

hysterectomy [post-hysterectomy colpexy and hysteropexy] and concurrent hysterectomy vs hysteropexy.

RESULTS: 59 patients underwent prolapse surgery with follow-up at 12 months (hysterectomy N=28, 47.5%, non-hysterectomy N=31, 52.5%, hysteropexy N= 17, 28.8%). There was improved sexual function for all patients at 6 and 12 months post-operatively (p-value 0.008 and 0.001, respectively) (Table 1). The proportion of sexually active patients increased from 43.9% preoperatively to 53.7% postoperatively. Stratified by sexual activity, sexually active patients had significant improvement in sexual function (+0.38 [-0.05, 0.71], p=0.005) at 12 months exceeding the MCID; no statistically significant improvement was seen in non-sexually active patients. The incidence of de novo dyspareunia decreased from 16.2% at 6 months to 8.1% at 12 months (p=0.08) for all patients. On univariate analysis, no variables were associated with dyspareunia. At 12 months, there was no difference in the PISQ-IR score in patients who underwent a hysteropexy compared to hysterectomy (p=0.24), and no difference between non-hysterectomy and the hysterectomy group (p=0.61). There were no differences in post-operative dyspareunia or de novo dyspareunia after hysteropexy compared to the hysterectomy group (p=0.99).

CONCLUSION: At 12 months, there was a statistically significant and clinically meaningful improvement in sexual function after all types of native-tissue pelvic organ prolapse surgery in sexually active women. There was no difference in sexual function in patients undergoing hysteropexy or post-hysterectomy colpexy compared to patients undergoing apical prolapse surgery with concurrent hysterectomy.

Table 1. Changes in sexual function over time after pelvic organ prolapse surgery

	Baseline	N	6 months	Change in score	P value*	N	12 months	Change in score	P value*
PISQ-IR total score									
All patients (N=58)	3.1 [2.8, 3.5]	55	3.4 [3.1, 3.8]	0.20 [-0.05, 0.47]	0.008 ^a	46	3.3 [3.0, 3.9]	0.25 [-0.14, 0.57]	0.001 ^a
Sexually active (N=25)	3.3 [3.1, 3.9]	25	3.8 [3.6, 4.0]	0.24 [0.00, 0.68]	0.008 ^a	23	3.9 [3.5, 4.1]	0.38 [-0.05, 0.71]	0.005 ^a
Not active (N=33)	2.9 [2.8, 3.3]	30	3.1 [2.8, 3.3]	0.08 [-0.17, 0.35]	0.11 ^a	23	3.1 [2.7, 3.3]	0.00 [-0.27, 0.26]	0.99 ^a
Dyspareunia									
All patients (N=57)	20 (35.1)	54	16 (29.6)	-	0.78 ^b	54	13 (24.1)	-	0.13 ^b
Sexually active (N=25)	12 (48.0)	25	13 (52.0)	-	0.74 ^b	29	12 (41.4)	-	0.48 ^b
Not active (N=32)	8 (25.0)	29	3 (10.3)	-	0.32 ^b	25	1 (4.0)	-	0.16 ^b
De novo dyspareunia	N/A	37	6 (16.2)	-	-	37	3 (8.1)	-	0.08 ^{a,b}

a^a Paired one sample t-test, b^bMcNemar test
 *In this table, patients were paired with themselves to tests between baseline and 6 months or baseline and 12 months.
^aComparison of incidence of de novo dyspareunia from 12 months to 6 months

patients undergoing vaginal uterosacral hysteropexy (USHP) and sacrospinous hysteropexy (SSHP)

MATERIALS AND METHODS: This was a multi-center retrospective cohort study of patients who underwent USHP or SSHP with a FPMRS surgeon between 2015 and 2019. Patients were excluded if they had no follow up greater than 6 weeks postoperatively. Anatomic failure was defined as prolapse beyond the hymen. Composite failure was defined as anatomic failure, bulge symptoms, and/or re-treatment for prolapse.

RESULTS: At 4 sites, 147 patients underwent SSHP and 114 underwent USHP. SSHP patients were younger (62±13 vs 58±13 yrs, p=0.01) and had a higher BMI (28 vs 26 kg/m², p=0.002) otherwise there were no differences in characteristics between groups. USHP patients were more likely to undergo concurrent anterior repair (86% vs 70%, p=0.002), posterior repair (84% vs 65%, p=0.001) and incontinence procedures (52% vs 38%, p=0.033). Operative time was longer in the USHP group (125 (105, 160) vs 91 (70, 118) min, p<0.001). 49% of USHP utilized permanent or permanent and delayed absorbable sutures, while 82% of SSHP were performed with delayed absorbable sutures (p<0.001).

The 6-week follow up rate was 95% (138 SSHP and 111 USHP patients), at which time there were 4 (1.5%) anatomic failures: 1 (0.7%) SSHP and 3 (2.6%) USHP (p= 0.321) while 25 patients (9.9%) reported bulge symptoms (10%SSHP vs 9.8%USHP) and none underwent retreatment. At 1 year, the follow up rate was 32% (83/261) with no difference between groups. There were 10 (3.8%) anatomic failures: 3 (2%) SSHP and 7 (6.1%) USHP (p=0.109). There was no difference in bulge symptoms(10%), composite failure(13%) or median POP stage (2).

Only 8 SSHP and 2 USHP patients had cervical elongation. 50% of the SSHP patients without trachelectomy required surgical retreatment. Of the 4 SSHP patients who underwent trachelectomy, none had retreatment for prolapse though 1 reported bulge symptoms. No USHP patients underwent partial trachelectomy or retreatment for prolapse but 1 patient had anatomic and symptomatic failure.

The overall incidence of complications was low (7%) with a higher rate of ureteral kinking in the USHP group (7% vs 1.4%, p=0.023).

With median follow up of 17 months, 12 patients (4.6%) underwent subsequent hysterectomy, 11 of which were for recurrent prolapse, with no difference between the groups (6.8%SSHP vs 1.8% USHP, p=0.073). Additionally, 17 patients (6.5%) underwent treatment for uterine/cervical pathology (12 SSHP vs 5 USHP, p=0.313)

CONCLUSION: One year after hysteropexy, 1 in 3 patients were available for follow-up and there were no differences in prolapse recurrence between patients who underwent USHP versus SSHP. The incidence of adverse events was low and less than 5% of patients underwent subsequent hysterectomy for prolapse.

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09 Sacrospinous fixation and vaginal uterosacral suspension: evaluation in uterine preservation surgery



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OBJECTIVES: To compare anatomic failure, prolapse symptoms, retreatment and incidence of peri-operative adverse events between