Apical Prolapse –
Which Approach Should I Choose?

MODERATOR
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FACULTY
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Professional Education Information

Target Audience
This educational activity is developed to meet the needs of residents, fellows and new minimally invasive specialists in the field of gynecology.

Accreditation
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While anterior vaginal prolapse (POP) is most common, loss of apical support is usually present in women with POP that extends beyond the hymen. Adequate apical support is an essential element of a durable surgical repair for women with advanced POP. Because of the significant contribution of the apex to anterior vaginal support, the best surgical correction of the anterior and posterior walls may fail unless the apex is adequately supported. This course reviews the commonly used laparoscopic/robotic and vaginal reconstructive and obliterative approaches to apical POP. It is geared toward advanced surgeons with an interest in pelvic reconstructive surgery.

**Learning Objectives:** *At the conclusion of this course, the participant will be able to:* 1) Choose appropriate candidates for laparoscopic/robotic versus vaginal POP repair; 2) describe reconstructive procedures for apical prolapse; and 3) describe obliterative techniques for apical prolapse.
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**Management Options for Apical Prolapse**

Peter L. Rosenblatt, MD
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Mount Auburn Hospital, Cambridge
Assistant Professor, Harvard Medical School

**Disclosures**
- Grants/Research Support: Boston Scientific Corp. Inc., Coloplast
- Consultant: American Medical Systems, Boston Scientific Corp. Inc., Coloplast, CooperSurgical, Covidien, Ethicon Women’s Health & Urology, Medtronic, VECTEC
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- CooperSurgical
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**Pelvic Organ Prolapse: Epidemiology**
- 11% lifetime risk for at least one prolapse surgery
- 400,000 procedures for POP per year in US
- 29% re-operation rate

*Olsen at al. Obstet Gynecol 1997;89:501

**Risk Factors for POP**
- Vaginal delivery
- Cigarette smoking
- Prior hysterectomy
- Estrogen deficiency
- Obesity
- Advancing age
- Ethnicity
- Neuropathy
- Underlying connective tissue disease

- Underlying connective tissue disease
Factors to consider

- What does the patient want?
  - Sexually active?
  - Prefer to avoid surgery?
- Pathophysiology of patient's prolapse
- Previous abdominal surgery (op notes)
- Estrogen status, presence of erosions
- Presence of stress incontinence
- Age / medical status / BMI.

Management Options for POP

- Observation with serial examination
- Pessary
- Surgery
  - Reconstructive
  - Obliterative
- Extended perineorrhaphy +/- pessary

Is hysterectomy necessary for the treatment of uterine prolapse?

Rosenblatt’s Law of Prolapse

<table>
<thead>
<tr>
<th>Procidentia</th>
<th>Uterus</th>
<th>Vault Prolapse</th>
</tr>
</thead>
</table>

Your uterus is showing....
“...a protruding uterus is the result of genital prolapse and not the primary cause of the symptomatology”

David Nichols. Vaginal Surgery 3rd ed
M.L.
- 82 year old G5P5 with h/o HTN, AODM
- Not sexually active
- Gelhorn pessary for many years, but interested in definitive surgery
- No stress incontinence, but c/o difficulty voiding

S.B.
- 52 year old healthy, active G2P2
- No previous pelvic or abdominal surgery
- Sexually active
- Not interested in pessary
- Reports daily stress incontinence

B. R.
- 75 year old G4P3 with 5 year h/o worsening bulging and pelvic pressure
- S/P VH, BSO 7 years ago for prolapse
- Widow, not currently sexually active, but wants to keep open the option
- h/o ruptured Appy
A.R.
- 62 year old G3P3 with 3 h/o pressure, bulging, and urge incontinence
- S/P TAH, BSO 20 years ago (menorrhagia)
- Stage III prolapse (Aa +1, Ba +2, C -3)
- Posterior wall well supported
- Sexually active

P.C.
- 56 year old G3P2 with symptomatic bulge
- Reports vaginal splinting for BMs
- Stage II prolapse
  - Aa/Ba – 2
  - Ap/Bp +1
  - C – 3
- No c/o stress incontinence

J.B.
- 66 year old G4P3 mildly obese with mild HTN, otherwise healthy
- Previous VH, APR, TVT 12 years ago
- Symptomatic prolapse with stress incontinence
- Stage III prolapse
  - Aa – 3
  - Ba – 2
  - C +5
Vaginal Native Tissue Approaches to Apical Prolapse

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Associate Professor of Ob/Gyn and Urology
Georgetown University School of Medicine

Disclosures
I have no financial relationships to disclose.

Objectives
1. Outline considerations for surgical approach
2. Summarize techniques of native tissue vaginal repairs for anterior and apical prolapse

Levels of Support
- **Level I**
  - McCall culdeplasty
  - Sacrospinous suspension
  - Uterosacral suspension
  - Posterior mesh procedures
- **Level II**
  - Paravaginal defect repair
  - Anterior mesh procedures

Surgical goals for apical support
- Establish continuity of anterior and posterior muscularis at apex
- Suspend vagina
- Restore a posterior axis
- Maintain vaginal length

Prevention
McCall culdeplasty

- Correction of enterocele and deep cul-de-sac during TVH
  - Closes redundant cul-de-sac and enterocele
  - Provides apical support
  - Lengthens vagina
- Superior to uterosacral plication and simple peritoneal closure in prevention of post-hysterectomy enterocele


Treatment

Obliterative procedures
**Colpocleisis**
- LeFort partial colpocleisis
  - Uterus in place
  - 85-95% cure
  - 2-5% breakdown with recurrence
  - 10-30% risk of urinary incontinence
- Total colpocleisis
  - Post-hysterectomy prolapse
  - 90-100% cure

**Total colpectomy / colpocleisis**
- Useful for:
  - Vault prolapse
  - Medically frail
  - No desire for sex
- Goal:
  - Narrow / shorten vagina
  - Relieve symptoms
  - Short OR time
  - High cure rate / low risk
    - 90-100% cure

**Partial colpocleisis (LeFort)**
- Used when uterus in place
- Obliterative
  - Patient cannot have penetrative sex
  - Many older patients are sexually active w/o penetration
- Good for medically frail

**Why LeFort?**
- Simple
- Accessible for most GYN surgeons
- High cure rates
  - 85-95%
- Low risk
  - 2-5% breakdown with recurrence
  - 10-30% risk of urinary incontinence
- Long track record (described in 1877!)
Levatorplasty and perineopasty (tight posterior repair) are most important parts of procedure

- Elevates and lengthens vagina
- Narrows opening
- Rebuilds perineal musculature
Suture-based vaginal reconstructive procedures

Uterosacral ligament vaginal vault suspension (USLS)

USLS: Goals
- Reestablish continuity of pubocervical and rectovaginal muscularis
- Elevate vault toward uterosacral ligaments
USLS: Helpful tips

- Enter enterocele
- Place uterosacral ligament on tension
- Use long Allis clamp to help place stitch on intermediate portion of ligament
- 2-3 sutures each side
- Highest stitch most medial
- Cystoscopy

Uterosacral ligament suspension

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Number</th>
<th>Follow-up</th>
<th>Cure Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jenkins 1997</td>
<td>50</td>
<td>6-24 mos</td>
<td>100%</td>
</tr>
<tr>
<td>Webb 1998</td>
<td>693</td>
<td>11-22 mos</td>
<td>82%</td>
</tr>
<tr>
<td>Shull 2000</td>
<td>289</td>
<td>2-6 yrs</td>
<td>87%</td>
</tr>
<tr>
<td>Barber 2000</td>
<td>46</td>
<td>16 mos</td>
<td>90%</td>
</tr>
<tr>
<td>Karram 2001</td>
<td>202</td>
<td>22 mos</td>
<td>95%</td>
</tr>
<tr>
<td>Silva 2006</td>
<td>72</td>
<td>5 yrs</td>
<td>85%</td>
</tr>
</tbody>
</table>

USLS

- Advantages
  - No abdominal incisions
  - Physiologic axis
  - No mesh
- Disadvantages
  - 1-11% intraop ureteral obstruction
  - 90% resolved intraoperatively
  - 0.9% ureteral injury rate requiring further intervention
  - Worse for larger prolapse?


Sacrospinous ligament fixation

- Vagina suspended to SSL through R pararectal space
  - 2 sutures >2cm medial to spine
  - Pass through apex
- Vagina directly opposed to SSL

SSLF: Surgical Tips

- Measure vagina
  - Must reach ligament
  - Mark apex
- Visualize ligament
  - Lighted suction/irrigator
  - Lighted retractor
- Sew full thickness vagina to ligament
  - Capio device
  - Pulley stitch
SSLF

- Cure ~ 70%
- Good for post-hyst apical prolapse, esp posterior apical
- Advantages
  - Extraperitoneal
  - Can be used if poor USL
- Disadvantages
  - Posterior axis deviation
  - Risk vascular / nerve injury

Iliococcygeus vaginal vault suspension

- Posterior incision
- Iliococcygeus exposed
  - Briesky-Navartil retractors
- Single delayed absorbable suture through levator muscle
  - 1-2cm caudad and posterior to spine
- Both ends passed through posterior apex
- Procedure repeated on opposite side


Iliococcygeus vaginal vault suspension

- 152 pts 1981 - 1993
- 8% recurrence 6 wks - 5 yrs
  - 2 apical recurrences
  - 3 posterior recurrences
  - 8 anterior recurrences


Summary

- LeFort or total colpocleisis
  - Older, not sexually active, high risk
- Uterosacral ligament suspension
  - Primary prolapse repair or wants vaginal repair
- Sacral colpopexy
  - Young, active, recurrent, wants gold-standard
- Sacrospinous fixation
  - Cannot enter peritoneum or poor USL
  - High posterior wall prolapse
- Vaginal mesh
  - Older, minimally sexually active, recurrent
  - Wants to retain uterus

References

- In slides
Laparoscopic, Robotic and Mesh Approaches to Apical Prolapse

Eric R. Sokol, MD
Co-Chief, Urogynecology and Pelvic Reconstructive Surgery
Stanford University School of Medicine

1. Review LSC/robotic approaches to apical prolapse
2. Review LSC/robotic sacrocolpopexy setup
3. Review LSC/robotic sacrocolpopexy technique
4. Review techniques and evidence for vaginal mesh kits

LSC and robotic prolapse surgeries
1. Paravaginal defect repair
2. Uterosacral ligament uterine suspension
3. Uterosacral vaginal vault suspension
4. Sacral colpopexy
5. Sacral hysteropexy
   - Single mesh
   - Dual mesh

Grants/Research Support: Contura
Consultant: American Medical Systems
Stockholder: Pelvalon
Laparoscopic USLVVS

- Miklos et al 1998 - laparoscopic assisted
  - 19 women with 100% cure for enterocele
  - 12% recurrence of apical prolapse (mild) at 6.3 mos
- McKinney 1999
  - 70 women with 97% cure for apical prolapse with follow-up to 5 years
  - 2 anterior enteroceles and one conversion to laparotomy
- Pott-Grinstein and Liu 2000 AAGL
  - 124 patients with 86% cure rate over 3 years
  - Reoperation in 5.6%

Mesh Sacrocolpopexy

- Open (abdominal)
  - Good long-term results: 93-100% success rates with durable repair¹
  - Increased morbidity: invasive mid-line incision leading to prolonged recovery time (5-6 hospital days) ¹
  - Limited patient candidates
- Laparoscopic
  - Reproduce open approach minimally invasively
  - Technically difficult learning curve due to complex suturing and dissection
- Robotic
  - Small series show short term success
  - Cost effective compared to open ASC²

¹Elliott DS, et al., J Urol 2006; 176: 655-659

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Port Placement

What I do

- Camera (12 mm disposable cannula) at (or cephalad to) umbilicus
- Right da Vinci port (8 mm cannula) 10 cm to right of umbilicus and “30” inferior to camera
- Left da Vinci port (8 mm cannula) 10 cm to left of umbilicus and “30” inferior to camera
- Assistant port (5 mm cannula) at far left side “10” cm from left instrument port just inferior to camera port
- Assistant port (5 mm cannula) cephalad and medial to 12 mm assistant port

NOTE: Measurements should be made AFTER insufflation

Robotic (or LSC) sacrocolpopexy

Suggested Instruments for Dissection

- Right hand:
  - Hot Shears™ (Monopolar Curved Scissors)
- Left hand:
  - Maryland Bipolar Forceps
  - PK Dissecting Forceps
- 3rd instrument arm
  - Fenestrated Bipolar Forceps
Instruments for Suturing

- Two Large Needle Drivers
  or
- One Large and one SutureCut Needle Driver
- 3rd Instrument Arm
  - Fenestrated Bipolar Forceps

Assistant Instrument Choices

- Laparoscopic instruments
  - 5 mm endoscopic suction/irrigator (long 45 cm)
  - 5 mm endoscopic scissor (long 45 cm)
  - 5 mm endoscopic atraumatic graspers (long 45 cm)
  - 12 mm EndoPaddle
  - 10/12 mm specimen retrieval pouch

Sutures

- Vaginal Cuff (Cervix) Closure
  - 0 Vicryl on CT-1 needle cut to 6 inches length
    - for “figure-of-8” interrupted repair
    - must use 12 mm port due to CT-1 needle size
- Attaching Mesh
  - CV2 Gore-Tex, 2-0 Prolene or 2-0 PDS on CT-2 needle for attaching mesh to vagina and sacrum
  - 12-20 cm
  - Start with short sutures
  - Use 12-15 cm for sacral suture
- Closing the Peritoneum
  - 2-0 Vicryl on an SH needle to close peritoneum
  - 20 cm (Can use LaparoHeck)

Develop Bladder Flap Anteriorly (0° scope)

- Dissect the bladder off the anterior vaginal wall
  - I often do this laparoscopically
- Dissect close to wall to avoid cystotomy and to identify avascular plane
- Place an EEA in the vagina to manipulate the vaginal apex to help with the dissection

Develop Rectovaginal Septum (0° scope)

- Place EEA sizers in the vagina (and possibly rectum) to identify the rectovaginal septum
- Orient vaginal EEA anteriorly to better expose the posterior vaginal wall
- Dissect 6-10 cm of the posterior vaginal wall
  - I often do this laparoscopically
- Keep camera midline
Develop rectovaginal septum

Expose Anterior Longitudinal Ligament
• (0 or 30° down scope)
• Retract sigmoid laterally (3rd instrument arm or assistant port)
• Tent peritoneum in the midline to avoid injuring a vessel
• Identify the anterior longitudinal ligament
• Extend the presacral peritoneal dissection inferiorly to vagina to help close over mesh
  – I often do this laparoscopically

Develop presacral space

Attach Mesh to Anterior Vaginal Wall (0 or 30° down scope)
• Use polypropylene mesh (Y-shape) introduced in anatomic orientation, trimmed to appropriate width and length
• Place distal and lateral (corner) sutures first
• Attach several (4-8) sutures to secure mesh to the anterior vaginal wall (avoid full thickness)

Attach mesh to anterior wall

Attach Mesh to Posterior Vaginal Wall (0 or 30° down scope)
• Roll sacral end of mesh using 4th robotic arm or grasper and pull anteriorly to allow posterior mesh to drape over vaginal wall
  – Trick: this is unnecessary with new thinner meshes and 4th arm is not needed
• Secure longer posterior mesh to posterior vagina (4-8 sutures)
• Place distal (corner) sutures first
Attaching Mesh to Sacrum (0 or 30° down scope)

- Avoid middle sacral vessels or presacral venous plexus, can often place suture under middle sacral vessels
  - Trick: you can ablate vessels first if necessary
- Use slip knot to secure 1st sacral suture (or excessively elevate vagina)
- Additional sutures (2-3) are placed superiorly to allow for adequate visualization
- Excess portion of the mesh is trimmed

Closure of Peritoneum (0 or 30° down scope)

- Retroperitonealize the mesh to help prevent small bowel obstruction
- Use a locking stitch pattern while running the peritoneum closing suture
- Use suture needle to hook and retract mesh to expose peritoneum
- This step is facilitated by the earlier opening of the peritoneum from the sacrum to the vagina

Dual mesh sacrohysteropexy
Evidence for LSC sacral hysteropexy

- At mean of 20.3 months (n=81)\(^1\)
  - 88% no prolapse symptoms
  - 95% no objective prolapse
- 23 pts at 12 months s/p LSC hysteropexy\(^2\)
  - No patients with recurrent POP symptoms
  - Median POP-Q point C=-5

\(^1\) Krause HG et al. Int Urogynecol J. Pelvic Floor Dysfunct. 2006; 17:378-381

Internal fixation mesh kits (examples)

- Elevate Anterior®
- Uphold®
- Elevate Posterior®
Sub-Muscularis Dissection

Elevate Anterior

- Four point fixation system
  - Obturator internus muscle and sacrospinous ligament

- One anterior incision
  - Provides both anterior and apical support
Evidence for use of mesh - efficacy

- Mesh kits effective in restoring apical prolapse over short term, but long-term outcomes unknown1
- Mesh may improve anatomic outcomes for anterior repair2
  - May not translate to superior symptomatic outcomes or lower repeat surgery rates
- Apical or posterior repair with mesh does not appear to provide benefit compared to traditional surgery3
- Traditional POP repair has equivalent QoL improvement compared to transvaginal mesh POP repair4,5

Evidence for use of mesh - safety

- 10% erosion rate within 12 months of surgery
  - Systematic review of 110 studies/11,785 patients\(^1\)
- Mesh complications are not rare
  - Vaginal erosions are most common complication\(^2\)
- SUI more common after mesh anterior repair\(^3\)
- Vaginal mesh apical suspension associated with more complications requiring repeat surgery\(^4\)
- >50% with erosion need surgery, often more than once\(^1\)

\(^1\)Abed et al. Int Urogynecol J, 2011.

Evidence for use of mesh - safety

- Mesh contraction, causing vaginal shortening, tightening, and/or vaginal pain, is increasingly reported in the literature\(^1,2\)
- Transvaginal surgery with mesh to correct vaginal apical prolapse is associated with a higher rate of complications requiring reoperation and reoperation for any reason compared to traditional vaginal surgery or sacral colpopexy\(^3\)


REFERENCES

- Listed with each slide
CULTURAL AND LINGUISTIC COMPETENCY

Governor Arnold Schwarzenegger signed into law AB 1195 (eff. 7/1/06) requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California’s physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP).

California Business & Professions Code §2190.1(c)(3) requires a review and explanation of the laws identified above so as to fulfill AAGL’s obligations pursuant to California law. Additional guidance is provided by the Institute for Medical Quality at http://www.imq.org

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 http://www.usdoj.gov/crt/cor/pubs.htm.

Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency”, signed by the President on August 11, 2000 http://www.usdoj.gov/crt/cor/13166.htm was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (California Government Code §7290 et seq.) requires every California state agency which either provides information to, or has contact with, the public to provide bilingual interpreters as well as translated materials explaining those services whenever the local agency serves LEP members of a group whose numbers exceed 5% of the general population.

~

If you add staff to assist with LEP patients, confirm their translation skills, not just their language skills. A 2007 Northern California study from Sutter Health confirmed that being bilingual does not guarantee competence as a medical interpreter. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538.