Infundibulopelvic colpopexy with partial resection of vagina for repair of posthysterectomy vault prolapse

To the Editors: Vaginal vault prolapse after hysterectomy is a rare but very unpleasant complication. I read with great interest the paper on this subject by Barber et al in the 2000 December issue.

They stated that numerous surgical techniques had been described for the treatment of posthysterectomy vaginal vault prolapse, yet none of them has been shown to be superior as a long-term treatment that is safe, well-tolerated, and effective. They cited a recent review of transvaginal repair of vault prolapse that found more than 40 different procedures in the literature.

In the available literature, I have not found any data on transabdominal colpopexy to the infundibulopelvic, uterosacral, and round ligaments after partial resection of the vagina. I learned this method from Professor László Lampé in Debrecen, Hungary. He described his procedure as “suspensio vaginae physiologica” carried out in 14 patients with posthysterectomy vault prolapse between 1973 and 1982. The suspension is “physiologic” because the vagina is not fixed to the symphysis, promontorium, or sacrum, which could cause malposition of the vagina and pelvic pain. This colposuspension procedure has been combined with the Burch urethral suspension in 8 cases by Domány and Bódis also in Hungary.

During the last 10 years (July 1990-July 2000) in the I. Department of Obstetrics and Gynecology, Semmelweis University Medical School in Budapest, the procedure was slightly modified and performed in 52 patients. Operative procedure: After laparotomy, the peritoneal covering of the vaginal vault between the bladder and the rectum is opened, and the vaginal wall is drawn upward by Kocher clamps. The bladder and the rectum are separated downward, and the ureters are prepared and separated laterally from the vaginal wall in the paracolpium. Three to 5 cm of the elongated vaginal wall is resected, and sutures with an absorbable surgical suture material produced from polyglycolic acid (1 or 1/0) are used to close the vagina, which is fixed by the sutures placed into the infundibulopelvic, sacrouterine, and round ligaments. If the adnexa are present, bilateral adnexectomy is also performed. The area is covered and elevated by the overlapping peritoneum. After 6 weeks, an anterior or posterior vaginal colporrhaphy, or both, was subsequently needed. Patients were followed up yearly by pelvic examination; in 3 of 52 patients the vaginal eversion partly recurred and the infundibulopelvic colpopexy was repeated. All patients (including the 3 recurrent cases) have a functional vagina without urine incontinence and without pelvic pain or any pelvic discomfort. Forty-eight of 52 patients (92.3%) indicated satisfaction with the result. Intraoperative complications included entry into the bladder (2/55, 3.6%), vault hematoma (3/55, 5.5%), and transient voiding difficulty (5/55, 9.0%).

The operation seems simpler than others that are commonly used, and our patients are satisfied.

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REFERENCES
6/8/118149

Reply
To the Editors: We appreciate Dr Papp’s interest in our article and found the description of his abdominal colpopexy technique intriguing. We hope that we will be able to review this work in greater detail, and we encourage him to submit his data as a manuscript to a peer-reviewed journal.

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6/8/118148

Computed tomography and locating ureters in relation to the uterine cervix

To the Editors: I would like to comment on 2 points made in a recent article by Hurd et al.

First, the authors’ finding that 12% of the 52 women in their study had at least 1 ureter located <0.5 cm from the lateral cervix suggests an explanation as to why a surgeon is shocked to find that a ureter has been transected or obstructed during “a chip shot” benign hysterectomy, ostensibly accomplished without incident, while perform-