Obliterative Procedures for Pelvic Organ Prolapse
Le Fort Partial Colpocleisis

Introduction
• 63 million women will be 45 yrs or older by 2030.
• 33% will be postmenopausal by 2050.
• 11% of all women will undergo POP or incontinence surgery.
• Some studies suggest a reoperation rate of 30% with most being the anterior compartment.

Historical Perspective
• Gerardin, a Frenchman in 1823 was the first to suggest, but not perform, an operation for complete procidentia by denuding the anterior and posterior walls and suturing them together.
Historical Perspective

• JA Neugebauer, a German in 1867 first performed a colpocleisis but did not publish until 1881.

Historical Perspective

• LeFort published a report on this operation in 1877. He added a colpoperineorrhaphy as his modification. Many others followed in publishing after this.
Historical Perspective

• Martin in 1898 described a total colpectomy and colpocleisis at the time of hysterectomy or post hysterectomy.

Historical Perspective

• Rubovits and Litt in 1935 added a Levator Plication to the procedure.

Preoperative Evaluation

• When choosing patients for an obliterative procedure one must base it on age, medical comorbidities, desire for sexual function, and patient preference as well as your personal skill level.
• General anesthesia or spinal are best but one can perform this under local quite easily.
Preoperative Evaluation

• As always, a thorough history and physical exam is of paramount importance especially when trying to determine if a mid urethral sling will be needed.
• A gaping introitus frequently precludes the use of a pessary.

Preoperative Evaluation

• TVUS is needed to evaluate the endometrial cavity. An EMB or a D&C is necessary if the endometrial stripe is 4mm or greater. Urodynamics and IVP are rarely needed. However, reducing the prolapse and having the patient valsalva can be helpful.

Techniques and Outcomes

• The ideal candidate for a LeFort partial colpocleisis has uterine procidentia and symmetric eversion of the anterior and posterior vaginal walls.
Techniques and Outcomes

• Let’s take a look at the procedure on a patient in Togo, West Africa performed last March.
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**Outcomes**

- 90-95% achieve good anatomic results.
- Recurrence or breakdown occurs in 2-5% and is usually secondary to hematoma or infection and occasionally poor technique or failing to perform a high perineorrhaphy.
- SUI may be as high as 27-48%.

**Additional Procedures for Improvement in Outcome**

- Levator Plication
- High Perineorrhaphy
- Mid Urethral Sling
- Kelly Plication

**Urinary Function**

- It is very difficult to predict urinary function after colpocleisis.
- One must obtain a good history of leakage before their prolapse as well as after the prolapse in order to make the decision to perform a Kelly Plication or a Mid Urethral Sling.
Urinary Function

Sling lysis rates are 2-7% after colpocleisis. Many studies show it may be best to put the sling on everyone but I would caution against doing this. If need be, then place it at a later date. Read the studies as they are numerous. My personal experience shows fewer slings are placed if you wait. The High Perineorrhaphy may be responsible for maintaining continence [reduces downward traction on the urethra].

Quality of Life and Regret

Most studies have shown >90% satisfaction for complaints of vaginal bulging, urinary frequency and urgency, restoration of normal anatomy, and self image.

Quality of Life and Regret

>80% were satisfied with physical activity, urinary leakage and bladder emptying. >65% were satisfied with colorectal symptoms.
Conclusion

- Obliterative procedures for POP continue to be an excellent option for patients who desire to avoid extensive reconstructive procedures or who have comorbidities that preclude such an option. It is not difficult to perform and can be done quickly and efficiently.
References