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**TVT TECHNIQUE ON COMBINED OPERATIVE TREATMENT OF STRESS URORRHEA AND GENITAL PROLAPSE IN WOMEN**

**Introduction.** Stress urorrhea in women is one of the most frequent problems in urology and gynecology. The aim of this research is to estimate the efficiency of TVT operation on combined treatment of stress urorrhea and genital prolapse in women.

**Patients and methods.** We analysed the results of surgical treatment of stress urorrhea in 32 female patients operated on by TVT technique in gynecologic department of CPC in Surgut. All the patients were operated on by TVT technique (100%) in combination with hysterectomy, anterior colporrhaphy, posterior colporrhaphy and perineolevatoroplasty in 21,9% cases, in combination with anterior colporrhaphy in 62,5% cases

and in combination with posterior colporrhaphy, perineolevatoroplasty in 15,6% cases.

Urethropexy was performed by traditional technique with intraoperative cystoscopy. All the patients mentioned the high quality of living and the absence of urorrhea symptoms in postoperative period.

**Conclusions.** The efficiency of TVT technique urethropexy in combination with reconstructive – plastic operations on vagina and perineum is rather high. This operation allows to improve the quality of living in patients. Following the standards of pre-operative examination and the operation technique diminishes the number of intra- and postoperative complications.

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**THE COMPLETE MANAGEMENT OF PELVIC PROLAPSE BY LAPAROSCOPIC PROMONTOFIXATION & MODIFIED BURCH COLPOSUSPENSION**

**Introduction:** Genital prolapse is a common problem in women. About 50% of parous women are estimated to have some form of pelvic organ prolapse, with 10% to 30% requesting treatment of their symptoms. The wide variety of surgical techniques used to treat this problem demonstrate how difficult it is to manage. Laparoscopic surgery offers a new approach. It allows a good view of the anterior and posterior compartments so that a global approach for the prolapse is possible by the same surgical route. Laparoscopic promontofixation with synthetic mesh, combined with a approach to the posterior compartment by the posterior extension of the mesh, provides a complete range of treatment for all types of feminine genital prolapse and associated symptoms

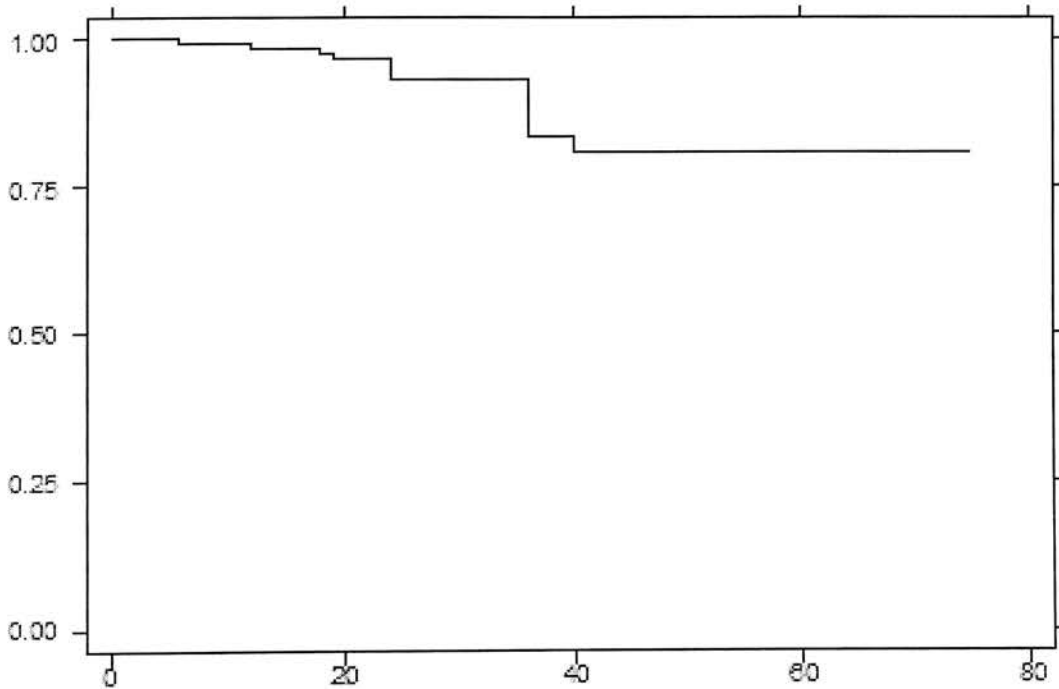
**Patients and operative procedure.** This was a retrospective study based on operations performed at our institution from January 1998 to December 2003. 138 patients with genital prolapse were operated laparoscopically. This laparoscopic technique follows the usual steps for pelvic prolapse repair. The first stage is the identification and preparation of the sacral promontory, including the fixation of the sigmoid colon by suture. The dissection from the posterior parietal prevertebral peritoneum is continued to the base of the right

utero-sacral ligament. The rectovaginal space is then dissected for sufficient space to reinforce the rectovaginal space with mesh. The vesico-uterine space is then opened for placement of the anterior mesh. A subtotal hysterectomy is performed in the majority of cases in order to better preserve the pericervical ring. A 4 x 30 cm polyester mesh is used. Posteriorly, it is applied to the levator ani muscles bilaterally, covering the vagina posteriorly, and fixed to the base of the uterosacral ligaments. The opposite end is applied to the vesico-uterine space, and fixed at three points, causing the mesh to be doubled over itself. Reperitonisation is performed so as to allow space for the folded end to extend superiorly towards the sacral promontory. This is then fixed to the sacral promontory. The upper reperitonisation from the promontory to the cul-de-sac is then performed. A modified Burch colposuspension is then performed with the installation of TfloatingY mesh for longevity. The procedure is completed with morcellation of the uterus.

**Results.** The median follow up was 31 months (range from 11 to 79 months) for 131 patients followed. 12 patients (9%) presented subjective symptoms (discomfort) of prolapse recidive. 7 patients (5%) presented mesh erosion.

**Comparative (anatomical) results for maximal level of prolapse**

	Pre-operative	1 month	Long term
Stade 0	0	80 (63%)	28 (26%)
Stade 1	0	37 (29%)	42 (39%)
Stade 2	2 (1%)	9 (7%)	26 (24%)
Stade 3	66 (50%)	1 (1%)	11 (10%)
Stade 4	63 (49%)	0	1 (1%)

**Prolapse recidive curve**

**Conclusion.** Laparoscopic promontofixation provided good long term support of the pelvic floor in 89%. Our experience confirms the tremendous potential of laparoscopic surgery for the treatment of all aspects of pelvic floor disorders by the same

route. Stress incontinence, cystocele, hysterocele, rectocele, or enterocele can be treated effectively and safely. However, the operative time is longer than with the open route, and the surgeon must be highly experienced.

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**THE ROLE OF CTD IN GENITAL PROLAPSE GENESIS**

**Background:** now the role of connective tissue displasia (CTD) in genesis of genital prolapse is known. Genital prolaps as nondifferentiated kind of CTD is a manifestation of generalized CTD on the level of reproductive system which develops in young unipara women after noncomplicated delivery without hormonal disorders and factors provided intraabdominal pressure increasing.

**Materials and methods.** First of all connective tissue defects are connected with altered synthesis of collagen. The immunohistochemical investigation of intraoperative samples: vessels and surrounding tissues,

pelvic fascia and ligaments was performed in patient with CTD to evaluate the morphological structure and quality of collagen content.

**Results.** 61,9% of 21 patients with CTD did not have macroscopic changes of examined tissues. The ISt and IIIId types of collagen were expressed in all patients with CTD but both collagens had atypical structure and did not form fiber funiculus. Instead of ISt and IIIId types of collagen a lot of IV type of collagen was expressed that realized in decreasing of elasticity of ligamental apparatus.

Clinical and constitutional signs of CTD were re-