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Uterine preservation during surgery for uterovaginal prolapse: a review

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Abstract The traditional surgical treatment for uterovaginal prolapse has been vaginal hysterectomy. For many reasons, women may request uterine preservation at the time of prolapse surgery. The purpose of this paper is to review the medical literature pertaining to the role of uterine preservation during reconstructive surgery for uterovaginal prolapse. A MEDLINE search of literature in the English language (1966 to current) was carried out using the keywords ‘hysterectomy’, ‘hysteropexy’, ‘uterine preservation’, ‘uterine suspension’ and ‘uterovaginal prolapse.’ Fourteen articles primarily addressing the surgical repair of uterovaginal prolapse with uterine preservation were included in this review. Papers primarily addressing other forms of pelvic organ prolapse, incontinence or obliterate procedures were excluded. Existing procedures and their clinical outcomes were reviewed. The current literature suggests that uterine preservation during surgery for uterovaginal prolapse may be an option in appropriately selected women who desire it; prospective, randomized trials are needed to corroborate this.

Keywords Hysterectomy · Hysteropexy · Uterine preservation · Uterine suspension · Uterovaginal prolapse

Abbreviations EBL: Estimated blood loss · OR: Operating room · PCOS: Polycystic ovary syndrome

Introduction

Pelvic organ prolapse is a common concern for women and their physicians; estimates of surgical intervention for this indication exceed 10% of women who reach 80 years of age [1], and this number is likely to increase with the current aging of our population. Vaginal hysterectomy has been the traditional surgical treatment for uterovaginal prolapse; in fact, prolapse is the most common indication for hysterectomy in women over 55 years of age in the United States [2]. Conventional wisdom has suggested that maintenance of the uterus in situ may subject pelvic reconstructive efforts to undue stress and result in increased risk of prolapse recurrence. However, hysterectomy alone often fails to address the underlying deficiencies in pelvic support that cause uterovaginal prolapse [3]. Hysterectomy at the time of prolapse surgery has not been proved to improve the durability of the repair and may, in fact, increase morbidity, blood loss, and operative and postoperative recovery times. Additionally, it has been suggested that hysterectomy and the associated pelvic floor dissection may increase the risk of pelvic neuropathy and disrupt natural support structures such as the uterosacral–cardinal ligament complex [4]. Some authors have suggested that women may be at increased risk for new-onset urinary incontinence, bladder dysfunction or prolapse following hysterectomy [5, 6]. In addition, Masters and Johnson suggested that the uterus and cervix may have a vital role in orgasm and sexual function [7]. In some individuals, removal of the uterus may even influence sexual and personal identity. Although controversy surrounding the concept of uterine preservation at the time of uterovaginal prolapse surgery certainly exists and will continue to exist, as surgical techniques and technologies progress, the concept of
prolapse repair with uterine preservation warrants re-evaluation.

The concept of uterine preservation during surgery for prolapse was suggested by Bonney in the early 1900s: he emphasized the passive role of the uterus in uterovaginal prolapse [8]. Ross later described the pericervical fascia as the cornerstone of pelvic reconstruction [9]; this structure, however, is not always addressed during vaginal hysterectomy with anterior and posterior colporrhaphy. Since that time, various authors have reported their experiences with reconstructive pelvic surgery with uterine preservation. The objective of this paper is to review and summarize the medical literature pertaining to the role for uterine preservation during the surgical management of uterovaginal prolapse. Although ideally such a review would include a comparison of various uterus-sparing pelvic reconstructive procedures with vaginal hysterectomy, there is a paucity of such comparative data within the medical literature. Furthermore, whereas colpolceis is a potentially ideal procedure for a very select subset of patients with uterovaginal prolapse, it is an ablative procedure which does not allow maintenance of sexual function and is therefore beyond the scope of this review.

A MEDLINE search of literature in the English language (from 1966 to the present) was carried out with the keywords 'hysterectomy', 'hysteropexy', 'uterine preservation', 'uterine suspension' and 'uterovaginal prolapse'. Those articles primarily addressing surgical techniques for the repair of uterovaginal prolapse with uterine preservation were included in this review; a total of 12 articles met the inclusion criteria and were reviewed. An additional two articles, referred to by papers identified by the search strategy but published prior to 1966, and otherwise pertinent and significant, were included. Papers addressing ablative procedures (such as colpolceis), or procedures for indications other than prolapse (such as pelvic pain [10, 11, 12, 13, 14, 15, 16, 17], endometriosis [18, 19] or symptomatic uterine retroversion [20, 21, 22, 23, 24]) were not included. Papers primarily addressing procedures for the correction of forms of pelvic organ prolapse other than uterovaginal prolapse (i.e. cystocele, rectocele, enteroccele, vaginal vault prolapse) or procedures for urinary incontinence were excluded from this review.

Vaginal procedures

Manchester procedure

In 1888, Archibald Donald of Manchester, England, described the Manchester procedure as an alternative to vaginal hysterectomy for the management of uterovaginal prolapse in patients with cervical elongation and intact uterosacral–cardinal ligaments. It should be noted that many experts feel that this subtype of patients with cervical elongation does not represent true pelvic organ prolapse, and the POP-Q system with point D has been designed to help differentiate cervical elongation from suspensory failure of the uterosacral–cardinal ligament complex. The Manchester procedure consists of transvaginal cervical amputation, colporrhaphy, and fixation of the cervical stump to the cardinal ligaments. Some have claimed that this procedure has similar cure rates to vaginal hysterectomy for uterovaginal prolapse, with decreased morbidity and mortality. In a retrospective chart review, Thomas et al. (1995) compared the outcomes of 88 consecutive Manchester procedures to the outcomes of 105 randomly selected vaginal hysterectomy patients [25]; anterior and/or posterior repairs were performed as indicated. Compared with these controls, patients undergoing the Manchester procedure were older (66 vs 52 years) and were more likely to have advanced prolapse (third-degree uterine prolapse, cystocele or rectocele). Mean operating room (OR) time was 30 min shorter for the Manchester procedure group, and estimated blood loss (EBL) was lower, at 200 vs 300 ml. Postoperative cuff abscess or cellulitis occurred in 5% of hysterectomy patients but was not seen in Manchester procedure patients. No other differences in postoperative complications were noted. Follow-up data (mean 2.5 years, range 22 days to 4.6 years) in patients who underwent the Manchester procedure was obtained via questionnaires sent to surgeons; data on 67 patients were returned. Four (6%) of these patients, all of whom had initially presented with third-degree prolapse, experienced recurrent prolapse. The time to recurrence ranged from 8 weeks to 5.5 years. Similar follow-up data for patients undergoing vaginal hysterectomy were not reported by these authors.

Although clearly subject to bias on the parts of both the responding surgeons and the patients, the findings generally support those of a prior review by Conger in 1958 involving 960 Manchester procedures, which reported a prolapse recurrence rate of 4.3% [26]. This study, however, was based on a questionnaire sent to patients with a response rate of only 52%. In another study with 6–12 years of postoperative follow-up, Tipton et al. [27] found that 17 of 82 patients (21%) undergoing the Manchester procedure later required additional uterine operations, including eight hysterectomies. It should be pointed out, however, that this number included patients undergoing hysterectomy for non-prolapse indications, including bleeding and carcinoma, and therefore may not accurately portray the likelihood of prolapse recurrence.

Transvaginal uterosacral suspension/plication

In 1966, Williams [28] described a transvaginal uterosacral–cardinal ligament plication in a case series including 20 young women aged 21–37 years. After entering the peritoneal cavity via a posterior colpotomy, the uterosacral ligaments were divided from the cervix, plicated across the midline and reinserted into the cervix. Next, a transverse incision was made at the junction of the
bladder reflection with the cervix and the cardinal ligaments were plicated across the midline. The plicating sutures were then tied tightly, drawing the cervix upward. Eleven patients had uterovaginal prolapse to the introitus or up to 3 cm beyond, and nine had prolapse beyond this point. The mean parity of these patients was 2.9, and four underwent concurrent procedures for the correction of cystocele, rectocele, and/or enterocele. One patient later underwent a subtotal hysterectomy for vaginal bleeding. Of the remaining 19 cases, three (15.5%) failures, all treated with vaginal hysterectomy, occurred within 6 months of surgery. Six women subsequently had full-term pregnancies with no recurrence of prolapse, although the duration of follow-up is unknown. Postoperative morbidity occurred in four (20%) patients: genitourinary tract infection in one, pelvic cellulitis in two and atomic bladder in one. Although Williams found this procedure to have low morbidity and high success in patients without marked vaginal relaxation, this study is limited by its small sample size and its lack of controls. Furthermore, the method with which women were assessed perioperatively is not described.

Sacrosinous hysteropexy

Richardson et al. [29] reported on a transvaginal sacrosinous hysteropexy in a case series of five patients with uterovaginal prolapse ranging in age from 24 to 31 years. First, the uterosacral ligaments are identified via a posterior colpotomy. The right sacrosinous ligament is then exposed and attached to the uterosacral ligaments, and the posterior colporrhaphy is completed. Four of the five patients underwent concurrent Pereyra or Stamey procedures for stress urinary incontinence. During the follow-up period of 6–24 months there were no recurrences of prolapse; no pregnancies were reported. Although this case series supports the concept of uterine preservation during the management of uterovaginal prolapse, it is limited by its very small sample size and its lack of controls. Concerns that some surgeons have expressed regarding the asymmetry of unilateral sacrosinous vaginal vault fixation are likely to be exaggerated with the uterus in situ; no comment is made with regard to patient comfort or the development of postoperative dyspareunia. Furthermore, no description of preoperative evaluation of degree of uterine prolapse and concurrent pelvic support defects is included.

Kovac and Cruishank [30] subsequently reported results of transvaginal sacrosinous uterosacral fixation in a case series of 19 women aged 17–37 years with a mean parity of 1.3; all had symptomatic uterovaginal prolapse and desired fertility. Eight patients (four parous) had stage 2 uterovaginal prolapse, and 11 (nine parous) had stage 3 or 4 prolapse. All had markedly attenuated uterosacral ligaments on examination. The rectovaginal space was entered via a posterior colpotomy. Uterosacral ligaments were then anchored to the sacrosinous–coccygeus complex, unilaterally (right side) in four patients and bilaterally in the remaining 15; a McCall culdoplasty was performed concurrently. Other concurrent procedures were performed as indicated and included anterior and posterior colporrhaphy, enterocoe repair, paravaginal repair and anti-incontinence procedures. Mean follow-up time was 3.1 years, with two patients lost to follow-up. Pre- and postoperative assessments were performed by operating physicians.

These authors reported one rectal injury repaired with no sequelae and no bladder or nerve injuries. Average OR time for the sacrosinous fixation was 15 min, with an average EBL of 75 ml (200 ml with adjunct procedures) and an average hospital stay of 2.4 days. Eleven of 12 patients not achieving pregnancy retained excellent vaginal depth with no defect recurrence in the follow-up time. The one recurrence, a patient who initially received a unilateral procedure, was treated with a second, bilateral, suspension. Five patients achieved six uncomplicated vaginal deliveries; although four of these retained excellent support, one subsequently underwent a vaginal hysterectomy for recurrent moderate uterovaginal prolapse. Since the original report, eight additional sacrosinous uterosacral fixations with three resultant vaginal deliveries have been reported. These authors found sacrosinous fixation to be a feasible option for the correction of uterovaginal prolapse. Vaginal depth, axis and function are restored, and enterocoele formation is avoided by uterosacral plication. The authors feel that this procedure avoids the problems of recurrent prolapse, decreased fertility and dyspareunia seen with other uterus-sparing procedures, and is less time consuming with decreased morbidity and recovery time compared to transabdominal techniques. However, pre- and postoperative assessments were not blinded, and subjective data were not routinely collected. In addition, this study is limited by its lack of controls.

Maher et al. [31] subsequently reported the results of a similar procedure in 70 women ranging from 23 to 87 years of age with symptomatic stage 3 or 4 uterovaginal prolapse. Eligible patients were offered sacrosinous hysteropexy or total vaginal hysterectomy with sacrosinous vault fixation; 34 selected sacrosinous hysteropexy. The groups were similar in age, parity, BMI, menopausal status, prior pelvic reconstructive surgical history, presence of stress incontinence, and percentage with grade 2 or 3 vault prolapse. The groups were retrospectively assessed for subjective outcomes via standardized questionnaires and visual analog scales, and objective success via site-specific vaginal examinations. Data regarding time to return to normal activity, OR time, EBL, transfusion requirement and thromboembolic events were also collected. Women were independently evaluated by a non-surgical author blinded to the surgery performed. Mean follow-up time was 26 months for the hysteropexy group and 33 months in the hysterectomy group, with seven patients in each group lost to follow-up.
Subjective success rates were similar for the hysterectomy and vaginal hysterectomy groups (78% and 86%, respectively) as were objective success rates (74% vs 72%), patient satisfaction rates (85% vs 86%), and duration of hospitalization. When women achieving pregnancy after surgery were excluded, the rate of recurrence was 3.6% (one of 28 patients). No patients required transfusion or experienced thromboembolic events. Mean OR time was significantly shorter for the hysterectomy group (59 vs 91 min), and EBL was significantly lower for the hysterectomy group (198 vs 402 ml). These authors concluded that sacrospinous hysterectomy is an effective alternative to hysterectomy in treating uterovaginal prolapse, with decreased mean OR time and EBL. Though retrospective and non-randomized in nature, this study benefits from several methodological strengths, including the use of controls, the standardized assessment of subjective outcomes, and the objective patient assessments by a blinded non-surgical author.

Abdominal procedures

Sacrohysterectomy/sacrocervicectomy

Various transabdominal approaches to the surgical correction of uterovaginal prolapse with uterine conservation have been described. In 1955, in a case series of 22 women ranging in age from 18 to 44 years, Stoesser described a transabdominal sacrocervicectomy for women with uterovaginal prolapse and markedly attenuated uterine support ligaments [32]. After excising a strip of external oblique fascia through an abdominal incision, the retroperitoneum was entered via the posterior cul-de-sac. The strip of fascia was then used to construct a ‘sacrocervicical ligament’ adjoining the posterior cervix to the sacral periosteum to provide uterine support. Initially, rectus sheath and abdominal scar derivatives were used to create sacrocervicical ligaments; subsequently, external abdominal oblique aponeurosis was found to be superior. Twenty-one patients underwent simultaneous surgical procedures, including appendectomy, cervical cataractomy, myomectomy, resection of endometriosis, colporrhaphy, presacral neurectomy and round ligament plication. After the performance of 17 procedures with coincident round ligament plications, it was felt safe to omit this plication in future cases. Stoesser reports ‘good’ operative results with no postoperative infections or failures. Stoesser’s case series supports the feasibility of uterine preservation but is limited by its small sample size and the ‘short’ (undefined) duration of follow-up. Further, there is no mention of baseline degree of prolapse, and it is unclear how patients were assessed pre- and postoperatively.

Addison et al. [33] have described a transabdominal hysterectomy using Mersilene mesh (Ethicon, Somerville, NJ) as a suspensory bridge in three women with total uterovaginal prolapse. Two women, both in their 20s, were born with bladder extrophy and had undergone prior urinary diversion; the third, 18 years of age, had uterine prolapse of unknown etiology. Following a Halban culdoplasty, a triangle of mesh was attached to the posterior lower uterine segment and to the anterior sacral surface retroperitoneally. In the initial small case series, Addison et al. report no recurrences during an undefined follow-up period; they also report no subsequent pregnancy. The author acknowledges that sufficient data with which to assess this procedure do not yet exist; in addition to the very small number of patients in this series, details regarding pre- and postoperative assessment and follow-up duration are omitted. Sufficient data to comment on the incidence and impact of synthetic mesh erosion are also lacking.

Pectineal ligament suspension

Joshi [34] has described a transabdominal procedure for uterine suspension via the pectineal ligaments. In this technique, the abdomen and subsequently the retroperitoneal space are entered through a Cherney incision; the uterus is suspended to the pectineal ligaments bilaterally with Mersilene tape. In this case series of 20 women ranging in age from 17 to 32 years, simultaneous Burch procedures were performed in five patients, anterior colporrhaphy in one, posterior colporrhaphies in three patients, and Moschcowitz culdoplasty in one. Joshi reported no intraoperative or postoperative complications. Except for one woman who was lost to follow-up after 6 months, all patients were followed regularly for 6–30 months. The author reports no long-term morbidities or recurrence of symptoms during the follow-up period, although he does not specify how patients were assessed, by whom they were assessed, or at what frequency. He does note that of nine women desiring further childbearing, seven conceived within 6 months of surgery. Except for one patient who had symptoms of threatened abortion, all had uneventful antenatal courses. At the time that this case series was initially reported, five had delivered vaginally at term with no recurrence of prolapse at 6 weeks postpartum; two were still pregnant. Joshi suggests that the suspension of the uterus from strong ligaments such as the pectineal ligaments via Mersilene tape, which has good tensile strength, minimizes the chances of prolapse recurrence. He also notes that this procedure has the advantage of requiring minimal dissection in an area which is distant from important structures, including the ureters, the rectosigmoid colon and the median sacral vessels. The author of this case series concludes that the technique of uterine suspension from the pectineal ligaments 'may be considered a simple, safe, and effective treatment for [uterine] prolapse of any degree in young women'. However, he also acknowledges the limitations of this
study owing to its small sample size and limited duration of follow-up, and he suggests that further study is warranted to evaluate this technique.

Combined procedures

Retropubic suspension

Nesbitt [35] has described a combined vaginoabdominal retropubic suspension of the uterine isthmus and vesical neck for the correction of combined uterovaginal prolapse and stress urinary incontinence with uterine conservation. First the vesical neck, paraurethral tissues, uterine isthmus and uterosacral-cardinal ligament complex were mobilized transvaginally, and a Moschowitz culdoplasty performed. The paraurethral endopelvic fascia and the uterosacral-cardinal ligaments were then suspended from the conjoined tendon via a transverse suprapubic incision. Nesbitt reviewed operative outcomes in a case series of 16 patients ranging in age from the third to the eighth decades; seven had previously undergone between one and three anti-incontinence procedures. Additional procedures for PCOS, fibroids, vulvar disease and anal sphincter incompetence were performed in four of the patients. Patients were followed for 5 years or longer; no unusual operative or postoperative complications, and no recurrences of symptomatic uterine prolapse or stress incontinence were reported. Subsequent pregnancies have not been reported. Nesbitt suggests that anatomic reconstruction is accomplished without severing natural supports and without major dissection, which might denervate the urethral sphincter; the cervix and uterus remain readily accessible for screening and diagnostic procedures. Although this study supports the concept of uterine preservation, its results are limited by the small sample size and the lack of a control population.

Laparoscopic procedures

Round ligament plication/suspension

With modern innovations in minimally invasive surgery, several laparoscopic procedures for the treatment of uterine prolapse with uterine preservation have been described. O'Brien et al. [36] presented a case series in which nine postmenopausal women with genital prolapse awaiting vaginal surgery were recruited to undergo laparoscopic round ligament ventrosuspension. The procedure involved laparoscopically advancing segments of the round ligaments through the rectus sheath with ligament fixation. Within 3 months, eight women had recurrent prolapse; four later underwent anterior repair and four underwent vaginal hysterectomy with anterior repair. Only one woman remained asymptomatic 18 months postoperatively.

Uterosacral plication/culdoplasty

Wu [37] subsequently described a more successful laparoscopic approach to the surgical management of uterine prolapse with uterine conservation. In this case series, seven women ranging in age from 32 to 37 years with a mean parity of 2.1 and with moderate to severe uterovaginal prolapse underwent laparoscopic high McCall colpoclepsy. Three pursestring sutures were laparoscopically passed from the left uterosacral ligament, through the posterior vaginal wall and cervix, the right uterosacral, the peritoneum of the rectosigmoid gutters, the serosa of the rectosigmoid, and then back to the left uterosacral. Anterior/posterior repair and Burch colposuspension were performed as indicated. Average hospital stay was 1.7 days, and during the follow-up time of 9–17 months no recurrent prolapse occurred. Although this study involves few patients with a short period of follow-up, it lends credence to the concepts of uterine conservation and laparoscopic management of uterovaginal prolapse, with the attendant advantages of minimally invasive surgery.

Maher et al. [38] have also reported laparoscopic correction of uterovaginal prolapse with uterine preservation. In this case series, 43 women with symptomatic uterine prolapse to or beyond the introitus underwent laparoscopic suture hysteropexy via the Hassan technique. After completing a Moschowitz culdoplasty, the uterosacral ligaments were plicated in the midline and reattached to their normal anatomic cervical insertion points. Concomitant laparoscopic Burch colposuspension was performed in 15 patients, laparoscopic paravaginal repair in 13, anterior repair in eight, and posterior repair in 28 patients. Each woman was assessed via a standardized history and site-specific vaginal examination during Valsalva, performed by the authors. These authors reported mean hysteropexy and total OR times of 42 and 99 min (respectively), a mean EBL of 148 ml, a mean hospitalization of 5 days and a mean return to normal activities of 25 days. At follow-up examination, subjective and objective success was reported in 35 (81%) and 34 (79%) patients, respectively. Seven (16%) later required further surgery for recurrent uterine prolapse; these women did not differ from the others in age, parity, BMI or degree of preoperative prolapse. One patient's left uterine artery was lacerated intraoperatively, necessitating repair via laparotomy; no postoperative complications occurred. Two women subsequently underwent cesarean sections for term pregnancies without recurrent prolapse. Although limited by its lack of a control group and its short follow-up period, this case series found laparoscopic suture hysteropexy to be effective; the standardized histories and examinations further strengthen this study. These authors found the surgical result to be anatomically correct, suggesting that this procedure may be appropriate for women with uterovaginal prolapse desiring uterine conservation without
the morbidities and long recovery periods of abdominal surgery.

Table 1 summarizes the reports included in this review.

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Procedure</th>
<th>n</th>
<th>Follow-up duration</th>
<th>Failure and/or reoperation rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thomas</td>
<td>1995</td>
<td>Manchester</td>
<td>88</td>
<td>22 days to 4.6 years</td>
<td>6%</td>
</tr>
<tr>
<td>Conger</td>
<td>1958</td>
<td>Manchester</td>
<td>960</td>
<td>Unstated</td>
<td>4.3%</td>
</tr>
<tr>
<td>Tipton</td>
<td>1970</td>
<td>Manchester</td>
<td>82</td>
<td>6-12 years</td>
<td>21% b</td>
</tr>
<tr>
<td>Williams</td>
<td>1966</td>
<td>Vaginal uterosacral plication</td>
<td>20 (1 lost to follow-up)</td>
<td>Not stated</td>
<td>15%</td>
</tr>
<tr>
<td>Richardson</td>
<td>1989</td>
<td>Sacrospinous hysterectomy</td>
<td>5</td>
<td>6-24 months</td>
<td>None</td>
</tr>
<tr>
<td>Kovac</td>
<td>1993</td>
<td>Sacrospinous fixation of uterosacral ligaments</td>
<td>19 (2 lost to follow-up)</td>
<td>1-6 years</td>
<td>5%</td>
</tr>
<tr>
<td>Maher</td>
<td>2001</td>
<td>Sacrospinous hysterectomy</td>
<td>34 (7 lost to follow-up)</td>
<td>5-81 months</td>
<td>26% (3.6% excluding women who subsequently became pregnant)</td>
</tr>
<tr>
<td>Stoesser</td>
<td>1955</td>
<td>Abdominal sacrocolpopexy</td>
<td>22</td>
<td>Unstated</td>
<td>None</td>
</tr>
<tr>
<td>Addison</td>
<td>1993</td>
<td>Abdominal sacrocolpopexy</td>
<td>3</td>
<td>6 weeks to 20 years</td>
<td>None</td>
</tr>
<tr>
<td>Joshi</td>
<td>1993</td>
<td>Pectineal ligament suspension</td>
<td>20</td>
<td>6-30 months</td>
<td>None</td>
</tr>
<tr>
<td>Nesbitt</td>
<td>1989</td>
<td>Vaginoabdominal retropubic hysterectomy</td>
<td>16</td>
<td>5-10 + years</td>
<td>None</td>
</tr>
<tr>
<td>O’Brien</td>
<td>1994</td>
<td>Laparoscopic Round ligament ventrosuspension</td>
<td>9</td>
<td>3-18 months</td>
<td>89%</td>
</tr>
<tr>
<td>Wu</td>
<td>1992</td>
<td>Laparoscopic high McCall suspension</td>
<td>7</td>
<td>9-17 months</td>
<td>None</td>
</tr>
<tr>
<td>Maher</td>
<td>2001</td>
<td>Laparoscopic uterosacral suspension</td>
<td>43</td>
<td>6-32 months</td>
<td>16%</td>
</tr>
</tbody>
</table>

*Objective data given where available
bIncluded surgery for non-prolapse indications

The current body of medical literature surrounding the concept of uterine preservation during surgery for uterovaginal prolapse is inadequate to assist physicians in determining which patients are ideal candidates for uterine conservation and in selecting the ideal uterusparing procedure for a given patient. The decision will be determined by both the patient’s preferences and the surgeon’s skills and experiences. However, pelvic floor reconstruction with uterine preservation has been shown to be feasible and safe. Well designed comparative studies of pelvic floor reconstruction with and without hysterectomy are currently not available. Studies involving more patients, longer follow-up, appropriate controls and objective assessment techniques are certainly necessary before we can routinely recommend uterine preservation at the time of uterovaginal prolapse surgery. Although continued evaluation of uterine preservation during pelvic reconstruction will further assist women and their physicians in determining the most ideal treatment options, the current literature suggests that uterine preservation at the time of pelvic reconstructive surgery may be considered in appropriately selected women who desire it. It is imperative, however, that those women deemed appropriate candidates fully understand the ongoing possibility of incurring uterine and cervical pathology over time, and the need for continued, routine surveillance measures to assess for such pathology.

References