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IS A CONCOMITANT ANTERIOR REPAIR ALWAYS NECESARY IN PATIENTS UNDERGOING VAGINAL APICAL REPAIR SURGERY

Aims of study: To compare anterior defect recurrence rates at 24 months follow-up in patients who underwent a vaginal apical defect suspension surgery with or without a concomitant classic anterior compartment repair.
Material and methods: All patients with severe concomitant apical and anterior defects defined as a POP Q stage 2 or greater for Ba and C points that underwent a vaginal surgery had at the beginning of the surgery an intra-operative simulation of the corrected apical defect. This maneuver was made by pushing the cervix or vaginal vault to the desired post suspension position. All patients with POP Q point Ba at stage 2 or greater always underwent a Kelly plication. If POP Q point Ba was between stages 0-1 after the simulation, they were considered as mild anterior defects, the concomitant Kelly plication was left to the criteria of the surgeon (Group A without anterior repair and Group B with anterior repair). We performed a retrospective study of these 209 patients with mild anterior defect. In both groups the apical defect was repaired using a High Uterosacral Vault Suspension (HUVS) for POP Q point C greater than 2. Patients with stage 2 apical defects underwent a Mayo-McCall suspension (MMC). Recurrence of the anterior defect was defined as POP Q point Ba higher than stage 2 at 24 months follow-up. Secondary objectives were to compare surgical times, intra and post surgical complications, apical compartment defects recurrence and hospital stay between both groups. The recurrence of the anterior compartment defect is shown as actuarial survival rates using Kaplan Meier method.
Results: Of the 209 patients, 106 underwent apical surgical correction alone (group A) and 103 underwent a concomitant anterior repair (group B). The mean follow-up was 24,1 $\pm$ 12 and 27,4 $\pm$ 15 (p= 0,08) respectively. Both groups had similar epidemiologic features and characteristics: Age: 56,2 $\pm$ 9 v/s 58.3 $\pm$ 10 (p= 0,11) ; Parity 3,6 ±1.7 v/s 4,0 ± 2.0 (p= 0,14); Body Mass Index 29.3 ± 6 v/s 30,7 ± 14 (p= 0,38); Previous Hysterectomy 4,7% v/s 5.8% (p=0.72). The frequency of HUVS performed in each group was 41,5% vs 38,8% (p= 0,69). After comparing both groups (A and B) we found no significant difference in anterior compartment recurrence rate at 24 months follow up: 10.4% vs 12.2% (p= 0,32) respectively. Also there was no significant difference between anterior compartment failure rate in patients who underwent a HUVS or MMC in group B: 19.4% vs 22.3% (p=0,53). The apical compartment failure rate was 4.7% for Group A vs 5.8% for Group B, (p= 0,72). The mean operative time was 66,5 $\pm$ 21min for group A vs 79,1 $\pm$ 27min for Group B (p= <0,01). The mean hospitalization stay was 2.1 $\pm$ 0.6 vs 2.1 $\pm$ 0,6 (p= 0.67). There were no differences in intra and post operatory complications rates between the groups: 0% vs 1% (p=0.30) and 7.5% vs 6.8%(p=0.83) respectively.
Interpretations of the results: Our study suggests that the concomitant prophylactic anterior defect repair during a vaginal apical suspension surgery has no impact in the anterior compartment failure rate at 24 months of follow-up. These results support the idea that a good apical suspension is the central key for severe anterior defects repair associated with apical defects. It does raise the question, if a prophylactic anterior repair to reduce failure rates is beneficial or if it is better to do nothing and warn patients of the possibility of future interventions.
Conclusion: Our study suggests that prophylactic anterior repair, in patients with mild anterior defects after a vaginal apical suspension, does not achieve a significant impact in reducing anterior defect failure rates.

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Was this study approved by an ethics committee?	**Yes**
Specify Name of Ethics Committee	**Comite de Etica, Hospital Padre Hurtado**
Was the Declaration of Helsinki followed?	**Yes**
Was informed consent obtained from the patients?	**Yes**