A NEW TECHNIQUE OF VAGINAL COLPOPEXY

M. MANESCHI, S. M. RUBINO

Department of Obstetric and Gynecology
University of Palermo

SUMMARY

The correction of a total or partial vaginal prolapse after hysterectomy is often difficult to perform, particularly when the possibility of sexual intercourse must be preserved.

A method of vaginal retropubic colpopexy is proposed. In addition to preserving the vaginal functionality, it can be performed for preventive purposes during hysterectomy for uterine prolapse or conspicuous cystorectocele and finally, it corrects the topographic modification of the bladder and of the urethra.

This method has had excellent results on 18 patients and relapse has not occured after two or three years.

Generally, one tends to explain the continuous proposals of new techniques for surgical treatment of a determinate pathology as an indirect sign of not yet finding an ideal technique. This has also happened to the surgical correction of partial or total vaginal prolapse after hysterectomy. In this case we do not agree with this explanation but instead believe that one should choose the "ideal" technique for each particular case rather than an ideal surgical technique to be used in all cases.

Surgical correction of vaginal vault prolapse can be conducted, according to various techniques, by abdominal or vaginal approach. This has created two schools of thought: on one side the sustainers of the vaginal approach, on the other side the sustainers of the abdominal approach.

Undoubtedly from the anatomic point of view, vaginal correction theoretically is the most logical one as it respects all the criteria normally followed for the correction of hernias. However it is based on the possibility of finding and using various structures that often have disappeared or are inconsistent ([2]).

Equally, because of general conditions, weakness of the abdominal fascia or diastasis of the abdominal recti muscles, the abdominal approach is in many cases less indicated ([1]).

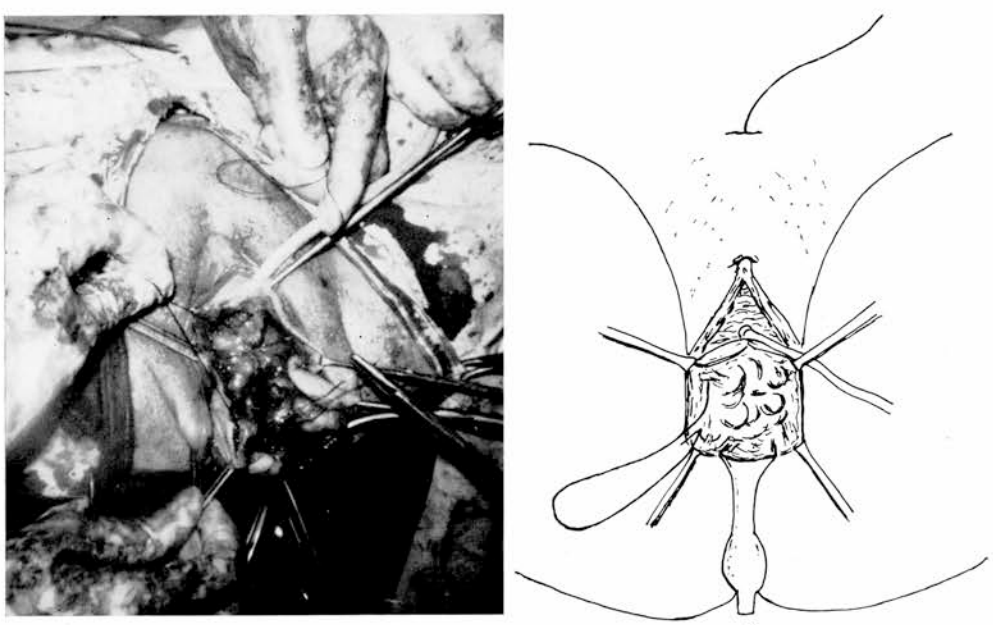
Therefore, one can be a defender of a technique but he must be prepared to choose another one when a lack of favourable conditions occurs.

The gynecologist must know a large number of techniques for surgical correction of a vaginal vault prolapse because the only way to choose one operation rather than another, is to evaluate thoroughly the case instead of preferring a standardized personal choice.

Here we are proposing a vaginal technique of retropubic colpopexy which, beside being sufficient, can easily be integrated into other vaginal techniques and because

a *b* *c*

Fig. 1. — *a*) Needle needed for this technique. *b*) The needle is introduced along the posterior wall of the pubic symphysis. *c*) The thread is introduced inside the needle, 15-20 cm of which should emerge from the point.



a *b*

Fig. 2. — *a*) and *b*) The thread's vaginal extremity is set up on a curve lanceolate needle and the vaginal angle is transfixed in its internal side.

of its convenience can be performed for a preventive purpose, contemporaneously to a colpohysterectomy for utero-vesico-vaginal prolapse.

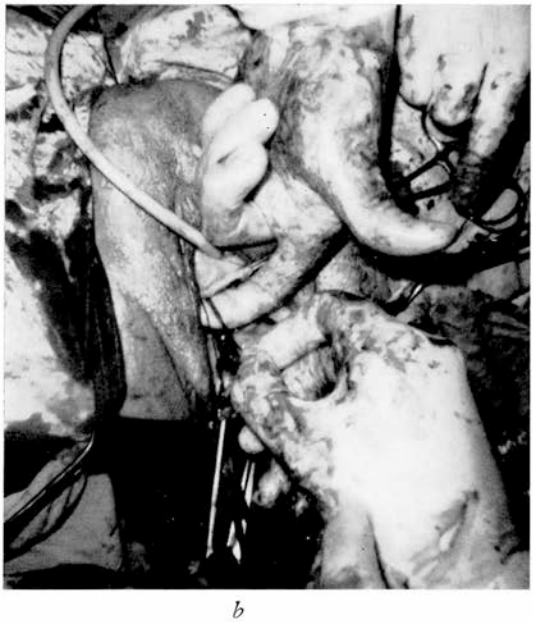
TECHNIQUE

The proposed technique, based on the same criteria of Pereyra retropubic urethropexy ([4, 5]), aims to repair the pubo-vesico-vaginal ligaments through a post-cicatricial thickening.

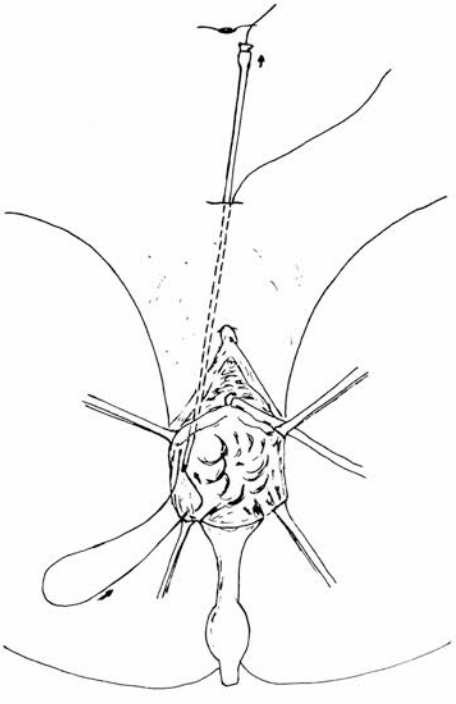
For this purpose, a needle 15-20 cm long is needed, its caliber should allow a Dexon or a chromic catgut thread to run into it (fig. 1 *a*).

After colpotomy, the posterior wall of the bladder and the Douglas pouch peritoneum are separated and its excess portion is removed. The utero-sacral ligaments are then brought together by two suture stiches and the cystocele is reduced by a tobacco-bag stich. The needle is then introduced into the Retzius space through a small suprapubic abdominal incision and is moved along the posterior side of the pubic symphysis. Its point should emerge, under the guidance of a finger placed in the paraurethral site, lateral to the urethro-vesical junction, which the finger can easily locate if an assistant exerts a slight traction on the Foley catether (fig. 1 *b*).

The thread is introduced inside the needle, 20-30 cm of which should emerge from the point (fig. 1 *c*), the needle is then removed leaving the thread *in situ*. The thread's vaginal extremity is set up on a curve lanceolate needle and the vaginal angle is transfixed in its internal side (fig. 2 *a-b*).



b



a

Fig. 3. — *a)* and *b)* The needle is reintroduced in the retropubic space and the thread's vaginal extremity is introduced inside the needle.

The needle is reintroduced in the retropubic space and the thread's vaginal extremity is introduced inside the needle through its distal extremity, and after making it emerge on the opposite side, the needle is removed (fig. 3 *a-b*).

The same procedure is carried out on the other side and the vaginal edges are sutured up to 2-3 cm from the apex.

At this point the extremities of each, thread having emerged from the suprapubic incision, are bond together, trying to exert the same traction on both sides in making the knot and verifying the position and the entity of the vaginal lifting, by a finger placed along the anterior vaginal wall (fig. 4 *a-b*).

Finally colpoperineoplasty is performed, whose limit is at the level of the uterosacral ligaments.

RESULTS

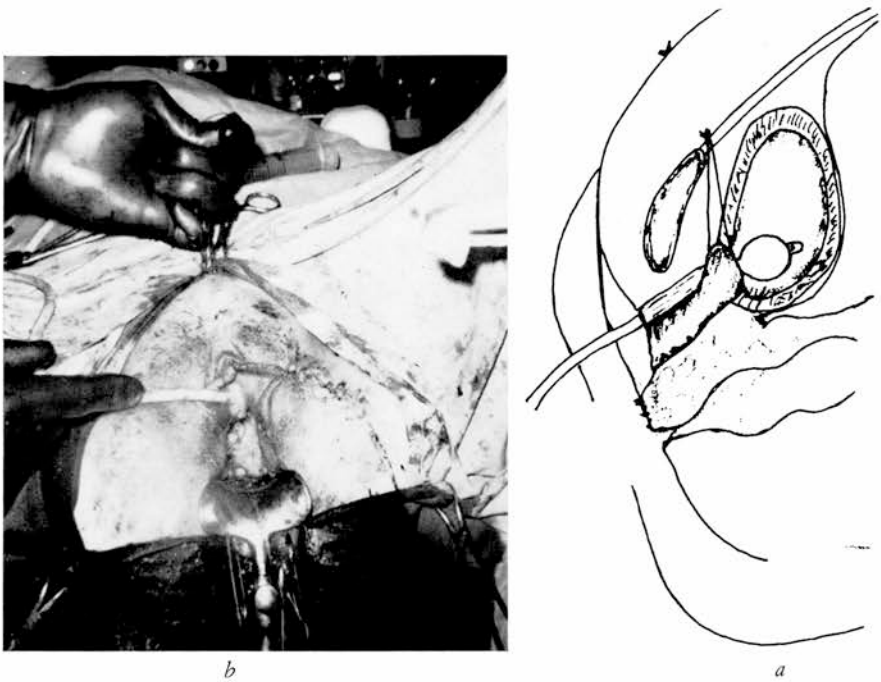
The above technique has been used in 6 cases of vaginal vault inversion and associated to colpohysterectomy according to Stoekel in 12 cases of uterine prolapse of 3rd degree with complete vaginal inversion.

All patients had a regular post-operative course with spontaneous micturition between the 5th and 8th day after surgery.

No relapsing has been observed after two or three years, but naturally for a final evaluation of this technique, a control of longer duration is necessary.

In conclusion we believe that the proposed technique offers the following advantages:

1) It is easy and fast to perform; performed preventively during the course of



b *a*

Fig. 4. — *a*) and *b*) The extremities of each thread having emerged from the suprapubic incision, are bond together.

a hysterectomy it will require only an additional 8-10 minutes.

2) It preserves the functionality of the vagina that is shortened only 15-20%.

3) It can be associated to the McCall ([3]) or Simmonds ([6]) method, and in the presence of not very consistent utero-sacral ligaments, it produces an ulterior element of support to the vagina.

4) It corrects the cysto-urethrocele that generally accompanies a vaginal prolapse. It restores the normal urethro-vesical angle and in such a way urinary incontinence due to sphincter insufficiency is cured or prevented.

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