mesh for the correction of post-hysterectomy vaginal vault prolapse

Histerektomi sonrası gelişen vajinal kaf sarkmasının mersilen mesh'le abdominal düzeltilmesi

Davut Güven*, Cazip Üstün, İdris Koçak

Department of Obstetrics and Gynecology, Faculty of Medicine, Ondokuz Mayıs University, Samsun, Turkey

ARTICLE INFO

Article History

Received 07 / 05 / 2011
Accepted 29 / 01 / 2012

* Correspondence to:

Davut Güven
Cumhuriyet Mahallesi
Atatürk Bulvarı 11. Sokak
No:1 Bahadır Apartmanı D:6
Atakum, Samsun, Turkey
e-mail: dguven@omu.edu.tr

Keywords:

Vaginal vault
Mersilene
Colpopexy
Prolapse
Abdominal colpopexy
Posthysterectomy prolapse

Anahtar Kelimeler:

Vajen kafi
Mersilen
Kolpopeksi
Sarkma
Abdominal kolpopeksi
Histerektomi sonrası sarkma

ABSTRACT

The aim of this study was to evaluate the efficacy of rectus fascia colpopexy with mersilen mesh in the correction of posthysterectomy vaginal vault prolapse. We have done this operation like denoted; we entered lateral rectus muscle of patients whom we had done hysterectomy with kelly klemp. We worked up until vagen cuff in retroperitoneal area. We took up mersilene tape with klemp and the rectus muscle is pulled of from its lateral. All cases who had not intraoperative morbidity, mortality and recurrent prolapse did not occur postoperatively.

J. Exp. Clin. Med., 2012; 29:177-178

ÖZET

Bu çalışmanın amacı, Mersilen mesh kullanarak yapılan rektus fascia kolpopeksi vaginal cuff prolapsusu düzeltme operasyonunun etkinliğini değerlendirmektir. Biz bu operasyonu ifade ettiğimiz gibi yaptık; biz kelly klemp ile histerektomi olmuş hastaların rektus kasının lateralinden girdik. Biz retroperitoneal alanda vagen kafına kadar ilerledik. Biz klemp ile mersilen bandı koyduk ve rektus kası lateralinden çektik. Hastaların hiçbirinde morbidite, mortalite ve tekrarlama olmadı.

J. Exp. Clin. Med., 2012; 29:177-178

1. Introduction

Vaginal cuff prolapse after hysterectomy is seen by 0.2-4.3%. Prolapse is more commonly seen after the vaginal hysterectomy (Tooze et al., 1998). The surgeon who faces a patient with vaginal vault prolapse is dealing with a complex and intriguing challenge. Part of the complexity is due to the lack of standardization and routine application of tools to assess pre and postoperative anatomical and functional outcomes. There are a lot of surgeries to repair of the vaginal cuff prolapse, such as abdominal and vaginal. Apart from these treatment methods are also available as a medical, such as topical appli-

cation of estrogen. Patient satisfaction is a major end point for surgical success; thus all aspects of the prolapse pathology and the patient's lifestyle should be considered. The surgeon needs to be well versed and flexible in order to choose the most appropriate operative approach to achieve optimal results for an individual patient (Hung et al., 2004; Arbel and Lavy, 2005)

2. Material and methods

The aim of this study was to evaluate the efficacy of rectus fascia colpopexy with mersilen mesh in the correction of

posthysterectomy vaginal vault prolapse. The study was prospectively designed in 10 patients who admitted to the Obstetrics and Gynecology Department of Faculty of Medicine, Ondokuz Mayıs University in a period between 01.01.1999 to 01.05.2001 with a complaint of posthysterectomy vaginal vault prolapse and transabdominal retroperitoneal rectus fascial colpopexy with mersilene mesh is performed. The mean age of the patients were 63.5 years, mean of parity was 4.9. Four cases had prior vaginal and six cases had abdominal hysterectomy; mean latency time was 9.3 years. The cases were evaluated for parity, operation and hospitalization time, intraoperative bleeding, efficacy of the method and complications. The tips of these forceps were passed through the peritoneum in the region of the internal inguinal ring and then passed to the lateral angles of the vaginal vault in a similar manner to Giliam's ventrosuspension.

3. Results

Mean operation time was 50 minutes, hospitalization time 5 days, intraoperative bleeding 250 ml. Treatment of prolapse was successful in all cases (100%). All cases who had not intraoperative morbidity, mortality and recurrent prolapse did not occur postoperatively. All of the cases who had not postoperative stress urinary incontinency.

4. Discussion

Abdominal retroperitoneal rectus fascial colpopexy with mersilene mesh is an effective method for the treatment of posthysterectomy vaginal vault prolapse. These techniques can be surgical procedure of choice in vaginal cuff prolapsus cases due to the high efficacy and less likely the development of complication. Vaginal vault prolapse and enterocele represent challenging forms of female pelvic organ relaxation. These conditions are most commonly associated with other pelvic organ defects. Proper diagnosis and management is essential to achieve longterm successful outcomes. Physical examination should be carried out in the lithotomy and standing positions (if necessary) in order to detect a loss of vaginal vault support. With proper identification of the vaginal cuff, one should assess the degree of mobility of the vaginal cuff with a Valsalva maneuver. If there is significant descent of the vaginal cuff, vaginal vault prolapse is present, and cor-

rection should be considered (Winters et al., 2000; Revital et al., 2005).

There are new techniques in prolapse surgery. These techniques require skill. Our technique does not require special tools and skills. Laparoscopy may not be available in all hospitals in Turkey. So presented technique is effective, simple and inexpensive. Sacrospinous ligament suspension and endopelvic fascia fixation are effective in managing vaginal vault prolapse. Of the 1229 patients who had undergone sacrospinous ligament suspension, 1062 were available for varying periods of follow-up; 193 (18%) of these developed recurrent pelvic relaxation-including 32 vaginal vault eversions, 81 anterior vaginal wall defects, 24 posterior vaginal wall prolapses, and 56 support defects at unspecified or multiple sites. Of the 367 patients who had undergone endopelvic fascia vaginal vault fixation, 322 were available for follow-up ranging from 1 to 12 years; 34 (11%) of these patients developed recurrent pelvic relaxation including nine vaginal vault prolapses, two anterior vaginal wall defects, 11 posterior vaginal wall relaxations, and 12 support defects at unspecified or multiple sites (Sze and Karram 1997). The number of our patients is low but no complications and did not prolapse again.

We have done this operation like denoted; we entered lateral rectus muscle of patients whom we had done hysterectomy with kelly clamp. We worked up until vagen cuff in retroperitoneal area. We took up mersilene tape with klemp and the rectus muscle is pulled off from its lateral. One of the ends of mersilene mesh is sutured to vaginal cuff with zero prolén. Tonicity that we wanted was provided. Vagen cuff is closed with visseral periton and parietal periton is closed. Before the fasia was closed, the mersilene tape is sutured with zero prolén under the fasia. Finally we closed the tissue and skin. So the operation was finished.

Presented technique is safe, easy to apply and effective, in addition to find the best technique is required to make a lot of work. We will re-examination of patients after 5 years and we will publish the results. We will publish the results of longer follow-up of patients. The discovery of new techniques is important but should be noted that the old ones. Because sometimes be preferable the former technique.

REFERENCES

- Arbel, R., Lavy, Y., 2005. Vaginal vault prolapse: Choice of operation. *Best Pract. Res. Clin. Obstet. Gynaecol.* 19, 959-977.
- Hung, M.J., Liu, F.S., Shen, P.S., Chen, G.D., Lin, L.Y., Ho, E.S., 2004. Factors that affect recurrence after anterior colporrhaphy procedure reinforced with four-corner anchored polypropylene mesh. *Int. Urogynecol. J. Pelvic Flor. Dysfunct.* 15, 399-406.
- Sze, E.H., Karram, M.M., 1997. Transvaginal repair of vault prolapse: A review. *Obstet. Gynecol.* 89, 466-475.
- Toozs-Hobson, P., Boos, K., Cardozo, L., 1998. Management of vaginal vault prolapse. *Br. J. Obstet. Gynaecol.* 105, 13-17.
- Winters, J.C., Cespedes R.D., Vanlangendonck R., 2000. Enterocele repair in the management of vaginal vault prolapse. *Urology.* 56, 55-63.