

## **TRANSOBTURATOR APPROACH AND INFRA-COCCIGEAL SACROPEXY FOR CYSTOCELE, RECTOCELE, UTERINE AND VAGINAL VAULT PROLAPSES**

### Synopsis of Video

Anterior vaginal wall prolapse is a frequent condition that affects 11% of american women. A new transobturatory approach to treat anterior vaginal wall prolapse is presented. The device set consists of four helical needles and an intepro mesh (polypropylene) with two lateral self-anchoring arms to repair both central and lateral defects. This device also allows for uterine sparing surgery when used along with posterior compartment meshes. This videotape aims is to show the new trends in reconstructive biosurgery.

This is a patient with uterine prolapse and grade III cystocele. An inverted U subcervical incision is made. Hydro dissection is performed to facilitate dissection and hemostasia. Blunt and sharp dissection allows for the roll over of the vaginal wall to the bladder neck. The superior needles are inserted parallel to the ischio-pubic branch, and using only the wrist rotation, the needle is guided till the vaginal incision. The arm of the graft is connected to the tip of the needle and pulled the length till the armpit is at the lateral edge of the cystocele. The same maneuver is repeated on the other sites. Inferior needles are passed 2 cm lateral and 3 cm inferiorly to the superior ones. The mesh should be underneath the cystocele in a tension-free manner and the redundant material is trimmed off. The incisions are closed in the usual manner. The procedure is completed with an infra-cocccigeal sacropexy using an specially designed self anchored polypropilene mesh. It is available in a kit including 2 needles and a specially constructed mesh that has two anchoring tails. It is used for the creation of neo-sacrourterine ligament and the posterior vaginal wall, from the sacrouterine ligament to the perineal body. After the posterior wall incision and dissection, the index finger is introduced in the ischio-rectal space just in front of the ischial spines. The mesh is connected to the to the needles tip and retracted back to skin incisions. The central mesh is fixed to the remanants of the sacro-uterine ligaments. The upper vaginal wall is closed in the usual manner. The exceeding length of the self-anchoring tails are removed and the skin incisions are closed.

Despite the short follow-up, the preliminar results are promising. There were no extrusion, infection or vaginal stenosis.

We concluded that these devices represent steps foward in the organ sparing management of uterine prolase and complex pelvic floor defects as well.