Colporrhaphy anterior (Upper vaginal wall repair)

- **Operation Concept:**

Fusion of the lateral collapsed supporting tissue under the bladder floor to reduce a cystocele. This is not an incontinence operation.

- **Indication:**

Central Cystocele (protrusion of the urinary bladder into the vagina) with symptoms

- **Contraindication:**

Common Contraindications for an operation

- **Pre-operative Information for the patient:**

- Risk of a bladder lesion
- Postoperative incontinence
- De-novo-urge incontinence
- Painful sexual intercourse
- Success rate 78% (for the first operation)

- **Operation planning:**
  - Gynaecological examination with Vaginal- and Introitus-Ultrasound, Debarment of a lateral damage
  - Urodynamic Measurement: Clarification of apparent or hidden incontinence
  - An Arabin-Pessary could be inserted to correct a prolapse as an alternative to urodynamic assessment.
  - If the patient complains about a newly developed or worsening urge-ncontinence an additional incontinence operation is necessary.
  - Local application of oestrogen for four weeks prior operation, such as Ovestin Ovula 1x1
  - Perioperative antibiotic prophylaxis

- **Positioning of patient and cover:**
  Positioning of the patient in lithotomy position (dorsosacral position). Disinfection of the genital area up to the lower abdomen and emptying of the bladder with single-use catheter.

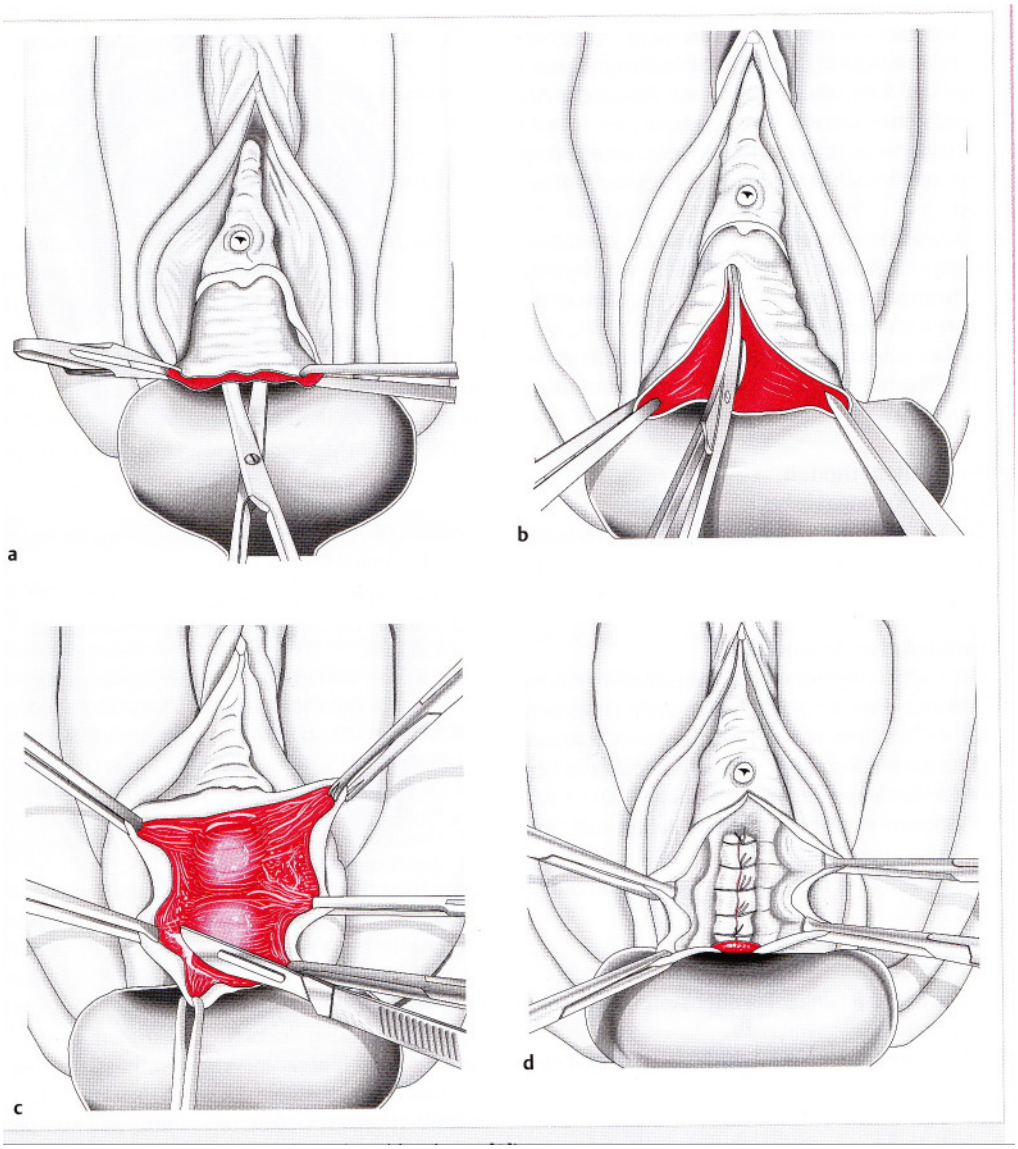
Operation technique

The colporrhaphy anterior can be performed prior to or after a vaginal hysterectomy. The procedure is principally the same.

- Positioning of the vagina, median kolpotomy. A weighted speculum is placed in the vagina to push the posterior vaginal wall forward to the sacrum. Grasp the anterior vagina close to the bladder at the end of the vagina close to the portio with two Kocher-clamps. Cut the wall of the vagina in the midline. Grasp both edges of the wound with two Allis-clamps.
- Dissection until the bladder neck. Undermine the vaginal wall from the underlying tissues in the spatium vesicovaginale with a combination of blunt and sharp dissection. (Picture a). Elongate the median colpotomy where you

underminded the skin and grasp the edges of the wound with Allis-clamps, too. (Picture b) This dissection should be performed until close to the bladder neck. Further preparation results in a functional disorder and is not necessary for the treatment of a cystocele.

- Separation of the cystocele. The assistant holds the Allis-clamps without pulling it laterally. Separate the cystocele from the vaginal wall carefully with the scalpel. (Picture c) Fascia of bladder and vagina stay with the urinary bladder. Dissection should be almost bloodless in the right layer. Where possible, use a gauze-wrapped finger.
- Mobilization of the lower bladder part. Suture. If you didn´t perform a prior hysterectomy you must mobilize the lower bladder part via preparation of the Septum supravaginale and if necessary you have to cut through the fascial envelope of the bladder. Grasp the lateral fascial envelope of the bladder with single button sutures (interrupted suture) to sink the cystocele. (Picture d) The sutures should be as far laterally as you can without perforating the vaginal wall. Remove redundant vaginal wall, but not too much to suture the anterior colpotomy tensionless with single buttons.



- Frequent errors and risks:
  - Dissection of the false layer followed by bleeding, haematoma, perforation of the vaginal wall and risk of bladder lesion. Correct stretching of the vaginal wall by the assistant (Don´t pull laterally)
  - Dissection too laterally until you reach the Cavum Retzii with its vein plexus. Increased risk of bleeding (even packing won´t stop it)
  - Extensive resection of the vaginal wall followed by wound dehiscence and coitus complaints

- Alternative methods:
  - in case of a laterally defect lateral colpopexia
  - Insertion of an anterior mesh (relapse situation)

- Postoperative treatment:
    - Tight packing of the vagina (soaked with Ovestin cream for painless removal) for 48 hours to avoid haematoma (promote relapse)
    - No lift of heavy weights (not more than 5kg) and no sexual intercourse
    - Don´t strain during defecation
    - Aftercare:
    - Local or systemic oestrogen
    - Pelvic floor exercises
    - Behaviour modification in lifting, carrying etc.