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EDITORIAL

ABDOMINAL REPAIR OF CYSTOCELE

The repair of cystocele by the abdominal route is not a common practice and is usually restricted to cases undergoing abdominal hysterectomy. The common technic used is to support the vaginal vault with parametrial stumps and the anterior vaginal wall by triangular excision, the base of the triangle being at the vault and the apex towards the bladder neck. Should there be an enterocele, a similar procedure on the posterior vaginal wall alongwith obliteration of the peritoneal cul-de-sac is carried out.

This technic which covers the transverse and midline defects at the vaginal vault however fails to support the paravaginal or the bladder neck areas. The result is a recurrence of cystocele, stress urinary incontinence or vault prolapse.

A. C. Richardson of Atlanta, U. S. A. who made a special study of this problem feels that the pubocervical fascial defects are not correctly identified pre-operatively. In addition to the midline defects, the vaginal walls can prolapse in the paravaginal sulcii. This is quite possible as the pubo-cervical fascia has paravaginal attachments to the white line, the fascial origin of the levator ani muscle. When the lateral attachments of the pubocervical fascia are attenuated, the entire anterior vaginal wall will descend. He feels that the paravaginal defects are more common and is seen in 85% of the cases while the central defect is in only 15%, a minority. The standard procedure of supporting only the top or midline regions of the vaginal walls will thus fail, eventually causing a recurrence.

The abdominal operation advocated by him is paravaginal colpopexy. It is similar to the Burch colpopexy but differs

in two main respects. Firstly, the superior point of fixation is the white line; the tendinous origin of levator ani and not the Cooper's ligament and secondly the region of vaginal fixation is from the bladder neck region right upto the vaginal vault and not restricted to the paraurethral regions. Since he performs this operation even in cases where no hysterectomy is done, the dissection of the bladder from the lateral vaginal sulcus is aided by operator's fingers in the vagina. He places the top suture at the vaginal vault first and then proceeds up and down along the white line. The line of the sutures in the end extends from paraurethral region to the point about 1 cm anterior to the ischial spine. The procedure is carried out on both sides. The veins in the region are coagulated or underrun with sutures. Synthetic non-absorbable sutures are used. Using this technic in over 1000 cases Richardson has good result in all his cases, but he still considers the operation not suited for cases of established stress urinary incontinence.

Few gynecologists from all over the world will have the same enthusiasm for the abdominal paravaginal colpopexy for surgery of cystocele alone. A trans-vaginal operation achieving the same results has been described and practised in the past. However the extensive experience gained by Richardson with his abdominal operation will be of great help to the surgeon who has to manage a cystocele repair along with abdominal hysterectomy. The author has given this procedure a trial in abdominal hysterectomy cases and finds it quite satisfactory provided that the supporting of the vaginal vault and enterocele repair is also carried out simultaneously.

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