

SACROSPINOUS LIGAMENT FIXATION FOR PELVIC FLOOR RELAXATION.

Aims of Study

Aged women are often annoyed with decrease in QOL owing to pelvic floor relaxation including cystocele, rectocele, uterovaginal prolapse, vaginal vault prolapse, and sometimes stress urinary incontinence. These symptoms often recur during follow-up after the previous surgical treatment. Transvaginal sacrospinous ligament fixation is one of the most popular and simple procedures for treating vaginal vault prolapse in women. To assess the feasibility of transvaginal sacrospinous ligament fixation for pelvic floor relaxation, patients with mainly cystocele or other vaginal prolapse were treated with sacrospinous ligament fixation in combination with other procedures for a variety of symptoms of pelvic floor relaxation.

Methods

From 1997 to 2002, 26 patients with a mean age of 62.6 (47–77) underwent sacrospinous ligament fixation procedure via vaginal approach with other surgical procedure such as anterior or posterior colporrhaphy or bladder neck suspension/sling operation. Past surgical histories were hysterectomy in 8 patients, bladder neck suspension in one, anterior colporrhaphy in one. Twenty-five patients and 13 patients were associated with cystocele and rectocele, respectively. Eleven patients were concomitant with stress urinary incontinence whereas 8 patients were uterovaginal or vault prolapse. We evaluated the medium-term outcome of treating these patients with pelvic floor relaxation basically by using vaginal sacrospinous ligament fixation and colporrhaphy.

Results

Two patients were treated with sacrospinous ligament fixation monotherapy while remaining 24 patients underwent sacrospinous ligament fixation combined with other operations as follows. Anterior and posterior colporrhaphy were performed in 23 patients and 9 patients, respectively. Hysterectomy for uterovaginal prolapse was selected for 6 patients with uterovaginal prolapse. Bladder neck suspension and sling operation were combined for 5 patients with stress urinary incontinence. All patients with cystocele and rectocele were cured. Ten of 11 patients with stress urinary incontinence showed complete disappearance of stress urinary incontinence whereas one patient continued to have slight stress urinary incontinence (Grade 4→1) by anterior colporrhaphy. Uterovaginal prolapse and vault prolapse were cured in 5 and 3 patients, respectively. At a mean follow-up of 22 months, however, 3(12%) of 26 patients had developed recurrence of asymptomatic cystocele with grade 2. Only one (4%) patient showed recurrence of the slightest rectocele 40 months after anterior and posterior colporrhaphy with hysterectomy. One (4%) patient had shown recurrence of stress urinary incontinence 4 months after anterior colporrhaphy and bladder neck suspension. Thereafter, this patient was treated with TVT. All patients continued to have vaginal wall fixation to sacrospinous ligament. There had been no recurrence of vaginal vault prolapse. On the other hand, there was no severe adverse event such as wound infection or rectovesical injury caused by sacrospinous ligament fixation, only 2 patients complained of transient neuralgia of ipsilateral gluteal and dorsal thigh lesion.

Conclusions

Our medium-term outcome suggests that sacrospinous ligament fixation is a safe and feasible procedure for various types of pelvic floor relaxation, not only to treat vaginal vault prolapse, but also to prevent the secondary vaginal prolapse such as cystocele and rectocele.