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SACROSPINOUS LIGAMENT FIXATION (SSF) VERSUS GYNECARE PROLIFT®: A COMPARISON IN A 3-YEAR OUTCOME OF SURGICAL MANAGEMENT FOR ADVANCE (GRADE 3 AND 4) APICAL PROLAPSE

Hypothesis / aims of study
- To compare the objective and subjective cure rate between Sacrospinous ligament fixation (SSF) and Gynecare Prolift® after 3 years.
- To assess and compare the functional outcomes and long-term complications following these two surgical modalities.

Study design, materials and methods
In our settings, patients with grade 3 and 4 apical prolapse according to the Baden-Walker classification system [1] were either surgically managed with SSF or mesh repair using Gynecare Prolift® (total or posterior). Mesh repair was mainly performed for patients with procidentia (grade 4 prolapse in all compartments). Retrospective data was collected for patients who underwent these surgeries under the supervision of a single experienced surgeon between 1st January to 31st December 2007. Patients who underwent a combination of SSF and mesh repair were excluded.
Peri-operative and long-term post-operative details were recorded at follow-up intervals of 6, 12, 24 and 36 months. Patients who defaulted follow-up were recalled via the telephone.
Objective cure was determined by anatomical criteria of Baden-Walker ≤ grade 1 [1]. Subjective cure was defined as the absence of lump at introitus, overall satisfaction with surgery and no re-treatment (surgery or use of ring pessary).

Results
There were 29 and 34 patients who underwent SSF and Gynecare Prolift® surgery respectively. Both groups of patients were comparable in term of their demographic details, pre-existing genito-urinary symptoms and previous pelvic surgeries.
There were more Prolift® than SSF patients with grade 4 cystocele (79.4% vs 10.3%, p<0.005). Peri-operative blood loss was also significantly more in the Prolift® group (177.79ml vs 79.14ml, p<0.005). There was 1(3.4%) case of bladder injury in the SSF group, but no visceral injury in the Prolift® group.
The incidence of voiding difficulty (31% vs 2.9%, p<0.005), prolonged IDC (20.7% vs 0%) and thigh pain (13.8% vs 8.8%) was higher in the SSF than Prolift® group.
At 36 months, 28 (96.6%) and 31 (91.2%) patients were available for follow-up (inclusive of telephone interview) in the SSF and Prolift® group respectively. There was no recurrent apical prolapse in the SSF group, but 2(6.5%) cases of vault prolapse in the Prolift® group.
2 cases of recurrent cystocele were reported in each group (8.7% in the SSF group and 9.1% in the Prolift® group). However, none of these patients were symptomatic.
The incidence of de novo urinary incontinence was higher following Prolift® surgery than SSF surgery (SUI: 16.1% vs 3.6%; UUI: 9.7% vs 3.6%).
The incidence of mesh erosion in the Prolift® group was between 3.0% to 4.2%; and 0% in the SSF group throughout the follow-up durations.
There was no reported dyspareunia or pelvic pain cases after Prolift® surgery at all follow-up intervals. However following SSF surgery, there were 2(6.9%) cases of pelvic pain at 6 months and 1(3.8%) case of dyspareunia at 12 months.
The objective cure rate at 3 years following SSF and Prolift® surgery was 96.4% and 90.3% respectively. The subjective cure rate was 100% following SSF surgery, and 93.5% following Prolift® surgery.

Interpretation of results
In experienced hands, SSF and Gynecare Prolift® are equally safe with minimal complications. The incidence of long-term genitourinary dysfunction was similar in both groups, with acceptably low risk of mesh erosion.

Concluding message
After 3 years, both surgical methods were effective in achieving anatomical apical correction and patients from both groups were satisfied with their surgery outcome.

References
1. Baden WF, Walker TA, Lindsay HJ. The vaginal profile. Tex Med J 1968;64:56–58

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