

# Laparoscopic lateral suspension with mesh for the management of pelvic organ prolapse: an educative video (case report)

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**Abstract:** Laparoscopic sacrocolpopexy (SCP) using a mesh has been the treatment of choice for pelvic organ prolapse for more than 20 years. However, the potential surgical difficulties associated with the promontory dissection have prompted reflection on surgical alternatives that completely avoid the promontory. Laparoscopic lateral suspension (LLS) is a promising option that gives satisfactory anatomical and functional results. The originality of LLS with mesh is the subperitoneal tunnel of the lateral long arms of the T-shaped mesh through the lateral abdominal wall, leaving the skin above the iliac crest. This suspension prevents potential major risks of injury to the blood vessels, nerves, or bowel, and provides symmetrical lateral tension-free suspension in an anatomical vaginal axis. The indications for LLS are anterior pelvic organ prolapse and apical descent. LLS can be considered when the access of the promontory is difficult; for instance, in the presence of severe adhesions, sigmoid megacolon, or a low-positioned left common iliac vein that partially covers the promontory. LLS is also a practical alternative technique for surgeons with only moderate experience in dissecting the promontory area. LLS represents a simple, effective and reproducible technique that rarely causes complications. In this article, the different surgical steps of the procedure are described, providing practical tips for a successful surgery.

**Keywords:** Lateral suspension; genital prolapse; vaginal vault prolapse; laparoscopy; case report

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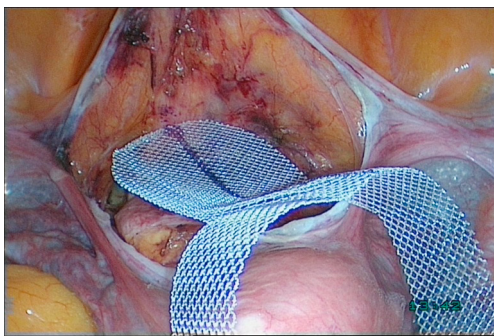
## Introduction

Pelvic organ prolapse (POP) is a common pathology that affects up to 30% of women of older than 50 years (1,2). In the 1960s, an alternative approach to vaginal surgery for POP was introduced, SCP, which consisted of a laparotomy and fixation of the pelvic organs (especially the uterus) to the lumbosacral disc (3). However, advances in minimally invasive surgery have made it possible to consider a laparoscopic approach for POP. Laparoscopic SCP with mesh was developed in the late 90s (4). SCP is now the most frequently performed abdominal surgical procedure to treat POP with satisfactory results (5). However, this technique

involves a difficult surgical step comprising the dissection of the promontory area where the mesh will be moored. The dissection and release of the promontory area are sometimes difficult and hemorrhagic, especially in women with obesity, severe pelvic adhesions, megacolon, large varicose veins, and anatomic anomalies such as low bifurcation of the vena cava with coverage of the promontory with the primary left iliac vein or artery. In addition, a recent study reported that *de novo* back pain occurs in 25% to 50% of patients after laparoscopic SCP with the use of sutures or tackers on the promontory (6). Finally, there is a risk of spondylodiscitis at the points of fixation of the mesh on the promontory,

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**Figure 1** TiLoop mesh (Titanium-coated Polypropylene mesh, pfm medical, Koln, Germany) applied to the pubovesical fascia and the anterior wall of the vagina as well as to the isthmus.

although this is very rare (7).

The potential difficulties associated with the promontory dissection and the risks of postoperative lumbosacral pain have prompted reflection on laparoscopic surgical alternatives that completely avoid the promontory (8). We therefore devised a new technique in the late 90s, namely laparoscopic lateral suspension (LLS) with mesh (9,10).

We propose in this article to describe the different surgical steps of the technique and to precise the indications.

We present the following case in accordance with the CARE reporting checklist (available at <http://dx.doi.org/10.21037/gpm-21-6>).

### Case presentation (Video 1)

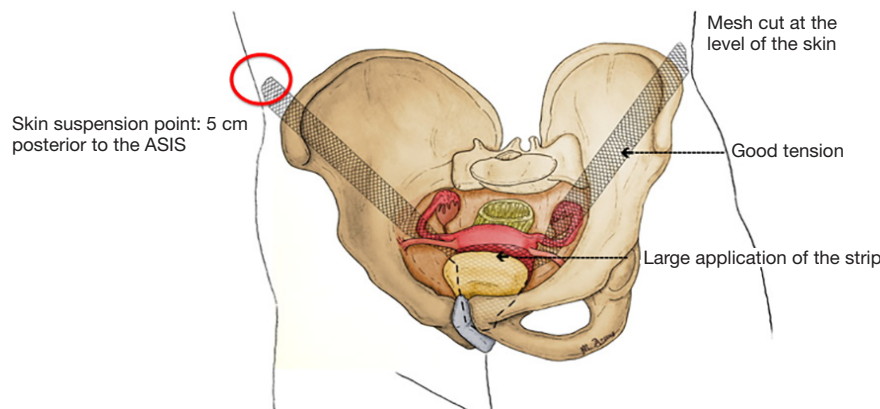
A 65-year-old woman was referred to our institution for the surgical management of a symptomatic POP. She suffered from bulge symptoms related to a stage 3 apex descent with cystocele according to the POP-Q classification. We decided perform the LLS technique with mesh to repair the pelvis.

We decided to preserve the uterus as long as the uterus was healthy, i.e., normal ultra-sound imaging, cervical cytology and endometrial biopsy.

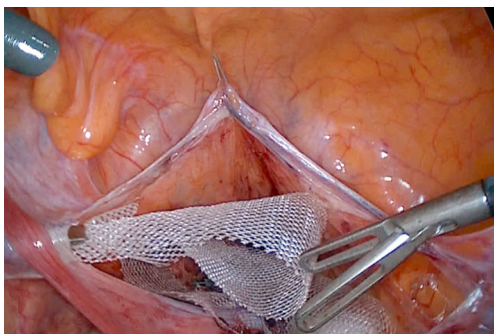
A standard laparoscopy under general anesthesia was performed. In addition to the umbilical trocar used for the laparoscope, three 5-mm ancillary trocars were needed.

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee(s) and with the Helsinki Declaration (as revised in 2013). Written informed consent was obtained from the patient.

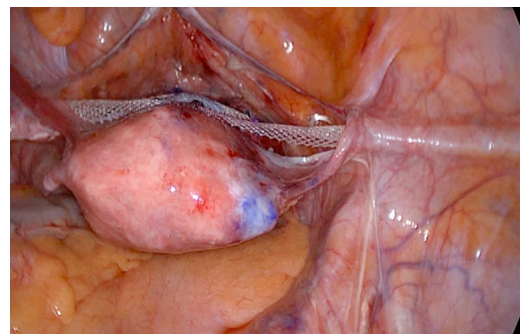
- (I) The first step of LLS was the anterior cleavage. After opening the anterior cul-de-sac, the vesicovaginal cleavage was carried out as low as possible, below the bladder trigone, which makes it possible to treat the entire cystocele and to avoid any residual low hernia.
- (II) The second step was the introduction of the delicately rolled-up mesh into the abdominal cavity through the optical trocar. An “inverted T” mesh was used, and could be cut with scissors from a large polypropylene mesh, as for laparoscopic SCP. Since 2011, we have used the TiLoop titanium-coated polypropylene mesh (pfm medical, Köln, Germany) (11,12) (*Figure 1*). The size of the mesh was as follow: wing spread 415 mm, width including the subvesical tab 90 mm, width at the level of the wings 30 mm. The subvesical tab was applied to the pubovesical fascia and the anterior wall of the vagina, as well as to the isthmus; it was fixed by absorbable polyester tackers derived from lactic and glycolic acids (AbsorbaTack, Medtronic) (13) and also by absorbable thread. The fixation with tackers facilitated the technique, limiting the number of sutures.
- (III) The third step was the lateral suspension proper, which constitutes the originality of the “Dubuisson” technique (14). The objective was for the suspension axis to be strictly transverse, so that the preserved uterus remains in the center of the pelvis. The suspension must be exact, without too much tension, to avoid modifying the axis of the vagina. In this step, the arms of the mesh were held with traction forceps, such as 5-mm laparoscopic forceps with claws. The forceps were introduced from the “outside-in” at a precise location on the lateral abdominal wall referred to as “the skin point of the suspension”. This point is a 5-mm skin incision made 2 cm above the iliac crest, approximately 4–5 cm behind the anterior superior iliac spine (ASIS) (*Figure 2*). The selected skin point of the suspension should allow the uterus or vaginal vault to return to the middle part of the pelvis. Using this point as the mesh exit point avoids «opening» the anterior compartment to limit iatrogenic urinary disorders and reduce the risk of cystocele recurrence; it also prevents opening the posterior compartment, which reduces the risk of enterocele or high rectocele. Starting from the skin point,



**Figure 2** Principles of the correct technique for LLS.



**Figure 3** The forceps grips the extremity of the ipsilateral arm of the mesh in the subperitoneal left tunnel.

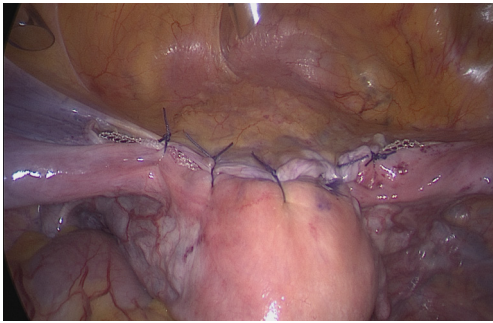


**Figure 4** Symmetrical lateral tension-free suspension in an anatomical vaginal axis.

the route of the forceps from the outside-in was the well-defined “bayonet path”. Under a fairly firm pneumoperitoneum, the forceps were pushed through the skin incision and initially course perpendicular to the abdominal wall, puncturing the fascia and stopping at the peritoneum, without injuring it. For the bayonet path, the forceps were then oriented at a right angle and moved in a horizontal subperitoneal direction, parallel to the peritoneum until they reached the ipsilateral round ligament. The forceps then passed below the ipsilateral round ligament to the area of the vesicovaginal dissection to grip the extremity of the ipsilateral arm of the mesh (*Figure 3*). This end of the mesh was gently pulled backwards through the previously formed tunnel and exteriorized to the skin. The arm of the mesh must lay flat without any twist. The same procedure was performed on

the contralateral side. The tension of the mesh was symmetrically adjusted (*Figure 4*). The tension was adapted and maintained until the end of the operation. Kocher forceps were used to fix the arm of the mesh at the level of the skin on each side, and establish symmetry and adequate tension. Compliance with hygiene standards was mandatory to avoid any infections related to the presence of the mesh.

- (IV) The final step of the procedure was the reperitonealization of the mesh with a few absorbable sutures (*Figure 5*). The two exteriorized distal ends of the mesh were cut at the level of the skin. The arms were therefore not fixed (“tension-free” principle).
- (V) The last step was not compulsory and depends on the severity of the posterior damage. It is performed to treat associated descent of the posterior



**Figure 5** Reperitonealization and final view of the LLS.

compartment or to prevent potential elytrocele and rectocele, as assessed intraoperatively. This step may be performed via two options.

- i. One option is to do the posterior repair via laparoscopy. This begins with posterior cleavage of the rectovaginal septum. A rectangular mesh cut to the size of the dissected surface of the rectovaginal septum is then applied.
- ii. Another option is to perform a posterior colporrhaphy through the vaginal route, with the advantage to treat low rectocele and widened vagina.

(VI) In women with vaginal vault prolapse or associated supracervical hysterectomy, a cross-shaped mesh can be used (size 415 mm × 150 mm) (11). The anterior and posterior tabs are applied and fixed to the fasciae covering the corresponding walls of the vagina. Concerning the patient, the clinical follow-up at 1 year was uneventful with no recurrence of the symptoms.

## Discussion

### *Indications of the LLS technique*

The main indication for LLS is anterior organ prolapse, which represents the most common form of POP (14). When LLS is chosen, we recommended the use of a synthetic mesh in the shape of an “inverted T” with the median tab providing bladder support, and the lateral arms provide suspension, like the wings of a plane.

The LLS procedure can be used for isolated apex descent or uterine descent associated with cystocele. The “inverted T” mesh must be securely attached to the uterine isthmus to reconstitute part of the pericervical ring. The procedure is often performed with posterior anchorage using high suspension to the uterosacral ligaments.

Vaginal vault prolapse is also a good indication for LLS (15). A cross-shaped mesh is used in women with vaginal vault prolapse. The anterior tab provides the anterior subvesical mesh reinforcement, while the central part of the mesh is fixed to the vaginal vault, the site of previous total hysterectomy scar, or to the cervix after supracervical hysterectomy. Finally, the posterior tab is applied to the rectovaginal septum, securing the distal end of the tab.

In women with associated cervical elongation, cervical amputation can be considered in combination with LLS and uterine preservation.

When rectocele is the predominant element of POP, the LLS technique may not be indicated. Indeed, LLS creates an axis of suspension too anterior to the physiological axis of the rectum. In such cases, SCP or a vaginal approach may be chosen instead.

## Results

Several studies have reported the short- and long-term results of LLS with mesh to treat POP (9,10,15). The largest series evaluated 417 patients treated between 2003 and 2011 in the University Hospitals of Geneva, Switzerland (16). At the 1-year follow-up, 78.4% of patients were asymptomatic, and the anatomic success rates, defined as POP Quantification grading system (POP-Q) points Ba, C and Bp of less than -1cm, were 91.6% for the anterior compartment, 93.6% for the apical compartment, and 85.3% for the posterior compartment. The rate of complications (Clavien-Dindo grade 3 or higher) was 2.2% at 1-year follow-up (16,17). After LLS, only 7.3% of patients undergo reoperation for POP with a follow-up of at least 4 years (5.3% by vaginal route and 2% by laparoscopy) (16); this problem is observed with all procedures, including SCP. The recurrence rate of POP after laparoscopic SCP is up to 23% (18).

Of the 417 patients, 214 participated in a telephone interview for the long-term follow-up (mean 7.2 years). Of the 214 patients interviewed, 187 (87.8%) rated their situation as “improved” or “very much improved”, using the Patient Global Impression of Improvement (PGI-I) questionnaire, and satisfaction was associated with the absence of concomitant hysterectomy. This large series of women who underwent LLS with mesh showed that the technique is feasible and effective with low postoperative complications at 1 year and a high degree of long-term satisfaction (16).

Other recent studies have also reported excellent results of LLS. Mereu *et al.* (19) performed LLS in a series of 120 patients. After 2 years, 89% of patients were asymptomatic, and the anatomic success rate (defined as POP-Q points Ba, C and Bp of less than -1 cm) was 94.2% for the anterior compartment and 94.9% for the apical compartment. The rate of complications (Clavien-Dindo grade 3 or higher) was 0.8%. Repeat surgery for POP was performed in 6.4% of cases. Yassa and Tug (20) reported their experience with LLS with a median follow-up period of 24 months. The anatomical cure rate (defined as POP-Q points C and Ba of less than -1 cm) was 100% for the apical compartment and 88.2% for the anterior compartment. The subjective cure rate (defined as the absence of bulge symptoms) and patient satisfaction scores (using the PGI-I) were 94.12% and 100%, respectively.

### *Why consider LLS?*

As early as the 1990s, we developed the technique of LLS with mesh using a very precise procedure (9). The LLS with mesh procedure was initially developed to simplify the laparoscopic treatment of POP and avoid the operative complications of SCP, which are uncommon but sometimes severe, particularly at the promontory level. The rare but serious adverse events reported after laparoscopic SCP include injuries to the middle sacral vessels and iliac veins, or varicose veins (21).

When SCP is planned, but the access to the promontory is difficult or risky, hemorrhagic (due to adhesions), or impossible (due to osteophytosis or coverage by an iliac vessel), our experience has shown that it is easy to change the planned protocol to LLS. For a gynecological surgeon who has limited experience with the laparoscopic approach, LLS is less risky than laparoscopic SCP, as the mesh passes through the lateral wall of the abdomen under strict laparoscopic vision, away from dangerous anatomical structures.

### *The key to successful LLS*

The main difficulty of the LLS technique is to properly position the uterovaginal apex. The uterus should be in the correct anatomical position, in the center of the pelvis. As with laparoscopic SCP, the final “tailor-made” mark is essential to prevent discomfort and recurrence.

The technique of grasping and externalizing the mesh is important for the success of the procedure. The sliding

of the mesh in its tunnel must be performed carefully and slowly. It is important not to widen the tunnel diameter to avoid any risk of secondary slip. The arms of the mesh are not fixed in the abdominal wall and are left tension-free to avoid the wall pains of traction during mobilization movements. However, the arms can be fixed by an aponeurotic suture placed laparoscopically when it is considered that there is a risk of slipping of the mesh arm due to conditions such as chronic cough or morbid obesity.

### *Consequences of changes in the pelvic axes after LLS*

A recent controlled study evaluated the vaginal axis on MRI after LLS with mesh (22). It is the first study to compare the results of changes in the vaginal axis after LLS with mesh. After LLS, the angles measured between the pubococcygeal line and the lower vaginal segment and between the levator plate and the pubococcygeal line were similar to the angles found in the nulliparous control women. This finding confirms that the vaginal axis is almost normal after LLS with mesh, and supports the practice of this LLS technique in patients with cystocele and apical prolapse.

### *Uterus-preserving LLS or LLS with hysterectomy?*

There is usually no need to perform any additional operative procedure during LLS with the T-shaped mesh. Our study showed that uterus-preserving LLS is an effective technique (23). We evaluated 224 women who underwent uterus-preserving LLS and 94 who underwent LLS and hysterectomy. All patients had stage 2 or greater POP in at least two of the three compartments. The uterus-preserving LLS group tended to achieve better improvement in the anterior compartment than the group with LLS and hysterectomy (98.7% *vs.* 94.6%,  $P=0.35$ ).

### *Complications of LLS*

Several studies have reported that LLS achieves good results, with sufficient follow-up and limited non-severe complications (15,19,20). The risk of intravesical mesh migration is theoretically small, as the tensile forces of the mesh arms are not in the direction of the bladder; this type of complication is mostly related to a technical error (24). The risk of vaginal mesh exposure after LLS is low. In our experience, the mesh exposure rate was 4.3% (16). The risk of vaginal mesh exposure appears to be more limited with the use of polypropylene meshes with large pores and

limited weight. The use of polypropylene meshes coated with titanium film limits the occurrence of a foreign body reaction (12). However, no randomized study has yet compared the use of polypropylene versus titanium-coated polypropylene for LLS.

In conclusion, it is important to appropriately select women who will benefit from LLS with mesh. In women with cystocele and/or descent of the apical compartment or procidentia, the results of LLS with mesh are satisfactory and as effective as SCP. The “Dubuisson” technique is simple, effective, and reproducible, with a limited rate of non-severe complications. LLS with mesh is a viable option if the surgeon prefers to avoid any dissection of the promontory.

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### Footnote

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