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TRANSVAGINAL CADAVERIC FASCIAL PROLAPSE REPAIR WITH SLING (CAPS): FIVE-YEAR PROSPECTIVE FOLLOW-UP

Aims of Study

To present our ongoing experience with cystocele repair and sling (CaPS procedure) using non-frozen cadaveric fascia lata and transvaginal bone anchors.

Methods

210 women, ages 33-90 (mean 69 years) had the CaPS procedure with a maximum follow-up of 5 years (range 6-60 months, mean 20 months). A 6 x 8 cm "T" shaped piece of non-frozen cadaveric fascia lata is placed transvaginally to repair the cystocele and to provide sling support from the proximal urethra to the bladder neck. The sling is secured to the pubic bone with transvaginally placed bone anchors. The remainder of the fascial patch is fixed to the levator muscles bilaterally and the vaginal cuff or cervix to reduce the cystocele. Pelvic examination, validated questionnaires (quality-of-life and incontinence), and SEAPI scores provided outcomes data for our prospective database.

Results

All patients had Baden-Walker grade 2-4 prolapse preoperatively. 44% (92/210) underwent CaPS alone while 56% (118/210) had CaPS plus vaginal hysterectomy, transvaginal vault suspension, or rectocele repair. Mean preoperative and postoperative SEAPI scores were 6.9 and 2.3 ($p < 0.001$). Mean prolapse quality of life scores decreased from 8.7 preoperatively to 5.4 postoperatively ($p< 0.001$). 62% (130/210) of patients reported they were $\geq$ 80% “satisfied with their results”. Median patient satisfaction was 85% and 73% (153/210) would undergo CaPS again.

Validated incontinence questionnaires revealed 76% (160/210) of patients were $\geq$ 50% improved. 23% (49/210) with <50% improvement were considered “failures”. Of these incontinence “failures”: 6% (12/210) had stress urinary incontinence, 11% (23/210) had urge incontinence, and 7% (14/210) were unclear regarding the type of incontinence. All incontinence “failures” occurred in the first year of follow-up.

Cystocele recurrence occurred in 15% (32/210). Of the cystocele recurrences, 66% (21/32) were asymptomatic grade I and have not required further treatment. Symptomatic cystocele recurrence was 5% (11/210) with reoperation for recurrent cystocele performed in 2% (4/210).

128 patients had preoperative urgency symptoms. Urgency resolved postoperatively in 79% (101/128) and persisted in 21% (27/128). De novo urgency symptoms developed in 13% (11/82). No patient had long-term postoperative urinary retention. Osteitis pubis occurred in 2 patients (1%) managed with non-steroidal anti-inflammatory drugs with no cases of osteomyelitis.

Conclusions

Our results performing transvaginal cystocele repair and sling using non-frozen cadaveric fascia lata and transvaginal bone anchors are encouraging. Cystocele correction has been excellent with a mean follow-up of 20 months and a maximum follow-up of five years.