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Pelvic organ prolapse surgery. What techniques should be used?

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Urogynecology, a field of medicine that deals with pelvic floor diseases in women, is increasingly taking a key place in both the percentage of surgical interventions in gynecological departments and the number of women treated for this reason in outpatient care. Therefore, we increasingly ask the question how to treat to achieve the best therapeutic result. This question refers to many aspects of therapy, ranging from the objective effectiveness, the impact on the quality of life in all its aspects, perioperative risk, the risk of recurrence, the difficulty of the procedures used, the learning curve and, finally, the costs for the health care system.

The last 30 years have been years of intensive development of urogynecology, a time in which we try to understand the mechanisms of pelvic organ prolapse, introduce new techniques, return to old ones and learn from our own mistakes.

At that time, effective methods of treating urinary incontinence were introduced, *e.g.*, suburethral slings, the use of transvaginal meshes was widely introduced and then almost abandoned, and laparoscopic techniques in various technical versions began to be widely used.

Due to FDA warnings regarding the use of transvaginal meshes, implants were withdrawn in many countries, although today experience shows that it was not the implants themselves that were responsible for the complications, but the lack of understanding of the mechanisms of static disorders, the lack of reference to the repair of the apical compartment in most systems, and poor qualifications for specific procedures including the use of meshes [1].

This led to the creation and recommendations indicating that in order to avoid complications and ensure the safety of patients, surgical treatment of pelvic organ rolapse should start with the minimally invasive procedures, including, above all, native tissue repair.

And here the question arises: what does a minimally invasive procedure mean? Does this mean no synthetic materials are used? Does this mean vaginal rather than abdominal access? Does this mean the procedure is the shortest, the easiest technically, or the cheapest for the medical care system?

I am sure that each reader will have a different answer to this question and potentially propose a different procedure as the one they would consider minimally invasive and the best.

Some elements of this answer are obvious. We will adapt the technique to the type of defect and the mechanism of damage of the pelvic floor structures. We will propose a safe procedure that is adapted to the patient's general condition. But whether we should use native tissue repair, vaginal, abdominal, laparoscopic aproach, use synthetic material or not — this will be the subject of heated discussion.

This is where the element of individualization of the technique and approach to the patient and her problem comes into play. This is also where the philosophy of treating pelvic floor disorders should be different than in the past.

What do we deal with in the case of pelvic organ prolapse? Certainly with anatomical pathology, certainly with functional disorders in the lower urinary tract, colorectal problems, sexual dysfunctions and undoubtedly with the patient's self-esteem and psychiatric status [2–4]. The anatomical defect is for sure the leading symptom seen by the urogynecologist, but for the patient it is associated with numerous dysfunctions in many areas of her life.

Therefore, the current priority goal in the treatment of pelvic organ prolapse is not so much to obtain an anatomical effect that corrects the defects to the POP0 stage, but to improve the quality of life in all impaired areas.

Given the above, what procedures should we choose and should native tissue repair always be the first choice? Shouldn't we have the right to use, for example, scarocolpopection first, in the case of an apical defect, in a situation where we expect a recurrence after using vaginal techniques? In an older, obese, sexually inactive patient with an apical and anterior defect, should we always start with the native tissue technique, with a high risk of recurrence and

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the need for reoperation, while the use of a well-designed transvaginal implant would bring good results with a minimal risk of recurrence and complications?

In my professional experience, I have come across very different approaches to this issue. Some specialists believe that procedures in which you have the most experience should be performed. Some believe that the use of a transvaginal implant is justified only in case of recurrence after using the native tissue repair. Colposacropexy, despite its high effectiveness and safety, is sometimes considered a difficult and expensive technique.

So what should qualification for surgery look like in an ideal world? What challenges and problems does urogynecology face? Is it possible to recommend general principles regardless of where we are in the world? And finally, should every gynecologistp ractice urogynecology? In the case of hysterectomy, it does not really matters whether the procedure was performed by a specialist or a resident. The only thing that may change is the recovery time, the operation time itself, or, for example, blood loss, the consequences of which will not be felt after two weeks. In the treatment of pelvic organ prolapse, incorrect selection of technique, incorrect use of a specific technique, recurrence or complications will accompany the patient throughout her life.

Therefore, the way we perform surgery is crucial for our patients. When undertaking surgical treatment of pelvic organ prolapse, we should be aware of all complaints accompanying the prolapsus. Examine, preferably using validated questionnaires, areas in which both anatomical and functional aspects are disturbed. In the second stage, it is necessary to define to what extent individual problems affect the patient's functioning and how much they interfere with her daily life. And finally, taking into account the general condition of the patient, the her other diseases and her own expectations, we should propose optimal surgical treatment tailored to each individual patient [5].

What does this mean in our everyday practice? First of all, a specialist undertaking surgical treatment should be well-educated in his field, so as to be able to diagnose the patient's pathology in all affected areas, he should have the widest possible range of surgical procedures, and he should also be able to solve problems in the event of complications.

This is needed to solve all the patient's problems through surgery. Lower urinary tract symptoms, potential colorectal symptoms, sexual dysfunction, and prolapsus per se should be addressed. We need to understand the consequences of the selected technique, which may be irreversible even after using native tissue repair, analyze the sequence of procedures in the case of multi-stage treatments, which are becoming more and more common, modify and individualize the therapy.

Therefore, in my opinion no recommendations will indicate the most appropriate surgical technique, universal for every patient, and the selection of the most appropriate one must be based on deep knowledge and experience in this field.

Does this mean the need to create specialized centers? Certainly yes.

Does this mean that one need to perform a large volume of procedures to become proficient in them? Definitely yes.

But above all, it requires training, learning and endless learning for the benefit of our patients.

Therefore, once again, I appeal to the decision-making bodies to create conditions for such training of specialists.

Article information and declarations

Conflict of interest

The author declares no conflict of interest.

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