

and were ligated together with a special modified fixator. By this way there were no periphreal contacts of sutures. Sutures were fixed above aponeurosis.

**Results.** In 20 (71,4%) pts in postoperative period we corrected the pulling of sutures for obtaining of maximal results. In 22 (78,6%) pts symptoms of incontinense absolutely disappeared. In 4 (14,3%) – symptoms redused significantly. Transvaginal ultrasonography and vaginal exam of all patients didn't revealed any rough scarring defects in postoperated area. The follow up of patients was 2 years. Complete rehabilitation was attained in 21 (75%) pts, in 5 (17,9%) pts incontinence decreased, in 2 (7,14%) pts incontinence after operation

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didn't reduced. Postoperative complications: blockage of urine and need in catheterization were marked in 4 (14,3%) pts, activation of urinary infection was found in 7 (25%) pts. Pain in pubic area – in 10 (35,7%) pts. In one patient (3,6%) there was the replace of incontinence due to straining exercise. Examined her we found the break of pubovaginal sutures.

**Conclusion.** Turndown from mobilization of anterior wall of vagina minimized the danger of development of dystrophic and scarring changes in vesico-urethral segments. The given method helps to form new anatomo-physiologic understanding between proximal urethra and pelvic diaphragma in short-term

## COMBINED SURGICAL TREATMENT OF CYSTO- AND RECTOCELE IN DESCENT AND ABASEMENT OF FEMALE REPRODUCTIVE ORGANS

**The purpose of study:** improvement of surgical treatment results of cysto- and rectocele in pelvic prolapse due to combined correction of anatomic and functional disorders using lesser invasive technologies.

**The material and study methods.** The results of treatment of 47 women with pelvic prolapse and complaints for uroclepsia in strain, astrictions, rectal dissatisfaction, incopresis, gas incontinence were analyzed, necessity of manual textbook in defecation (pelvic distention syndrome). Clinical, laboratory, ultrasound (including transvaginal), urodynamic, proctographical (including straining effort) and endoscopic investigations were carried out. According to indications and technique, surgical treatment was performed which included: loop urethroplasty (TVT and TVT-O), transvaginal sacrovaginopexy (LS MESH) and prolapse correction (front and dorsal vaginal hysterotomy, Shturm-dorf operation and so on).

The results were being studied from 3 months to 3 years after operation. At that questionnaires, clinical, laboratory and ultrasound investigations were used.

**The results of study.** From second day after opera-

tion in patients under investigation, the complaints connected with pelvic distention syndrome disappeared. First of all, the patients noted disappearance of stress incontinence and then problems connected with defecation act.

As a result of clinical and laboratory-instrumental investigation we did not educe the cases of backset of relapse and pelvic distention syndrome.

**Conclusion.** The optimal way for treatment of patients with pelvic prolapse complicated by cysto- and rectocele is combined operation which makes it possible to carry out correction of genital prolapse (including remodeling of pelvic floor) and to eliminate functional disorders of annexa. At that the best functional results are reached by means of loop urethronexy (TVT and TVT-O) and sacrovaginoplasty (LS-MESH). In addition, it is necessary to note that single-step prolapse correction, incontinence and disorders of defecation act using lesser invasive technologies, significantly decrease operational trauma, improve the results of surgical treatment, have high medical, social, economic effect and improve the quality of patient's life.

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## LESSER INVASIVE TECHNOLOGIES IN CORRECTION OF STRESS UROCLEPSIA IN PELVIC PROLAPSE

**The purpose:** improvement of results of stress uroclepsia treatment in women with pelvic prolapse using free synthetical loops from prolen (TVT, TVT-O).

**The material and methods.** The analysis of treatment of 132 women with pelvic prolapse and uroclepsia. All women were operated for prolapse and correction of incontinence. Control group consisted of 53 women

operated before who also suffered from prolapse and incontinence but surgical treatment was carried out only in respect of prolapse. Then these patients were operated in urological hospitals where the operation of Kraats in modification using short autodermal flap was carried out. The operations in patients of main group were performed in two stages. At first stage the cor-

rection of uroclepsia was carried out. At second stage elimination of prolapse was carried out. For correction of uroclepsia free synthetical loops TVT (in 112 cases) and TVT-O (in 20 cases) were used. The indications for usage of TVT and TVT-O were uroclepsia predominantly in strain of second type according to Mc. Guire in combination with pelvic prolapse. Intubation narcosis was used in all cases.

**Results.** Immediate and long-term results of operations were studied. The fates of surgical treatment were estimated as positive and negative. Positive results are the results when patients after operation can keep urine; negative results are the results when the operation did not affect and the patients had to use cappings. During 2-5 days of postoperative period positive results in main group were achieved in all 132 (100%) of patients. In these women natural urination was restored, uroclepsia symptoms disappeared. Ultrasonography was carried out in regard of all patients with the purpose of postop-

erative control; it discovered decrease of urethra size, absence of residual urine and basis of urocyt was situated higher; its pathologic instability disappeared – it is the result of prolapse correction.

The analysis of long-term results of operations comparatively in patients of main and control group showed that in patients of second group (according to data of retrospective) negative results were observed in 2 (3,7%) patients in 3 months, in 3 patients (5,7%) in 6 months, in 6 (11,3%) in 12 months and in more than year – in 3 (5,7%). Total number of backsets in patients of control group amounted to 14 (26,4%). As a result, operation with usage of free synthetical loops (TVT and TVT0) was effective in all 100% women who suffered from genital prolapse in combination with stress uroclepsia.

**Results.** Besides, the best results are achieved in accurate selection of patients and observance of surgical interference technique.

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## SURGICAL REPAIR OF VAGINAL VAULT PROLAPSE: COMPARING OF VAGINAL AND ABDOMINAL PROCEDURES

**Introductions.** Uterovaginal prolapse beyond the hymenal ring is always associated with multiple defects of pelvic organ support, which requires complex reconstruction of pelvic floor. Conventional vaginal repairs of enterocele and vault prolapse often do not prevent vaginal prolapse recurrences (Karram M., 1999). High uterosacral vaginal vault suspension with fascial reconstruction is aimed to repair all the apical defects, thus restoring the entire anatomy of apical support (Barber M., 2001).

**Objective.** To compare the results of abdominal sacrocolpopexy and vaginal high uterosacral vaginal vault suspension with fascial reconstruction for the uterovaginal and vault prolapse repair.

**Material and methods.** 62 consecutive women with III and IV stages of vaginal vault prolapse underwent one of the aforementioned surgical procedures during the period from 2001 to 2004. In group 1 (n=20) patients had posthysterectomy vault prolapse. In group 2 (n=42) advanced uterovaginal prolapse was observed. In the first group we performed abdominal sacrocolpopexy using Prolene mesh (GyneMesh PS), in the second group – vaginal hysterectomy followed by high uterosacral vaginal vault suspension with fascial reconstruction (J. Miklos, 1998). Also, we performed concomitant repairs of cystocele with reinforcement by the Prolene mesh, posterior colporrhaphy, levatoroplas-

tics, TVT or TVT Obturator where needed. The vaginal profile was evaluated according to a standard POP-Q system (ICS, 1996) before and 1 year after surgery. Complete objective cure was estimated as POP-Q point C stage 0, satisfactory cure result – stage I, and objective failure  $\geq$  stage II.

**Results.** The complete objective cure or satisfactory results were observed in 100% patients from group 1 and in 41 (97,6%) patients from group 2 (P=1,0). Indeed, complete objective cure was achieved in 19 from 20 patients in group 1 and in 31 from 42 in group 2. Objective failure (stage C II) was observed in only 1 patient in group 2. Among that, 2 recurrent cystoceles (stage Ba II) were noted in sacrocolpopexy group.

**Conclusions.** Vaginal repair of apical support defects by site-specific fascial reconstruction and high uterosacral ligament suspension has comparable results with abdominal sacrocolpopexy and could be used successfully in patients with advanced stages of uterovaginal prolapse, especially in those who require concomitant enterocele, cystocele and rectocele repair. Abdominal sacrocolpopexy is a highly effective method for post-hysterectomy vault prolapse correction, including recurrent cases. Randomised controlled trials are needed to obtain more evidence for choosing the surgical route and procedures in patients with advanced uterovaginal, vault prolapse and enterocele.