

Editorial

Vaginal vault prolapse and enterocele represent challenging forms of female pelvic organ relaxation and usually associated with other pelvic organ defects. Vaginal vault prolapse has been defined by the International Continence Society as descent of the vaginal cuff below a point that is 2 cm less than the total vaginal length above the plane of the hymen.¹ It occurs when the upper vagina bulges into or outside the vagina.

Coexistent pelvic floor defects like a cystocele, rectocele or enterocele are present in 72% of patients with vault prolapse.² Prolapse does have a negative impact on these women's quality of life due to associated urinary, ano-rectal, as well as coital dysfunction. It is therefore important to counsel these women and carefully assess the defects of the various vaginal compartments before planning management. A clear understanding of the supporting mechanisms for the uterus and the vagina is important in order to make the right choice of the corrective procedure and also to minimize the risk of posthysterectomy occurrence of vault prolapse.³

The incidence of vault prolapse, which required surgical correction following hysterectomy is 3.6 per 1000 person-years of risk. The cumulative risk rises from 1% three years after a hysterectomy to 5% 15 years after hysterectomy. Also the risk of prolapse following hysterectomy is 5.5 times in women whose initial hysterectomy was for genital prolapse as opposed to other reasons. Some studies have reported an incidence of up to 43%.^{4,5}

Recurrence rates for surgical correction of pelvic organ prolapse are in rate 10% to 30% range.^{6,7} By analysing the different risk factors for developing severe pelvic organ prolapse, the previous surgery to correct prolapse was the single greatest risk factor.⁶ It appears that pathophysiology of the prolapse is not fully understood and the current practice for surgical correction of prolapse may be inadequate.

The surgical options for the correction of vault prolapse lie between the vaginal and the abdominal approach. The choice of procedure should be based on the patient's age, co-morbidity, previous surgery and the level of physical and sexual activity.⁴ Also the experience of the surgeon influences the choice of

operation. Importantly, greater awareness of the pelvic anatomy and the technique at the time of the original hysterectomy will significantly reduce the incidence of subsequent vault prolapse.³

Abdominal sacrocolpopexy with mesh interposition is widely accepted surgical method.^{9,10} Abdominal sacrocolpopexy employing retroperitoneal interposition of a suspensory synthetic, autologous or all graft prosthesis between the vaginal vault and the sacral promontory was first described by Lane in 1962. This method has proven to be superior to other surgical techniques in terms of restoration of the normal vaginal axis and maintenance of vaginal capacity and coital function. Consistent cure rate of more than 90% has been reported, with some studies reporting up to 95%. Mesh erosion following the use of polypropylene graft was reported to complicate 2–2.7% of cases.

Vaginal wall defect in varying degrees with divided opinion and debate amongst surgeons on completing it either vaginally or abdominally.⁸ There is no simple answer, but every patient has to be considered individually and the associated defects assessed properly, so that a clear plan of surgical repair can be agreed with the patient bearing in mind other factors like coital function.

There is no consensus on the mechanism and management of vault prolapse, but what is accepted by all is the need to properly assess these patients, involve them in the management and to agree on the type of surgery that will be suitable for their own peculiar circumstance. The mesh is gaining popularity, but there are no studies yet on its long-term efficacy though initial results are very encouraging.³

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