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Female Urology: Update in Reconstructive Surgery: From Minis to Organ-Sparing Surgery

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Female Urology: Update in Reconstructive Surgery: From Minis to Organ-Sparing Surgery

E. Kocjancic

In the past decade female urology has experienced some major changes in the evaluation and treatment of common conditions such as stress urinary incontinence and pelvic organ prolapse. We have witnessed a shift towards less invasive procedures and organ-sparing surgery.

The concept of sparing organs is not new in medicine and there are several different reasons for organ-sparing surgery. The organ can be preserved in order to maintain its function, as for instance with kidney-sparing surgery, or psychological, as in the case of breast cancer attempts are made to conserve the body image.

In Pelvic Organ Prolapse (POP) surgery the reasons to spear the uterus are more complex and linked with patients' self-esteem, sexuality, and psychological background.

Hysterectomy is the most frequent gynecological operation after Caesarean sections and there are several reasons to perform it, the most important being uterovaginal prolapse correction.

However the effects of hysterectomy on the urogenital tracts are open to debate. Some reports say it is not associated with *de novo* or deteriorating urogenital tract symptoms while several other reports link hysterectomy with increased risk of incontinence and the need for incontinence surgery.

More specifically the role of hysterectomy in POP surgery is still debatable. Many surgeons believe hysterectomy prevents prolapse recurrence because uterus preservation may subject pelvic reconstruction to undue stress and increase the risk of prolapse recurrence. But hysterectomy alone often fails to address the underlying deficiencies in pelvic support that cause uterovaginal prolapse. Additionally hysterectomy and the associated pelvic floor dissection may increase the risk of pelvic neuropathy and disrupt natural support structures.

Another point to consider in patients counseling is that uterus preservation can expose the patient to potential pathologies as cancer. Epidemiology studies however are indicating that the risk of cervical cancer after subtotal abdominal hysterectomy is less than 0.1 % and the incidence of endometrial cancer is only 0.2 %.

The advantages of preserving uterus are: less blood loss, shorter operating time, fewer post-operative complications, and a lower erosion rate.

There are some controversies regarding the risk of erosion in concomitant POP repair with mesh material. According to Detyrac and other investigators hysterectomy may increase infection or graft erosion given the chance of contamination from vaginal microbes. In these different trials they showed significantly higher percentages of mesh erosion in patients treated with hysterectomy (13.6–27 %) compared with uterus-sparing surgery (0–4.1 %).

On the contrary two reports by Fedorkow and Brizzolara failed in showing any differences in mesh erosion rates regarding the concomitant hysterectomy.

Uterus preservation surgery can be performed with vaginal, open abdominal, laparoscopic, and robotic approach.

Costantini published recently the results of a long-term follow-up study of urogenital prolapse repair associated with uterus preservation. Authors showed that the surgery can be effective (vaginal prolapse of less than or equal to grade 2 and cervix and/or vaginal apex remaining well supported more than 6 centimeters above the hymen plane). Researchers also found that 82.97 % of the 47 patients were satisfied with the treatment results. None of the patients required further surgery and few patients reported persisting symptoms. Three patients reported persistence of voiding symptoms and 6 patients reported persistence of storage symptoms. Two patients reported *de novo* urgency and 4 reported *de novo* urinary incontinence. Sexual activity was maintained in 95.5 % of patients.

These findings are encouraging, because the procedures were so effective, and also because they help to dispel the myth that a hysterectomy is the only treatment for pelvic organ prolapse.

The data from the literature suggested that also on long-term follow-up uterus-sparing surgery is feasible and safe. The ideal candidates for this procedure are women without uterine or urogenital disease, usually aged between 40 and 60 years, who want to preserve their sexuality, have a marked self image, and are perceiving the procedure as an "amputation" and a loss.

Recommended reading:

Costantini E, Mearini L, Bini V, et al. Uterus preservation in surgical correction of urogenital prolapse. Eur Urol 2005; 48: 642–9.

Diwan A, Rardin CR, Kohli N. Uterine preservation during surgery for uterovaginal prolapse: a review. Int Urogynecol J 2004; 15: 286–92.

Maher C, Baessler K, Glazener CMA, et al. Surgical management of pelvic organ prolapse in women. Cochrane Database Syst Rev 2004 (18): CD004014.

Olsen AL, Smith VJ, Bergstrom JO, et al. Epidemiology of surgically managed pelvic organ prolapse and urinary incontinence. Obstet Gynecol 1997; 98: 501–6.

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