Letters to the Editor

Is Laparoscopic High McCall Colpopexy Effective in Treating Uterine Prolapse with Uterine Preservation?

To the Editor:

Vaginal hysterectomy remains the accepted surgical treatment for women with symptomatic uterine prolapse. However, in young women who wish to preserve uterine function and psychosexual satisfaction, preservation of the uterus is a prime consideration. To do this, several approaches have been proposed, including transabdominal and transvaginal routes.1,2

In transabdominal hysterocolposacropexy with Gore-Tex mesh and transvaginal uterosacral fixation, the cervix is attached to the sacrum or sacrospinous ligament, respectively.3 These repairs rely on support to the upper vagina that is functionally nonphysiologic. With the advent of videolaparoscopy, such minimally invasive surgery has been applied in field of the pelvic floor reconstruction. Laparoscopic sacral colpopexy was described as an alternative treatment for vaginal vault prolapse.4 Our previous work pointed out that laparoscopic high McCall colpopexy is technically feasible in women with uterine prolapse who desire to preserve uterine function or fertility.4 However, the long-term outcome remains to be determined. Subsequently, laparoscopic suture hysteropexy was described.5

From January 1996 through December 1999, 16 women (mean age 34.7 yrs, range 31–41 yrs, mean parity 1.9 births, range 1–3 births) with moderate to severe uterine prolapse were recruited. (Seven of these patients were described in our previous work.)5 The most common symptoms were interference with coitus, bulging mass while walking or straining, increased pelvic pressure or bearing-down sensation, and low back pain. Patients were examined in supine and standing positions, both with and without Valsalva maneuver, to determine the degree of uterine prolapse and associated pelvic relaxation. They were treated by laparoscopic high McCall colpopexy in conjunction with other procedures according to individual conditions (paravaginal repair, posterior colporrhaphy, shortening of round ligament, Burch colposuspension).

Laparoscopic techniques are available elsewhere.4 Briefly, both ureters were dissected from the pelvic brim downward to the level of endocervix. A no. 2 Gore-Tex non-absorbable suture with CV-2 needle and extracorporeal knot-tying techniques were used. Two to three purse-string sutures were placed through the uterosacral ligament-cardinal ligament complex to suspend the posterior surface of the cervix to the presacral area. After surgery the vaginal apex was attached to the sacrum over the third and fourth sacral vertebrae, which resulted in physiologic correction.

All patients withstood the procedures well without incident. Mean length of follow-up was 52.5 months (range 33–72 mo). Four patients were lost to follow-up. On review, 11 of the 12 remaining women had no symptoms of prolapse. This included two who subsequently completed term pregnancies and delivered vaginally. The only woman who failed colpopexy developed severe uterine prolapse in the second trimester of pregnancy. She had a cesarean delivery and then underwent total abdominal hysterectomy with sacral colpopexy as definitive treatment.

Laparoscopic suture hysteropexy was performed to treat urogenital prolapse and preserve the uterus.5 Over mean follow-up of 12 months, the procedure was successful in over 80% of women. Two women subsequently completed term pregnancies, delivered by cesarean section, and were without prolapse.

We found that with mean follow-up of 52.5 months, laparoscopic high McCall colpopexy is effective and safe in the management of symptomatic uterine prolapse. Most important, two of these patients had successful vaginal deliveries and remained without prolapse, emphasizing the usefulness of this procedure. Due to the limited number of patients, however, vaginal delivery after this procedure should be undertaken with extreme caution.

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References