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Rosenblatt P¹, Dessie S¹, Park M¹

1. Mount Auburn Hospital

LAPAROSCOPIC SUPRACERVICAL HYSTERECTOMY WITH TRANSCERVICAL MORCELLATION AND SACROCERVICOPEXY FOR THE TREATMENT OF UTERINE PROLAPSE

Introduction

Laparoscopic sacrocolpocopexy is considered the gold standard in the treatment of apical pelvic organ prolapse. In this video, we describe our surgical approach for the management of uterine prolapse.

Design

The patient is a 59 year old woman with symptomatic Stage III prolapse with point C at +2. We start by performing a laparoscopic supracervical hysterectomy with a bilateral salpingectomy.

We use the CISH instrument, which consists of a 15mm serrated hollow outer cylinder with a solid cylinder that fits within, to core out the endocervical canal. Once the coring is completed, a disposable morcellator is placed through the cervical defect and used to morcellate the uterus and fallopian tubes. We then remove the handle from the morcellator, and it acts as an access cannula for the sacrocervicopexy. A 0-Vicryl purse-string suture is placed vaginally but not tied down until the end of the case.

We then dissect the peritoneum over the sacral promontory to expose the anterior longitudinal ligament. The incision is carried down the right pelvic side wall. The rectovaginal space is developed and the bladder is dissected off the vagina. The Y-shaped polypropylene mesh is prepared by rolling and loosely suturing the sacral extension to keep it out of the way during vaginal suturing and placing a hole in the upper aspect of the posterior arm of the mesh to fit over the transcervical cannula. The mesh is inserted through the transcervical cannula and secured to the anterior and posterior vaginal wall with permanent suture, using extracorporeal knot tying. Needles are introduced and removed one at a time through the transcervical cannula. We decide on adequate tensioning and suture the mesh to the anterior longitudinal ligament. A barbed delayed absorbable suture is then used to close the peritoneum, and the 0-Vicryl suture that was placed transvaginally as a cerclage is tied down when the cannula is removed.

Results

At the patient's six week post operative visit, she was doing well with no prolapse in any compartment. She reported that she had minimal pain following the procedure and was overall very satisfied.

Conclusion

This video demonstrates a method for performing a laparoscopic supracervical hysterectomy with sacrocervicopexy for pelvic organ prolapse maintaining all 5 mm port sizes via transcervical morcellation. We hope that this simple technique could possibly decrease postoperative pain, risk for incisional hernias, cyclical vaginal bleeding from residual endometrial tissue in the endocervical canal, and risk for cervical cancer.

Disclosures

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