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# ANATOMICAL AND FUNCTIONAL OUTCOME IN SURGICAL TREATMENT OF PROLAPSE

## Hypothesis / aims of study

Genital prolapse is frequently associated with low urinary tract and/or defecatory dysfunction but the relationship between severe genital prolapse and the correlate symptomatology is not clear. It is commonly taught that women with significant uterovaginal prolapse and/or cysto-rectocele have difficulty evacuating their bladder or their rectum and often require digital replacement in order to void. On the other hand prolapse and urinary incontinence can be associated and women with prolapse but without incontinence may be at risk for incontinence when the prolapse is reduced. With significant advancements in pelvic anatomy knowledge over the last several decades, the surgical approach to the treatment of vaginal profile alterations has evolved from the traditional muscolar plication to the repair of specific fascial defect. The main issues in the corrent literature is the importance of not only the importance of anatomic restoration, but also of quality of life issue related to visceral and sexual function. Aim of our study was to assess morbidity, anatomical and functional results of surgical menagement of genital prolapse.

## Study design, materials and methods

Eighty-five women underwent surgical treatment for uterovaginal prolapse between July 2002 and July 2003: seventy-five (88,2%) had cistocele at stage 2° or more and fourthy-two (49,4%) had rectocele ≥ 2°. All patients were diagnosed with uterine descensus ≥ 2 ° (in 39 pat the stage of prolapse was ≥ 3°). A physical exam was performed before and 6 months after surgery and all the women were assessed for micturing and bowel symtoms using a specific questionnaire at the same time. The diagnosis of descensus was made and quantified during maximal Valsalva maneuver in the supine position.
Vaginal hysterctomy with or without salpingooforectomy, utero-sacral legaments vaginal apex suspension, fascial defect repair for the correction of cysto and/or rectocele was performed.
Parameters to evaluate the outcome were: complications, recurrent prolapse within 6 months, changes in micturing and/or defecation complains. Statistical analysis was performed with univariate and nonparametric tests (IC $\alpha$=0.05). We considered as anatomical failure the presence of segmental vaginal descent ≥ 2° stage.

## Results

The following table show the subjective perception of symptoms before and after the operation.

| Symptom | Before | After | p |
|---|---|---|---|
| Disuria | 54% | 5.9% | <<0.0001 |
| Urge incontinence | 30.6% | 21.2% | 0.060 |
| Urgency | 41.2% | 31.8% | 0.078 |
| IUS | 38.8% | 30.6% | 0.120 |
| Constipation | 38.8% | 38.8% | 1 |
| Difficulty of evacuation | 24.7% | 21.2% | 0.454 |
| Fecal incontinence | 25.9% | 23.5% | 0.613 |
| Recurrence rectocele | | 10.6% | |
| Recurrence cistocele | | 9.4% | |

The stress leakage was positive in 36.5%(31/85 pat.) before surgery, and in 24.7%(21/85 pat.)of the patients at the follow-up. At cystomanometric evaluation11.7%(10/85 pat.) had detrusor overactivity before surgery. The same number of patients had this urodynamic diagnosis at follow-up.

There were no intraoperative complications.

**Interpretation of results**

It is the common thinking that women with more severe degree of genital prolapse have some degree of ostructed voiding: our results conferm this observation with a 54% of patients complains of disuria (41/85 pat.). The resolution of this symptoms after surgery is statistically significant (5.9%, p<<0.0001). The IUS and urge incontinence were not affected by surgery in our series. This is in agreement with the literature for IUS whereas several authors demonstrated resolution of detrusor overactivity postoperatively in relation to the decrease of urethral resistence. In our serie there is a very minimally improvement of this symptoms (from 30.6% to 21.2% for urge incontinence and from 41.2% to 31.8% for the urgency).
In our series the more specific defecatory symptoms are not correlated to a significant anatomical vaginal posterior wall alteration. In fact, in the group of women who referred defecatory sympoms before and after surgery (33 constipation, 21 difficulty of evacuation and 22 fecal incontinence), only seven presented rectocele stage 2 to 4 in association with descensus of the other segments. In these patients there were not significant changes in defecation complains after surgery.

**Concluding message**

The fascial specific repair is a good tecnique for the correction of the anterior and posteriore vaginal wall prolapse. The Mc.Call vaginal suspension is a very important procedure for the axis of the vagina and the prophilaxis of vaginal prolapse recurrence.
Unfortunately a good anatomic result do not always guarantee good functional results.
Thank to minimally invasive surgery the problem of persistence of IUS is today substantially solved. Urge incontinence related to detrusor overactivity may be faced with perineal electrostimulation or pharmacological treatment. The most important problem involves the posterior segment: we need to better define the correlation between defecatory disfunction and rectocele.

**References**


1. Incontinence and voiding difficulties associated with prolapse. J Urol. 2004 Mar; 171(3):1021-8.
2. Posterior vaginal wall prolapse: transvaginal repair of pelvic floor relaxation, rectocele, and perineal laxity. Tech Urol. 2001 Jun; 7(2): 161-8.
3. Evaluation and management of rectoceles. Curr Opin Urol. 2002 Jul; 12(4): 345-52.