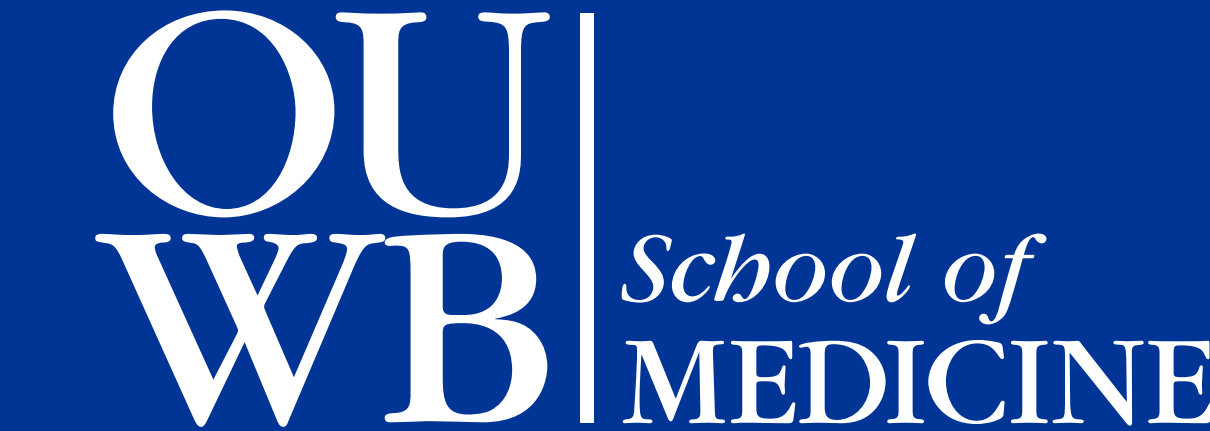
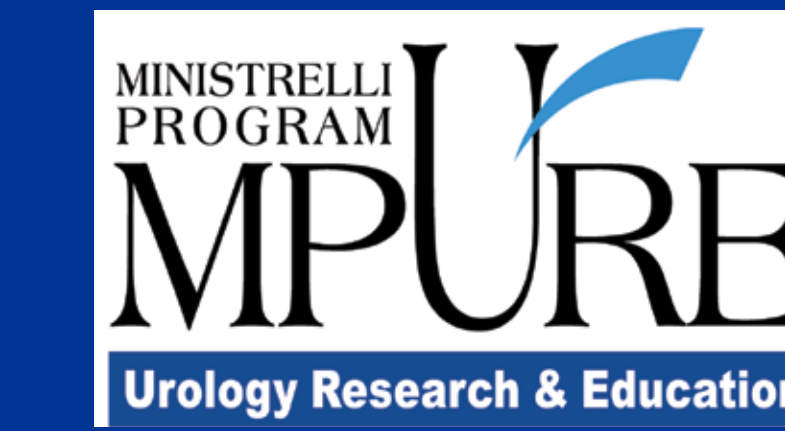


# Prolapse Surgery Improves Bowel Function Even when No Posterior Repair is Done

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## Introduction

- Women have a 19% risk of undergoing pelvic organ prolapse surgery in their lifetime<sup>1</sup>
- 76% of women with multiple compartment defects may have posterior compartment prolapse<sup>2</sup>
- Many studies report weak association between posterior vaginal support and specific anorectal symptoms<sup>3-5</sup>
- Currently, there is a general consensus that posterior repair is not completed unless symptomatic<sup>6</sup>
- We evaluated whether bowel function improved with surgical prolapse repair whilst comparing different approaches

## Methods

- Prospective database of prolapse patients
- Patients were grouped by having surgery (SGY) or no surgery (No SGY) within the first year
- Sub-analyses of the SGY group were performed: vaginal (Va) or abdominal (Ab) approach, with or without concurrent hysterectomy (HYS vs. No HYS), placement of mesh (mesh vs. No mesh), and with or without concurrent posterior repair (POS vs. No POS)
- Data collected:
  - History and baseline demographics
  - Colorectal-Anal Distress Inventory-8 (CRADI) collected at baseline (BL) and at 1 year follow-up

## Results

- Of 274 prolapse patients total, 230 were in the SGY group and 44 were in the No SGY group
- No significant differences in age, race, or marital status were found between SGY and No SGY groups
- 24.8% (57/230) of SGY patients underwent a concurrent posterior repair (POS); all vaginally
- 40.1% (57/142) of the vaginal group had a concurrent posterior repair
- CRADI scores in the SGY group improved significantly at 1 year; this was not found in the No SGY group
- Significant improvements in CRADI scores were seen for all within group comparisons for the SGY group (vaginal (Va) or abdominal (Ab) approach, with or without concurrent hysterectomy (HYS vs. No HYS), placement of mesh (mesh vs. No mesh), and with or without concurrent posterior repair (POS vs. No POS))

Table 1.

	Surgery (n)	No Surgery (n)	p-value
Median Baseline CRADI	21.9 (230)	15.6 (44)	0.05
Median 1 year CRADI	9.4 (176)	10.9 (38)	0.36
p-value within group	0.0001	1.00	

Table 2.

	Abdominal (n)	Vaginal (n)	p-value
Median Baseline CRADI	20 (75)	22 (142)	0.22
Median 1 year CRADI	9.4 (62)	6.3 (104)	0.76
p-value within group	0.0001	0.0001	

Table 3.

	Hysterectomy (n)	No Hysterectomy (n)	p-value
Median Baseline CRADI	14 (68)	28 (165)	0.012
Median 1 year CRADI	6.3 (52)	9.4 (125)	0.55
p-value within group	0.0002	0.0001	

Table 4.

	Mesh (n)	No Mesh (n)	p-value
Median Baseline CRADI	22 (177)	27 (56)	0.10
Median 1 year CRADI	9.4 (134)	12.5 (43)	0.29
p-value within group	0.0001	0.003	

Table 5.

	Posterior (n)	No Posterior (n)	p-value
Median Baseline CRADI	37.5 (57)	14 (85)	<0.0001
Median 1 year CRADI	9.4 (44)	6.3 (60)	0.37
p-value within group	<0.0001	0.019	

Tables above. Median CRADI scores at baseline and 1 year for surgery vs no surgery, abdominal vs. vaginal, with or without concurrent hysterectomy, mesh vs. no mesh use, and with or without concurrent posterior repair.

## Conclusion

Women who underwent surgical repair for prolapse had significantly improved CRADI scores regardless of vaginal or abdominal approach, with or without concurrent hysterectomy, placement of mesh, and with or without concurrent posterior repair.

## References

1. Smith FJ, Holman CD, Moorin RE, et al. Lifetime risk of undergoing surgery for pelvic organ prolapse. *Obstet Gynecol* 2010; 116: 1096-1100. DOI: 10.1097/AOG.0b013e3181f73729.
2. Guiahi M, Kenton K and Brubaker L. Sacrocolpopexy without concomitant posterior repair improves posterior compartment defects. *Int Urogynecol J Pelvic Floor Dysfunct* 2008; 19: 1267-1270. 2008/05/22. DOI: 10.1007/s00192-008-0628-5.
3. Barber MD. Symptoms and outcome measures of pelvic organ prolapse. *Clin Obstet Gynecol* 2005; 48: 648-661. 2005/07/14.
4. Hale DS and Fenner D. Consistently inconsistent, the posterior vaginal wall. *Am J Obstet Gynecol* 2016; 214: 314-320. 2015/09/05. DOI: 10.1016/j.ajog.2015.09.001.
5. Bradley CS, Brown MB, Cundiff GW, et al. Bowel symptoms in women planning surgery for pelvic organ prolapse. *Am J Obstet Gynecol* 2006; 195: 1814-1819. 2006/09/25. DOI: 10.1016/j.ajog.2006.07.008.
6. Pelvic Organ Prolapse Evaluation and Treatment, [https://university.aunet.org/core\\_topic.cfm?coreid=140](https://university.aunet.org/core_topic.cfm?coreid=140) (Created: December 28, 2017).

DISCLOSURES: None