

## THE UK NATIONAL PROLAPSE SURVEY: 5 YEARS ON.

### Hypothesis / aims of study

Currently, there are widespread variations in practice in the conservative and surgical management of prolapse in the UK. 5 years ago a National survey on the management of Prolapse (1) in the UK was conducted which highlighted these variations. The objective of the National prolapse survey was to gain insight into the surgical management of various types of prolapse in different clinical settings, and to compare practice amongst the urogynaecologists working in the tertiary centres, generalists with a special interest in urogynaecology and the general gynaecologists within the UK.

We hypothesised that there would be a significant change in the surgical trends for the management of prolapse particularly with the increasing popularity of meshes. The aim of repeating the National Prolapse Survey was to assess these changes amongst UK practitioners 5 years after the first National UK prolapse Survey.

### Study design, materials and methods

This was a Postal questionnaire survey. Case scenarios formulated for the first survey were modified to incorporate a further range of options taking into account the current practice trends in surgical correction of prolapse. 218 responses were received of which 190 were completed. The aim was to assess the trends in the surgical management of pelvic organ prolapse amongst UK practitioners, and compare practice between urogynaecologists, gynaecologists with a special interest in urogynaecology and general gynaecologists. We also aimed to establish the change in trends in the past 5 years.

### Results

For anterior vaginal wall prolapse, anterior colporrhaphy was the procedure of choice in 71% of respondents. 11% of respondents used a graft for primary prolapse, whereas 56% would do so for a recurrent anterior wall prolapse either alone or in combination with fascial plication. In women with concomitant urodynamic stress incontinence 86% of respondents would perform a midurethral tape in conjunction with a standard repair. In women with uterovaginal prolapse the procedure of choice was a vaginal hysterectomy combined with a repair (82%). 35% of respondents would operate in women whose family was incomplete and the procedures of choice was a sacrohysteropexy. The procedure for supporting the vault intraoperatively was suturing the uterosacrals to the vault (56%). In women with posterior vaginal wall prolapse, the procedure of choice was posterior colporrhaphy with midline fascial plication in 66% of respondents. 12% of respondents would use a graft for a primary posterior wall prolapse and 49% would use a graft for a recurrent posterior wall prolapse. 73% of respondents would operate on a vault prolapse, and 43% would perform UDS prior to surgery. In vault prolapse patients the procedure of choice was an abdominal sacrocolpopexy (44%). When there was associated occult incontinence, 35% of respondents who would operate would perform an additional incontinence procedure at the time of surgery. The differences seen in practice amongst the urogynaecologists, gynaecologists with a special interest in urogynaecology and general gynaecologists in the previous survey were evident in the repeat survey.

Shown in tables 1-4 are the changes in practice from 5 years ago.

### Interpretation of results

There are wide variations in the management of different types of prolapse. Overall surgical practice in the management of pelvic organ prolapse has not altered dramatically in the past five years. The uptake of meshes has increased marginally but rise was seen predominantly in patients with recurrent prolapse. This caution in the uptake of meshes could be related to the lack of long term evidence of benefit, associated complications, particularly with trocar devices as well as the financial implications of using these devices on the NHS.

### Concluding message

Basic trends in prolapse surgery remain unchanged. The increase in the use of mesh is in patients with recurrent prolapse.

**Table 1 Anterior vaginal wall prolapse**

		5 years ago	Current
Procedure of choice for primary repair	Anterior colporrhaphy	77%	71%
	Mesh +/- fascial plication	10%	11%
	Paravaginal repair	6%	9%
	Others	7%	9%
Procedure of choice for concurrent USI	TVT/TVT-O + anterior Repair	71%	86%
	Colposuspension	11%	1%
	Others	18%	13%
Procedure of choice for recurrent anterior wall prolapse	Anterior colporrhaphy	45%	21%
	Mesh +/- fascial plication	34%	56%
	Paravaginal repair	15%	11%
	Others	6%	12%

**Table 2 Uterine + Vaginal wall prolapse (Stage II)**

		5 years ago	Current
Preoperative UDS if concurrent SUI	Yes: 70%	70%	59%
	No: 30%	30%	41%
Procedure of choice	Vag Hyst + repair	82%	82%
	Others	18%	18%
Method of vault support intra-operatively	Suturing uterosacrals to the vault	63%	56%
	McCall culdoplasty	13%	16%

	Sacrospinous	19%	20%
	Posterior	1%	3%
	Others	4%	5%

**Table 3 Posterior vaginal wall prolapse**

		5 years ago	Current
Procedure of choice	Posterior colporrhaphy	75%	66%
	Mesh +/- fascial plication	9%	12%
	Site specific repair	11%	18%
	Others	5%	4%
Procedure of choice for recurrent posterior wall prolapse	Posterior colporrhaphy	38%	23%
	Mesh +/- fascial plication	49%	49%
	Site specific repair	6%	14%
	Others	7%	14%

**Table 4 Vault prolapse**

		5 years ago	Current
Preop UDS with no SUI symptoms	Yes	36%	43%
	No	64%	57%
Procedure of choice	Anterior +post repair	28%	20%
	Abdominal sacrocolpopexy +/- repair:	38%	44%
	SSF +/- repair	19%	26%
	Prespinous fixation +/- repair	1%	} 10%
	Posterior IVS +/- repair	6%	
	Uterosacral lig fixation + repair	3%	
Others	5%		
Perform a continence op concomitantly for occult incontinence	Yes	54%	35%
	No	41%	62%
	Others	5%	3%

References

1. National Survey on the management of prolapse in the UK. Jha S, Moran P. Neurology Urodynamics. 26:325-331. 2007.

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<b>Is this a clinical trial?</b>	<b>No</b>
<b>What were the subjects in the study?</b>	<b>NONE</b>