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ABDOMINAL SACRAL COLPOPEXY USING AUTOLOGOUS FASCIA LATA

Aims of Study

Numerous techniques and materials have traditionally been employed to surgically correct symptomatic vaginal vault prolapse, including the use of donor or cadaveric fascia, synthetic materials, and autologous rectus fascia. We report our experience using autologous fascia lata for abdominal sacral colpopexy. This study is aimed at determining the treatment efficacy of, harvest site morbidity of, and patient satisfaction with abdominal sacral colpopexy using autologous fascia lata.

Methods

According to Institutional Review Board protocol, a retrospective database review identified all women who underwent abdominal sacral colpopexy using autologous fascia lata for repair of symptomatic vaginal vault prolapse with at least eighteen months follow-up. Preoperative and postoperative Pelvic Organ Prolapse-Quantification (POP-Q) scores, relevant clinical and operative parameters, postoperative course, treatment efficacy, and patient satisfaction and quality of life were assessed through clinical chart review and correspondence questionnaires.

Results

A total of ten women underwent abdominal sacral colpopexy using autologous fascia lata between 1999 and 2001 for POP-Q Stage II, III or IV pelvic organ prolapse as determined by POP-Q scoring. Mean age was 68.3 years (range 54-82 years). Follow-up ranged from 19 to 42 months (average 30.8 months). One patient died 19 months following surgery from unrelated causes. Obstetric history for the ten patients ranged from G0P0 to G6P6. Eight of the ten women had undergone previous hysterectomy, one transvaginally and seven via an abdominal approach. Preoperatively, three women were POP-Q stage II, five POP-Q stage III, and two POP-Q stage IV. Postoperative POP-Q scores improved to and remained at Stage II or less in all ten patients. Mean operative time was 182 min (range 136 to 265 min). Mean blood loss was 107.5cc (range 50-200cc). All ten patients underwent concomitant enterocele repair, nine perineoplasty, and one each hysterectomy and bilateral salpingoophorectomy, pubovaginal sling, cystocele repair, and rectocele repair. Postoperatively, three patients have been noted to have anterior prolapse consistent with cystocele (POP-Q stage II) on physical exam. The same three women describe symptoms consistent with stress urinary incontinence. None of these patients had an anti-incontinence procedure or anterior colporrhaphy performed at the time of abdominal sacral colpopexy. There has been no morbidity or complication with the abdominal incision. There has been no morbidity or complication associated with fascia lata harvest. The thigh incision was cosmetically acceptable to all patients. The harvest site did not delay or negatively impact the post-operative course or hospital discharge in any patient.

In the survey arm of this study, seven of the nine women still alive at the time of this review completed and returned the questionnaire regarding their postoperative course and satisfaction. None of the women have developed pelvic or abdominal discomfort or pain with urination postoperatively. Of the four respondents who are sexually active, three report no intercourse-related problems. One woman describes mild dyspareunia, which does not preclude intercourse. When asked if they could go back to how they were before surgery, would they still have the same procedure done, all respondents answered yes. When asked if they would recommend the procedure to a friend, all respondents answered yes.

Conclusions

Given the immunologic concerns regarding disease transmission from donor or cadaveric fascia, autolysis of allograft material, and the complications associated with possible erosion and infection of synthetic materials, the use of autologous tissue has demonstrable advantages over other materials. Autologous fascia lata compares favorably in efficacy to other materials and is not associated with any significant morbidity. There have been good

medium-term follow-up results. Patient satisfaction with the procedure is high. Abdominal sacral colpopexy using autologous fascia lata should be considered not only in those women who have failed a prior transvaginal suspension procedure, but also as the primary surgical approach in women with symptomatic vaginal vault prolapse.