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THE EXPERIENCE OF GENITAL PROLAPSE TREATMENT AND URINE INCONTINENCE USING SYNTHETIC MATERIALS

Background: genital prolaps which developes especially in young unipara women after noncomplicated delivery without hormonal disorders and factors provided intraabdominal pressure increasing is a common manifestation of generalized connective tissue defect (CTD) on the level of reproductive system. The Ist and IIId types of collagen define mechanical structure of ligaments. The immunohistochemical investigations in cases of CTD showed sufficient expression of the Ist and IIId types of collagen but they did not form typical dimensional structure and were replaced of IVth type of collagen that led to altered mechanical characteristics of ligaments.

Materials and methods. The method of surgery in patients with altered uterine fixation was aimed on liquidation of uterine prolapse and prevention of its further reccurence. The basic surgery – hysterectomy- was added of vaginopexy with prolen transplantant (Gyne Mesh or Gyne Mesh soft). At 13,5% of patients with CTD MESH – vaginopexy was performed as the basic surgery. Also vaginal hysterectomy, anterior vaginl plastics using synthetic materials, TVT or TVT-O and other surgeries were made. 10 patients with CTD desired to save the reproductive function underwent nonradical surgery.

Results. The using of synthetic materials in patients with CTD is rational because of insufficiency of their own tissues, development of severe genital prolapse and high risk of reccurence.

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SACROVAGINOPEXY WITH PROLENE NET APPLICATION IN GENITALIA PROLAPSUS CURE

Introduction. In last decade life duration has increased, so women are concerned with keeping femininity and sexual potential. One of the most impedimental diseases is vaginal prolapsus, which can be accompanied with falling of the womb (28%). Among the gynecological patients having abdominal and transvaginal operations in 8-26% of cases one can see vagina cupola falling, vaginal prolapsus and fall vagina inversion with enterocele. In some cases it is connected with inadequate fixation of vagina stump. Patients suffer from accompanied urinary bladder falling and rectum prolapsus. The main complaints are boring pain and heaviness at the bottom of the belly, perception of foreign body in the genitalia area, incontinence of urine and gas, quickened urination.

Objective. The goal of the given research is studying of genitalia prolapsus operational cure results, near and distant ones.

Material and methods. 170 been operated patients at age of 35-78 (average age was 47) were under dynamic observation with complex examination during 5 years. All the examined patients were divided into 5 groups according to their pathologies. The first group consisted of 24 patients with vagina prolapsus and cysto- and rectocele. The second group consisted of 39 patients with incomplete womb falling. The third one – 98 patients with fall womb falling. The fourth one – 8 patients with womb stump falling after abvaginal amputation. The fifth group – 1 patient with vagina cupola prolapsus after abdominal womb extirpation.

A lot of ways of surgical correction of this pathology are well-known now (including laparoscopy), what is the witness of urgency of this problem at one hand, and insufficient effectiveness of surgical methods and disease high frequency recurrence at the other hand. According to the various researches data every third patient suffers from recurrence within the first three postoperational years. Searching for optimum technology of genitalia prolapsus cure we have implemented synthetic materials into pelvis fundus surgery.

For the sake of stump falling surgical correction after abvaginal womb amputation and correction of vagina cupola falling after womb extirpation, we made sacred bone colpopexy.

We used prolene net of GyneMech series with length of 8cm and width of 2 cm as fixing material.

The main steps of surgical interference we have outworked, are given below:

1. Patient is on her back in metotomic position. Two clamps are applied at the apex of vagina. If hysterectomy have been done earlier, sutures on the vagina apex are seen.

2. Vaginal celiotomy (PfannenstieFs incision, seldom – median incision).

3. After intestine abduction with moisturized cloths surgeon finds right ureter and rectosigmoid part of intestine. He makes the incision of parietal peritoneum down from the promontory of the sacrum, across Douglas space and vagina apex. Vagina places into peritoneum with the help of 4 cm in length obturator or spongy tampon on the oval clamp.

4. Fixing material (prolene net in our case) is sew-

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