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Presentation Abstract

Session: Non-Discussed Posters - E Posters

Wednesday, Jun 10, 2015, 6:00 PM - 4:30 PM

Presentation: NDP 310 - **SURGICAL TREATMENT OF GENITAL PROLAPSE WITH SURELIFT® MESH IN PATIENTS AT RISK OF RECURRENCE**

Category: Pelvic Organ Prolapse

Keywords: pelvic organ prolapse; mesh surgery; complications

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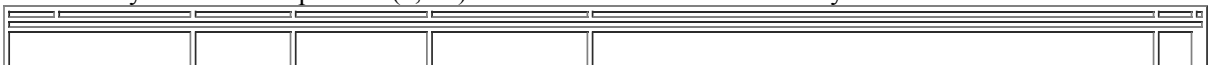
Abstract:

Introduction
Pelvic organ prolapse (POP) is a common condition in urogynecology, with a reported prevalence ranging from 2 to 48%. Management can be conservative or surgical, the latter in the form of an anterior or posterior colporrhaphy associated or not with vaginal hysterectomy.
Based on the most recent survey, the lifetime risk of undergoing surgery for pelvic organ prolapse (POP) is 19% among the general female population, which is higher than the previously reported rate by Olsen of 11-12% [1]. Success following traditional surgeries has been suboptimal, with recurrence rates ranging up to 50% and a significant number of patients require a second surgical procedure [3]. In addition, most patients (60%) who undergo POP repair are aged < 60 years. Therefore, an ideal surgical intervention for POP should be one that is safe, efficient and durable. Several potential predictors of POP recurrence have been identified including age, previous prolapse surgery, preoperative severity of prolapse, size of genital hiatus, levator contraction strength or levator avulsion [2].
In an attempt to improve the long-term results of conventional techniques, the use of meshes in pelvic floor reconstructive surgery emerged in recent years. Higher anatomic success rates and satisfactory functional outcomes have been reported. However, mesh use is associated with a higher risk of complications. Therefore, the use of meshes must be restrictive to those patients at high risk of prolapse recurrence.
Objectives
The aim of this paper is to analyze the results obtained in pelvic floor surgery using non-absorbable mesh (Surelift®) in selected patients with risk factors of recurrent prolapse.
Methods
Case series including a total of 54 patients who were surgically treated for severe genital prolapse, from November 2009 to April 2014, with risk factors for recurrence of genital prolapse. We considered risk factors: Recurrence of previous pelvic floor surgery, paravaginal defect, age <50 years, congenital or acquired connective tissue abnormalities, chronic increased intra-abdominal pressure (chronic lung disease, smoking, constipation), Body Mass Index >29 or hard work activity/sports.
We defined the cure criteria according to ICS definition: Objective cure would be the difference in anatomical success after surgery, defined as grade 1 or 2 of prolapse. Subjective outcome would be the absence of a bulge. Symptomatic POP recurrence was defined as prolapse > grade 2 of Baden Walker scale. The complications related or not to the mesh implant were classified according to the terminology and classification report of the IUGA/ICS.
Results
We used Surelift® system (anterior and posterior). Fourty-nine women (90,7%) underwent anterior Surelift® System and five patients (9,3%) underwent Posterior Surelift® System.



		BMI	Vaginal Births	Max birth weight	Time lapse between first POP surgery to mesh surgery (months)	
N	Valid	54	13	54	50	51
Mean		29,4716	2,35	3679,00	7,59	
Standard error mean		1,39393	,122	70,078	1,088	
Median		29,1363	2,00	3600,00	5,00	
Standard Deviation		5,02588	,894	495,528	7,767	
Minimum		22,03	1	2750	0	
Maximum		42,72	6	5000	35	

Table 1: Clinical characteristics of the patients

Anterior Surelift®:

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Objective results: three cases (6%) of prolapse > grade 2 of Baden Walker scale, two (4%) corresponded to the medium compartment and one to the anterior compartment (2%). One case (2%) presented with a prolapse of the posterior compartment.

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Subjective results: six cases (12.2%) of subjective fail, but only three (6%) correlated with objective prolapse in genital examination (one of each compartment).

Posterior Surelift®: one symptomatic prolapse of another compartment (20%) which corresponded to the medium compartment.

Regarding to surgical complications: three cases (5,6%) of hematoma were detected in the Anterior Surelift® group, one of whom presented with an abscess and an extrusion of the mesh within 8 days of the surgical procedure which required readmission, antibiotherapy and parcial excision of it.

During the follow-up we detected three cases (5,6%) of de novo urgency: one (4,1%) in the Posterior Surelift® group and two (20%) in the Anterior Surelift® group and nine cases (18,4%) of de novo stress urinary incontinence, all in the Anterior Surelift® group.

There were two cases (3,7%) of inguinal pain, one case (1,9%) of pelvic pain in the Anterior Surelift® group and 8 (14,8%) cases of mesh extrusion, seven (13%) of which were treated conservatively with estrogenic therapy and one (1,95%) required partial resection.

Conclusions

The use of mesh in pelvic floor reconstructive surgery in selected patients with risk factors for recurrence is a good treatment option to prevent or attempt to reduce the recurrence or reoperation rates described with low complication rates.

References

[1] Obstet Gynecol 2010;116:1096-100.

[2] Ultrasound Obstet Gynecol 2013; 42: 230[[unable to display character: –]]234

[3] Am J Obstet Gynecol 2008;198:555. e1-5.