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LABHARDT`S COLPOPERINEOCLEISIS: OPTIMAL VAGINAL OCCLUSIVE SURGICAL ALTERNATIVE IN PATIENTS WITH HIGH SURGICAL RISK AND WITH NO SEXUAL ACTIVITY

Aims of study

Despite that the goal of surgery for the correction of pelvic organ prolapse (POP) in most of the cases is to restore the anatomy and function, in cases of patients with no sexual activity this is less important. In this kind of patients and with high surgical risk, the vaginal occlusive techniques become relevant. The aim of this abstract is to present our experience in this minimally invasive surgery. We report the epidemiological features with the associated morbidity, surgical results, the intraoperative - perioperative complications, the postoperative anatomical, subjective surgery satisfaction and change in quality of life (QoL).

Study design, materials and methods

This is a retrospective cohort of patients with severe POP sexual activity.

Data of all women who underwent to Labhardt Colpoperineocleisis with or without other POP surgery between January 2008 and December 2009 were obtained from the hospital database by search for surgery classification. Case notes were reviewed to obtain information including demographics, symptoms, gynaecological exam (including POPQ quantification), follow-up at 3 weeks, 6 weeks, 3 month, 6 month, 1 year and then yearly. Recurrence was defined as stage II or higher in POPQ. Three months after surgery, and then in every visit, patients were asked for surgery satisfaction and subjective change in QoL. Methods, definitions and units conform to the standards jointly recommended by the International Continence Society and the International Urogynecological Association, except where specifically noted.

The surgeries were performed by urogynecology unit surgeons. Informed written consent was obtained from the clinical patients to perform the surgery.

Surgical Technique: The procedure was carried out under spinal or general anesthesia with the patient in the lithotomy position. It starts with the resection of vaginal mucosa of the posterior and lateral wall. The first one is made in a rhomboideal incision with the vertices at 1 cm below posterior cervix lip and 2 cm above the anus, at the perineal skin. The resection of lateral vaginal mucosa it's started from the union of the two upper thirds of the posterior mucosa incision until the mucocutaneous junction, 2 cm below the urethral meatus, on the inner part of the labia minora. Thus there is a complete exposure of the posterior and lateral submucosal tissue (in a star-shaped). The vaginal mucosa is closure starting at the nearest vertex to the cervix, with triple zero vycril continuous sutures. This is alternated with the midline high plication of the puborrectalis part of the levator ani muscles and the bulbospongiosus with zero separated PDS suture. A superficial plane of #1 vicryl suture to cover the PDS knots it is placed. Finally the skin it's closure with triple zero vicryl. At the end of the surgery there is a highest neoperineal floor that supports the genital prolapse. In some cases concomitant other vaginal procedure was performed. The re-feeding and walking was within twelve hours. The patients fed themselves and walked at will as of 8 hours post operation and the Foley catheter was removed in all of them before 24 hours post operation.

Results

Forty nine consecutive women underwent to Labhardt's colpoperineocleisis between January 2008 to December 2009. Demographic details including comorbidities and previous gynaecological surgeries are shown in Table 1.

Table 1 Demographic data

Demographic Data	
Mean age±SD, range/mode (years)	72±5,9, 59-85/75
Median total parity±SD, range/mode	4,29±2,8, 0-13/2
Median Vaginal spontaneous birth±SD, range/mode	3,9±2,85, 0-13/2
Median heaviest newborn weight±SD, range/mode (grams)	3688±712,7, 2000-5500/3500
Median menopause age±SD, mode (years)	45,7±5,88, 50
Mean BMI±SD, range (kg/m^2)	27,3±4,7, 19-44
High risk medical or cardiovascular history	38/48
Previous gynaecological surgeries	
POP (no details)	3
VH with or without anterior or posterior colporrhaphy	3
Anterior colporrhaphy + TOT	1
Non POP Abdominal hysterectomy	2

VH: Vaginal Hysterectomy, TOT: Transobturatris vaginal tape

The symptoms before surgery are shown in Table 2

Symptom	**Percentage (n)**
Bulge/vaginal pressure	100 (49)
Voiding difficulty	44,9 (22)
Urgency/urge incontinence	55,1 (27)
Stress Incontinence	38,7 (19)
Colorrectal symptoms	6,1 (3)

Two patients were in stage II, thirty-three patients were in stage III and fourteen were in stage IV, in POPQ classification.

The average general and by compartment POPQ is shown in table 3:

Compartment (n)	Aa±SD	Ba±SD	C±SD	TVL±SD	Ap±SD	Bp±SD	D±SD

General (49)	1,5±1,8	3,6±2,2	1,5±4,1	8±1,2	-0,4±2	0±2,6	-3,2±2,4
Anterior (31)	1,4±1,7	3,6±1,7	0,4±3,6	7,9±1	-1,2±1,6	-0,9±2,1	-3,7±2,2
Apical (15)	2,2±1,3	4,7±1,8	6±1,8	8,3±1,5	0,9±2	1,7±2,9	-1,5±1,6
Posterior (3)	-2±1	-2,3±1,1	-4,3±1,5	7±1,7	2,6±1,1	3,6±0,5	-7±1,4

Surgical details:

Forty-three surgeries were under regional anaesthesia, the rest were under general anaesthesia. Perioperative data are shown in table 4.

Table 4

Perioperative Data	
Mean operating time±SD, range/mode (min)	50,2±19,3, 25-120/40
Mean Estimated blood loss±SD, range/mode (ml)	56,6±44,5, 10-200/50
Intraoperative complications	0
Concomitant vaginal surgeries	6[1]
Median hospital stay±SD, range/mode (days)	2,6±2,99, 1-20/2

[1] One TOT, one dilatation and curettage, three vaginal hysterectomy

Follow-up:

Details are shown in table 5

Follow-up Details	
Mean follow-up±SD, range/mode (month)	6,5±5, 1-22/4
Recurrence (percentage)	6 (12,2)[2]
Post operative events	9[3]
Surgery Satisfaction	33/40[4]
Improve in QoL	34/40 [4, 5]

[2] Recurrence occur at 5,5 month average, three (6,1%) required recolpoperineocleisis with optimal results in 3 month of average follow-up. [3] One De novo incontinence, one de novo constipation, seven treated with antibiotics for vaginal discharge. [4] Only 40 patients responded to the questionnaire. [5] One worse and one equal QoL.

Interpretation of results

Labhardt colpoperineocleisis is an excellent surgery for patient without sexual activity. It's fast with very low blood loss, with no intraoperative complications, few and minimal post operative complications. The rate of recurrence needing for surgery approach is very low (6,1%). This surgery improved the quality of life in this sample and it is associated with high patient's satisfaction.

Concluding message

This cohort is the biggest published data of Labhardt colpoperineocleisis, that show a fast, easy, effective and with low peri and post operative morbidity. The excellent results must be challenged in prospective studies with larger samples, so it can be installed like the gold standard in the treatment of severe genital prolapse for patients without sexual activity.

References

1. Van Huisseling JC. A modification of Labhardt's high perineoplasty for treatment of pelvic organ prolapse in the very old. Int Urogynecol J Pelvic Floor Dysfunct. 2009 Feb;20(2):185-91.
2. Kilic G, Tunca JC. Use of the Labhardt procedure to repair pelvic organ prolapse. Clin Exp Obstet Gynecol. 2007;34(2):91-2.
3. Braun H et al. Labhardt's Colpoperineocleisis For The Treatment Of Severe Genital Prolapse. Int Urogynecol J (2009) 20 (Suppl 2):S73–S239

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What were the subjects in the study?	**HUMAN**
Was this study approved by an ethics committee?	**No**
This study did not require ethics committee approval because	**It was a retrospective cohort**
Was the Declaration of Helsinki followed?	**Yes**
Was informed consent obtained from the patients?	**Yes**