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FEASABILITY,COMPLICATIONS & SHORT TERM RESULTS OF VAGINAL APEX OR VAULT SUSPENSION WITH POSTERIOR IVS(:PRELIMINARY RESULTS ON 113 CASES.

Hypothesis/aims of the study

We performed a prospective clinical study to evaluate the feasability,the complications and the results of the vaginal apex or vault suspension with the posterior IVS®.

Study design/materials and methods

From May 2002 to december 2003, 113 patients from 2 belgian centres have beeen treated for vaginal vault(v.v.) prolapse with posterior IVS®.All the patients complain about prolapse.The mean age is 63,2 years(33-83).The majority of the patients has previous pelvic operation:hysterectomy(n=59), cystocele(n=16)& rectocele(n=7) repair, no v.v. suspension.
Pre-operative examination shows 112 v.v. or uterine prolapse: 29 stage 1 (POPQ -8 à -1), 46 stage 2 (POPQ -1 à +1), 26 stage 3 (POPQ >+1) & 8 stage 4 (POPQ >+8), 1 stage 0 with elythro-rectocele stage 3 (POPQ>+1). The associated prolapses are: 20 cystocele stage 1 (POPQ -3 à -1), 28 stage 2 (POPQ –1 à +1), 44 stage 3 (POPQ >+1) ; 25 rectoceles stage 1 (POPQ –3 à -1), 47 stage 2 (POPQ –1 à +1), 29 stage 3 (POPQ >+1). Fifty four patients have GSI. Seventy three (65%) complain of urge incontinence &/or pollakiuria &/or nocturia ; 45 (40%) has dyschesia.
The operative technique described by P.Papapetros modified by P. Von Théobald has been used in all cases :posterior colpotomy,dissection of the pararectal space to the ischial spine, finger-guided progression of the tunneler through the ischio-rectal space & the pelvic muscles,suture of the tape on the utero-sacral ligaments or the cervix.Spinal anesthesia is commonly performed(82%).In 109 cases, the posterior IVS® is associated to other vaginal surgery: 55 TOT/TVT, 6 cervix ablation,27 hysterectomy, 78 cystocele & 76 rectocele repair with or without graft.

Results

No peroperative complication due to the IVS® occured :no bladder or rectal perforation,no hemorrhage. During the hospital stay,we noticed 8 postoperative hematomas of the recto-vaginal or para-rectal space.Seven have been drained spontaneously,1 under general anesthesia.One hundred & four patients (92%) have been clinically reviewed between 3 weeks & 20 months ;61% of them have a mean follow-up of 10 months. The post-operative results show a good suspension of the v.v.in 97% (n=101 ;POP-Q <-8).Two patients have early recurrence of v.v. prolapse (4 & 6 months) and one at 19 months.All the three have a POP-Q of <-1 to+1. No « de novo » dysuria,dyschesia,or overactive bladder symptoms occured .One patient developed GSI. Five patients(5%) had wound complications :1 granuloma and 4 erosions of the vaginal vault with partial rejection of the IVS® between 4& 15 months.One patient developed a chronic cutaneo-vaginal fistula along the IVS®documented by fistulography. They all have been treated by ablation of the non-colonised tape and local desinfection. Four of the five erosions followed a post-operative hematoma but without predictive event during surgery.In all cases the v.v.suspension remained.

Conclusions

The treatment of the v.v.or uterine prolapse with posterior IVS® is a reproducible and efficent technique(97% of success) without peroperative complications.These results are comparable to the litterature( ).But postoperative complications as rejections of the tape(5%) and early recurrencies(3%) are more frequent than in the others publications.These complications could be avoided.The type of the IVS® tape(polypropilene,multifilament) and the large dissection with risk of postoperative bleeding, are probably responsible of recurrencies and tape infection and rejection.A monofilament or may be a biomaterial mesh,a smaller dissection with very careful hemostasis could probably improve the results.