

HIRURŠKO LEČENJE EVERZIJE VAGINE NAKON HISTEREKTOMIJE – PRIKAZ SLUČAJA I PREGLED LITERATURE

PRIKAZ SLUČAJA

CASE REPORT

INDIVIDUALIZED TREATMENT FOR POSTHYSTERECTOMY VAGINAL EVERSION – CASE REPORT AND LITERATURE REVIEW

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SAŽETAK

Uvod: Trenutno postoje različite preporuke za tretman vaginalne everzije. Prikazan slučaj pokazuje trenutne mogućnosti za lečenje potpune vaginalne everzije.

Prikaz slučaja: Pacijentkinja, starosti 61 godinu, imala je potpunu vaginalnu everziju, četvrtog stadijuma, sedamnaest godina nakon operacije – klasične abdominalne histerektomije sa bilateralnom adnektomijom. S obzirom na prolaps prednjeg vaginalnog zida, odlučeno je da se uradi prednja kolpoplastika i elevacija mokraćne bešike, u šavovima, po Keliju. Nikolsova bilateralna sakrospinalna fiksacija bila je tehnika izbora za korekciju rektokele/enetrokele i prolapsa zadnjeg zida vagine. Postoperativni tok protekao je bez komplikacija, a potpuno izlečenje vaginalne everzije potvrđeno je šestomesečnim pregledom.

Zaključak: Hirurško lečenje koje obuhvata prednju kolpoplastiku u kombinaciji sa bilateralnom fiksacijom sakrospinalnog ligamenta savetuje se za uznapredovalu fazu složenih vaginalnih everzija. Ova hirurška tehnika je efikasna i sigurna metoda lečenja.

Ključne reči: vaginalna everzija, histerektomija, prednja kolpoplastika, fiksacija sakrospinalnog ligamenta

ABSTRACT

Introduction: Currently, there are different recommendations for obtaining optimal treatment of vaginal eversion. The presented case highlights current options for individualized treatment of complete vaginal eversion.

Case report: A 61-year-old woman presented with complete vaginal eversion stage IV seventeen years after classic abdominal hysterectomy with bilateral adnexectomy. For anterior compartment prolapse, it was decided to perform anterior colpoplasty and bladder elevation using sutures, plication by Kelly. Nichols bilateral sacrospinal fixation was the chosen technique for correction of the rectocele/enterocele and prolapse of the posterior vaginal wall. The postoperative course was uneventful, and the resolution of vaginal eversion was confirmed on a six-month check-up.

Conclusions: The surgical repair incorporating anterior colpoplasty combined with bilateral sacrospinous ligament fixation is advised for the advanced stage of complex vaginal eversions. This treatment option is an effective and safe technique.

Keywords: vaginal eversion, hysterectomy, anterior colpoplasty, sacrospinous ligament fixation

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UVOD

Potpuna vaginalna everzija (prolaps/svoda/kupole) predstavlja spuštanje apikalnog, odnosno gornjeg, srednjeg dela i donje trećine vagine iza introitusa. Everzija vaginalne manžetne može nastati kao posledica prethodne histerektomije, kako vaginalne, tako i abdominalne. Dodatni faktori rizika su urođena ili starosno zavisna insuficijencija mekog tkiva, defekt dna karlice, oštećenje karličnog dna nakon rođenja, težak fizički rad, neurološka oboljenja i gojaznost sa abdominopelvičnim disbalansom [1,2].

Sa starenjem ženske populacije, sve više pacijentkinja zahteva lečenje zbog prolapsa oba karlična organa. Prolaps vaginalnog svoda nakon histerektomije je česta komplikacija (0,2% do čak 36%) i može izazvati značajnu nelagodnost kod pacijentkinja kao što su bol, svrab, vaginalna erozija i probleme sa zadržavanjem urina i stolice. Štaviše, čini se da stope vaginalne everzije nakon histerektomije pokazuju vezu sa indikacijama za histerektomiju (1,6% nakon histerektomije zbog prolapsa i 1,8% zbog drugih patologija) [1,3].

Dostupni su različiti tretmani (konzervativni i hirurški), ali ne postoje jasne smernice koje preporučuju koji je pristup najbolji. Konzervativni ili mehanički tretmani se razmatraju kod žena sa blagim stepenom prolapsa ili kod onih koje ne žele ili ne mogu da se podvrgnu operaciji zbog različitih kontraindikacija. Hirurška intervencija je često neophodna kada konzervativni tretman nije uspešan. Hiruršku tehniku treba prilagoditi svakom pacijentu na osnovu anatomije, starosti, komorbiditeta i drugih faktora. Ipak, sve hirurške metode, bez obzira na njihov pristup (vaginalni, abdominalni otvoreni ili laparoskopski), imaju za cilj resuspendovanje vaginalnog vrha (nativnim tkivom ili sintetičkim materijalom) do čvrstih karličnih struktura koje mogu omogućiti njegovu dalju podršku (sakrum ili sakrospinalni ligamenti) [4,5].

Ovaj slučaj pokazuje dostupne opcije za lečenje vaginalne everzije kod pojedinačne pacijentkinje.

PRIKAZ SLUČAJA

Žena stara 61 godina upućena je u našu ustanovu zbog potpune vaginalne everzije. Pacijentkinja je pre 17 godina bila podvrgnuta klasičnoj abdominalnoj histerektomiji sa bilateralnom adnektomijom zbog značajnog mioma materice. Pacijentkinja nije imala ginekološke tegobe 12 godina, nakon čega je počela da primećuje malu izbočinu koja viri iz vaginalnog introitusa tokom fizičke aktivnosti. Izbočina se vremenom povećavala, a stanje je napredovalo sa značajnom nelagodnošću i poteškoćama pri početku mokrenja, ali bez urinarne inkontinencije. Pacijentkinja nije imala vaginalno krvarenje, bol u stomaku i/ili karlici, ali je

INTRODUCTION

Complete vaginal eversion (cuff/vault/dome prolapse) represents a descent of the apical, i.e., upper, midportion, and lower third of the vagina beyond the introitus. Vaginal cuff eversion can occur as a consequence of prior hysterectomy, both vaginal and abdominal. Additional risk factors are congenital or age-dependent insufficiency of soft tissue, pelvic floor defect, damage of the pelvic floor after birth, heavy physical work, neurological illnesses, and obesity with abdominopelvic imbalance [1,2].

With the aging of the female population, more patients require treatment for both pelvic organ prolapse. Vaginal vault prolapse following hysterectomy is a common complication (0.2% to even 36%) and can cause significant discomfort for patients as pain, itching, vaginal erosion, and issues with urinary and stool retention. Moreover, it seems that rates of posthysterectomy vaginal eversion show a relationship with indications for hysterectomy (1.6% following hysterectomy for prolapse and 1.8% for other pathologies) [1,3].

Various treatments are available (conservative and surgical), and there are no clear guidelines to recommend which is the best. Conservative or mechanical treatments are considered for women with a mild degree of prolapse or those who are unwilling or unable to undergo surgery due to different contraindications. Surgical intervention is often necessary when conservative treatment does not succeed. The surgical technique should be adapted to each patient based on anatomy, age, comorbidity, and other factors. Still, all surgical methods, regardless of their approach (vaginal, abdominal open, or laparoscopic), aim at resuspending the vaginal apex (with native tissue or by synthetic material) to firm pelvic structures that can enable its further support (sacrum or sacrospinous ligaments) [4,5].

This case shows the available options for the treatment of vaginal eversion in the individual patient.

CASE REPORT

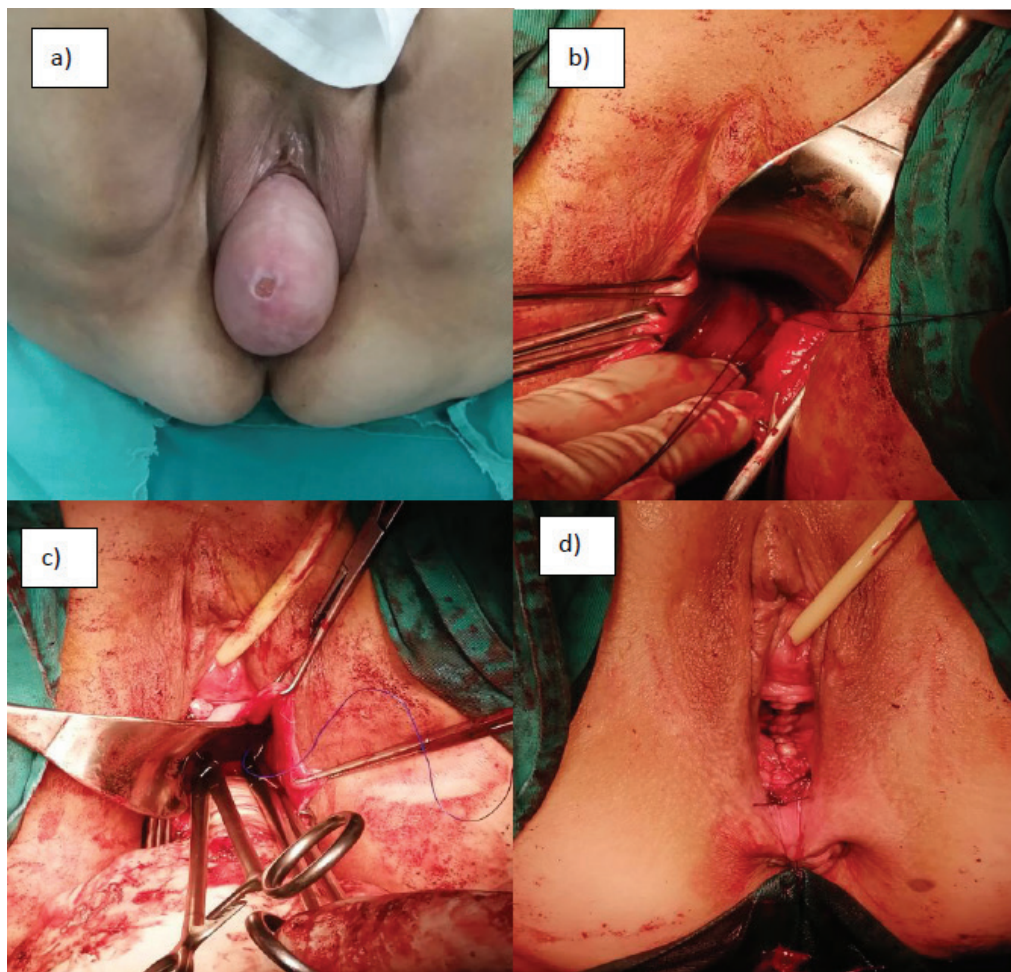
A 61-year-old woman was referred to our institution because of complete vaginal eversion. The patient had undergone a classic abdominal hysterectomy with bilateral adnexectomy 17 years ago due to a sizeable uterine myoma. The patient had no gynecological complaints for 12 years, after which she started noticing that during physical activity, a small bulge was slightly protruding from the vaginal introitus. The protuberance increased over time, and the condition progressed with significant discomfort and difficulties in voiding commencement but without urinary incontinence. The patient declined any vaginal bleeding,

imala eroziju vagine, poteškoće sa defekacijom i zadržavanje urina. Pacijentkinja je imala hroničnu hipertenziju, dijabetes melitus tip II i gojaznost (indeks telesne mase 34,53 kg/m²). Bila je zainteresovana za održavanje seksualne funkcije.

Tokom fizikalnog pregleda po prijemu u našu ustanovu, primenom Sistema za kvantifikaciju prolapsa karličnih organa, identifikovan je prolaps vaginalnog svoda IV stadijuma, sa dekubitalnim promenama na sluzokoži. Iako nije bilo prisutne stresne urinarnе inkontinencije, postvoidni rezidualni urin izmeren je na 57 ml tokom kateterizacije. Zbog toga je indikovana operativna intervencija. Odlučeno je da se prolaps prednjeg kompartmenta koriguje prednjom kolpoplastikom i elevacijom mokraćne bešike, dok je Nicholsova bilateralna sakrospinozna fiksacija izabrana kao tehnika za korekciju rektocеле/enterocеле i prolapsa zadnjeg zida vagine. Pre operacije uzeta je detaljna medicinska i ginekološka anamneza, i obavljene su standardne laboratorijske i mikrobiološke analize. Ultrazvučni pregled karlice i abdomena nije pokazao patološke nalaze.

abdominal and/or pelvic pain but had vaginal erosion, defecation difficulties, and urinary retention. The patient had chronic hypertension, diabetes mellitus type II, and obesity (Body Mass Index 34.53 kg/m²). She was interested in maintaining sexual function.

During the physical examination upon admission to our institution, a stage IV vaginal vault prolapse was identified using the Pelvic Organ Prolapse Quantification System, with decubital changes on the mucosa. Although stress urinary incontinence wasn't present, postvoid residual urine was measured at 57 ml during catheterization. Thus, operative treatment was indicated. It was decided to correct the anterior compartment prolapse with anterior colpoplasty and bladder elevation, while Nichols's bilateral sacrospinous fixation was the chosen technique for correction of the rectocele/enterocele and prolapse of the posterior vaginal wall. Before surgery, detailed medical and gynecological history and standard laboratory and microbiological analyses were taken. An ultrasonographic scan of the pelvis and abdomen showed no pathological findings.



Slika 1. (a) Preoperativno stanje, desna (b) i leva (c) sakrospinalna fiksacija, (d) nakon operacije

Picture 1. (a) Preoperative status, (right b, left c) sacrospinous fixation, (d) final result

Nakon primene opšte anestezije, pacijentkinja je postavljena u litotomiju i aseptički pripremljena. Postavljen je uretralni kateter. Vaginalni vrh je identifikovan i povučen nadole. Na prednjoj strani, napravljen je vertikalni srednji rez, približno jedan centimetar od uretralnog meatusa do vrha vagine. Koristeći oštru i tupu disekciju, bešika i creva su odvojeni od zida vagine. Poprečni šavovi su postavljeni na vezikovaginalnu fasciju kako bi se podigla i podržala bešika. Višak sluzokože vagine je odstranjen, a prednji zid vagine je zašiven. Nakon toga, napravljen je vertikalni srednji rez od vrha vagine do perineuma pozadi. Urađena je pararektalna tupa disekcija prema ishijalnoj kičmi, prvenstveno na desnoj, a zatim na levoj strani. Sakrospinozni ligament je digitalno i vizuelno identifikovan. Kod Breisky-Navratila, retraktor rektuma je pomeren medijalno, čime je omogućena vizualizacija ligamenta. Koristeći dugu ravnu iglu, jedan resorptivni i jedan neresorptivni šav postavljeni su kroz sakrospinozni ligament na desnoj i levoj strani, otprilike 2 do 3 cm medijalno od ishijalne kičme, i fiksirani za vaginalni vrh. Vaginalni prolaps je repositioniran u karlicu tako što su četiri šava pričvršćena šavom Pullei. Višak sluzokože vagine je odstranjen, a zadnji zid vagine je zašiven.

Nakon operacije, vagina je zadržala dužinu od 7 cm. Prvog dana nakon operacije, kateter je uklonjen, a pacijentkinja je mogla spontano da isprazni bešiku. Otpuštena je trećeg postoperativnog dana u stabilnom stanju. Postoperativni oporavak je protekao bez komplikacija, a razrešenje vaginalne everzije potvrđeno je šestomesečnim pregledom. Praćenje pacijentkinje se nastavlja.

DISKUSIJA

Genitalni organi se održavaju u karličnoj šupljini uglavnom uz pomoć endopelvične fascije (uključujući vezikovaginalnu fasciju, rektovaginalni septum, sakrouterini ligament i kardinalni ligament) i karlične dijafragme (koja se sastoji od mišića levator ani) [1,6]. Apikalni prolaps, praćen prolapsom oba zida, odnosno kompartmenta, javlja se u 67% slučajeva i naziva se složena vaginalna everzija. Kompleksne everzije se sastoje od apikalnog prolapsa sa cistocelom u 7%, rektokele u 30% i cistocele i rektokele u 30% slučajeva. Potpuna vaginalna everzija ili složena everzija do tačke niže od 2 cm ukupne vaginalne dužine klasifikovana je kao faza IV u sistemu kvantifikacije prolapsa karličnih organa [1,6]. To je bio slučaj sa našom pacijentkinjom.

Vaginalna everzija, odnosno prolaps svoda nakon abdominalne ili vaginalne histerektomije, jedan je od najizazovnijih stanja u rekonstrukciji karlice i obično zahteva kombinovane hirurške tehnike, kao i upotrebu sintetičkih materijala. Druge metode lečenja, lekovi i vežbe za jačanje mišića karličnog dna, pokazale su

Following the administration of general anesthesia, the patient was positioned in lithotomy and prepared aseptically. A urethral catheter was placed. The vaginal apex was identified and pulled downwards. Anteriorly, the vertical midline incision was made approximately one centimeter from the urethral meatus to the vaginal apex. Using sharp and blunt dissection, the bladder and intestines were detached from the vaginal wall. Transverse sutures were placed on the vesicovaginal fascia to elevate and support the bladder. Excess vaginal mucosa was cut off, and the anterior vaginal wall was sutured. Afterward, the vertical midline incision was made from the vaginal apex to the perineum posteriorly. Pararectal, blunt dissection was made toward the ischial spine, primarily on the right and then on the left side. The sacrospinous ligament was digitally and visually identified. With Breisky-Navratil, the retractor rectum was displaced medially, and the visualization of the ligament was enabled. Using a long straight needle, one resorptive and one nonresorptive suture was placed through the sacrospinous ligament on the right and left side, approximately 2 to 3 cm medial to the ischial spine, and fixed to the vaginal apex. The vaginal prolapse was repositioned into the pelvis by securing the four sutures with a Pulley stitch. Excess vaginal mucosa was cut off, and the posterior vaginal wall was sutured.

After the surgery, the vagina maintained a length of 7 cm. On the first day after surgery, the catheter was removed, and the patient was able to empty her bladder spontaneously. She was discharged on the third postoperative day in a stable condition. The postoperative recovery lasted without any complications, and the resolution of vaginal eversion was confirmed on a six-month check-up. Patient follow-up continues.

DISCUSSION

The genital organs are maintained in the pelvic cavity mainly by the support of the endopelvic fascia (including the vesicovaginal fascia, rectovaginal septum, sacrouterine ligament, and cardinal ligament) and the pelvic diaphragm (which comprises the levator ani muscles) [1,6]. The apical prolapse accompanied by the prolapse of both walls, i.e., compartments, occurs in 67% of cases and is referred to as complex vaginal eversion. Complex eversions consist of apical prolapse with cystocele in 7%, rectocele in 30%, and both cystocele and rectocele in 30% of cases. Complete vaginal eversion or complex eversion to the point lower than 2 cm of the total vaginal length is classified as stage IV in the Pelvic Organ Prolapse Quantification system [1,6]. This was the case for our patient.

Vaginal eversion, i.e., vault prolapse after abdominal or vaginal hysterectomy, is one of the most challenging

se neadekvatnim i ne rešavaju problem u potpunosti. Iako se često koristi abdominalni (ponekad otvoreni, a češće laparoskopski) pristup, vaginalni operativni pristup se generalno smatra optimalnim za korekciju svih tri kompartmentalna defekta karličnog dna [3-5].

U literaturi su opisane prednosti upotrebe sintetičkih materijala za korekciju prolapsa prednjeg zida vagine. Sintetički materijali pružaju izdržljivu dugotrajnu podršku za zidove i vrh vagine. Podaci iz literature ukazuju na to da često korišćeni setovi mreže imaju prilično visoke (do 95%) stope uspeha za korekciju vaginalne everzije nakon jednogodišnjeg praćenja. Štaviše, primena polipropilenske mreže je minimalno invazivna, sa brzim postoperativnim oporavkom i značajno smanjenom stopom morbiditeta u poređenju sa otvorenim ili laparoskopskim pristupom [7-9].

Međutim, poslednjih godina objavljuje se sve veći broj upozorenja o bezbednosti upotrebe sintetičkog vaginalnog materijala (retke, ali ozbiljne komplikacije kao što su infekcije, duboka fascijalna nekroza, fistule i dispareunija). Najistaknutija komplikacija je ekstruzija mreže (4 do 20%), posebno kod starijih žena čije se vaginalno tkivo i ligamentna potpora vremenom dodatno smanjuju. Ekstruzija mreže može dovesti do oštećenja susednih organa i stoga zahteva ponovnu intervenciju [10]. Zbog ovih ozbiljnih komplikacija koje su prijavljene, setovi mreže u nekim zemljama su reklasifikovani u visokorizične medicinske uređaje, a njihova upotreba je čak i ukinuta. Stoga, transvaginalnu primenu bilo kog tipa mreže treba izvoditi samo u složenim slučajevima praćenim teškom urinarnom inkontinencijom, gde korist opravdava priznati rizik. Shodno tome, operacije popravke nativnog tkiva ponovo su privukle pažnju u rekonstrukciji karlice [11,12].

Vagina se može uspešno vratiti u svoj anatomske položaj zadnjeg nagiba fiksacijom sakrospinoznog ligamenta bez implantacije bilo kakvog veštačkog materijala. Još jedna prednost je očuvanje vaginalne dužine i, posledično, koitalne funkcije [4,13]. Ova procedura se izvodi vaginalno, za kratko vreme i uz minimalan gubitak krvi, što je čini bezbednom i efikasnom tehnikom. Dokazano je da sakrospinozna fiksacija daje dobre dugoročne objektivne ishode, kao i poboljšan kvalitet života sa manje komplikacija od mesh aplikacije. Podaci iz literature ukazuju na značajno poboljšanje svih simptoma kod više od 90% pacijenata. Štaviše, utvrđeno je da ova vrsta operacije ima manji rizik od ponovnog prolapsa, ponovljene operacije zbog prolapsa, postoperativne stresne urinarne inkontinencije i dispareunije u odnosu na druge vaginalne operacije [5,14]. Fiksacija sakrospinoznog ligamenta se izvodi jednostrano ili bilateralno, tradicionalno koristeći tehnike zadnje, a povremeno i prednje disekcije. Utvrđe-

conditions in pelvic reconstruction, and it usually necessitates combined surgical techniques as well as the use of synthetic materials. Other treatment methods, medication, and exercises for strengthening pelvic floor muscles have been shown to be inadequate and do not entirely resolve the problem. Although the abdominal (sometimes open, but more often laparoscopic) approach is frequently used, the vaginal operative approach is generally considered optimal for the correction of all three compartmental defects of the pelvic floor [3-5].

The literature describes the advantages of using synthetic materials for correcting anterior vaginal wall prolapse. Synthetic materials provide durable long-term support for the vaginal walls and apex. Literature data indicate that commonly used mesh kits have pretty high (up to 95%) success rates for vaginal eversion correction on one-year follow-up. Moreover, the application of polypropylene mesh is minimally invasive with fast postoperative recovery and significantly reduced morbidity rate compared to the open or laparoscopic approach [7-9].

However, an increasing number of warnings about the safety of synthetic vaginal material use has been released in recent years (infrequent but serious complications such as infections, deep fascial necrosis, fistulae, and dyspareunia). The most prominent complication is mesh extrusion (4 to 20%), especially in aging women whose vaginal tissue and ligamentous support reduce over time even more. Mesh extrusion may cause damage to adjacent organs and, therefore, necessitates re-intervention [10]. Due to these severe complications that were reported, mesh kits in some countries have been reclassified as high-risk medical devices, and their use has even been abolished. Therefore, the transvaginal application of any mesh type should be performed only in complex cases accompanied by severe urinary incontinence, where the benefit justifies the recognized risks. Consequently, native tissue repair surgeries have regained attention in pelvic reconstruction [11,12].

The vagina can be successfully restored to its anatomic posterior inclination position by sacrospinous ligament fixation without implanting any artificial materials. Another advantage is the preservation of vaginal length and, consequently, coital function [4,13]. This procedure is performed vaginally in a short time and with minimal blood loss, which makes it a safe and effective technique. Sacrospinous fixation was proven to give good long-term objective outcomes as well as improved quality of life with fewer complications than mesh application. Literature data indicate significant improvement of all symptoms in more than 90% of patients. Moreover, this type of surgery was found to have a lower risk of recurrent prolapse, repeat surgery

no je da bilateralna tehnika omogućava bolji kvalitet života od unilateralne fiksacije jer se čini da smanjuje dispareuniju i simptome creva uzrokovane devijacijom vaginalne ose na jednu stranu do kojih može doći u slučaju jednostrane fiksacije [15,16]. Kod prikazane pacijentkinje urađena je bilateralna fiksacija sakrospinoznog ligamenta, koja se pokazala uspešnom, bez komplikacij, sa povoljnim ishodom šest meseci nakon operacije.

Najznačajnije komplikacije povezane sa fiksacijom sakrospinoznog ligamenta uključuju vaskularne povrede i krvarenje (približno 5%), oštećenje rektuma (0,5%), povredu pudendalnog ili išijadičnog nerva (do 2%) i hronični bol (2%). Pored toga, rekurentni prolaps vaginalnog svoda može se pojaviti u do 19% slučajeva nakon procedure. Nakon fiksacije sakrospinoznog ligamenta, rekurentni defekti najčešće nastaju u prednjem odeljku zbog postoperativne vaginalne retroverzije, zbog čega je prednji vagini zid više izložen abdominalnom pritisku, ali su takođe prijavljeni rekurentni rektokele i uretralni sindrom [13]. Zbog toga se, u cilju sprečavanja recidiva, predlaže istovremeni tretman prednjeg zida sa svakom kolpopeksijom, kao što smo prikazali u ovom izveštaju. Ipak, iskustvo i dobra operativna tehnika, uz odgovarajuće indikacije i selekciju pacijenata, uglavnom smanjuju komplikacije i učestalost recidiva [17].

Transperitonealni pristup sa uterosakralnom suspenzijom, danas obično laparoskopijom, opisali su Shull i saradnici, sa 88,2% uspešnih suspenzija, ali je bio povezan sa rizikom od okluzije uretera do 11% [18].

Alternativne manje transvaginalne operacije su obliterativne procedure (kolpokleiza). Međutim, nakon ovih procedura, postoji veći rizik od stresne urinarnе inkontinencije, poteškoća u dijagnostici maligniteta materice i gubitka seksualne funkcije. Abdominalna sakralna kolpopeksija, otvorena ili laparoscopska, takođe se može izvesti u nekim slučajevima. Ipak, vaginalni pristup je često bolji jer omogućava i popravku karličnog dna, dok se mogu izbeći potencijalne komplikacije povezane sa opštom anestezijom, laparotomijom ili laparoskopijom, što je posebno važno za starije pacijentkinje koje su često medicinski kompromitovani [4,5,13].

Konačno, može se zaključiti da je hirurška sanacija posthisterektomske vaginalne everzije primenom bilateralne fiksacije sakrospinoznog ligamenta efikasna i sigurna, čak i za najnaprednije stadijume vaginalne everzije.

Sukob interesa: Nije prijavljen.

for prolapse, postoperative urinary stress incontinence, and dyspareunia than other vaginal operations [5,14]. Sacrospinous ligament fixation is performed unilaterally or bilaterally, traditionally using the posterior and occasionally anterior dissection techniques. The bilateral technique was found to enable a better quality of life than unilateral fixation as it seems to reduce dyspareunia and bowel symptoms caused by deviation of the vaginal axis to one side that might occur in the case of unilateral fixation [15,16]. As for the presented patient, bilateral sacrospinous ligament fixation was performed, and it proved to have no complications and a favorable outcome six months after the operation.

The most significant complications associated with sacrospinous ligament fixation include vascular injury and hemorrhage (approximately 5%), rectal damage (0.5%), pudendal or sciatic nerve injury (up to 2%), and chronic pain (2%). Additionally, recurrent vaginal vault prolapse may occur in up to 19% of cases after the procedure. After sacrospinous ligament fixation, recurrent defects most commonly arise in the anterior compartment due to the postoperative vaginal retroversion making the anterior vaginal more exposed to abdominal pressure, but recurrent rectoceles and urethral syndrome have also been reported [13]. Therefore, in order to prevent recurrence, simultaneous treatment of the anterior wall is suggested with every colpopexy, as we presented in this case report. Still, experience and good operative technique, along with appropriate indications and selection of patients, mainly reduce complications and incidence of recurrences [17].

The transperitoneal approach with uterosacral suspension, usually by laparoscopy today, was described by Shull et al., with 88.2% successful suspensions, but it was associated with a risk of ureteral occlusion of up to 11% [18].

Alternative minor transvaginal operations are obliterative procedures (colpocleisis). However, following these procedures, there is a higher risk of stress urinary incontinence, difficulties in diagnosing uterine malignancy, and loss of sexual function. Abdominal sacral colpopexy, either open or laparoscopic, can also be performed in some cases. Nevertheless, the vaginal approach is always better, as it also enables the repair of the pelvic floor while potential complications associated with general anesthesia, laparotomy, or laparoscopy can be avoided, which is particularly important for elderly patients who are often medically compromised [4,5,13].

Finally, it can be concluded that surgical repair of posthysterectomy vaginal eversion using bilateral sacrospinous ligament fixation is both effective and safe, even for the most advanced stages of vaginal eversion.

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