448

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MANAGEMENT OF SEVERE VAULT AND POSTERIOR VAGINAL WALL PROLAPSE BY ILIOCOCCYGEUS FASCIAL FIXATION AND WIDE POSTERIOR REPAIR

Synopsis of Video

Vaginal vault prolapse combined with a significant rectocele is a common occurrence after hysterectomy. Several procedures for managing this troublesome condition have been applied including sacrospinous fixation, abdominal sacrocolpopexy with mesh implantation and the iliococcygeus fascial fixation (named also as iliococcygeus hitch), being a less commonly utilized vaginal procedure for correcting vault and posterior vaginal wall prolapse.

The patient underwent multichannel urodynamic study with her prolapse reduced in order to rule out a concomitant stress urinary incontinence. The patient is placed in a modified lithotomy position with the legs in Allen stirrups. The vagina is prepped with betadine solution and is draped in a sterile conventional manner. The bladder is drained and 10-20 ml of Adrenaline 1:200,000 solution is injected into the vaginal mucosa. The vault is incised vertically down to the perineum and the rectum is dissected as far laterally as possible from the vaginal skin and puborectal fascia. The right ischial spine is palpated. Using a Navartil-Breisky retractors a 1-0 polydioxanone (PDS) suture is inserted medial and caudal (2-3 cm) to the right ischial spine into the iliococcygeus muscle fascia. The suture is then passed through the full thickness of the vaginal skin on the right side of the vaginal vault. The same procedure is repeated on the patient's left side. The large rectocele is reduced posteriorly with several 1-0 vicryl sutures creating a reinforcement of the puborectal fascia and plicating the levator muscles. Excess posterior vaginal skin is now trimmed and the posterior vaginal wall is closed with continuous locking 2-0 vicryl suture. The iliococcygeus muscle fascial stitches are then tied bilaterally to reapproximate and suspend the vaginal vault to its normal position. If genuine stress incontinence coexist a Tension-free Vaginal Tape procedure can be performed together with anterior repair if needed. A urethral catheter is inserted for 24 hours.

In our one-year follow up with the iliococcygeus muscle fascial fixation with wide posterior repair for a combination of vaginal vault prolapse with huge rectocele no recurrence occurred. Sexual intercourse was resumed successfully and constipation was not reported.

For challenging and exceptional clinical presentation of vaginal vault prolapse combined with severe rectocele the iliococcygeus muscle fascial fixation is a safe and effective procedure. Application of a synthetic mesh implant or acellular porcine dermal collagen graft for reinforcement of the upper 2/3 of the posterior vaginal wall may be considered.