

Clinical Study of Prolapse Vault – Anterior Fixation and Posterior Colpoperineoraphy

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Abstract

Introduction: The purpose of the clinical study was to assess the result whether the anterior fixation is better than posterior fixation in cases of vault prolapse for post hysterectomy patients.

Materials and Methods: Randomised prospective studies were performed in 20 cases of anterior fixation and posterior colpoperineoraphy. Technique is simple, without bleeding and reproducible with least post operative complications And the results were recorded.

Results: There were significant and marked improvement and the results after follow up of 3 years were very good. In one case we had recurrence and surgery was repeated with good results.

Conclusion: Posterior fixation for vault prolapse is standard procedure and we have achieved the results with our anterior fixation technique.

Key words: Prolapse vault, Anterior fixation, Posterior fixation, Proline suture & Posterior colpoperineoraphy.

INTRODUCTION

Vaginal vault prolapse is a condition in which the upper portion of the vagina loses its normal shape and sags or drops down into the vaginal canal or outside of the vagina^{1,2}. This can occur either in conjunction with uterine prolapse or even after a hysterectomy³.

Levels of support defects (according to DeLancey classification)-Level 1: Apical defects caused by loss of support of the uterosacral ligaments, paracolpium, and parametrium; Level II: Disruption of the normal lateral attachments of the midvagina; and Level III: Lower vaginal defects in the perineal body or fusion of the distal urethral to the pubic bone^{4,5}.

As women live longer and healthier lives, pelvic floor disorders continue to become even more prevalent and are an important health and social issue. The lifetime risk of surgery for pelvic prolapse or incontinence has been estimated at 11%, with a reoperation rate for failure at 29%. The management of pelvic organ prolapse can be difficult because different support defects often coexist. The pelvic surgeon must be adept in the thorough evaluation and management of these issues. An understanding of the anatomy and the relationship of the vagina to surrounding structures is imperative^{6,7}.

The true incidence of vaginal vault prolapsed is unknown. However, there is an overall perception that the number of procedures being performed for vaginal vault prolapsed is increasing. The main goal of any procedure aimed at suspending the vaginal vault should be to suspend the vaginal vault as near as possible to its normal anatomic position. This should reapproximate the upper vagina in the midline over the levator plate⁸. Distortion of the vaginal vault, whether in an anterior or posterior direction, can lead to a recurrent prolapsed opposite the vaginal vault in a significant number of patients.

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The ultimate goal of pelvic reconstructive surgery is to restore anatomy, maintain or restore visceral function, and maintain or restore normal sexual function. It is extremely important to determine preoperatively whether lower urinary tract dysfunction, sexual dysfunction, and defecatory dysfunction exist. Urinary dysfunction may be masked in patients with advanced pelvic organ prolapsed by obstructing or kinking the urethra. Thus, reductive maneuvers aimed at simulating what surgery will accomplish should be used in the hope of identifying those patients who will require an anti incontinence procedure in conjunction with their pelvic reconstructive surgery. It is also important to initiate local estrogen therapy preoperatively in patients who have urogenital atrophy^{9,10}.

Many operations have been described for suspending the prolapsed vaginal vault. There is no general consensus on what is the best procedure. The procedure that the surgeon ultimately chooses is influenced by many factors, including the comfort and skill of the surgeon performing the operation, whether the prolapse is primary or recurrent, the patients age state of health, anticipated outcome, sexual activity, and overall state of the tissue. We believe it is important for the surgeon to have a variety of operative approaches available for the individual patient^{11,12}.

MATERIALS AND METHODS

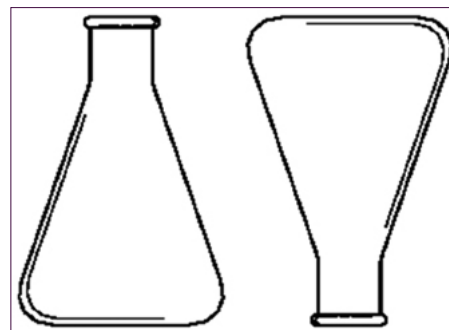
The protocol was approved by the local Ethics committee and written informed consent was obtained from each patient.

Randomised prospective studies were performed in 20 cases of anterior fixation and posterior colpoperineoraphy in post hysterectomy patients were taken up for this study. Technique is simple, without bleeding and reproducible with least post operative complications the results were recorded. Grade I prolapse 10 cases, Grade II prolapse 7, Grade III prolapse 3 cases.

OPERATIVE TECHNIQUE

The patient is kept in modified lithotomy position and suprapubic transverse incision given. Perurethrally 16F Foleys catheter passed with 10 ml to balloon. Bladder neck is dissected and urethra with catheter was held. Sponge on stick passed vaginally and pushed right paraurethral area at vaginal vault apex. Prolene 1 suture was taken bites and mesh was taken and it is suspended to periosteum retropublically. And same time it is repeated other side also.

By doing this the prolapse imaginarily looks like beaker. After correction it appears like inverted beaker. The vagina is inspected and evaluated for any remaining defects. Usually a posterior colporrhaphy and a perineoplasty are also required in all cases.



RESULTS

Overall the long term results from Colpopexy have been very good. Automatically cystocele is corrected in this repair. Intraoperative complications are unusual.

DISCUSSION

DeLency divided the support of the vagina into three levels. This concept is helpful in understanding normal anatomic, in some patients and not in others. Level I support defects are apical defects caused by loss of support of the uterosacral ligaments, paracolpium, and parametrium. Level II support defects result from disruption of the normal lateral attachment of the midvagina. Level III support defects result from defect in the perineal body or fusion of the distal urethra to the pubic bone. Although the exact indication were controversial many surgeons primarily try vaginal repair in all cases of posthysterectomy vault prolapse.

This procedure indicated due to average operative time, reproducible, in failed vaginal repairs and also in cases of fore shortened vagina.

Excellent results have been reported by us. The complications are very minimal

CONCLUSION

On the basis of our surgical technique and simplification this procedure has got advantage over posterior colpopexy in post hysterectomized patients.

REFERENCES

1. Mant, J., Painter, R., Vessey, M. Epidemiology of genital prolapse: Observations from the Oxford family planning association study. *BJOG*. 1997;104:579-585.
2. Marchionni, M., Bracco, G., Checcucci, V. *et al*, True incidence of vaginal vault prolapse. *J of Reproductive Medicine*. 1999;44:679-684.
3. Hung, M.J., Liu, F.S., Shen, P.S. *et al*, Ho ES. Factors that affect recurrence after anterior colporrhaphy procedure reinforced with four-corner anchored polypropylene mesh. *Int Urogynecol J Pelvic Floor Dysfunct*. Nov-Dec. 2004;15:399-406.
4. Soderberg, M.W., Falconer, C., Bystrom, B. *et al*, Young women with genital prolapse have a low collagen concentration. *Acta Obstet Gynecol Scand*. Dec.; 2004;83:1193-1198.
5. Uustal Fornell, E., Wingren, G., Kjolhede, P. Factors associated with pelvic floor dysfunction with emphasis on urinary and fecal incontinence and genital prolapse: An epidemiological study. *Acta Obstet Gynecol Scand*. 2004;83:383-389.
6. Wiskind, A.K., Creighton, S.M., Stanton, S.L. The incidence of genital prolapse after the Burch colposuspension. *Am J Obstet Gynecol*. 1992;167:399-404.
7. Baden, W.F., Walker, T.A. Genesis of the vaginal profile: A correlated classification of vaginal relaxation. *Clin Obstet Gynecol*. 1972;15:1048-1054.
8. Bump, R.C., Mattiasson, A., Bo, K. *et al*, The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. *Am J Obstet Gynecol*. 1996;175:10-17.
9. Maher, C.F., Qatawneh, A.M., Dwyer, P.L. *et al*, Abdominal sacral colpopexy or vaginal sacrospinous colpopexy for vaginal vault prolapse: A prospective randomized study. *Am J Obstet Gynecol*. 2004;190:20-26.
10. Kearney, R., DeLancey, J.O.L. Selecting suspension points and excising the vagina during Michigan four-wall sacrospinous suspension. *Obstet Gynecol*. 2003;101:325-330.
11. Richter, K., Albrich, W. Long-term results following fixation of the vagina on the sacrospinal ligament by the vaginal route (vaginaefixatio sacrospinalis vaginalis). *Am J Obstet Gynecol*. 1981;141:811-816.
12. Arthure, H.G. Vault suspension. *Proc R Soc Med*. 1949;42:388-390.

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