Surgery for urogenital prolapse

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Urogenital prolapse is a common distressing condition affecting 32-41% of women. There is an 11% lifetime risk of needing surgical correction of urogenital prolapse with a third of these women requiring further surgery. Surgical management should be individualised depending upon presenting symptoms and life-style. The aims of surgery in urogenital prolapse are to relieve symptoms, maintain or restore bladder/bowel function and maintain (or improve) sexual function.

The type of surgery depends on the compartment involved, age, medical fitness of the patient and the presence of associated gynaecological conditions or complications. The surgical routes of access may be abdominal, vaginal, perineal, anal or laparoscopic. Surgery for anterior compartment includes anterior colporrhaphy and paravaginal repair. Uterine prolapse is usually managed with vaginal hysterectomy although there are several uterus preserving procedures. Apical compartment prolapse maybe managed either by vaginal sacrospinous ligament fixation or abdominal sacrocolpopexy, with colpocleisis as a last resort. Traditional levator plication used in the management of posterior compartment prolapse is associated with high incidence of post-operative dyspareunia unlike the site specific fascial repair. There had been a growing trend toward use of mesh in the surgical management of prolapse without robust large research trials. Serious complications such as erosions, infections and dyspareunia have led to withdrawal of some mesh kits and questions raised about the use of mesh.