OPEN ACCESS

PEER-REVIEWED JOURNAL

# SCIENCE REVIEW

Scientific Edition

Published by:

World Science

RS Global

**Open Access Peer-reviewed Journal**

# Science Review

**1(8), January 2018**
**Vol.3**

**Publisher** –
RS Global Sp. z O.O.,

Scientific Educational Center
Warsaw, Poland

Numer KRS: 0000672864
REGON: 367026200
NIP: 5213776394



**Publisher Office's address:**
Dolna 17,
Warsaw, Poland,
00-773

**Website:**
https://ws-conference.com/
**E-mail:**
rsglobal.poland@gmail.com
**Tel:**
+4(857) 898 55 10

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# PELVIC PROLAPSE - AS ONE OF THE MANIFESTATIONS OF VENTRAL HERNIA, THE BENEFITS OF LAPAROSCOPIC ACCESS

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***Abstract.*** *The different treatments of pelvic hernia or pelvic prolapse were analyzed. 83 patients with pelvic prolapse were treated. The 1st group – 43 patients with pelvic hernia who were under laparoscopy sacrocolpopexy with mesh; 2nd group – 40 patients with pelvic prolapse who were under the different pelvic surgery. During the research found that laparoscopy is better and more physiological looking on the fact that pelvic hernia starts from abdominal cavity and, so, should be corrected from abdominal cavity. It was proved by results – in the 1st group the relapse was just once, but in the 2nd group it happened in 15 %, there were not mesh – associated complications in the 1st group, but in the 2nd group there were from 7 to 20 % of them.*

***Keywords:*** *pelvic hernia (pelvic prolapse), laparoscopy sacrocolpopexy, mesh-associated complications, pelvic hernia relapse.*

**Introduction.** Annually in Ukraine about 90000 operations are performed on hernial postoperative defects [1]. A separate case of ventral hernias of the lower floor of the abdominal cavity is a pelvic prolapse or pelvic hernia. One of the reasons leading to a pelvic prolapse is laparoscopic panhysterectomy, laparoscopically assisted vaginal hysterectomy, vaginal hysterectomy, which intersects the ligamentous apparatus of the uterus using electrocoagulation, previously transmitted by patients. As a result, the scar in the area of intervention is formed by a secondary tension. Thus, conditions are created for the formation of weaknesses in the lower abdominal cavity, which lead to the appearance of ventral hernias of the pelvis - prolapses [2].

In modern literature, there is a large amount of information on the causes and mechanisms of development of various variants of pelvic prolapse, including the proposed and substantiated set of techniques for its correction.

In particular, the simplest and practically applicable is the division into anterior prolapse or cystocele, central prolapse, posterior prolapse or enterocele.

All of the above types of prolapse are divided into four degrees, depending on the degree of severity [2].

The anterior or central prolapse to date is, as a rule, one of the manifestations of urogenital maladaptive deficiency.

Central prolapse is a consequence of insufficiency of the ligament apparatus of the uterus and its appendages.

Rear prolapse occurs, as a rule, due to the failure of the basal muscle of the pelvic floor - m. levator ani

As a rule there is a combination of different variants of genital prolapse with different degrees of its severity.

The most common method of correction of genital prolapse continues to be surgical treatment. The most common access to the present remains - pelvic, which is used in urology, gynecology, and surgery. To date, in our country, as in many countries of the world, a new specialty has appeared - pelvic surgery, which requires a surgeon to fully understand the anatomical features of the pelvic floor, the complex relationship between the adjacent organs.

The most simple and most common operation is the anterior colporarhia (there are many methods of this operation, proposed by various authors, the essence of which is to restore the relationship between the legs of the urogenital orifice with its own tissues) in conjunction with colpoperineurrafia with levatoroplasty.

However, it should be noted that this technique has up to 25 % relapse within the next six months, which is not acceptable, while the use of mediastinal colporrhage to correct the central prolapse is not appropriate from the standpoint of onco-alertness.

To date, in all countries of the world there is a widespread use of allotransplants in the surgical correction of the pelvic floor. It's about such operations as TVT, TVT-O, and various variants of the pelvic PROLIFT [3]. These operations are well tolerated by patients, usually taking 1-2 beds per day, with practically no relapses; however, more and more information has recently appeared in the literature about a rather high percentage of complications associated with the individual intolerance of the prosthesis. In particular, the formation of bedsores and erosion of the vaginal mucosa, the formation of granules and abscesses in the area of the grid, diasporeuniya, expressed pain in sexual intercourse [4].

To date, sacrocolipopecia is becoming increasingly common with the use of allograft (mesh) laparoscopic access [5]. In our country, in many surgical and gynecological hospitals, despite the modern equipment and the availability of laparoscopic equipment, this technique has not been widespread due to its so-called labor intensity, as well as the needs of high surgical skills and knowledge of the electrosurgery required by medical personnel for its safe implementation. Indeed, unified methods of conducting and fixing mesh prosthesis in various pelvic access modifications, at first glance, do not require an absolute understanding of anatomy of the small pelvis and have not been prolonged over, have found wide application and are popular among practicing surgeons. And yet, one should pay attention to the fact that the pelvic prolapse begins with the abdominal cavity and, accordingly, surgery for its correction should also begin with the abdominal cavity. During laparoscopic sacrocolipopecia, the surgeon works in close proximity to the urinary bladder, ureter, trunk vessels, and the rectum has a clear visualization of the tissues to which the prosthesis is fixed, which, in our opinion, is much safer. Than the establishment and fixation of the net with pelvic access, when the surgeon is forced to act in the blind [6].

*The purpose of improving* – the results of treatment of pelvic prolapse using laparoscopic access using alotransplants (nets).

**Materials and methods.** Only at the clinical bases for the period from 2015 to 2017 were treated 83 patients with genital prolapse after laparoscopic uterine extravasation, laparoscopically assisted vaginal hysterectomy, transvaginal hysterectomy. All patients were divided into 2 groups: 1 group - 43 patients who had laparoscopic sacrocolipopecia using alotransplants, and 2 groups – 40 patients, for which the pelvic floor correction was performed with different variants of the pelvic access. The age of the patients varied from 41 to 80 years. All patients in the postoperative period examined at the expiration on the 3rd day, after 1, 2, 6 months and 1 year. Groups of patients were evaluated for the above-mentioned period of time from the positions of the frequency of the following complications: mesh-associated complications (erosion of the vaginal mucosa in the location of the net, shrinkage of the mesh, abscessing of tissues in the area of the localization of the mesh, diazareuronia, sinechia in the vagina), pain during intercourse, relapse prolapse (and 1-2 degrees of omission were not considered as a problem).

**Results and discussion.** In group 1, there was no case of erosion, wrinkling or abscessing of the net; no cases of sinechia in the vagina or discomfort in the sexual intercourse were observed, dyspareunia was observed in 45 % of patients within 2 months, after 6 months and years of patients did not complain about pain. Regarding relapse, there was a 1 case in a patient of 68 years who, after 3 weeks after sacrocolipopecia, had the need to remove the alotransplantant due to the reaction of periosteum (it should be noted that the patient suffered from an autoimmune disease, which became the cause of rejection) At examination, after 2 months, a central prolapse of 3 degrees was noted.

In 2 groups of patients, erosion of the vaginal mucosa was noted in 7 (15 %) (requiring incision of the edges of the wound and re-suturing), vaginal sinnehia occurred in 8 (20 %) patients. Sharpening of the mesh with abscessing of tissues occurred in 2 x (5 %) patients (requiring removal of parts of the prosthesis), the phenomena of dyspareunia remained for 6 months in 58 % of patients, one year later - remained in 35 % of patients. Virtually all patients in the two groups, to varying degrees, experienced discomfort and pain during intercourse throughout the year after surgery; relapse was noted in 15 % of women. It should be noted that the relapse of the prolapse in all cases is noted in patients after classical anterior colporarie in conjunction with colpoperinonephrine with levatoroplasty.

**Conclusions.** When choosing a treatment method in patients with pelvic prolapse after previous radical operations on gynecological pathology, it is advisable to give laparoscopic sacrocolipopecia with the use of an allotransplant (mesh), paying attention to the fact that pelvic prolapse is a separate manifestation of ventral hernia and its correction on the part of the abdominal cavity is the most effective.

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**Open Access Peer-reviewed Journal**

# Science Review

**1(8), January 2018**
**Vol.3**

SCIENTIFIC EDITION

Indexed by:

Academia.edu
share research

Passed for printing 22.01.2018. Appearance 27.01.2018.
Typeface Times New Roman.
Circulation 300 copies.
Publisher RS Global S. z O.O., Warsaw, Poland, 2018
Numer KRS: 0000672864
REGON: 367026200
NIP: 5213776394
https://ws-conference.com/

Open Access Peer-reviewed Journal

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Tel: +4(857) 898 55 10
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Publisher
RS Global Sp. z O.O.
Dolna 17, Warsaw, Poland