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TRANSVAGINAL LATERAL AND CENTRAL DEFECTS REPAIR OF CYSTOCELE WITHOUT PROSTHETIC MESH AND ANTI-INCONTINECE PROCEDURE

Hypothesis / aims of study
Prolapse of the anterior bladder wall, defined as a cystocele, can be associated with a variety of abnormalities including urethral hypermobility, lateral and central defects. The patients with cystocele often have overt or occult stress urinary incontinence (SUI). A number of studies have been performed to determine whether concomitant anit-incontinence procedures should be taken at the time of prolapse repair to treat overt SUI or prevent the postoperative unmasking of SUI who does not have SUI preoperatively. However, the indication of concomitant anti-incontinence procedure in the setting of primary prolapse still remains controversial. Recently, prosthetic mesh was often used in attempt to reinforce the repair and prevent recurrence. However, erosive or infectious complications can sometimes occur and are often difficult to treat. The indication of using prosthetic mesh for the treatment of cystocele remains also controversial. We have performed transvaginal lateral and central defects repair without using suburethral sling procedure and prosthetic material for Baden-Walker classification grade II or III cystocele patients who have no overt SUI and mild SUI. The aims of this study were to evaluate the feasibility, efficacy and safety of the repair.

Study design, materials and methods
Between 2004 and 2005, we performed prolapse repair surgery in 12 consecutive cystocele patients with a mean age of 69.2 years (range, 52 to 77 years). Preoperative diagnosis of cystocele was Baden-Walker classification grade II 7 (prolapse halfway to the introitus; 58%) and III 5 (the bladder outside the introitus with strain; 42%). Preoperatively, SUI was symptomatic in 7 women (mild USI; Pad test < 5 g) and occult SUI in 2 women with a positive stress test during repositioning of the prolapse. All patients had urethral hypermobility which was defined by a straining Q-tip angle greater than 30 degrees from the horizontal. None had intrinsic sphincter deficiency. The repair of lateral defect was carried out through a vaginal approach, exposing the infralevetor obturator fascia, which is just posterior to the periostium of the descending rami of the pubic bone. The paravaginal fascial defects were corrected through suspension of vesicovaginal fascia and periurethral fascia to the infralevetor obustrator fascia with 4-6 bilateral No.1 PDS sutures. The central defect is corrected using vertical mattress sutures of 2-0 vicryl. Eleven out of 12 patients underwent concomitant trasnvaginal vaginal hysterectomy, all patients had rectocele repair.

Results
All patients were followed-up at least for 6 months. Mean postoperative follow-up periods were 9 months (range 6-18 months). No patients showed de novo urinary incontinence. All 7 symptomatic SUI patients were completely cured postoperatively. No patients showed urethral hypermobility postoperatively. No subjective symptoms related to recurrence of prolapse were noted in the follow-up periods. In postoperative physical examination and chain cystourethrography, no patients had recurrence more than grade II. No perioperative complications were observed.

Interpretation of results
A short-term follow-up demonstrated trasnvagnal lateral and central defects repair without prosthetic mesh and anti-incontinece procedure can provide excellent support of cystocele and urethra in grade II-III cystolele patients with no overt SUI or mild SUI. The procedures were simple, safe, and less-expensive. Long-term follow-up is necessary to evaluate the effectiveness of the repair in this type of cystocele patients.

Concluding message
The transvaginal lateral and central defects repair without prosthetic mesh and anti-incontinece procedure may be an effective minimum invasive procedure for cystocele unless patients have severe cystocele or SUI.

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