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PROLAPSE SURGERY:- COLPOCLEISIS VERSUS TRADITIONAL VAGINAL PROLAPSE REPAIR

Hypothesis / aims of study

The population is ageing and increasing numbers of women are seeking treatment for the symptoms of urinary incontinence and pelvic organ prolapse. Current treatments include the use of pessaries or surgery. Increasing numbers of women are requesting surgical management and in some cases repeat procedures. Colpocleisis offers an alternative treatment option for elderly women with complete procidentia, who are no longer sexually active and who would be considered 'high risk' for a more complex and lengthy prolapse procedure. Colpocleisis was originally described by Le Fort in 1877 but first performed by Neugebauer in1867. It has re-emerged as a useful technique in selected women and current literature quotes success rates ranging from 91-100% with recurrence being a rare event. Randomised controlled trials looking at the success and complications of Colpocleisis are limited. This study looks to compare the outcomes and success of colpocleisis against those of traditional surgical methods of pelvic organ prolapse repair.

Study design, materials and methods

A retrospective review of 30 cases of Colpocleisis surgery performed in a single centre between March 2007 and August 2012 was completed. Patients ranged from 67-89 years old, were all white British and were no longer sexually active. These were compared with 30 non-sexually active, age-matched control patients who underwent traditional vaginal repair surgery for their prolapse symptoms. Patients were seen in a follow up clinic 3 months post-operatively to assess outcomes and patient satisfaction. The success and complications of both surgical approaches were then compared.

Results

At follow up, 100% of patients who had colpocleisis were fully satisfied and had no prolapse symptoms. 50% of these patients had undergone previous prolapse surgery and with the exception of one case, all were performed under spinal anaesthetic. There were no cases of regret in the colpocleisis group and compared to the vaginal surgery cohort there were fewer new post-operative urinary and bowel symptoms. There were reports of new onset dyspareunia in the vaginal surgery group amongst those who had become sexually active following surgery.
Overall the audit demonstrated very low complication rates for both groups. There were no cases of bladder injury or significant voiding dysfunction in either group. Despite an elderly population with multiple co-morbidities in the colpocleisis group, there were no cases of VTE, cardiovascular or cerebrovascular events or death.

Interpretation of results

The vast majority of patients in both groups were satisfied with their surgical procedure and there were no statistically significant differences in outcomes between the two groups.
Only a small number of patients were reviewed in this study, therefore greater patient numbers would add weight to the success demonstrated for colpocleisis.
There are areas of ambiguity relating to pre-operative investigations required prior to colpocleisis. These include endometrial biopsy and TV scan in cases of postmenopausal bleeding, urodynamic studies in women with voiding disorders and taking smears from women with cervical abnormalities.

Concluding message

Although vaginal repair surgery remains the mainstay of treatment for pelvic organ prolpase, Colpocleisis is still a highly acceptable and successful procedure, provided it is performed within a carefully selected patient population. Adequate training in this procedure should be undertaken by surgeons to ensure competence is maintained.

References

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Disclosures

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