

THE USE OF SOLVENT-DEHYDRATED CADAVERIC FASCIA LATA (TUTOPLAST) IN SLINGS AND CYSTOCELE REPAIRS: THE VIRGINIA MASON EXPERIENCE.

Aims of Study

To evaluate our experience to date with the transvaginal sling and cystocele repairs using solvent-dehydrated cadaveric fascia lata (Tutoplast) and bone anchors with regard to outcomes and patient-perceived improvement and satisfaction.

Methods

134 patients underwent a transvaginal sling by a single surgeon (KCK) using cadaveric fascia lata and bone anchors between October 1999 and March 2001. Of these, 117 underwent concomitant cystocele repair using cadaveric fascia. Mean age was 61.1 years (range 36-90). Patients were evaluated by physical examination and through the use of a mailed validated questionnaire. 85/134 (63.4%) returned the completed instrument, and mean and median follow-up of this group was 15 months (range 6-24). 101/134 (77.6%) have a minimum of 6 month postoperative physical examination, and the mean follow up is 11.5 months (range 6-23).

Results

82 (61.2%) patients had undergone previous pelvic prolapse repair, anti-incontinence surgeries, and/or hysterectomy. Mean preoperative and postoperative SEAPI scores [1] in the 101 patients with physical exams were 5.63 and 1.01, respectively, representing a significant improvement ($p < 0.0001$). Continence status includes 15/134 (11.2%) patients with de novo urge incontinence (UI), 20 (14.9%) with persistent UI, and 12 (8.9%) with stress urinary incontinence (SUI) of any degree. 1 patient had persistent urinary retention at 3 months postoperatively and underwent urethrolisis. She is now voiding to completion with mild urgency but no UI or SUI. There have been 2 (1.5%) cases of osteitis pubis which responded to anti-inflammatory medications and no cases of osteomyelitis. 26/85 (30.1%) patients who returned the questionnaire reported 100% satisfaction, 56 (65.9%), were $\geq 80\%$ satisfied, and 13 (15.3%) were $\leq 50\%$ satisfied. 22/85 (25.9%) reported 100% improvement, 59 (69.4%) were $\geq 80\%$ improved, 3 (2.4%) were improved, but to a degree of $\leq 50\%$. 5 (5.9%) described that they were worse than before surgery. 74 (87.0%) would repeat the surgery, and 67 (78.9%) would recommend it to a friend.

The intermediate results using cadaveric fascia for concomitant cystocele repair and sling have been excellent. As of yet, there have been no long-term data reported using cadaveric fascia with or without bone anchors for cystocele repair and sling, and follow-up is ongoing. Our results are comparable to those seen in the few series available to date reporting results using a similar technique [2,3]. Important parameters which must be determined are the long-term results of this technique with regard to both continence status and pelvic floor support.

Conclusions

The Virginia Mason experience using solvent-dehydrated cadaveric fascia lata (Tutoplast) for slings and cystocele repairs has been excellent. The authors have been pleased with the SUI cure rate, the success of the cystocele repair, and the patient satisfaction rate. The technique is simple and very well-tolerated by the patients, as the entire surgery is performed transvaginally. Avoidance of harvesting of autologous tissue, passage of needles through the retropubic space, and suprapubic incisions afford a fast recovery with minimal patient morbidity. Close follow-up continues in order to evaluate the long-term durability of this technique.

REFERENCES:

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