

Start	End	Topic	Speakers
		Advantages and disadvantages of hysteropexy	Christopher Maher
		Manchester repair/ vaginal USL suspension-how to & evidence	Peter Dwyer
		Sacrospinous hysteropexy; how to; tips, how to manage complications; the evidence	Hugo van Eijndhoven
		Robotic sacrohysteropexy; how to, tips, options, how to manage complications	Elisabetta Costantini
		Laparoscopic hysteropexy; suture and graft; how to; the evidence	Matthew Izett-Kay

Aims of Workshop

To present the advantages and disadvantages of uterine conservation in detail. To present the different surgical techniques of uterine conservation in detail including native tissue and graft techniques both vaginal and laparoscopic/ robotic.

Learning Objectives

Understand the considerations in shared decision making re uterine conservation

Target Audience

Urogynaecology and Female & Functional Urology

Advanced/Basic

Advanced

Suggested Learning before Workshop Attendance

SOA ICS 2020-holly Richter -uterine preservation

Professor Peter Dwyer

Department of Urogynaecology

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MANCHESTER REPAIR/ VAGINAL USL SUSPENSION-HOW TO & EVIDENCE

The uterosacral/lateral cervical ligament complex is the cornerstone of apical support of the uterus, cervix and upper vagina and is an important element in the prevention of pelvic organ prolapse (POP). Loss of apical support will lead to uterovaginal and vaginal vault prolapse but is also a major etiological factor in most cystoceles and enteroceles. Anatomically, the ligaments act in unison not only to provide apical support but also the correct vertical orientation of the vagina and uterus to the bony pelvis and other pelvic viscera.

So what do women want? This may vary with their circumstances but all would want an operation that will treat their prolapse symptoms ideally for the rest of their life with a low risk of re-operation and a low risk of complications particularly life threatening or changing ones. They also may wish to retain their fertility and uterus; and normal sexual function.

In a recent study by Korby et al of patient preferences for uterine preservation and hysterectomy in women with POP, assuming outcomes were equal, 36% preferred uterine preservation, 20% preferred hysterectomy, and 44% had no strong preference. If uterine preservation was a less morbid option, the preference for uterine preservation was higher.

The Manchester repair (MR) was first performed in 1888 by Donald (1) with later modifications by Fothergill. Despite being performed for over a hundred years this procedure is having a renewal of popularity. The MR is currently not widely performed in USA but is becoming increasingly popular in Europe and is the operation of choice for uterovaginal prolapse in Scandinavia. The Manchester repair (MR) involves the clamping and mobilization of the UCC and their reattachment to the partially amputated cervix, usually with an anterior colporrhaphy. A racket shaped vaginal incision is made around the cervix to expose the UCC complex with reflection of the bladder off the cervix, the ligament is clamped and ligated and the 2 ends are sutured together to the anterior cervix with an overlapping figure of eight 2.0 PDS suture. The amputated cervix is reconstructed using anterior and posterior Sturmdorf sutures to re-epithelise the cervix. A video of the procedure will be shown (2).

In Norway Oversand (3) recently reported excellent results with a 5-year reoperation rate of 2.8% and low surgical morbidity. These results were corroborated in the current systematic review by Tolstrup. which reported a reoperation rate for MR of symptomatic recurrence of between 3.3-9.5% (4). Husby (5) was found the MR to have less recurrences compared to the uterine conserving sacrospinous hysteropexy and the vaginal hysterectomy. They compared 7247 operations for treatment of primary uterine prolapse and analyzed data from the Danish National Patient Registry. The authors found a higher reoperation rate and

anterior compartment prolapse recurrence in patients who had sacrospinous hysteropexy compared to MR. The 5 years reoperation rates for MR were 7% compared to 30% of sacrospinous hysteropexy and 11% of vaginal hysterectomy.

The MR is an effective low morbidity native tissue procedure with good long-term effectiveness which provides uterine conservation and possibly reproductive function if the cervix is conserved.

References.

1. Donald A: Operation in Cases of Complete Prolapse J. Obstet. Gynaec. Brit. Emp,1908: 13: 195-1
2. Walsh CE, Ow LL, Rajamaheswari N, Dwyer PL. The Manchester repair: an instructional video. Int Urogynecol J. 2017 Sep;28(9):1425-1427.
3. Oversand SH, Staff AC, Spydslaug AE, Svenningsen R, Borstad E. Long-term follow-up after native tissue repair for pelvic organ prolapse. Int Urogynecol J. 2014 Jan;25(1):81-9.
4. Tolstrup CK, Lose G, Klarskov N. The Manchester procedure versus vaginal hysterectomy in the treatment of uterine prolapse: a review. Int Urogynecol J. 2017 Jan;28(1):33-40.
5. Husby KR, Larsen MD, Lose G, Klarskov N. Surgical treatment of primary uterine prolapse: a comparison of vaginal native tissue surgical techniques. Int Urogynecol J. 2019 ;30(11):1887-1893

Hugo van Eijndhoven

Sacrospinous hysteropexy; how to; tips, how to manage complications; the evidence

Today, vaginal hysterectomy (VH) is still the gold standard to treat uterine prolapse. However, woman's attitude towards uterine sparing surgery has changed over the last decades and these surgical techniques have become more popular worldwide. At the same time, these changes can be challenging in both the consulting and operating room.

The sacrospinous hysteropexy (SH) is considered to be one of the more difficult vaginal operations. In a stepwise approach the operative technique will be presented. Use of surgical instruments, the anatomy, the access to the sacrospinous ligament and the optimal placement of the sacrospinous sutures will be discussed. Tips and tricks to avoid typical complications like bleeding and nerve entrapment will be shared.

The most important conclusion of the SAVE U trial (comparing SH and VH) is that the SH is at least non-inferior to the VH. Anatomical and functional outcome, recurrence risk and the most common complications described in this study and other relevant literature will be summarized.

"What a woman wants" will mainly depend on her individual belief and goals and on adequate counselling by the urogynaecologist. This and the other presentations of the workshop will provide tools to come to a fair process of shared decision making.

Elisabetta Costantini

Robotic sacrohysteropexy; how to, tips, options, how to manage complications

Pelvic organ prolapse (POP) surgery can be performed either transvaginally or transabdominally. The individual woman's surgical history and goals, as well as her individual risk for surgical complications, prolapse recurrence and de novo symptoms impact the selection of surgical route. Transabdominal procedures can be performed either by laparotomy or by laparoscopy. Several series have reported that laparoscopic approach to treat POP (with or without robotic assistance) is feasible and safe with good short and intermediate-term results, comparable to open approaches.

Hysteropexy to treat uterovaginal prolapse has a long history dating back to the 1800s and has gone through many changes. Recent literature describes vaginal, open abdominal and laparoscopic approaches and recently some study demonstrated comparable results using the robotic approach, with high cure rates.

The principal surgical steps will be presented through the use of videoclips, demonstrating how the procedure can be performed using the robot. In particular the knowledge of some surgical tips, described in the presentation, is the key to obtain the better results avoiding complications. The procedure is not standardized and some steps can be discussed in the light of the surgeon experience and expertise.

Matthew Izett-Kay

Laparoscopic hysteropexy

This presentation will provide an overview of the evidence base and technical approaches for laparoscopic hysteropexy from a unit that undertakes the procedure in high volumes.

There has been a global increase in rates of uterine sparing prolapse surgery and increasing recognition that apical support is a key component of surgical management even for those with predominantly anterior wall defects. Laparoscopic hysteropexy confers the advantages of uterine preservation, a minimally invasive approach, and complete access to the pelvic allowing for higher apical suspension than can be achieved vaginally. Despite its growing popularity, there is limited quality evidence to

support use and for the mesh augmented approach concerns about mesh associated complications are warranted.

The key literature addressing safety and efficacy of laparoscopic hysteropexy will be summarised, with comparison to surgical alternatives where appropriate. However, most of this session will focus on technical aspects including port placement, relevant pelvic anatomy, key surgical steps, and tips and tricks accrued over nearly two decades of refining the Oxford approach. This will be done through the use of surgical videos that outline a range of clinical scenarios. Common pitfalls, anatomical variants, complications, and repeat hysteropexy will all be covered as well as approaching complications associated with the technique.

We aim for attendees to leave familiar with the latest literature to facilitate decision making and patient counselling, as well as feeling confident to undertake the procedure and adapt to common challenges encountered.