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Original Article

Term Pregnancy Following Uterine Prolapse Surgery, Literature Review and Case Presentation

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ABSTRACT

Objective: Herniation of the pelvic organs into or outside the vagina is what is known as pelvic organ prolapse (POP). This paper was prepared in order to offer a case report of our pregnant patient who reached term after undergoing this operation, as well as to conduct a literature review on the vaginally assisted laparoscopic sacrohysteropexy (VALSH) procedure, which is a new method in the surgical treatment of POP. Both of these goals were accomplished through the writing of this article.

Methods: A patient who 32 years old was admitted to our hospital with a palpable mass in the vagina. Because our patient was planned to get pregnant in the future, we suggested that she undergo a procedure known as VALSH, which is a uterus-preserving operation. The patient, who became pregnant spontaneously one year after the operation, had a healthy baby by cesarean section on at 38 weeks of gestation.

Results: We conducted a literature review on the vaginally assisted laparoscopic sacrohysteropexy procedure, which is a new method in the surgical treatment of POP. It is unknown what kind of surgical procedure should be used to treat POP in young women who are still of childbearing age. Studies have shown that young women have an increased chance of POP recurrence following surgical treatment; however, no studies have been conducted to investigate the effect of surgical POP repair on subsequent pregnancies and the kind of delivery that occurs during those pregnancies.

Conclusion: No signs of prolapse returning were detected during the tests conducted at the 6th week, 6th month of pregnancy, and the 12th month postpartum. We believe that the surgical procedure we utilized is an appropriate treatment for women of childbearing age who plan to become pregnant. The lack of prolapse recurrence indicates that the pregnancy can progress to full term without complications.

INTRODUCTION

Herniation of the pelvic organs into or outside the vagina is what is known as pelvic organ prolapse, or POP for short. It has been claimed that the prevalence rates of POP around the world range from 1-65%. There are not enough prevalence data available for POP, and the majority of the available prevalence data are based on symptoms rather than a physical examination.[1]

Women who have symptomatic prolapse have the option of having their condition maintained conservatively or being treated surgically for their condition. The options of conservative treatment and surgical treatment should both be made available to these patients. There is no data of sufficient quality available to compare these two methods.[2]

To restore anatomy with the least amount of morbidity and the lowest possible risk of recurrence, the appropriate surgery should be undertaken. The restoration of the pelvic floor can be done using abdominal, vaginal, or laparoscopic techniques, which are the three methods that have been presented thus far. However, in the majority of instances, hysterectomy does not repair problems linked to compromised pelvic support structures such as the uterosacral and cardinal ligaments. Hysterectomy is still regarded as the primary operation to correct uterovaginal prolapse.[3] In addition, there is a rise in the number of women who are opting out of having a hysterectomy because they are under the impression that the uterus plays a part in the level of sexual satisfaction one experiences.[4]

POP patients may undergo natural tissue healing, mesh operations, or minimally invasive surgical procedures as

part of their surgical treatment. Laparoscopic or robotic procedures for POP repair are currently experiencing a surge in popularity and are continuously undergoing development.[5] There is a wide selection of surgical therapies available, but there is no consensus on which one is the most effective.[6]

At this time, it is unknown what kind of surgical procedure should be used to treat POP in young women who are still of childbearing age. Studies have shown that young women have an increased chance of POP recurrence following surgical treatment; however, to this day, no studies have been conducted to investigate the effect of surgical POP repair on subsequent pregnancies and the kind of delivery that occurs during those pregnancies.[7]

This paper was prepared to offer a case report of our pregnant patient who reached term after undergoing this operation, as well as to conduct a literature review on the vaginally assisted laparoscopic sacrohysteropexy procedure, which is a new method in the surgical treatment of POP. Both of these goals were accomplished through the writing of this article.

MATERIALS AND METHODS

The laparoscopic and vaginal combination sacrofixation technique was initially described in 1999 by Godin et al.,[8] and its long-term effects have been discussed. On December 16, 2020, we carried out this procedure following the definition provided by Fayyad et al.,[9] and all three of the definitions provided by Sanverdi et al.[10] This procedure, planned for the patient who was brought into the operating room in the lithotomy position, was carried out. Following the completion of any necessary surgical operations, the operation will be divided into three distinct stages. The first and third portions were carried out using laparoscopic techniques, whereas the second section was carried out using vaginal techniques.

The placement of the laparoscopic ports was the first step, with the 10mm port being positioned umbilically and 2 or 3 ports being positioned laterally or suprapubically. At the beginning of the procedure, an incision was made on the sacral promontory, through the peritoneum. Under the peritoneum, a tunnel measuring five centimeters in length was excavated to reach the lower cervix from the sacral promontory. After that, the mesh was positioned on the surface of the promontory.

The procedure is now in its second stage, which has just begun. In the second part of the procedure, a vaginal semicircular incision was used to access the posterior cervicovaginal junction. This was done during the vaginal portion of the procedure. A retroperitoneal tunnel was constructed using the curved ring forceps to reach right adjacent to the promontory, and the peritoneum was perforated during this process. During the process of creating this tunnel, simultaneous laparoscopic visualization was carried out. The vaginal side of the mesh was then advanced towards the posterior cervicovaginal junction with the assistance of the constructed tunnel. This was done after the vaginal side of the mesh was carried into the abdomen with the assistance of a 10-gauge trocar. After that, the process of attaching the mesh to the cervix got underway. At this stage, in contrast to Fayyad et al.,[9] to protect the tissue integrity of the cervix, instead of performing cervical dissection, suturing was conducted by creating a tunnel at the 3 and 9 o'clock positions of the cervix. This was done to prevent the cervix from being cut open during the procedure. During the third and final stage of the procedure, the uterus was tightened laparoscopically, and on the promontory, four absorbable tuckers and four non-absorbable 0 prolene sutures were used to give fixation. After that, a peritonization procedure using an absorbable 3.0 polyglactin suture was carried out. After the bleeding was brought under control, the operation was finished. During the vaginal examination that was carried out on the first postoperative day, it was determined that the patient did not have a prolapse status.

CASE

A patient who was 32 years old and had a history of two normal spontaneous vaginal deliveries was admitted to our hospital with a palpable mass in the vagina. The patient's previous deliveries had been normal. According to the POP-Q staging system, the examination revealed that the patient had uterine prolapse at the stage 4 level. During the transvaginal ultrasound, the adnexa was examined, and nothing out of the ordinary was seen. Because our patient was of childbearing age and planned to get pregnant in the near future, we suggested that she undergo a procedure known as vaginally assisted laparoscopic sacrohysteropexy (VALSH), which is a uterus-preserving operation. The procedure was carried out as stated on December 10, 2021. The duration of the operation was sixty-three minutes. At the 36th hour after surgery, the patient was released from our care because there were no difficulties. In the controls that were performed at six weeks, six months, and twelve months after surgery, we did not find any instances of recurrence or any other complications.

The patient, who became pregnant spontaneously one year after the operation, had a healthy baby by cesarean section on February 22, 2022, at 38 weeks of gestation. The procedure was performed with the indication of oligohydramnios. During the pregnancy follow-up examination, the patient did not show any signs of prolapse recurrence.

The mesh that had been inserted in the prior procedure could be seen during the cesarean section (Figure 1). After a postoperative period of 48 hours, both the mother and the infant were released from the hospital.

RESULTS

When dealing with pelvic organ prolapse, surgical options are broken down into two distinct categories. One of them supports hysterectomy for female patients who

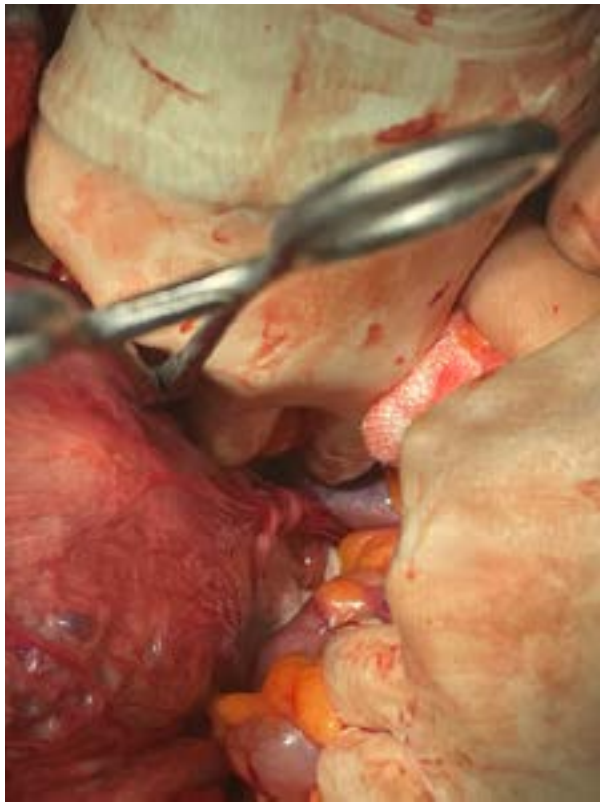

Figure 1. The mesh that had been inserted in the prior procedure could be seen during the cesarean section.

do not intend to become pregnant in the foreseeable future, while the other supports uterus-sparing surgery for female patients who do intend to become pregnant in the foreseeable future. In this particular instance, we opted for the VALSH procedure, which is a subtype of sacrohysteropexy and is one of the possibilities for surgeries that spare the uterus.

There was no evidence of a return of the prolapse in any of the examinations that were carried out during the sixth week of pregnancy, the sixth month, or the 12th month after delivery.

DISCUSSION

Currently, uterine-sparing procedures in POP are gaining popularity. The preferred surgical technique depends on the surgeon's experience, the patient's symptoms, age, comorbidities, the likelihood of pregnancy, and the desire to preserve the uterus.

The surgical technique VALSH, which is the subject of our article, is favored by the majority of surgeons due to its minimally invasive nature and low recurrence rate when literature data are followed. Since the cervix is surrounded by a membrane in the vaginal portion of our technique, its recurrence is anticipated to be lower than in other surgical procedures.

Even though it is an innovative method, it is preferable due to the decreased use of laparoscopic sutures and the fact that the majority of the surgery is conducted safely.

Reviewing the available literature, the operation was first conducted in 1999 by Godin et al.[8] In this study, 45 patients were examined, and control was attained six and thirty months after surgery. There was no recurrence of prolapse.

It was then presented in a retrospective study with 22 patients by Rae et al.[11] in 2003. At 12.5 months postoperatively, no recurrence other than cystocele was detected in 3 patients in this study.

Pechman et al.[12] presented a 2011 study comparing vaginally assisted laparoscopic sacrocolpopexy (VALS) and conventional laparoscopic sacrocolpopexy (LS) in patients undergoing concurrent hysterectomy. In this study, 44 patients underwent VALS surgery while 26 patients underwent conventional sacrocolpopexy. There was no significant difference between the complications and outcomes of the operation, and it was stated that the VALS operation required less time than the traditional sacrocolpopexy.

In 2012, Athanasiou et al.;[13] reported the postoperative 12-month outcomes of the VALS operation they performed on 27 vaginally hysterectomized patients, demonstrating that the patients' vaginal examinations improved in accordance with their anatomy.

Similarly, Zhu et al.[14] (2013) applied this technique to 21 vaginal hysterectomy patients and reported achieving 100 percent surgical success by evaluating the patients six weeks, six months, and twelve months postoperatively.

In 2014, Fayyad et al.[9] defined it. In this study, seventy patients with stages 3 and 4 uterine prolapse underwent vaginally assisted laparoscopic uterine sacropexy as surgical treatment. Patients completed the Prolapse Quality of Life Questionnaire (P-QOL) and were examined using the pelvic organ prolapse measurement system (POP-Q) preoperatively and postoperatively. The patients were evaluated three and twelve months after surgery. Sixty-four women (91.4%) reported relief in prolapse symptoms at 12 months postoperatively, and 67 women (95.7%) were determined to have POP-Q grade 0 or 1 uterine level at 12 months. Six women (8.5%) required additional surgical intervention for prolapse, three developed recurrent uterine prolapse, and the remaining three developed symptomatic recurrent anterior vaginal wall prolapse. The average vaginal length did not differ between the preoperative and postoperative periods. Two patients developed complications related to mesh. There has been an important reduction in prolapse symptoms and quality of life.

In 2014, Elvira et al.[15] shared a case series of 32 patients in a comparative study. In this study, 18 patients underwent VALSH surgery, while 14 patients underwent total laparoscopic sacrohysteropexy surgery. Although the duration and postoperative recurrence rates of both procedures are comparable, the study concluded that the VALSH procedure is safer and less invasive, which makes it preferable.

Liang et al.[16] evaluated the long-term outcomes of thirty patients in a case series after three years of follow-up. In almost all of the patients in this investigation, anatomical improvement and an increase in sexual function were observed.

Grigoriadis et al.[17] (2014) described VALS surgery in a single patient video report.

From June 2008 to July 2012, Nosti et al.[18] performed a study that was titled Transvaginal Versus Transabdominal Placement of Synthetic Mesh at Time of Sacrocolpopexy. This study was a retrospective cohort study with prospective follow-up for patients with uterovaginal prolapse who were undergoing laparoscopic supracervical hysterectomy (LSH-LSC). The results of this study were published in 2016. Participants in this research comprised 123 patients who had TVH-LSC performed, as well as 59 patients who had LSH-LSC performed. They discovered that patients did not vary from one another in terms of mesh-related issues, intraoperative or postoperative complications, or objective and subjective success. The only difference that warranted consideration was that TVH-LSC was linked with a noticeably shorter duration of time spent in surgery (256±53-344±81 minutes; P<0.01).

In the research conducted by Darwish and colleagues, the authors prospectively examined 15 patients to explore the viability, practicability, and efficacy of the vaginolaparoscopic sacrocolpopexy procedure, which they abbreviated as VLS.[19] The most important result is a postoperatively substantial improvement in prolapse, which in turn leads to an improvement in quality of life (QoL) after VLS. Six patients needed simultaneous reconstructive surgeries, and at the 6-month follow-up, the surgery was effective in 14 (93.34%) of 15 patients; however, one lady (6.66%) presented with recurrence at an earlier stage. Following the operation, there was seen considerable improvement in terms of vaginal symptoms, sexual well-being, quality of life, and clinical staging.

Aharoni et al.[20] published another comparison research in 2017. In this retrospective study, the short-term outcomes of 28 patients undergoing classical sacrocolpopexy (SCP) and 68 patients undergoing vaginolaparoscopic sacrocolpopexy (V-SCP) were compared. In addition, 11 of the patients who underwent classical laparoscopic SCP 3-7 years after the operation, and 40 of the patients who underwent V-LSCP, experienced a recurrence of the condition. One to five years after the operation, the patient was reevaluated and the long-term outcomes were examined. The short-term outcomes of the dual operation have demonstrated that it is faster without compromising patient well-being. A review of existing patients' long-term outcomes revealed that the subjective cure rate for Laparoscopic SCP patients was 73% and for combined operations, it was 88%. However, some degree of vaginal prolapse was observed in 82% (9/11) of Laparoscopic SCP surgeries, primarily cystocele or rectocele grade 1 or 2, whereas this recurrence was observed in only 30% of patients undergoing dual surgery.

Sanverdi et al.[10] presented a case series of 33 patients in which they conducted the operation in three stages as we did, however, they utilized the ascending retroperitoneal transfer approach. In these cases, there were no intraoperative complications, and no recurrence of prolapse was observed 12 months after surgery. VALSH is becoming more applicable as the peritoneal suturing is eliminated, as stated in a separate case report.[21]

Athanasiou et al.[22] shared the long-term outcomes of 114 patients with advanced POP who underwent VALS with at least 3 years of follow-up. The mean follow-up period is seven years (range: three to ten years), and the overall success rate of surgery is 95.7% (90/94). Failures (4.3%) included one (1.1%) case of anatomical recurrence (Bp: +1), one woman (1.1%), who reported vaginal swelling symptoms, and two women (1%) who underwent posterior colporrhaphy 6 and 12 months after the primary contains (2.1%).

In 2020, Tapisiz et al.[23] published an article that included a literature review and 20 cases. In this article, the authors emphasize the operation's viability and effectiveness. In numerous articles, the operation phases and short- and long-term outcomes are described. However, neither the pregnancy relationship nor its outcomes were specified. In a patient with uterine prolapse who was 12 weeks and 3 days pregnant, laparoscopic sacrohysteropexy was performed and only published as a case report.[24]

When it comes to prolapse procedures, we believe that the VALS procedure is one of the least intrusive and most simply applicable options. More research is required if we are going to have a better understanding of the connection between prolapse and pregnancy.

Informed Consent

Retrospective study.

Peer-review

Externally peer-reviewed.

Authorship Contributions

Concept: Ç.K.; Design: G.B.İ.; Supervision: Ç.K.; Fundings: E.B.; Materials: Ç.K.; Data: G.B.İ.; Analysis: E.B.; Literature search: G.B.İ.; Writing: G.B.İ.; Critical revision: E.B.

Conflict of Interest

None declared.

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Uterin Prolapsus Cerrahisi Sonrası Miada Ulaşan Gebelik, Literatür Taraması ve Vaka Sunumu

Amaç: Pelvik organların vajina içine veya dışına fıtıklaşması, pelvik organ prolapsusu veya kısaca POP olarak bilinen durumdur. Şu anda, henüz doğurganlık çağında olan genç kadınlarda POP'u tedavi etmek için ne tür bir cerrahi prosedürün kullanılması gerektiği bilinmemektedir. Bu yazı, bu ameliyatı geçirdikten sonra miadına ulaşan gebe hastamızı sunmak ve POP'un cerrahi tedavisinde yeni bir yöntem olan vajinal yardımlı laparoskopik sakrohisteropeksi prosedürü ile ilgili literatür taraması yapmak amacıyla hazırlanmıştır.. Bu hedeflerin her ikisi de bu makalenin yazılmasıyla gerçekleştirildi.

Gereç ve Yöntem: 32 yaşında iki normal spontan vajinal doğum öyküsü olan hasta vajinasında ele gelen kitle şikâyeti ile hastanemize başvurdu. Hastamızın doğurganlık çağında olması ve yakın gelecekte gebe kalmayı planlaması nedeniyle vajinal asiste laparoskopik sakrohisteropeksi (VALSH) olarak bilinen uterus koruyucu bir operasyon olmasını önerdik. Ameliyattan bir yıl sonra spontan gebeliği olan hasta, 38. gebelik haftasında sezaryen ile sağlıklı bir bebeğe sahip oldu.

Bulgular: POP'un cerrahi tedavisinde yeni bir yöntem olan vajinal asiste laparoskopik sakrohisteropeksi prosedürü ile ilgili literatür taraması yaptık. Şu anda, henüz doğurganlık çağında olan genç kadınlarda POP'u tedavi etmek için ne tür bir cerrahi prosedürün kullanılması gerektiği bilinmemektedir. Çalışmalar, genç kadınların cerrahi tedaviyi takiben POP nüksetme ihtimalinin arttığını göstermiştir; ancak bugüne kadar cerrahi POP onarımının sonraki gebelikler üzerindeki etkisini ve bu gebeliklerde meydana gelen doğum şeklini araştıran hiçbir çalışma yapılmamıştır.

Sonuç: Gebeliğin 6. haftasında, 6. ayında ve doğumdan sonraki 12. ayında yapılan tetkiklerin hiçbirinde prolapsus rekürrensine dair bir bulguya rastlanmadı. Uyguladığımız cerrahi yöntemin gebelik beklentisi olan fertil çağdaki hastalar için uygun bir teknik olduğunu düşünmekteyiz. Prolapsus rekürensinin olmaması, gebeliğin miada ulaşabilmesi ve komplike hale gelmemesi düşüncemizi desteklemektedir.

Anahtar Sözcükler: Prolapsus; term gebelik; vajinal yardımlı laparoskopik sakrohisteropeksi.