

398

Moore R¹, Miklos J², Kohli N³

1. Atlanta Urogynecology Associates, Northside Hospital, 2. Atlanta Urogynecology Associates, 3. Harvard University

VIDEO: CYSTOCELE REPAIR UTILIZING ANTERIOR WALL MESH GRAFT PLACED VIA DOUBLE TRANS-OBTURATOR APPROACH (PERIGEE SYSTEM)

BACKGROUND: Traditional approach to vaginal cystocele repair, ie midline plication or anterior repair has reported failure rates of up to 40%. Utilization of graft materials to augment the repair has been suggested to improve these cure rates, as this should theoretically treat either midline and/or paravaginal defects at the same time. However, to date an adequate technique to safely secure and fixate the apical portion of the graft to the lateral pelvic sidewalls has not been described.

SURGICAL SOLUTION: Anterior vaginal wall graft placement utilizing a minimally invasive transobturator approach to fixate the graft to the lateral pelvic sidewalls at the level of the bladder neck and apically through the white line approximately 1.5 to 2 cm from the ischial spine on each side.

VIDEO DESCRIPTION: Dissection is identical to approach for traditional anterior repair with midline anterior wall incision from bladder neck up towards apex for approximately 4cm. The vaginal epithelium is dissected off of the bladder out laterally to the sidewalls and up to the ischial spines bilaterally. The retropubic space is not entered, nor is the dissection taken to the sacrospinous ligaments. A midline plication of the cystocele can be completed to reduce the bulge for better exposure to the sidewalls if necessary. Once the dissection is completed, the anterior wall graft (soft macroporous polypropylene mesh with 4 mesh arms) is placed by attaching the mesh arms to the lateral pelvic sidewall with needles passed through the transobturator space. Four incisions are made in the groin for access to the transobturator space. The superior incisions are made in the genitofemoral crease at the level of the clitoral hood. These are utilized to attach the distal arms of the mesh graft to the sidewall at the level of the bladder neck. The inferior incisions are made in the groin 3cm inferior and 2cm lateral to the superior incisions. These incisions are used to pass the needles through the transobturator space and then through the sidewall into the vagina to attach the apical arms of the graft to the white line approximately 1.5 to 2 cm distal to the ischial spine. The tail of the mesh is fashioned to the patient and attached up to the vaginal cuff. The arms are adjusted, outer sheaths removed and vaginal incision closed with vicryl suture.

CONCLUSION: The procedure demonstrates a minimally invasive approach for vaginal cystocele repair with mesh graft augmentation utilizing a double transobturator approach to attach the graft to the lateral pelvic sidewalls both at the bladder neck and apically near the ischial spines.

FUNDING:

American

Medical

Systems