

Surgical pathway for the treatment of pelvic organ prolapse

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Abstract

During the last decade we have witnessed an unheralded time of change in pelvic organ prolapse surgery with the introduction and subsequent widespread restriction in the utilization of transvaginal mesh. To date no surgical pathway for the treatment of pelvic organ prolapse is available and this is reflected in a significant lack of clarity and variation in management of pelvic organ prolapse. We will present and discuss the evidence based 2017 International Consultation on Incontinence (ICI) surgical pathway for the treatment of pelvic organ prolapse.

Keywords hysterectomy; hysteropexy; uterine/apical/vault prolapse

Introduction

Following the unexpected complications associated with the utilization of transvaginal mesh for prolapse and the associated litigation and Government enquiries in multiple countries, there has been increased scrutiny of all prolapse surgery. The scrutiny demonstrates that there is lack of consistency in the rate at which prolapse interventions are performed in different countries and the type of interventions performed. Haya et al. reported that women in France and United States of America are at least ten times more likely to undergo sacral colpopexy as compared to women in Denmark, Sweden or New Zealand. There was also wide variation in the rates of transvaginal mesh utilization. Most of the recent enquiries and reviews have recommended that transvaginal mesh not be performed as a primary intervention for anterior or posterior compartment prolapse. In the face of increased media attention, the general community, referring medical officers and treating gynaecologist are seeking clarification and leadership as to the appropriate treatment pathways for the surgical management of prolapse. The International Consultation on Incontinence (ICI) produces evidence based treatment pathway for female pelvic floor dysfunction and for the first time delivered a surgical treatment of prolapse pathway (Figure 1) in 2017. A web based application of the pathway is available and simplifies the data that informs the pathway and is available at <http://www.urogynaecology.com.au/content.php?id=58a28e7bae443&refresh=954925>.

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While not reproducing the entire body of evidence underlying the pathway we will discuss important aspects.

Apical prolapse

The central pivot of the reconstructive pathway is the volume of evidence that demonstrates the importance of including adequate apical support at the time of prolapse repairs. Eilber et al. demonstrated a 50 % reduction in the rate of subsequent reoperation for prolapse when an apical suspending procedure was performed at the time of anterior colporrhaphy as compared to an anterior colporrhaphy alone. Importantly, this is the same degree of reduction in reoperation of prolapse achieved with the use of transvaginal mesh as compared to anterior colporrhaphy however there was no associated morbidity reported with the apical suspending procedures. The apical suspending procedures evaluated in Eilbers review of prolapse interventions performed in 1999 would have included sacrospinous and uterosacral colpopexy however a wider variety of contemporary apical suspending procedures are currently available.

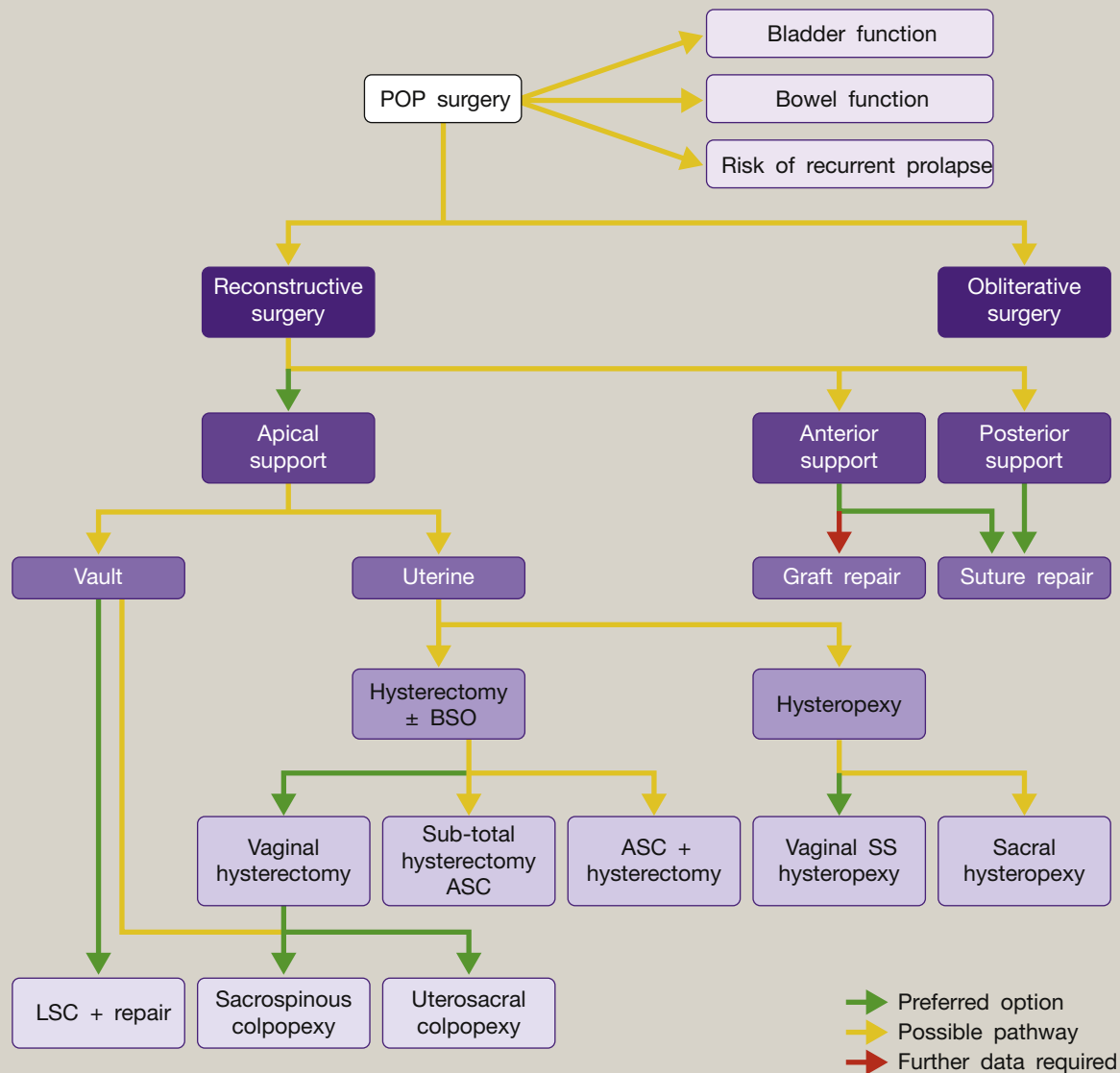
Vault prolapse: For the surgical treatment of post-hysterectomy vault prolapse the 2016 Cochrane review compared outcomes from six RCTs that compared sacral colpopexy with a variety of transvaginal apical suspensions including sacrospinous and uterosacral colpopexy and transvaginal mesh. The sacral colpopexy had lower rates of awareness of prolapse, prolapse on examination, reoperation for prolapse, post-operative stress urinary incontinence and dyspareunia as compared to the vaginal based interventions and points to the sacral colpopexy being the gold standard apical suspending procedure for vault prolapse. The pathway recognizes that not all women are suitable for sacral colpopexy (i.e. obese, hostile abdomen, prior radiation) and that the sacrospinous and uterosacral colpopexy remain viable treatment options in this group.

Uterine prolapse: While the preferred apical suspending treatment options for vault prolapse are well defined a myriad of surgical options for uterine prolapse are available and the pathway divides into uterine preserving options as compared to hysterectomy.

Relative contraindications to uterine preservation are listed in Table 1. Further to this discussion regarding uterine preservation and hysterectomy is the conversation regarding subsequent risk of gynaecological malignancy. Post-menopausal women who want to preserve the uterus should be informed during the consent process of the lifetime risk of cervical (0.6%), uterine (2.7%), and ovarian cancer (1.4%). Furthermore, pre-and perimenopausal women should be informed that bilateral salpingectomy at hysterectomy may decrease the risk of ovarian cancer (OR 0.51, 95 % CI 0.35–0.75).

In the reconstructive pathway the surgical options for uterine preservation include the vaginal based sacrospinous colpopexy as seen in Figure 2, as compared to the abdominal sacral hysteropexy which is an abdominal procedure where mesh suspends the uterus to the sacrum as seen in Figure 3. The pathway preferences the vaginal sacrospinous hysteropexy as a result of relatively high reoperation rate associated with sacral hysteropexy and the fact that the vaginal intervention avoids the utilization of mesh for a primary intervention.

Modified pathway for female pelvic floor dysfunction



From the International Consultation on Incontinence (ICI) 2017

Figure 1

The options for women electing to have hysterectomy at time of prolapse surgery include vaginal hysterectomy with apical suspension as compared to sacral colpopexy with hysterectomy or sub-total hysterectomy and sacral colpopexy. Sacral colpopexy with hysterectomy is associated with significantly higher rates of mesh complications as compared to sacral colpopexy without hysterectomy and is not preferred in the pathway for this reason. The data informing efficacy and safety of subtotal hysterectomy and sacral colpopexy is currently inadequate. However, in a single retrospective comparison between subtotal hysterectomy and total hysterectomy with sacral colpopexy, Myer et al. reported a higher rate of recurrent prolapse after the sub-total hysterectomy and sacral colpopexy. Until better quality data become available vaginal hysterectomy and apical suspension

are the preferred pathway options for uterine prolapse if a hysterectomy is to be performed.

An interesting dichotomy of outcomes is apparent in the pathway. For vault prolapse abdominal sacral colpopexy is the preferred option however for uterine prolapse including both hysterectomy and hysteropexy the vaginal options are preferred on the basis of relatively poor-quality data. As more research becomes available the treatment pathway may change.

Recurrent cystocele

One of the longstanding challenges in reparative Gynaecology remains the surgical management of recurrent cystocele. The ICI 2017 surgical treatment of prolapse pathway points to a variety of surgical options.

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