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PARAVAGINAL DEFECT REPAIR: THE ANATOMIC APPROACH TO CYSTOURETHROCELE AND FEMALE PELVIC RECONSTRUCTION

Aims of Study: Concepts of female pelvic prolapse are changing. The most common cause for cystourethrocele, and many times stress urinary incontinence (SUI), is a paravaginal defect due to detachment of the pubocervical fascia from the pelvic sidewall (arcus tendineus fascia pelvis [ATFP]). We present a prospective series of women undergoing paravaginal defect repair (PVdR) to correct cystourethrocele (with or without SUI).

Methods: One hundred fourteen consecutive patients with a mean age of 58 years (range, 33-77) underwent PVdR for lateral defect cystourethrocele. 83 (73%) women had prior hysterectomies and 38 (33%) had failed one or more prior continence procedures. All PVdRs were performed through an open retropubic approach using non-absorbable suture to approximate the lateral edge of the pubocervical fascia to the ATFP. 73 patients had associated SUI and received Burch sutures (35), rectus sling (23), or PVdR only (15). Associated pelvic support defects were repaired simultaneously and included rectocele (41), vault prolapse (32), enterocele (31), and midline cystocele (3).

Results: At a mean follow-up of 19 months (range, 5-31), overall success rate for continence was 90% (73% dry, 17% improved [≤ 1 pad/day]). 8 out of 12 post-operative continence failures were due to urge-incontinence, therefore overall SUI-specific success rate was 95%. Overall prolapse success rate was 89%, and paravaginal defect specific cure rate was 95%. Recurrent prolapse occurred in 13 patients; 6 paravaginal defects, 3 vault prolapse, 2 enteroceles, 1 rectocele, 1 midline cystocele.

Conclusions: Paravaginal defect repair (PVdR) has a high success rate in treating women with cystourethrocele with or without concomitant urinary incontinence. In female pelvic reconstruction, a "defect-oriented" approach will help to restore normal pelvic anatomy and offer the best chance for success.