

widely used procedure. It was originally developed as a therapeutic management of post-hysterectomy vaginal vault prolapse [4-5]. The indications for the procedure have recently been expanded to include its use for uterovaginal prolapse among patients who have received a vaginal hysterectomy and whose uterosacral-cardinal ligament complex seems insufficient to support the vaginal apex [6-7].

This study reviews our experience with sacrospinous colpopexy performed at the time of vaginal hysterectomy over a period of 3 years and discusses the anatomical and functional outcomes obtained, as well as the safety of the procedure.

Materials and Methods

Women with symptomatic uterovaginal prolapse who underwent a combination of vaginal hysterectomy and sacrospinous colpopexy between January 2006 and December 2008 at the Gynaecology Department of Jordan University Hospital were retrospectively evaluated. The only inclusion criterion was as follows: stage 2 or greater uterovaginal prolapse, which was based on the pelvic organ prolapse quantification system (POP-Q) [8]. Women who requested that their uterus be preserved were excluded. Ethical approval was obtained from the local ethics committee at the University of Jordan.

Surgical technique: Patients received surgical intervention under general or spinal anaesthesia while in the lithotomy position. Vaginal hysterectomy was completed first with high ligation of any enterocele sac and anterior vaginal wall repair. Sacrospinous colpopexy was performed as described by Nichols [9]. The posterior vaginal wall was incised

longitudinally from the introitus to the vaginal apex. Using sharp dissection, the vaginal epithelium was dissected from the rectovaginal fascia, and the rectum was reflected medially. The perirectal space was opened, and the dissection continued toward the ischial spines. A Miya hook [10] was utilised to deliver three delayed absorbable polydioxanone sutures (Ethicon, Somerville, NJ, USA) through the right sacrospinous ligament, 1.5 cm medial to the ischial spine to suspend the vaginal apex. The rectovaginal fascia was plicated in continuity with the perineum, and the vaginal incision was closed as previously described [11]. A vaginal pack was left overnight, and an indwelling catheter was maintained for 24 hours postoperatively. Patients who failed a voiding trial following catheter removal were taught to perform clean intermittent self-catheterisation. All participants received preoperative intravenous antibiotics (cefuroxime 1 g) and low-molecular weight heparin as antithrombotic prophylaxis.

Demographics, history of previous prolapse surgeries, the preoperative pelvic organ prolapse quantification system (POP-Q) score and peri-operative information, including operating time, blood loss, length of the inpatient stay, the duration of catheter use, time to return to activities of daily living and immediate and short-term complications, were collected. Postoperative evaluation occurred at 6 weeks after surgical intervention and every 6 months thereafter and included a pelvic examination with POP-Q assessment; patient satisfaction on a 0 to 10 visual analogue scale was also obtained. Functional outcomes were assessed by comparing pre- and postoperative pelvic floor symptoms related to bladder and sexual function.