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Regret, satisfaction, and symptom improvement: Analysis of the impact of partial colpocleisis for the management of severe pelvic organ prolapse

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KEY WORDS
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Objective: The purpose of this study was to assess a cohort of patients who underwent a colpocleisis procedure more than 1 year post operation to determine: 1) the proportion of patients who regretted having the procedure, 2) patient satisfaction with the procedure, and 3) changes in symptom severity after surgery.

Study design: Using the University of Alabama at Birmingham (UAB) Genitourinary Disorders Center database, a prospective analysis was performed on 54 patients who underwent colpocleisis between August 1996 and April 2003. From August to October of 2004, participants were contacted by an investigator not involved with the surgery and were asked 1) "do you regret having your surgery, and, if so, why?," 2) "how satisfied are you with your progress (completely, somewhat, or not)?," and 3) to repeat the short form Incontinence Impact Questionnaire/ Urogenital Distress Inventory (IIQ-7/UDI-6).

Results: Fifty-nine percent (32/54) of potential candidates participated in the study. Nine percent (3/32) of patients regretted having colpocleisis performed. Fifty-seven percent (16/28) were completely satisfied, 29% (8/28) somewhat satisfied, and 14% (4/28) not satisfied. Mean IIQ score improved significantly from 40.9 ($\pm$31.7) at baseline to 14.1 ($\pm$26.7) at last interview (P = .003). Mean UDI score improved significantly from 63.1 ($\pm$24.3) at baseline to 24.2 ($\pm$26.7) at last interview (P = .001). There was a negative correlation between change in UDI scores with time since procedure (r = −.397, P = .055) and age (r = −.435, P = .034).

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Conclusion: Few patients reported regret after partial colpocleisis. There was a high rate of patient satisfaction and significant symptom improvement more than a year post surgery. Stable but smaller improvements were reported with longer time from surgery and increasing age.

Partial colpocleisis with levator myorrhaphy and perineorrhaphy can be chosen as the surgical approach for severe pelvic organ prolapse. While the resulting vaginal septum and narrowed genital hiatus alleviates the prolapse, it also precludes the possibility of vaginal intercourse. Shorter operative time and less surgical risk are the advantages of this approach over vaginal reconstructive procedures.[1] Therefore, candidates are typically older, with no desire for vaginal function, and usually have concomitant medical problems.[1]

Objective surgical outcomes from case series on partial colpocleisis report high success rates up to 100%.[2-6] Reporting of regret and satisfaction is limited. One case series for partial colpocleisis and 3 for total colpocleisis report regret rates which ranged from 0 to 10%.[7-10] One description of satisfaction outcomes from a case series on total colpocleisis found 5% of patients not satisfied.[10] To the best of our knowledge, no published pre- versus postoperative comparison, using a validated quality-of-life instrument, exists.

Because it is estimated that one third of women over 78 years are sexually active, it is important to understand the incidence of regret after partial colpocleisis.[11] Furthermore, because of the impact of patient preferences and goals on surgical success, subjective outcomes such as satisfaction and symptomotology are also important.[12] The purpose of this report was to assess a cohort of patients who underwent a partial colpocleisis procedure more than 1 year post operation to determine regret, satisfaction, and urogenital symptom change.

Material and methods

Institutional Review Board approval was obtained. The University of Alabama at Birmingham (UAB) Genitourinary Disorders Center database was used to identify patients who underwent a colpocleisis procedure between August 1996 and April 2003. Thirty-five of these 54 patients were contacted by an investigator not involved with the surgery and were asked 1) "do you regret having your surgery, and, if so, why?," 2) "how satisfied are you with your progress (completely, somewhat, or not)?," and 3) to repeat the short form Incontinence Impact Questionnaire/Urogenital Distress Inventory (IIQ-7/UDI-6).[13] Preoperative baseline IIQ-7/UDI-6 scores were obtained from the Genitourinary Disorders Center database. All patients underwent reduction urodynamic testing before surgery to help determine if an incontinence procedure versus a Kelly type procedure or no further procedure be performed for urinary incontinence.

Surgical technique

Rectangular portions of the anterior and posterior vaginal walls were dissected off the underlying fibromuscular connective tissue, leaving a lateral 2-cm bridge of vaginal mucosa. The lateral vaginal canals were created using 2 0-gauge polydioxanone sutures. The anterior fibromuscular connective tissue was approximated to the posterior fibromuscular connective tissue, creating a septum of support with 3 or 4 interrupted 0-gauge vicryl sutures. The distal anterior and posterior vaginal borders were then closed. Next, a levator myorrhaphy and perineorrhaphy was performed using O-gauge prolene suture, after resection of the overlying vaginal epithelium. Dissection of the vaginal epithelium was initiated with an incision from the 3 o'clock to 9 o'clock positions outside of the hymenal ring and resulted in removal of a triangular shaped area of posterior vaginal mucosa, exposing the connective tissue overlying the puborectalis muscle laterally. After the initiation of the vaginal epithelial closure, care was taken to place the prolene sutures (usually 2) in a perpendicular orientation to the levator muscle/fascial fibers, approximately 3 cm from the puborectalis insertion into the pubic symphysis. If another suture was needed to ensure adequate distal vaginal closure, 0-gauge polydioxanone was used. The perineorrhaphy was then completed as in an episiotomy repair. Upon completion of the procedure the measured genital hiatus is typically between 1 and 2 cm and the vaginal depth is 3 to 4 cm.

Statistical analysis

Preoperative versus postoperative IIQ-7/UDI-6 scores were analyzed with the Wilcoxon signed rank test. Subscale UDI-6 analysis was performed with α set at .0083 to account for multiple testing (ie, .05 divided by 6). Wilcoxon rank sum was used to test for the effect of concurrent incontinence procedure on UDI/IIQ change. Spearman rank correlation coefficient was used to correlate change in UDI scores with time since procedure and age. All other data were analyzed with descriptive statistics.

Results

Fifty-four patients were identified as having undergone colpocleisis between August 1996 and April 2003. Retrospective chart review revealed that 4/54 (7.4%) had