

SURGICAL TREATMENT OF PELVIC STATIC DISORDERS - GENERAL PRINCIPLES AND DISCUSSIONS

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ABSTRACT

Introduction: Pelvic static disorders have a major impact on patients' quality of life, constituting a real public health problem, despite the fact that they are not life-threatening. Pelvic static disorders are characterized by varying degrees of damage to the structures of the pelvic floor, which leads to the appearance of some anatomical-clinical entities, the most common of which are urinary incontinence and pelvic organ prolapse. There is no consensus regarding the optimal treatment of pelvic static disorders, reconstruction techniques being extremely numerous, from classic techniques, which use the patients' own tissues to laparoscopic techniques and those using alloplastic materials

Methods: In the Surgery Clinic I of SCJU Constanța, 89 surgical interventions for the correction of uterine prolapse and 22 interventions for the correction of vaginal vault prolapse were performed on a group of 327 patients, using both reconstructive and obliterative surgical techniques

Results: The best anatomical success rate was achieved by performing laparoscopic colposuspension by the lateral suspension procedure, followed by laparoscopic sacrocolpopexy and colposuspension at the sacrospinous ligaments

Conclusions: Hystero/colposuspension is a lateral fixation procedure that fulfills the four major goals of surgical prolapse cure: reduction of prolapse, absence of functional symptoms, patient satisfaction, and avoidance of complications. The technique is simple, requires a short operative time with minimal operative trauma, rapid postoperative recovery with a high degree of satisfaction in terms of quality of life and early socio-professional integration of the patients.

Keywords : genital prolapse, laparoscopic hysteropexy

Introduction

With the formulation of the Integral Theory, Petros proposes a reconstructive surgery in the treatment of pelvic static disorders and the abandonment of excisional surgery, arguing that restoring the original anatomy of the perineum leads to the resumption of its normal functions (1).

The surgical techniques used for the treatment of this pathology are of two types: classic operations and operations that use synthetic materials (2).

Classic operations

These operations use the patient's own

structures to restore the anatomy of the pelvic floor, which they tension through different techniques (3). There are many postoperative recurrences, which can be explained by using the same weakened tissues of the patient to solve a pathology that is based precisely on the weakening of the means of support and suspension (4).

Although classical operations are widely used, surgeons are familiar with these techniques (5), the multifaceted nature of postoperative results, requires comprehensive evaluation of surgical techniques and patient-specific factors (6).

Operations using alloplastic material

These operations replace the affected

ligaments and fascia with solid materials capable of restoring their function (7). Synthetic materials that can be tolerated by the human body were developed after 1990, as was laparoscopy, allowing the invention of new techniques with increased effectiveness (8). The most used alloplastic material is polypropylene, which is immunologically inert (9).

The best results were obtained with monofilament nets and with macropores of 100-150 μ , weighing less than 20g/m² (light mesh) (10).

After the implantation of an alloplastic material, the tissues show a reaction to this foreign body by invading the table with macrophages that synthesize collagen and glycosaminoglycans, forming a resistant scar tissue, comparable to a neoligament (11).

The optimal methods of inserting these synthetic materials are still hotly debated among different surgical schools.

Anterior compartment surgery

The operations that are practiced for the restoration of the anterior compartment have in mind the reconstruction of the pubourethral, external urethral ligaments and the suburethral fascia (12).

Classic surgery

Kelly operation - The operation consists of folding the urethra to reduce its diameter followed by folding the pubovesical fascia in order to increase the support of the urethra and bladder and can be practiced both for the treatment of stress urinary incontinence and for the treatment of cystocele (4).

The Burch operation - The Burch operation has a pathogenic correction mechanism because it raises the urethrocytic junction in the abdominal area, and can be successfully practiced in the case of patients in whom repeated mounting of a suburethral band did not resolve stress urinary incontinence (13).

Direct urethrocystopexy (Pereira or Dan Alessandrescu operation) - The operation anchors the urethrocytic junction to the aponeurosis of the external oblique muscle through a digital retropubic groove, achieving a satisfactory angulation of the urethra (14).

Surgical techniques using alloplastic material

These techniques are increasingly used, the polypropylene strips mounted suburethral succeeding in reconstituting the physiological mechanism of occlusion by loosely anchoring the middle third of the urethra and vectorially optimizing the ligamentous apparatus supporting the urethra (15).

Retropubic suburethral tape (TVT - TransVaginal Tape)

In 1988, Petros and Ulmsten mounted the first retropubic suburethral strip – a retropubic tunnel is re-established between two incisions and the suprapubic skin, traversing the Retzius space, the aponeurotic layer and the subcutaneous cellular tissue (16). Each free end of the strip is inserted through a retropubic tunnel and is exteriorized at the level of the suprapubic skin incisions (17).

Tissue Fixation System for the Treatment of Stress Urinary Incontinence (SUI)

Neoligaments are created by impregnating synthetic strips with collagen that are inserted suburethral and that are fixed to the surrounding tissues by means of anchors (18).

With the help of this system, the pubourethral and external urethral ligaments can be reconstructed in the anterior compartment. Neoligaments are created by impregnating synthetic strips with collagen that are inserted suburethral and that are fixed to the surrounding tissues by means of anchors (19).

Transobturator suburethral tape (TOT – transobturator tape)

The technique of mounting the transobturator suburethral band was first described by Delorme in 2001(20) and involves passing the suburethral band through a space devoid of vascular, nervous or visceral structures, which is found between the fascia of the levator ani muscle - cranial, the perineal membrane - inferior, the obturator hole - laterally and the paraurethral space with the urethra - medially. The transobturator urethral suspension is looser than the retropubic one (21). Thus, the position and orientation of the suburethral fascia covering the urogenital hiatus, behind the urethra, from one puborectal muscle to the other, is imprinted on the suburethral tape (22).

As recommended by Petros and Ulmsten, the strip is positioned exactly at the level of the middle third of the urethra (16).

The advantages of the transobturator fitting of the suburethral band are: reduced risk of vascular, nerve and visceral injuries (20); urethral obstruction is less likely than with retropubic band placement.

Surgery of the middle compartment

The pelvic static disorder that occurs in the middle compartment is anterior vaginal prolapse, also called cystocele (23).

Classic surgery

Anterior colporrhaphy

The purpose of this operation is to strengthen the pubocervical fascia (24). The vaginal mucosa is dissected from the pubocervical fascia (25). The dissection continues laterally towards the fundus of the vaginal sac and proximally to the vaginal dome (if the patient has a hysterectomy) or to the cervix (26). The pubocervical fascia is folded with slow resorbable thread. Overstretching of the fascia can cause kinking and obstruction of the ureters. Suture of the vaginal mucosa with absorbable thread (24).

Surgical Techniques using alloplastic material

Surgical reconstruction with anterior four-arm "H" mesh

Through this operative technique, the pubocervical fascia is reinforced with a polypropylene mesh (131). The fitting of the posterior arms of the mesh is done differently, depending on whether or not there is uterine prolapse or vaginal vault prolapse. If there is no uterine or vaginal vault prolapse, the posterior arms are still passed transobturator, the skin incisions being made 1 cm inferior and 1 cm lateral to the previous skin incisions. If there is uterine prolapse, the anchoring of the posterior arms is done by suspending them to the sacrospinous ligaments, after their previous laterocervical passage. An Overholt laterocervical forceps is inserted, from posterior to anterior, from the level of the incision made on the posterior vaginal mucosa and with the externalization of the tip at the level of the anterior vaginal wound. The end of the posterior arm is grasped and by extracting the

forceps, the mesh fragment appears at the level of the posterior vaginal wound. The posterior arms of the mesh anchor to the sacrospinous wires that have already been passed at this level. The sacrospinous threads are knotted. By passing the posterior laterocervical arms and anchoring to the sacrospinous ligaments, the paracolposus is recreated, with its important role of vectorial interconnection of all the supporting mechanisms of the pelvic organs. If the anterior vaginal prolapse is associated with vaginal vault prolapse, anchoring to the sacrospinous ligaments of the posterior arms of the anterior mesh is also practiced, with the aim of restoring the vectorial disposition of the affected ligamentous structures. Dissect on the finger up to the ischial spines then continue posteriorly, palpating the sacrospinous ligaments bilaterally. With the help of the viper, a non-absorbable thread is passed bilaterally, 2 cm posterior to the sciatic spine. The posterior arms anchor to the sacrospinous threads.

Surgery of the posterior compartment

Posterior compartment defects occur through ligamentous defects involving the three DeLancey levels, the cardinal and uterosacral ligaments, the rectovaginal fascia, and the tendinous center of the perineum, leading to uterine prolapse and/or posterior vaginal prolapse (27).

This pathology has not benefited from pathogenic treatment in classical surgery, which only offers excisional techniques, which treat only the effect of pelvic static defects, not the causes.

Petros thought of uterine prolapse as a hernia in a weak area of the lower part of the abdominal cavity and made an analogy with hernias of the anterior abdominal wall where, in the absence of complications, the herniated organs are not removed but the parietal defect is restored (28).

Classic surgery

Currently, despite the high percentage of complications and recurrences, classical techniques are used for the surgical treatment of posterior compartment defects.

Classic hysterectomy

Vaginal hysterectomy

Surgical treatment of vaginal vault prolapse

The most used technique is the Amreich–Richter operation (29).

Colpocleisis - It is indicated for elderly patients, with multiple biological hardships and who do not have a sexual life. Through this operation, the vagina is obliterated, leaving only two lateral channels through which the vaginal secretions are eliminated. The most used procedure is Neugebauer–Le Fort partial colpocleisis (13).

Posterior colpoperineoraphia

It is a surgical technique to resolve the rectocele (13).

Surgical cure of rectocele with „posterior” bridge - This technique, which corrects De Lancey level 2, uses a homograft, made from a fragment of deepithelialized mucosa that plugs, thus reducing posterior vaginal prolapse (30).

Surgical cure of elythrocele - McCall's Culdoplasty is the most used procedure and has the best results in the correction of enterocele (31).

Restoring the tendinous center of the perineum - It is carried out by the plasty proposed by Goeschen, which has a pathogenic justification by restoring level 3 De Lancey. This technique is performed in addition to an operation to restore the posterior compartment (32).

Surgical techniques using alloplastic material

With the improvement of synthetic meshes, a multitude of procedures were proposed for the reconstruction of the posterior compartment without being able to impose a specific procedure.

Posterior intravaginal band - This operation aims to reconstruct DeLancey level I, cardinal and uterosacral ligaments. The technique consists of inserting a polypropylene strip with the help of a tunneler passing through the ischiorectal, pararectal and translevatorial fossa, so that the final position of the strip is approximately transverse, parallel to the interspinous line and located approximately 1 cm posterior to it. On the median line, it is attached to the posterior face of the cervix, at the level of the insertion on the neck of the uterosacral ligaments, or on the posterior face of the vaginal stump (33).

The main shortcoming of this technique is that it does not also correct the posterior vector component, but only the lateral one. The lack of pathophysiological correction is also reflected in the modest postsurgical results. The most common cause was anterior migration of the band through tearing of the fibers of the levator ani muscles.

Posterior intravaginal band with bilateral sacrospinous fixation

This technique is actually a modified Amreich–Richter operation that reconstructs the main supporting ligamentous elements of the posterior vaginal fornix and cervix: the cardinal and utero-sacral ligaments (34).

Anchoring is done only by digital identification of the ligaments, bilaterally and without the wide dissection specific to the classical operation. Passing the thread is done with the help of a tool invented by Prof. Dr. Klaus Goeschen – vaginal viper (35).

Posterior Compartment Tissue Fixation System - Restores the vectorial role of the uterosacral ligaments (LUS) and cardinal ligaments, successfully correcting posterior compartment defects (13).

Restoring the tendinous center of the perineum with the TFS technique (13) - Dissect the vagina from the rectum and laterally identify the separated fragments from the tendinous center of the perineum. With a curved needle loaded with resorbable thread, the two tendinous fragments are identified, each end being clamped with forceps. With the help of scissors, a small tunnel is created on each side, passing through the tendinous and medial portion of the deep transverse perineal ridge. The TFS applicator is inserted through this channel and the anchor is fixed in the muscle thickness. The same is done contralaterally.

The band is tensioned until a tension is felt, at which point the two dislocated fragments of the tendinous center will return to contact.

LAPAROSCOPIC TECHNIQUES

Laparoscopic sacrocolpopexy

This surgical technique fixes the vaginal vault to the anterior longitudinal ligament of the sacral promontory by means of a polypropylene

mesh, with reported success rates ranging from 74–98% (36).

Laparoscopic hysteropexy – the Oxford procedure

For uterine prolapse, the most frequent operation was represented by vaginal hysterectomy over time, but with the advent of the Integral Theory, its criticisms also appeared because it treats the effect and not the cause of the prolapse, excising an intact organ (37). Surgeons have invented other techniques to solve the cause of uterine prolapse either by folding the uterine suspensory ligaments or by suspending the uterus with alloplastic materials (hysteropexy).

This operation has the advantage of restoring the normal position of the uterus by strengthening its suspension means using a Y-shaped polypropylene mesh whose arms will be fixed around the cervix and the end will be fixed to the anterior longitudinal ligament of the sacral promontory (37).

Hysteropexy with lateral fixation

During the years of surgical practice I have made three observations that I consider important and that have contributed to the development of the laparoscopic hystero/colpopexy technique - procedure with lateral fixation.

The first observation was that laparoscopy offers good visibility and intraoperative exposure allowing accurate tissue dissection, without significant intraoperative bleeding, without surgical wound complications (which are common in classic abdominal wall surgery), the laparoscopic approach being preferable in patients obese; patients operated laparoscopically recover faster than those operated classically and the postoperative scars are tiny.

The second observation was that non-resorbable prosthetic materials provide increased resistance over time through the persistence of the implant which constitutes a skeleton on which the connective structures are reorganized.

The third observation was that when an implant is used to improve pelvic static it must be anchored to tissues with increased resistance (periosteum, sacrospinous ligament, anterior sacral ligament), which is not influenced by the decrease in estrogen levels.

The technique is similar to the Dubuisson procedure, the recently appeared procedure, but

presents specific modifications (38).

Operating times

Patient in Trendelenburg position. The lower limbs will be positioned in abduction. A Foley urethro-vesical catheter is inserted. Pneumoperitoneum on Veress needle.

Fitting the trocars: optical trocar - umbilical; working trocars: one suprapubic trocar and one trocar in each flank.

Cranial mobilization of intestinal loops

Dissection of the vesico-vaginal peritoneum near the cervical-isthmus junction, descending anteriorly in case of the existence of a cystocele.

A polypropylene strip is inserted that is fixed with absorbable fixing means (AbsorbaTack) or with separate threads on the anterior face of the uterine isthmus, and laterally this mesh is pulled bilaterally with forceps inserted through the inguinal canal following the path of the round ligaments and fixed to the aponeurosis the anterolateral muscles of the abdomen.

The mesh is covered by suture of the peritoneum with slow resorbable thread.

Skin suture.

Discussions

We performed a prospective study on a group of 327 patients diagnosed with various pelvic static disorders. This study had 3 objectives: optimizing the surgical resolution of pelvic static disorders by comparing the results of the different surgical techniques used; presentation of personal experience in the surgical treatment of uterine and vaginal vault prolapse using the hystero/colpopexy technique with bilateral lateral fixation of the uterus or vaginal vault, a technique developed in the Surgery Clinic of SCJU Constanța; studying the major causes that determine the installation of pelvic static disorders.

The fact that the methods of surgical treatment of static disorders are so numerous proves that an infallible technique of adequate restoration of the pelvic floor support apparatus has not yet been found, which is why I wanted to contribute my experience to solving this very common pathology.

The predisposing factors of pelvic static disorders are: the presence of hereditary

antecedents of pelvic static disorders and the coexistence of hernias, hernias, hemorrhoids, hydrostatic varices (denotes a congenitally weak quality of the ligamentous system of pelvic suspension and support; administrative category of residence (for for patients from rural areas, access to medical assistance is more difficult and the lack of education delays presentation to the doctor); obesity (through increased pressure on the pelvic organs); occupation (exercising jobs that require sustained physical effort increases the pressure on the pelvic organs and the pelvic floor); diabetes through hypoperfusion of the pelvis and pelvic support apparatus.

The determining factors of pelvic static disorders can be divided into three categories: hormonal factors (age at menopause and number of pregnancies); obstetric factors (number of vaginal births and obstetric complications) and surgical factors (pelvic surgery, especially that involving total hysterectomy and vaginal surgery by excision of excess vaginal wall). In the study, the prevalence of pelvic static disorders correlated with all of these factors.

We believe that the preoperative assessment of the patient, including the anamnesis, the general clinical examination, the paraclinical examinations is essential for formulating a complete diagnosis, both of the pelvic static disorders that she presents and of any associated pathology, which may be involved in the occurrence and their evolution.

Optimizing the surgical treatment of pelvic static disorders must take into account the following criteria: the patient's age, the presence of comorbidities, the patient's symptoms, the clinical diagnosis, the patient's preferences, the logistics of the service and the experience of the surgical team.

Pelvic static disorders do not endanger life, but affect the quality of life of patients, therefore their correction is a functional surgery, which requires a good postoperative functional result, essential in order not to affect the quality of life. If the postoperative result is not the expected one, aggravates the symptomatology or creates new symptoms, altering the patient's quality of life, conflict situations can be reached, some even with medico-legal implications. Therefore, it is mandatory to correctly inform patients

preoperatively about the possibility of such complications, followed by obtaining informed consent for surgical intervention.

If a patient presented simultaneous damage to several compartments of the pelvic floor, their resolution took place in the same operative session, thus avoiding the aggravation of pre-existing pelvic static disorders or the postoperative appearance of new ones.

For the surgical treatment of stress urinary incontinence, the most effective and safe method and which has a positive impact on the quality of life is the fitting of a suburethral band through the TOT procedure or the TVT procedure. I recommend the TOT way of mounting the band because it has a low risk of immediate intra- and postoperative complications and the operating time is shortened, as it is not necessary to check the extravesical passage of the tunnelers by intraoperative cystoscopy. The TVT way of mounting the suburethral tape will be used only in the case of recurrent urinary incontinence or in the case of patients with an occupation that requires great physical effort.

The optimal surgical treatment of cystocele is represented by anterior colporrhaphy in the case of sexually active women because, although recurrence is more frequent than in techniques using synthetic meshes, the percentage of postoperative dyspareunia is lower, ensuring a better quality of life. The four-arm anterior implant, which restores the pubocervical fascia, is recommended per primam for sexually inactive patients. Sexually active patients who relapse after the native tissue technique are also recommended the anterior four-arm implant.

The optimal surgical treatment of uterine prolapse involves the use of a technique that preserves the uterus and cervix, an element that provides insertion to the supporting and suspensory fascia and ligaments of the pelvic floor. Hysterectomy will only be used if there is uterine or cervical pathology. The hysterectomy will preferably be performed transabdominally using the laparoscopic technique or, when laparoscopy is not practicable due to a history of multiple abdominal surgery, the classic hysterectomy technique will be used. In elderly patients, in whom abdominal surgery was risky due to the precarious biological status, we used vaginal

hysterectomy. Whenever possible, we preserved the uterus and cervix, the operative approach for the correction of uterine prolapse being either transabdominal or vaginal. The transabdominal interventions performed were represented by two laparoscopic techniques: hysteropexy by the Oxford procedure and hysteropexy by the lateral fixation procedure developed in the Surgery Clinic of SCJU Constanța, a technique that was used for most patients. In the case of elderly, hardened patients, without pathology of the body or cervix, we had two situations: in patients who wanted to continue their sexual life, we applied the technique of fixing the cervix to the sacrospinous ligaments bilaterally using synthetic meshes, and in sexually inactive patients, we practiced an obliterative technique, colpocleisis. Comparing the techniques used for the correction of uterine prolapse, we came to the conclusion that laparoscopic techniques are the best due to the fact that we had the fewest intraoperative and immediate postoperative complications, the anatomical success rate was high, as well as the degree of postoperative satisfaction of the patients and the rate of relapse was very low.

Optimizing the surgical treatment of vaginal vault prolapse must take into account the following eventualities: advanced age, the presence of extragenital comorbidities, a history of multiple abdominopelvic surgeries and the patient's option to be sexually active. For elderly patients, with comorbidities and no sexual life, we recommended colpocleisis. In elderly patients, sexually active but who presented multiple comorbidities or had numerous abdominal operations, we practiced colposuspension at the sacrospinous ligaments bilaterally by means of synthetic meshes. For patients without significant comorbidities and who were sexually active, we used laparoscopic techniques (mainly colposuspension through the lateral fixation procedure and rarely sacrocolpopexy).

The surgical treatment of choice for rectocele was the technique that uses the own tissues (posterior colpoperineorrhaphy), avoiding the complications of the synthetic mesh implant. We obtained satisfactory results with this technique in terms of anatomical success that had a high rate and the patient's quality of

life, the dyspareunia rate being low, as well as the recurrence rate. In the patients who presented for a recurrent rectocele, we mounted a posterior band that we fixed to the sacrospinous ligaments, an operation that effectively corrected the rectocele (there was no case of recurrence one year after surgery), but which had an increased percentage of dyspareunia.

Patients presenting for correction of a rectocele recurrence will be recommended to accept the installation of a posterior tape fixed to the sacrospinous ligaments. This technique, although followed by a higher percentage of postoperative dyspareunia, ensures the maintenance of the rectocele correction, in the present study there was no case of recurrence at one year postoperatively.

The optimal surgical correction of the rectocele must also take into account the biological state of the patient as well as her desire to continue her sexual life or not. In most patients, we performed the McCall culdoplasty, an intervention preferred by sexually active patients, although it has a high recurrence rate. I practiced colpocleisis only in the case of elderly patients, sexually inactive and who presented important comorbidities.

Since many of the patients with pelvic static disorders showed damage to several compartments of the pelvic floor, we preferred to restore the anatomy and restore the physiological function in a single intervention, considering that the repair of a single compartment will lead to changes in forces that will weaken over time and the other compartments, requiring another surgical intervention.

Optimizing the surgical treatment of pelvic static disorders must also take into account the economic factor, therefore I think it is good that minimally invasive procedures and laparoscopic techniques are the main option of the operator. The advantages of these techniques are: short duration of the surgical intervention, short hospital stay, good and stable postoperative results, net improvement of the patients' quality of life, rapid postoperative socio-professional recovery and reintegration.

Intraoperative complications were few in number, most of the time in a lower percentage than those in the specialized literature. We

recorded no major intraoperative complications (major vascular injuries, nerve injuries, intestinal perforations). Urogynecological interventions in the antecedents of the patients were correlated with the increase in the number of intraoperative complications. Intraoperative complications were immediately recognized and promptly resolved, without jeopardizing the patient's subsequent evolution. Immediate postoperative complications were easily resolved and did not influence the outcome of the surgery. The percentages of occurrence of another pelvic static disorder, those of recurrence and those of erosion of synthetic meshes were also lower than those reported by other authors.

I frequently used synthetic meshes, both for the cure of stress incontinence (installation of suburethral strips) and for the correction of uterine prolapse (suspension of the cervix at the sacrospinous ligaments bilaterally), for the correction of prolapse of the vaginal vault (colposuspension at the sacrospinous ligaments), for the cure cystocele (anterior implant with four arms) or rectocele (mounting of the posterior band with fixation to the sacrospinous ligaments bilaterally). We have also used synthetic meshes in laparoscopic surgeries, for suspension of the uterine isthmus or for colposuspension either at the anterior sacral ligament (Oxford procedure) or at the aponeuroses of the anterolateral abdominal muscles (lateral fixation procedure). The recurrence rate of pelvic static disorders after surgical interventions in which synthetic meshes were used was lower than that in which the patient's own tissues were used for reconstruction. The percentage of synthetic table erosion was lower compared to the percentages reported by other authors. We observed that a higher number of table erosions occurred in elderly, diabetic patients with a history of urogynecological surgery. I believe that the preoperative preparation of the vaginal mucosa with estrogens contributes to avoiding the occurrence of erosions of the synthetic table, therefore I systematically recommend it to every patient who is to be operated on vaginally. In my experience, I noticed that the least erosions occurred after implants with meshes made of large-mesh polypropylene, which I adjusted according to the local anatomical conditions,

preferring to use as little synthetic material as possible.

We recommended to the patients the postoperative continuation of the estrogenic treatment for another 3 months for better healing, obtained by intensifying the synthesis of mature collagen that favors the increase in the thickness, consistency and elasticity of the vaginal mucosa.

We also observed that a long period of sexual abstinence (2 months) correlated with a small number of occurrences of mesial erosions.

We have developed a surgical technique to resolve uterine and vaginal vault prolapse: hystero/colposuspension – procedure with lateral fixation, which fulfills the four major goals of the surgical cure of prolapse: reduction of prolapse, lack of functional symptoms, patient satisfaction and avoiding complications. The technique is simple, requires a short operative time with minimal operative trauma, rapid postoperative recovery with a high degree of satisfaction in terms of quality of life and early socio-professional integration of the patients. This technique is preferable in the case of obese patients, where other types of operations are accompanied by important technical difficulties, intraoperative risks and additional postoperative morbidities. From an economic point of view, the application of this technique is advantageous due to the short duration of hospitalization, cheap postoperative medication and quick socio-professional integration.

I synthesized the optimization of the surgical treatment of pelvic static disorders by creating an algorithm that I applied constantly.

We identified the predictive factors of anatomical and functional postoperative success: removal of modifiable risk factors; good knowledge of pelvic floor anatomy; careful case selection; good preoperative preparation of the patient; choosing the most appropriate technique to solve the respective pathology; impeccable operative technique; extensive operative experience, which allows the immediate recognition of intraoperative complications and their rapid resolution; if a procedure that uses implants is chosen to solve the pelvic static disorder, the surgeon must know the intraoperative risks of their installation; the operator must have specialized training for each

synthetic mesh insertion technique; selection of the type of mesh based on its own characteristics and biomechanical properties; the way of inserting the implant is suitable for the repair of the respective defect, it being preferable that the tools used do not have an excessive size; the best operation is the first operation; if the patient simultaneously presents several pelvic static disorders, it is advisable that they be corrected in the same operative session; careful immediate postoperative care; continuation of local estrogen treatment 1 month postoperatively; physical and sexual rest for 2 months postoperatively; compliant patient.

Conclusion

Hhystero/colposuspension – lateral fixation procedure, which fulfills the four major goals of surgical prolapse cure: reduction of prolapse, absence of functional symptoms, patient satisfaction and avoidance of complications. The technique is simple, requires a short operative time with minimal operative trauma, rapid postoperative recovery with a high degree of satisfaction in terms of quality of life and early socio-professional integration of patients. This technique is preferable in the case of obese patients, where other types of operations are accompanied by important technical difficulties, intraoperative risks and additional postoperative morbidities. From an economic point of view, the application of this technique is advantageous due to the short duration of hospitalization, and rapid socio-professional integration.

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