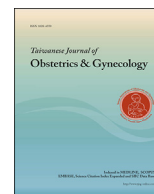


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Original Article

Obliterative LeFort colpocleisis for pelvic organ prolapse in elderly women aged 70 years and over

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ABSTRACT

Objective: Treatment of genital prolapse in elderly women is challenging. The aim of this study was to evaluate the long-term postoperative patient satisfaction and objective improvement in women aged 70 years and over with high stages of pelvic organ prolapse treated with obliterative LeFort colpocleisis.

Materials and methods: From January 2003 to December 2013, female patients aged 70 years and over who underwent colpocleisis surgery were included in this study. We reviewed the charts for preoperative and postoperative medical history, severity of prolapse, urodynamic studies, and early postoperative complications related to this procedure in these patients. Subjective outcomes were assessed by a nursing coordinator who interviewed patients by telephone in June 2014.

Results: Colpocleisis was performed in 22 elderly patients and 59% patients were of advanced age (≥ 80 years). The mean postoperative follow-up duration was 48.1 months (range, 7–118) months. Six patients (27.3%) had died of medical problems at the time of the telephone interview. Fourteen patients (87.5%) reported a successful outcome after the operation and two patients (12.5%) reported improvement. For present satisfaction, 93.8% of patients reported that they were satisfied.

Conclusion: Colpocleisis should be considered as one of the surgical options for treating advanced pelvic organ prolapse in elderly patients who do not wish to preserve vaginal function for sexual intercourse. Copyright © 2016, Taiwan Association of Obstetrics & Gynecology. Published by Elsevier Taiwan LLC. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Introduction

Pelvic organ prolapse (POP), is a disorder that decreases quality of life due to associated symptoms, recurrent urinary tract infections, and frequent surgical interventions in women [1]. In most countries, POP usually occurs in middle, elderly, or advanced age (≥ 80 years) female patients [2]. Pelvic reconstructive surgery is especially challenging in elderly and advanced age women with high stage POP (POP-Q ordinal stage \geq III) [3]. Most of these women have comorbidities such as cardiovascular diseases, chronic pulmonary diseases, impaired renal function, or prolonged duration of diabetes mellitus, which increases the incidence of adverse outcomes during and after surgical intervention [4].

The current trend of surgical management for POP includes hysterectomy, colporrhaphy with or without polypropylene mesh repair, sacrospinous colpopexy or sacral colpopexy according to the severity of prolapse in different vaginal compartments [5]. Although the use of synthetic mesh in pelvic reconstructive surgery may reduce the postoperative recurrence rate, this must be weighed against the disadvantages, which include longer operating time, greater blood loss or mesh exposure, which requires removal, especially in elderly women [6–8]. In contrast to the pelvic reconstructive surgeries mentioned above, colpocleisis is an obliterative procedure for women with uterovaginal or vaginal vault prolapse, who do not wish to preserve vaginal function for sexual intercourse [9–11]. The procedure was first described by Leon Le Fort in 1877 and the modified operation is still being performed today.

We conducted this study to evaluate the long-term postoperative patient satisfaction and objective improvement in women aged 70 years and over with high stages of POP treated with obliterative colpocleisis. We also evaluated the feasibility and safety of this surgical procedure in these women of advanced age.

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Materials and methods

From January 2003 to December 2013, female patients aged 70 years and over, who underwent obliterative colpocleisis surgery for POP at Chung Shan Medical University Hospital were included in this study. All patients had high-stage uterine prolapse or vaginal vault prolapse in combination with advanced anterior and posterior compartment prolapse especially cystocele. The preoperative stage of genital prolapse was classified by the POP-Q staging system. A Papanicolaou smear and transvaginal sonography were performed before surgery to exclude cervical and uterine pathology. Endometrial sampling or diagnostic dilatation and curettage may be performed to exclude any suspected endometrial pathology. Before the operation, all the patients were counselled about the desire for future vaginal intercourse. The pelvic operations were performed by two urogynecologists approved by the Taiwan Urogynecology Association (G.D.C. and S.C.N.). In patients with severe stress urinary incontinence, anti-incontinence surgery with a midurethral sling inserted concurrently was performed as indicated. We reviewed the charts for preoperative and postoperative medical history, pelvic examinations that determine the severity of POP, urodynamic studies, early postoperative complications, or adverse effects related to this procedure in these patients. The study protocol was approved by the Chung Shan Institutional Review Board.

All colpocleisis operations were carried out under general anesthesia. For thromboembolism prophylaxis, we used compression bandaging during the perioperative period. We did not perform concomitant hysterectomy in patients with uterovaginal prolapse. Briefly, the operation began with the marking of two rectangles in both the anterior and posterior vaginal mucosa and were then removed after dissection. The muscularis layers of the anterior and posterior vagina were brought together with a serial row of imbricating sutures with delayed absorbable sutures. The vaginal mucosa without dissection was sutured into a tunnel for drainage purposes. After obliteration of the vagina, perineorrhaphy was performed with plication of the levator ani muscle and perineal body, which reduced the size of the genital hiatus further. The intraoperative variables such as operation time, total blood loss, complications and concomitant surgery were obtained from the charts.

Subjective outcomes were assessed by a nursing coordinator who interviewed patients by telephone in June 2014. The interview was carried out with the patient's care-giver if the patient had died at the time of the interview. A global improvement questionnaire for POP was used to assess the treatment outcome. Regarding the patient's overall impression of the procedure, two main questions were asked of these women. For their perception of the operation's outcome: "Do you consider this operation to have been: successful, an improvement, or a failure? If you consider it a failure, when did it start to fail?" For present satisfaction: "Compare your present situation with that before the operation, do you feel satisfied with the outcome, and if not, when did your dissatisfaction begin and what are the symptoms that bother you?"

Data were analyzed using SPSS version 18.0 (IBM, Armonk, NY, USA) and are presented as mean \pm standard deviation, median, or percentage, depending on the variables. Student *t* test and paired *t* test were used to compare the continuous data before and after the operation. A *p* value of <0.05 was considered to be a statistically significant difference.

Results

Obliterative colpocleisis was performed in 22 elderly female patients (≥ 70 years) with advanced POP (\geq stage III) from 2003 to

2013 at Chung Shan Medical University Hospital. The mean postoperative follow-up duration was 48.1 months (range, 7–118 months). The mean age of the patients was 81 years (range, 70–96 years) as shown in Table 1. Thirteen (59%) patients were of advanced age (≥ 80 years). Seven (31.8%) patients had previous pelvic reconstructive surgery for POP. Twenty (90.9%) patients had at least one medical comorbidity and 13 (59.1%) patients had two or more medical comorbidities. Hypertension was the most common medical comorbidity. Other medical comorbidities included diabetes mellitus, cardiac disorders, chronic obstructive pulmonary disease, and dementia. Most of the patients presented with voiding difficulties and sensation of a dragging mass outside the vaginal introitus before surgery. Detrusor overactivity was the most common urodynamic diagnosis before surgery, followed by voiding dysfunction.

There were no intraoperative complications such as bladder or bowel perforation, blood transfusion needed or hematoma formation during the operations. The mean operation time was 78 minutes (range, 30–135 minutes) and the mean total blood loss was 153.8 mL (range, 30–450 mL; Table 2). Only one patient had concomitant anti-incontinence surgery with transobturator midurethral sling insertion. Five patients underwent suburethral Kelly-type operation with plication of pubourethral ligament. The median hospital stay after operation was 2.6 days (range, 1–5 days). The mean duration of Foley catheterization was 2.4 days (range, 1–7 days). Seven patients (31.8%) had voiding difficulty after removal of the Foley catheter. These patients were taught to perform intermittent self-catheterization by the patient herself or by her caregiver. There were no significant differences in the uroflowmetry parameters before and after the colpocleisis operation (Table 3).

Six patients (27.3%) had died of medical problems at the time of the telephone interview. Fourteen patients (87.5%) reported a successful outcome after the operation and two patients (12.5%) reported improvement. None of the patients reported surgical failure

Table 1
Characteristics of the study groups ($n = 22$).

Parameters	values
Age (y)	81 \pm 5.5 (70–96)
70–79	9 (40.1)
80–89	12 (54.5)
> 90	1 (4.5)
Body mass index (kg/m ²)	23.86 \pm 5.03
Vaginal deliveries	6 (1–9)
Previous prolapse surgery	7 (31.8)
Previous hysterectomy	6 (27.3)
Medical comorbidity	
Hypertension	16 (72.7)
Diabetes mellitus	4 (18.2)
1 comorbidity	20 (90.9)
≥ 2 comorbidities	13 (59.1)
Follow up (mo)	48.1 (7–118)
Preoperative LUTS	
Voiding difficulty	15 (68.1)
Overactive bladder	10 (45.5)
Urinary incontinence	5 (22.7)
Urodynamic diagnosis ^a	
Detrusor overactivity	12 (63.2)
Oversensitive bladder	5 (26.3)
Voiding dysfunction ^b	7 (36.8)
Urodynamic stress incontinence	5 (26.3)
Mixed urinary incontinence	3 (15.8)

Values are given as mean \pm standard deviation, median (range), or *n* (%).

LUTS = lower urinary tract symptoms.

^a Denominators differ because of missing data.

^b voiding dysfunction was defined as maximal flow rate < 15 mL/s and post void residual urine ≥ 100 mL.

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