

Anterior colporrhaphy, midurethral sling with Bard ALIGN and cystourethroscopy.

PREOPERATIVE DIAGNOSIS:

Stage II anterior vaginal prolapse and stress urinary incontinence.

POSTOPERATIVE DIAGNOSIS:

Stage II anterior vaginal prolapse and stress urinary incontinence.

PROCEDURE:

Anterior colporrhaphy, midurethral sling with Bard ALIGN and cystourethroscopy.

SURGEON:

ASSISTANT:

ANESTHESIA:

General and local with 0.25% bupivacaine with epinephrine.

ESTIMATED BLOOD LOSS:

FLUIDS:

URINE OUTPUT:

SPECIMENS:

DRAINS:

COMPLICATIONS:

CONDITION:

INDICATIONS:

This is a 75-year-old female with stage II anterior wall prolapse and urodynamic stress incontinence during barrier reduction on preoperative urodynamic testing. Preoperatively, we discussed with her the risks, benefits and alternatives of surgery as well as alternative management options and the patient elected to undergo the surgery with midurethral mesh sling. We specifically discussed the risks of mesh placement including pain, mesh erosion, need for further surgery, and then reviewed the FDA notification on this subject. All her questions were answered and written consent was obtained for the above-noted procedure.

FINDINGS:

On cystourethroscopy performed at the end of the procedure, intact bladder and urethra with efflux of clear urine from each of the bilateral ureteral orifices. No bladder masses or lesions. There was excellent anterior vaginal support obtained at the end of the surgery with adequate vaginal caliber and no undue tension.

PROCEDURE:

The patient was taken to the OR where anesthesia was administered. She was prepped and draped in the normal sterile fashion in the dorsal lithotomy position in the Allen stirrups. Care was taken upon positioning to avoid any areas of extreme flexion or extension. A transurethral Foley catheter was placed in the bladder and the bladder was drained. The Lone Star vaginal retractor was placed with the hooks placed at the level of the hymeneal ring for retraction and visualization.

The anterior vaginal epithelium was grasped in the midline with the Allis clamps at the level of the vaginal cuff. The bladder neck was palpated and the anterior vaginal wall was grasped 1 cm cephalad to the bladder neck. The anterior vaginal epithelium was infiltrated with 0.25% bupivacaine with epinephrine. A vertical midline incision was made with the 15-blade in the vaginal epithelium 1-2 cm distal to the bladder neck. The vaginal epithelium was retracted laterally and the Metzenbaum scissors were advanced under the vaginal epithelium, dissecting it from the underlying fibromuscular tissue and then serially incising the overlying epithelium up to 1-2 cm distal to the vaginal cuff. The underlying fibromuscular tissue was then dissected sharply to expose the entirety of the cystocele to the level of the pubic rami bilaterally with sharp dissection using the Metzenbaum. The dissection bed was inspected and noted to be hemostatic. The cystocele was serially reduced with vertical mattress stitches of 2-0 Maxon in 1 layer. Once the entirety of the cystocele was reduced, a vaginal exam was performed revealing excellent anterior vaginal support with adequate vaginal caliber and no undue tension. The excess vaginal epithelium was trimmed with the Metzenbaum scissors and reapproximated with 3-0 Vicryl in a running, locked stitch.

The level of the midurethra was palpated and the Allis clamps utilized to grasp the overlying vaginal epithelium. The epithelium was infiltrated with 0.25% bupivacaine with epinephrine and incised in the midline with a 15-blade, performing

a 1-cm vertical midline incision. The vaginal epithelial edges were retracted laterally with the Allis clamps. The underlying fibromuscular tissue was dissected from the epithelial edges with the sharp Metzenbaum scissors. Using the regular Metzenbaums a tunnel was made on both sides of the urethra to the level of the endopelvic fascia. The Bard ALIGN trocar was placed in the right-hand tunnel, advanced through the retropubic space and exiting via stab incision made at the skin at the abdominal wall 1-1/2 fingerbreadths from the midline at the level of the pubic symphysis. In a similar fashion the same was performed on the left-hand side with the trocar through the retropubic space exiting through a stab incision 1-1/2 fingerbreadths from the midline on the left-hand side of the abdomen at the level of the pubic symphysis. The vaginal epithelial edges were inspected to note no evidence of vaginotomy. The Foley catheter was removed and, with the trocars in the retropubic space, a cystourethroscopy was performed with a 17-French 70-degree cystoscope. As noted above, no evidence of cystotomy or bladder injury was visualized, and the bilateral ureteral orifices were seen to be effluxing clear urine. The cystoscope was removed, the Foley catheter was replaced and the bladder was drained. The Bard Align sling was brought through the retropubic space and the mesh was gently adjusted so that it lay flat against the urethra with no undue tension. The excess mesh was trimmed at the level of the abdomen and the abdominal skin was closed with Indermil. The vaginal epithelial edges were reapproximated with 3-0 Vicryl in interrupted stitches.

A transurethral Foley catheter remained in the bladder at the end of the procedure so the patient may undergo a void trial postoperatively. The patient tolerated the procedure well. Sponge, lap, needle and instrument counts are correct x2. The patient was taken out of dorsal lithotomy position and then was awakened from anesthesia. She was transferred to the recovery room awake, alert and breathing independently in stable condition.

Dr. _____ was scrubbed, present and participated throughout the entire procedure.