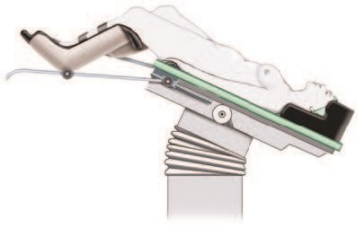
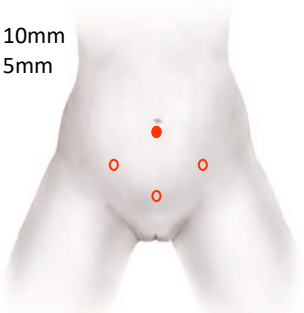
UPLIFT

Robina
Group Companies

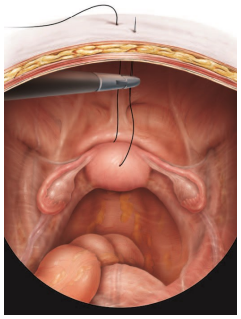
SURGICAL GUIDE



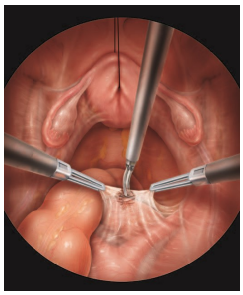
1. Place the patient with legs fully abducted and in a steep Trendelnburg position.
This allows an adequate exposure of the pelvic organs. For a correct exposure of the pelvic organs, move colon up and down.



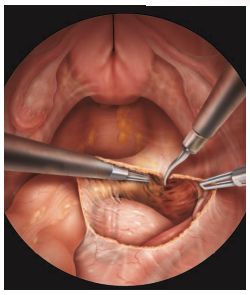
2. Port placement. Place a 10mm camera port at the level of the umbilicus or immediately below. Right and left, 5mm working ports inserted at 2/3 distance between the umbilicus and anterior superior iliac spines.
A forth 5mm port is placed midway between the umbilicus and symphysis pubis.



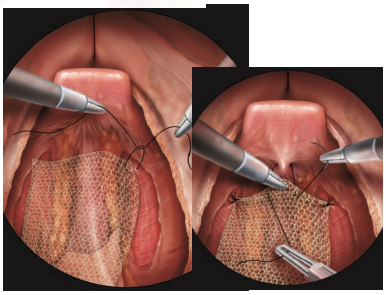
3. To allow access to posterior compartment, fix the uterus to the abdominal wall by percutaneous suture with straight needle. Pass the suprapubic suture through the abdominal wall, crossing the uterine fundus and out again through the abdominal wall. Tight the suture securely over a gauze.



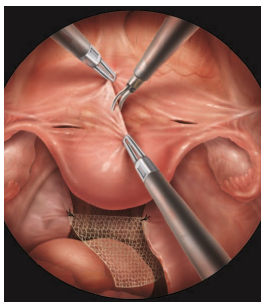
4. Identify the sacral promontory and make an incision on the peritoneum above it, avoiding the surrounding vessels.



5. Continue the incision of the peritoneum laterally to the rectus until the pelvic floor muscles of the back of the pelvis become visible. Preserve the perirectal fat to avoid injuries. Repeat dissection on contra lateral side.

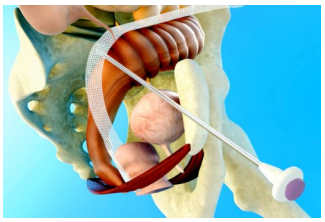


6. Fix the wide end of the UPLIFT mesh bilaterally to the anus elevators muscles and the vaginal vault on its midline. We recommend the use of any method for the correct identification of the vaginal vault.

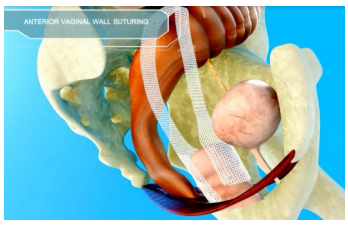


7. Identify the limit of the vaginal vault to guide bladder dissection from the vagina. Dissect until intuit the urethral tube baloon.

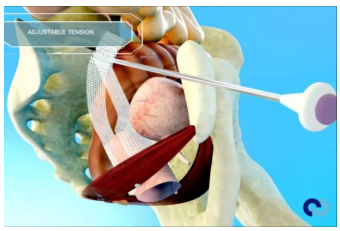
8. Charge the applicator. Keep the applicator perpendicular to the cartridge.



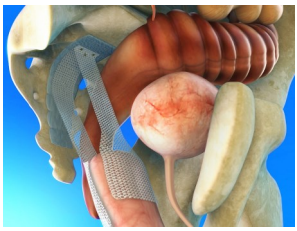
9. Fix the central part of the mesh free of tension to avoid constipation to the promontory with an anchor.



10. Pass the narrow free end of the mesh through the window of the broad ligament and, ensuring that it is not coiled on itself all the way, fix it with sutures to the apex and to both sides to the anterior dissection area.



11. Once anterior and posterior ends of the mesh are fixed, pull from the central part of the mesh with atraumatic forceps over the promontory and fix the mesh with two anchors applying the desired tension.



12. Cut the excess of mesh over the promontory and close the peritoneum with a continous suture avoiding any mesh exposure.

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