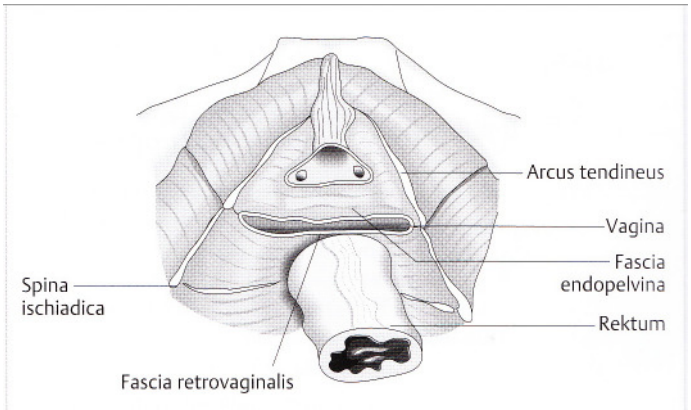
Lateral Colpopexy

- **Operation concept**
  - Reconstruction of the connective tissue anchorage of the lateral vaginal wall on the Arcus tendineus fasciae pelvis.



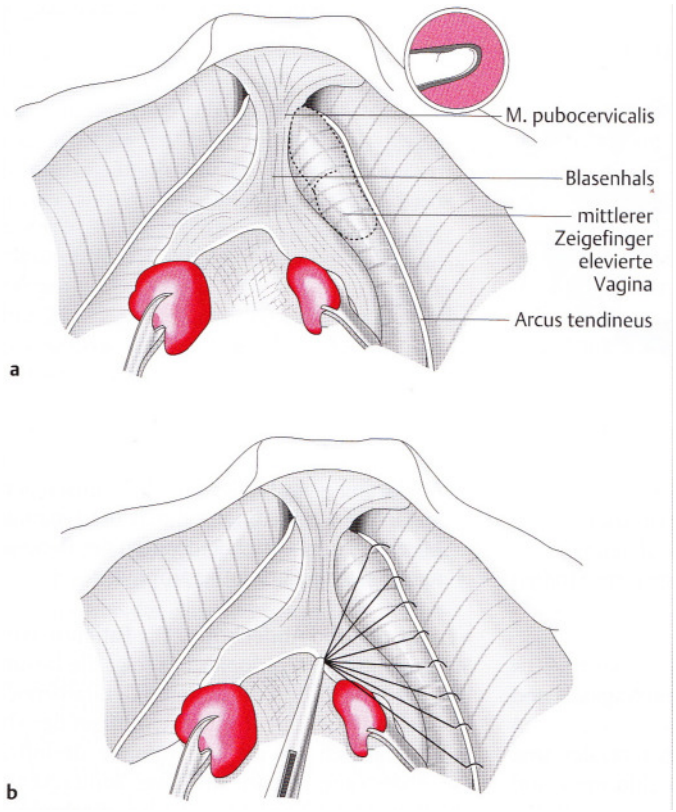
- **Indication:**
  - Vaginal access: symptomatic cystocele, which is caused by a lateral defect at level II after De Lancey (attachement of the vagina to the lateral pelvic wall in the region of the Arcus tendineus)
  - Abdominal access: often there is a descensus of the proximal urethra and the bladder neck, too, so that a kolpsuspension after Burch is necessary.
- **Contraindication:**
  - Common Contraindications for an operation
- **Pre-operative information for the patient:**
  - Risk of a rectum or bladder lesion
  - Increased rate of bleedings at vascular injury
  - No prospective-randomized studies for therapeutic success
- **Operation planning**
  - Gynecological examination with vaginal- and introitus-ultrasound
  - Differentiation between a lateral or central descensus (combinations possible)
    - Lateral descensus:
      - Flat folds of the vagina are preserved
      - Elapse, flatten and eversion of the lateral sulci
      - Disappearance or significant reduction of the cystocele in lateral elevation with the dressing forceps
      - Often combined with stress incontinence
    - Median descensus:
      - Flattening of the transverse folds
      - lateral sulci are preserved
      - elevation of the sulci doesn´t change the cystocele
  - Urodynamic Measurement: Clarification of an apparent or hidden incontinence
  - Perioperative antibiotic prophylaxis
- **Positioning of patient and cover:**

- Positioning of the patient in lithotomy position (dorsosacral position). Desinfection of the genital area. With new instrumentarium the abdominal area for laparotomy is then disinfected. The coverage starts with two leg sacks and a caudal cross cloth, which shields the anal region. Then the legs are lowered and two side cloths are fixed over the thighs laterally of the Spina iliaca anterior superior. Above the costal arch, the cranial cloth is fixed. Emptying of the bladder with indwelling catheter, which is blocked with 20ml balloon for a better identification of the bladder neck.

➢ **Operation technique:**

Laparatomy:

- **Abdominal cross-incision, preparation of the Space of Retzius (Spatium retropubicum).** Cross section laparotomy is performed in the usual way. In general, a cut length of 10cm is sufficient. The linea alba is divided down to the symphysis, the peritoneum stays closed. The Space of Retzius is preparated bluntly with fingers or a swab until you see the symphysis, the Mm. obturatorii, the Arcus tendineus (white line) and the bladder neck. The situs is presented well with two broad Breisky-specula. When the Arcus tendineus is not visible, the imaginary line between the lower edge of the symphysis and Spina ischiadica regarded as such.



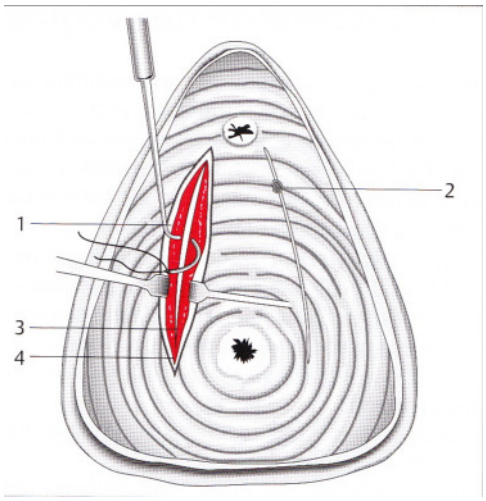
- **Representation of the lateral vaginal wall from vaginal.** The surgeon puts on a second glove on the left and presents the lateral vaginal wall at the area of the sulci with the index finger from vaginal.
- **Suture serie.** Creating a suture serie with atraumatic non-resorbable sutures starting near the Spina ischiadica to the lower edge of the symphysis (caution: bleeding!). The sutures are punched under digital control in the opposite lateral vaginal wall without perforating it. Each thread is initially captured with a Kocher clamp for a better overview. Are all the threads attached on

both sides, they are are knotted one by one. If the colpopexy is combined with a colposuspension or sacropexy, it makes sense, to perform these interventions prior lateral colpopexy.

- **Drainage:** The Space of Retzius is supplied with a Redon drainage and the laparotomy is finished as usual.

Vaginal access:

- **Positioning and cover.** Positioning of the patient in lithotomy position (dorsosacral position). Desinfection of the genital area until the undebelly and emptying of the bladder with single-use catheter. Two leg sacks cover the legs. Cranial a cloth is placed transversely across the underbelly. The surgeon sits in front of the patient and fixes a caudal cross cloth, which shields the anal region, one side over the patient, the other side with a tape on its own gown.
- **Presenting the situs and incision along the bladder neck**. Presenting the lateral sulci with a spreaded dressing forceps by lifting the anterior vaginal wall with the instrument against the pelvic wall. Along the so presented sulci a 4cm incision is performed at the height of the bladder neck. (catheterballoon palpable)
- **Mobilisation of the bladder, presenting of the Arcus tendineus.** The bladder is mobilised medially with the index finger and the Arcus tendineus and the Spina ischiadica are palpated on the lateral pelvic wall. After that the Arcus tendineus is presented with two Breisky specula.
- **Suture serie:** At the region of the Arcus tendineus several atraumatic, non-resorbable (2/0) sutures are laid. The most difficult part is the closeness to the lower edge of the symphysis. By firmly pulling the solid anchoring is tested. After that the needle should be inserted into the opposite lateral vaginal wall (fascia and muscle) without perforating it. Knotting only if all sutures are correctly placed. In the meantime the threads can be held by a Kocher clamp to keep a better overview.



- **Wound treatment, colporrhaphy anterior if cystozele.** Closure of the vaginal incision with resorbable single button sutures. (3/0) If there is also a central cystocele, the procedure described starts at the median colpotomy. Additional a colporrhaphy anterior is performed.

➢ **Frequent errors and risks:**

- Lesions of the Pudendus vessels close to the Spina ischiadica.
- Wrong postioning of the sutures on the lateral vaginal wall (for example too far posteriorly) Cross-folds in the posterior vaginal wall

➢ **Alternative methods:**
- suvesikal insert of a mesh with four point fixing. This is mainly in a relapse-situation a useful alternative

➢ **Postoperative treatment:**
- No lift of heavy weights (not more than 5kg) and no sexual intercourse
- Don´t push during defecation

➢ **Aftercare:**
- Local or systemic estrogen
- Pelvic floor exercises
- Behaviour Modification in lifting, carrying etc.