

## CONSERVATIVE VAGINAL SURGERY FOR TOTAL GENITOURINARY PROLAPSE

### Synopsis of Video

We propose a conservative vaginal operation for total genitourinary prolapse using a biological prosthesis to restore the pelvic floor. This technique is indicated in 3<sup>rd</sup> or 4<sup>th</sup> degree hysterocele with corresponding cystocele and enterocele. It does not correct rectocele.

We employ a biological mesh of bovine pericardium. The mesh is sterilized and treated by no react method to obtain a non-absorbable material. The mesh is shaped to create a support for the cystocele in its forward section, for the cervix in the central section and for the enterocele in its rear portion. The mesh has four firm anchoring sites: the sacrospinal ligaments which are the posterior anchoring sites and the arcus tendineous of the levator ani muscle which houses the two anterior anchoring sites.

A case of a 3<sup>rd</sup> degree cystocele and hysterocele is presented. A longitudinal incision is performed in the posterior vaginal wall. The vaginal walls are separated from the recto-vaginal fascia and the ischiadic rectal fossa is prepared. The right sacrospinal ligament is found and a 2-0 Prolene stitch is passed through it. The same maneuver is repeated on the left side. The anterior vaginal wall is incised from the bladder neck to the cervix. The pubo cervical fascia is separated from the vaginal wall and an opening through it allows a 2-0 Prolene stitch to pass through the arcus tendineous bilaterally. The cervix is isolated from the bladder by cutting the supravaginal septum. Two paracervical channels are created as low as possible to avoid ureteral lesions. The stitches fixed to the arcus tendineous are passed through the mesh, but they are not tied. The anterior wings are introduced through the opening in the pubo cervical fascia. The posterior wings are passed through the paracervical channels and they are sutured along their inner edges to form the support plane for the enterocele. The extremities of these posterior wings are sutured to the stitches fixed on the sacrospinal ligament, but they will be tied later. It is necessary to suture the posterior and anterior fornix for at least 3 cm. The vagina is reduced, the uterus is pulled up to its anatomical position and now the four stitches anchoring the mesh are tied. The posterior and anterior vaginal walls are sutured.

No intra- or post-operative complications occurred. After 11 months of follow up this patient presents no recurrence of the prolapse.

Between October 2001 and July 2002 we performed this operation on 10 women (mean age 69.5 years) with 3<sup>rd</sup> or 4<sup>th</sup> degree total genitourinary prolapse. The mean operation time and hospital stay for this caseload was 131±14.4 min. and 6.5±0.7 days respectively. Mean follow up was 10.7 months (range 8-17). Eight patients were completely cured. In one patient we observed a 2<sup>nd</sup> degree hysterocele relapse. We removed the mesh from another patient, one month after her surgery, because infection led to irritation in voiding, vaginal discharge, and light bleeding. Thus her symptoms were resolved.

While hysterectomy remains the habitual solution for severe uterine prolapse, our promising technique provides an alternative solution.