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QUALITY OF LIFE AND SURGICAL SATISFACTION FOLLOWING VAGINAL RECONSTRUCTIVE VERSUS OBLITERATIVE SURGERY FOR THE TREATMENT OF ADVANCED PELVIC ORGAN PROLAPSE

Hypothesis / aims of study

Previous research has shown improvements in prolapse- and incontinence-related quality of life measures in obliterative vaginal surgery[1], but only minimal work has been done comparing these types of outcomes in obliterative versus reconstructive surgeries. There is also significant criticism of obliterative techniques due to the potential for regret following the loss of coital function. We therefore sought to compare perioperative morbidity, quality of life, and patient satisfaction following obliterative and reconstructive surgery in a cohort of women sharing similar baseline characteristics.

Study design, materials and methods

This was a retrospective cohort study of women under our care with advanced pelvic organ prolapse who met the following inclusion criteria: age ≥ 65 years, leading edge of prolapse ≥ 4cm beyond the hymen, and vaginal reconstructive or obliterative (LeFort colpocleisis or total colpectomy) surgery between October 2004 and October 2006. Grafts were used in all the reconstructive cases. Preoperative demographics, perioperative morbidity, and preoperative responses to the Urogenital Distress Inventory (UDI-6) and Incontinence Impact Questionnaire (IIQ-7) were collected in a retrospective chart review. We then mailed the same questionnaires, as well as the Surgical Satisfaction Questionnaire (SSQ-8), to these subjects postoperatively.

Results

The type of surgery was evenly split (n=45 in each group) between the 90 patients who met the inclusion criteria. Of these, 72 (80%) completed the postoperative questionnaire with a median follow-up time of 17.5 (range 3-28) months. Demographics, baseline quality of life measures, length of follow-up, and loss to follow-up were comparable between the two surgical arms with the following exceptions: mean age (80.0 [±6.2] vs 75.7 [±5.2], *P*<.01) and preoperative leading edge of prolapse (+7.0 [±2.5] vs +5.0 [±0.9] cm, *P*<.01) were greater in the obliterative group. 32 (71.1%) of the obliterative and 33 (73.3%) of the reconstructive cases underwent concomitant sling procedures (*P*=.34). There were no significant differences in intraoperative complications (one in each group), blood loss (113.3 [±119.5] vs 83.4 [±63.3] ml, *P*=.15), and recurrent prolapse beyond the hymen (3 (6.7%) vs 1 (2.2%), *P*=.30) in the obliterative and reconstructive groups, respectively. Improvements from the pre- to postoperative IIQ-7 and UDI-6 (and its subscales) were comparable between groups, as were postoperative SSQ-8 scores (Table 1). Responses to individual questions of the SSQ-8 reveal that 92.1% of the obliterative and 85.7% of the reconstructive cases were satisfied with the results of their surgeries (question #6, *P*=.38) and 89.5% vs 88.6% (question #7, *P*=.90) would "do it all over again."

Table 1. Improvements in prolapse- and incontinence-related quality of life and postoperative patient satisfaction in vaginal reconstructive vs obliterative surgery

Instrument		Reconstructive	Obliterative	*P*
Change from pre- to post-operative score	IIQ-7	18.1 (±30.9)	16.2 (±33.1)	.84
	UDI-6 Total	26.0 (±25.5)	19.3 (±28.1)	.38
	Irritative symptoms	24.0 (±33.0)	14.8 (±33.4)	.32
	Obstructive/discomfort	34.7 (±32.2)	29.0 (±29.5)	.51
	Stress symptoms	19.3 (±29.9)	14.3 (±38.7)	.60
Postoperative SSQ-8 score		86.4 (±16.0)	89.6 (±12.7)	.33

All measures reported as mean (±standard deviation). IIQ-7 = Short form of the Incontinence Impact Questionnaire. UDI-6 = Short form of the Urogenital Distress Inventory. SSQ-8 = Surgical Satisfaction Questionnaire.

Interpretation of results

Improvements in condition-specific quality of life, perioperative morbidity, and postoperative patient satisfaction appear to be comparable in elderly women with advanced pelvic organ prolapse who undergo either vaginal reconstructive or obliterative surgery.

Concluding message

Given the similar outcomes between vaginal reconstructive and obliterative surgery in this study, surgeons should feel comfortable offering both of these options to appropriate patients after careful counselling.

References

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