

Apical pelvic organ prolapse dilemma

Atef Darwish

The classic definition of apical prolapse is the downward displacement of the vaginal apex which is both the uterus and cervix or, in women who have undergone subtotal or total hysterectomy, the cervix or vaginal cuff. Nevertheless, enterocele which is a break in the integrity of endopelvic fascia at the vaginal apex should be included in the definition as it represents failure of level I support of the upper vagina and cervix or the vaginal cuff) by the cardinal-uterosacral ligament complex.

The etiologic dilemma of apical prolapse is likely related to failure to precisely define the exact cause of it. It may be connective tissue, neural, and/or muscular defects of female genital organ supports. Some authors suggested a genetic factor as a molecular etiology of apical pelvic organ prolapse (POP) due to diminished sacral nerve function and/or defects in collagen. Since the underlying cause is not always clear, treatment modalities are many.

A good practical clinical test is to grasp the cervix by a tenaculum to reduce the prolapse then asks the lady to bear down (Valsalva maneuver). If the uterus comes first (cervix first) this means that uterine supports should be overcorrect so cardinal ligaments or uterosacral ligaments support is mandatory. Contrarily, vaginal descent firstly (cervix last) signifies overcorrection of the endopelvic fascia in the lower genital tract particularly pubocervical ligament, inferior central tendon and the rectovaginal septum.

Many classifications of POP exist. Pelvic organ prolapse-quantification is the most common universally agreed classification in modern practice. Despite its

well documented advantages, it is a bit complicated and missing comments on lateral vaginal wall defect and differentiation of enterocele from rectocele. So, we call for more refinement of this universally agreed classification.

The key of success of apical POP operation is to fix the apex to a strong ligament. Vaginally, both uterosacral ligaments and sacrospinous ligament are accessible while posterior fixation is commonly performed by sacropexy. Vaginal pexy procedures are somewhat tedious with a bit high complication and recurrence rate. Addressing the vaginal apex is a key component of successful prolapse repair. Every effort should be exerted to perform the most appropriate operation for the suitable patient. The ideal surgical treatment of POP is yet to be found. There is consistent and reproducible evidence that abdominal sacrocolpopexy (ASC) using mesh has a higher success rate than vaginal surgery along with less postoperative dyspareunia and less recurrence rate. Conventional or robotically assisted endoscopic sacropexy is being practiced with high success rates. A real problem of the endoscopic sacropexy is prolonged time consumption. Recently, we introduced a simplified vaginolaparoscopic technique of sacrocolpopexy. We performed posterior colpotomy with fixation of a mesh to the uterosacral ligaments and the back of the uterus that was further fixed to the anterior longitudinal ligament of the sacrum using a tacker via laparoscopy [1]. This trial and others aim to cut short the lengthy operative time of endoscopic sacropexy. The topic of apical POP is still controversial and requires more research to reach the best of diagnostic as well as therapeutic modalities.

Keywords: Apical prolapse, Genital organ muscular defects, Pelvic organ prolapse, Prolapse repair

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