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ROUHIER'S PROCEDURE : MODIFIED LEFORT COLPOCLEISIS WITH HYSTERECTOMY FOR COMPLETE PELVIC ORGAN EVERSION

Hypothesis / aims of study

Nowadays, in case of pelvic organ prolapse, patients are most often offered pelvic floor reconstructive surgeries. Surgery involving vaginal closure or colpocleisis is seldom chosen and is limited to fragile elderly patients. The benefits expected from colpocleisis are a shorter operating time, less surgical complications and a shorter hospital stay with a success rate between 91% and 100% [1]. However, colpocleisis can sometimes not be possible if the pelvic organ prolapse has been present for a quite long period and reintegrating the vaginal bulge inside the pelvis remains ineffective without prior hysterectomy. The aim of this video is to show how to perform a vaginal hysterectomy with colpocleisis. This procedure is required for complete pelvic organ eversion whenever reintegrating organs in the pelvis is impossible.

Study design, materials and methods

We present the exceptional case of a 75-year-old woman presenting with a Pelvic Organ Prolapse Quantification point C at +15cm. Magnetic resonance imaging confirmed the presence of almost the whole bladder, the uterus with the adnexae, and bowel in the vaginal bulge. Surgery was undertaken under general anaesthesia, with the patient in supine position. A Foley catheter was placed in the bladder and 100 cc of methylene blue dye was injected within so as to identify easily any bladder perforation. We marked the anterior and posterior vaginal tissue to be excised. A pair of tenaculum was placed on the cervix and a circular incision is made around the latter. We performed a conventional vaginal hysterectomy following Heaney's technique with bilateral salpingo-oophorectomy using Ligasure® cauterization. A large anterior colpectomy was made after dissecting the vaginal tissue from the bladder. The same procedure was undertaken for the posterior vaginal wall with wide vaginal tissue excision. Next, after closing the hysterectomy scar with Vicryl 1 resorbable interrupted sutures, the anterior edges of the anterior and posterior colpectomies were sutured together with interrupted sutures over a pair of forceps. A plastic drainage was inserted in the space created after suturing the two edges. Progressively, the bulge was integrated inside the pelvis as the anterior edge was sutured to the posterior one. After re-integrating the bulge in the pelvis, the posterior edge of the anterior colpectomy area was sutured to the posterior colpectomy area, thus completing the colpocleisis, with the drainage remaining between the edges. At the end of the procedure, a posterior perineorrhaphy was performed because of a distended large genital hiatus. A diamond-shape incision is made at the vulvar fourchette. The skin and vaginal tissue is excised. The puborectalis muscle fibers are dissected on each side and sutured together with Vicryl 2/0. Finally, the vaginal and the skin are closed with interrupted rapidly resorbable 2/0 sutures.

Concluding message

Associating hysterectomy with colpocleisis is a quick, reliable and efficient procedure for patients presenting with complete pelvic organ eversion and whenever reintegrating organs in the pelvis is impossible.

References

1. FitzGerald MP, Richter HE, Siddique S, Thompson P, Zyczynski H (2006). Colpocleisis: a review. Int Urogynecol J Pelvic Floor Dysfunct 17(3):261–71.

Disclosures

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