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Title (type in
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GRADE IV CYSTOCELE REPAIR USING CADAVERIC FASCIA AND TRANSVAGINAL BONE ANCHORS.
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Aims of Study: In the majority of patients with grade IV cystoceles, four defects exist. These include separation of the cardinal ligaments, loss of urethral and bladder neck support as well as central and lateral herniation of the bladder. Proper management would require fixation of all these defects in order to prevent recurrences and create a solid anterior vaginal wall and correct pelvic floor relaxation. We have previously described a technique of four-defect repair (FDR) which entails more retropubic dissection and a suprapubic incision for the suspension sutures. We describe a new technique that utilizes cadaveric fascia and transvaginally placed bone anchors to provide suburethral support. In addition to standard plication of the perivesical fascia, the cadaveric fascia is placed over the repair to facilitate correction of both central and lateral defects. This technique obviates the need for a suprapubic incision or extensive vaginal dissection.

Methods: 36 patients (mean age = 70.8, range = 46 – 85 years) underwent grade IV cystocele repair with cadaveric fascia and transvaginal bone anchors between April, 1998 and January, 1999. The initial dissection was standard and encompassed dissecting the vaginal epithelium from the perivesical fascia. The retropubic space was entered at the level of the bladder neck to facilitate placement of two separate titanium bone anchors preloaded with #1 Prolene sutures into the inferior aspect of the pubic symphysis. The cystocele is reduced with an absorbable mesh and the central defect was then repaired by reapproximation of the cardinal ligaments and perivesical fascia with 2-0 polyglycolic acid sutures. A posterior set of #1 Prolene sutures was placed through the cardinal ligaments to anchor the inferior edge of the sling. Placement of a cadaveric fascia sling beneath the entire bladder base and bladder neck

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repaired the lateral defect. The Prolene sutures were placed 5mm from the edge of a 7.0 cm wide sling, effectively creating a 6.0 cm wide hammock of support. This sling was anchored to the pubic bone anteriorly and the cardinal ligaments posteriorly. This obviated the need for a separate vaginal wall sling and for a suprapubic incision.

Results: Follow-up was via patient interview and physical examination. All patients had concomitant procedures including bladder neck suspension in 36/36, rectocele repair 29/36, enterocele repair 11/36, and vaginal hysterectomy 15/36. With a mean follow up of 5.1 months (range = 2 - 10.5), all patients are free of stress incontinence. Recurrent prolapse has not occurred. Two patients had transient urinary retention only and there were no operative complications or blood required for any patient. No cases of vaginal shortening have occurred and *de novo* urge incontinence occurred in 2/36 patients (5%).

Conclusions: The early experience with grade IV cystocele repair using cadaveric fascia and transvaginal bone anchors compares favorably with our previous four-defect repair. The elimination of the vaginal wall sling and suprapubic incision has simplified the procedure without compromising efficacy. This new procedure does not require additional surgical steps to support the bladder neck and urethra and provides an added layer of support to prevent recurrences. Long term follow up will establish the efficacy of this novel approach.