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VAGINAL MESH REPAIR FOR PROLAPSE IS AS EFFECTIVE, IN THE SHORT TERM AS THE TRADITIONAL REPAIR BUT CARRIES A HIGH EROSION RATE AS A DETERRENT FACTOR.

Hypothesis / aims of study
Vaginal Hysterectomy is the still the cornerstone in management of symptomatic uterine prolapse. The additions of anterior and posterior vaginal wall repairs are often necessary for site specific prolapse repair. The use of vaginal mesh for prevention of recurrence replaces the traditional anterior and posterior colporrhaphy. The objective of the study is to compare the results of the traditional repair of vaginal hysterectomy and vaginal wall repair with or without vaginal mesh placement.

Study design, materials and methods
Retrospective chart review of 78 women, who underwent vaginal hysterectomy for uterine prolapse from January 1st 2007 to October 31st 2009, was done. All women underwent McCall culdoplasty for vaginal cuff restoration. Forty six women had simultaneous vaginal wall repair by anterior and/or posterior colporrhaphy (Group 1). Thirty two women underwent concomitant anterior and/or posterior vaginal mesh repair (Group 2).

Results
The only difference between the two groups was age. Women in group 1 were significantly older (70.1 ± 8.6 years and 59.3 ± 8.4 respectively, $p<0.001$). There was no difference between the groups in gravidity, parity, menopausal state, HRT use, presenting symptoms, previous prolapse surgery, and the degree of prolapse stage (POPq C, POPq Aa, POPq Ap). There was no difference between the groups in adnexal removals (28.3% and 34.4% respectively) and sling addition (58.7% and 65.6% respectively) during the surgeries.
Anterior colporhapphy was done in 93.5% of the women in group 1, and posterior colporrhaphy in 54.3%. Anterior repair with mesh was done in 71.9% of the women and posterior repair with mesh was done in 34.4%. Length of surgery was significantly longer in group 2 (95.3 ± 37.5 minutes and 70.2 ± 22.1 respectively, $p<0.001$). An immediate severe post operative complication was observed in only one patient in group 1 which required explorative laparoscopy for intra-abdominal bleeding. In a follow up of at least 6 months there was no difference between the groups in urgency de novo rate, dyspareunia rate and recurrence of prolapse. Mesh erosion that required surgical management (limited local excision) was seen in 5 patients (15.6%) in group 2, of these, in 2 patients both anterior & posterior meshes were placed.

Interpretation of results
Mesh augmentation for vaginal wall prolapse was more common in younger women. The severity of the prolapse did not influence the use of mesh. This reflects our policy, to date, a time when there is still no consensus as to indications for mesh augmentations of POP repair. In most patients mesh augmentation was done for the anterior vaginal wall. Follow up of at least 6 months did not reveal that mesh augmentation superior in prevention of recurrent prolapse. Erosion rate of 15.6% remains the only concern and probably reflects our learning curve. This complication was managed without hampering the results.

Concluding message
Vaginal mesh augmentation concomitant with vaginal hysterectomy in the younger age group differs only in the erosion rate that necessitated repeat surgical intervention without hampering the short term end result. If we can avoid this complication, mesh placement may prove to be superior in long term.

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Is this a Randomised Controlled Trial (RCT)?	**No**
What were the subjects in the study?	**HUMAN**
Was this study approved by an ethics committee?	**Yes**
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Was the Declaration of Helsinki followed?	**Yes**
Was informed consent obtained from the patients?	**No**