

## Original article

### Failed laparoscopic sacrohysteropexy in a patient with total uterine and vaginal prolapse after delivery with major pelvic floor defect

### Laparoskopická sakrohysteropexie u pacientky s kompletním prolapsem dělohy a defektem pánevního dna – selhání a následné řešení

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**Study objective:** The recurrence rate of pelvic floor surgery regardless of its type is higher in the group of patients with pelvic floor muscle injury (1). Data from randomized studies show that using native tissue repair in this group of patients poses a risk for anatomical recurrence of more than 60% (2). We deal with the appropriate choice for primary treatment and, in case of failure, the choice of secondary treatment. In recurrent prolapse patients the investigation should not only describe the current situation but also, if possible, ascertain the failed effect of previous surgery. This is especially important in patients with failed mesh surgery. The polypropylenes implants are hyperechogenic, which means they are easily visible as white objects or lines during the ultrasound examination. Imaging adds accuracy and confirmation to the performed clinical examination, because our examination skills are limited, focusing on surface anatomy, rather than true structural abnormalities (3).

**Design:** Longitudinal follow-up of patients with major pelvic floor trauma after failed laparoscopic sacrocolpopexy for uterine and vaginal prolapse. We present a second look laparoscopy after failed sacrohysteropexy. We also documented the location of the abdominal mesh by ultrasound, and during the re-operation we documented the localization of abdominal mesh from the vaginal approach, additional documentation from other similar case has been added.

**Settings:** It is a unique follow-up of a 36-year-old woman (BMI 20.4) with the large symptomatic prolapse after second delivery. POPQ (Pelvic Organ Prolapse Quantification) – Aa +3, Ba +8, C +8, Ap +3, Bp +8, Gh 7, Pb 4. She suffered major pelvic floor trauma during delivery, with bilateral avulsion and levator hiatus size 46 cm<sup>2</sup> on Val-salva. She doesn't want the uterus to be removed. We document by ultrasound the preoperative situation, and laparoscopic sacrohysteropexy was suggested as a first choice of treatment. Six weeks after the procedure she was asymptomatic with POPQ Aa 0, Ba +1, C +1, Ap -3. Three months after the primary procedure it became obvious that there was a failure associated with symptoms of prolapse and POPQ – Aa +3, Ba +5, C +5, Ap -2, Bp -2. We examined the patient with ultrasound to ascertain the position of the mesh. The mesh was attached to the cervix and spread on the anterior and posterior wall. On the anterior wall it did not reach the bladder neck, which means that it didn't reach all prolapsed part of the vagina (4). The patient requested further treatment, and we had to suggest a secondary procedure. As second line treatment the anterior and posterior mesh was chosen. The rationale behind this decision was the need to better support the anterior compartment; in our experience the currently available anterior meshes with sacrospinous fixation do not provide sufficient apical support in such a large prolapse and uterus on site. During the second procedure we provided second look laparoscopy to establish whether there was some explanation for the previous

unsuccessful surgery, such as inappropriate placement of the mesh, detachment from promontory, etc. There was no obvious problem. There were no adhesions, and the sacral arm of the mesh was in place, covered by peritoneum. By "palpation" with instruments we were able to ascertain the location of mesh at anchoring points. This again suggested that we should not provide re-sacrohysteropexy, because we were not able to identify how we could provide the procedure in a significantly different manner. During the vaginal surgery we documented the position of the previously inserted mesh on the anterior wall and in the posterior wall. We were able to identify its location and previous attachment. The arms of abdominal mesh were lying flat, and this was a good guide for the surgeon during the vaginal preparation for reaching correct layer. It was obvious from the anterior wall that the mesh was not covering the entire anterior wall; this correlated with previous ultrasound findings. There was a different situation on the posterior wall, where the mesh reached to the perineum. On the posterior wall we were able to dissect the previously inserted abdominal mesh and easily reach the space between this mesh and rectum to insert vaginal mesh and attach it again to the sacrospinous ligament. After the surgery we provided follow-up and monitored the position of the meshes and the interaction. Without the imaging it would be not possible to gain feedback as to how the surgery was performed and to distinguish the final localization of all implants. We include several other images of another similar case performed with the same approach with similar findings and the same successful solution. The follow-up after 3 month showed no symptoms of prolapse, incontinence or pain, no mesh exposition. POPQ Aa-2, Ba -3, C -2, Ap -3, Bp -3, Gh 4, Pb 5, TVL 9 and the situation remained the same at one-year follow-up. The patient has no subjective symptoms - PFDI (Pelvic Floor Distress Inventory) score – 0) absence of dyspareunia with PISQ 12 (Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire) score: 45.

**Conclusion:** We present a unique combination of imaging, second look laparoscopy and images of the localization of the previously-inserted mesh during vaginal surgery on a young patient with uterine and vaginal prolapse after delivery and failed laparoscopical sacrohysteropexy. The video shows how to deal with some of the recurrent cases which are a feature of daily praxis in many urogynecological units. We believe that detailed examination provides us with important information for providing correctly tailored reoperation for prolapse as successful and uncomplicated surgery.

**Key words:** laparoscopic sacrohysteropexy, pelvic floor defect, uterine prolapse, failed surgery, vaginal mesh

**Link to the Videopresentation** [click here](#) (additional content)

#### Disclosure/Conflict of Interest Statement

K. Svabik – received speaker fee from Astellas  
 J. Masata – no disclosure  
 P. Hubka – no disclosure  
 A. Martan – consultation for Gynecare, Bard, AMS, Astellas

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