

Unsupported Anterior Wall Tied to Failed Repair

BY JANE SALODOF MACNEIL
Contributing Writer

SANTA FE, N.M. — Leaving the anterior wall of the vagina unsupported is a leading cause of failure in surgeries for vaginal vault prolapse, Thomas M. Julian, M.D., said at a conference on gynecologic surgery sponsored by Omnia Education.

"The reason we see so many recurrences is we don't attach the anterior vaginal wall. You have to attach the anterior vagina to something," said Dr. Julian, director of the division of gynecology at the University of Wisconsin in Madison.

Dr. Julian said he came to this conclusion because he was troubled by the number of patients who were referred to his

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medical center for repair of failed operations. He did not believe the problem originated with the surgeons doing these operations, but with the techniques they used. Reviewing established procedures, he found a common denominator was no incorporated support to the anterior wall of the vagina.

The roots of vaginal vault prolapse can often be found in hysterectomy, according to Dr. Julian. The surgeon attaches the broken segments of uterosacral ligament to each other. "Now that will probably support those two uterosacral ligaments really well, but it won't support the vagina unless you sew [them] back to the vagina at some point," he said.

Over time, the vagina descends until repair of the vaginal vault becomes necessary. Whichever repair procedure is used, Dr. Julian said locating and avoiding the ureter during surgery becomes a major concern.

One surgical option, the classic McCall culdeplasty, does a good job of pulling up the vaginal apex, Dr. Julian said. However, he added, it has a high incidence of catching the ureter, and it does nothing to support the anterior wall.

Sacrospinous ligament fixation also presents problems. "The recurrence of other pelvic support defects using this operation was unacceptably high," he said.

One problem he cited is that surgeons often proceed by touch without seeing the ligament. "If you are not seeing, I don't think you are going to be able to do the operation," he said.

Another occurs in women who have already been operated on several times. As the vagina becomes shorter, vaginal apex repairs may no longer reach to the anterior sacrospinous ligament. When that happens, surgeons make a suture bridge, which can pull and cause pain, Dr. Julian said.

The procedure itself pulls the vagina to one side, leaving the other side open to recurrence—and does not support the anterior wall, he added.

The Inmon-Meeks prespinous suspen-

sion, he continued, represents a major improvement, using the iliococcygeus fascia to support the posterior wall of the vagina. The anterior wall is still suspended, however.

A newer technique, intravaginal sling-plasty, gives more support to the apex and has cure rates of 91% and 94% without major complications, according to two published reports from Australian surgeons (Int. Urogynecol. J. Pelvic Floor Dysfunct. 2002;13:4-8 and Int. Urogyn-

necol. J. Pelvic Floor Dysfunct. 2001;12:296-303). "This is the new and coming thing that is going to be touted for suspending the vaginal apex," Dr. Julian said, adding that it still does not support the anterior wall.

He said he has been using a technique in which the uterosacral ligament provides the missing support. The surgeon puts a finger in the rectum to find the ligament and then grasps the uterosacral ligament with a clamp. The surgeon sub-

sequently places two sutures from lateral to medial (to avoid catching the ureter) attaching the ligament to the vagina. This pulls the vagina back, anchoring the anterior wall and posterior wall and restoring the axis of the vagina.

"All straining is going to push the vagina into the sacrum instead of the hiatus," Dr. Julian said, adding, "It's not a new concept. ... People have thought of it in the past, thought of it abdominally. For some reason we got out of doing that." ■

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