Laparoscopic mesh pectopexy for apical prolapse of the uterus or vagina

Interventional procedures guidance
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1 Recommendations

1.1 Current evidence on the safety and efficacy of laparoscopic mesh pectopexy for apical prolapse of the uterus or vagina is insufficient in quality and quantity. Therefore, this procedure should only be used in the context of research.

1.2 The procedure should only be done by surgeons experienced and trained in laparoscopic urogynaecological surgery.

1.3 All adverse events involving the medical devices (including the mesh) used in this procedure should be reported to the Medicines and Healthcare products Regulatory Agency.

1.4 Further research should include details of patient selection and long-term outcomes.

2 The condition, current treatments and procedure

The condition

2.1 Apical prolapse is the descent of the uterus, cervix, or vaginal vault. Vaginal vault prolapse is when the upper part of the vagina descends from its usual position, sometimes out through the vaginal opening. It is common after hysterectomy. Apical prolapse can affect quality of life by causing pressure and discomfort, and by its effect on urinary, bowel and sexual function.

Current treatments

2.2 Treatment is rarely indicated if there are no symptoms. Mild-to-moderate prolapse may be treated with conservative measures such as pelvic floor muscle training, electrical stimulation and biofeedback. Topical oestrogens and mechanical measures such as pessaries may also be used. Surgery may be needed when the prolapse is severe. Several surgical procedures are available including hysterectomy, mesh sacrocolpopexy, uterine suspension sling (including sacrohysteropexy) and uterine or vault suspension (without sling). Some procedures involve using mesh to provide additional support.

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The procedure

2.3 Laparoscopic mesh pectopexy is done with the patient under general anaesthesia. Using a laparoscopic approach, a polyvinylidene fluoride (PVDF) monofilament mesh is inserted into the abdominal cavity. The ends of the mesh are attached to the iliopectineal ligaments on each side of the pelvis, using nonabsorbable suture material. The cervical stump or vaginal apex is elevated to the intended tension-free position and sutured to the central part of the mesh. The mesh is then completely covered with peritoneum, secured using absorbable suture material, so that no mesh is visible in the abdominal cavity.

2.4 This procedure may offer an alternative to laparoscopic sacrohysteropexy when access to the sacral promontory is limited, for example because of abnormal anatomy, obesity, adhesions, or previous surgery.

3 Committee considerations

The evidence

3.1 To inform the committee, NICE did a rapid review of the published literature on the efficacy and safety of this procedure. This comprised a comprehensive literature search and detailed review of the evidence from 5 sources, which was discussed by the committee. The evidence included 1 randomised controlled trial (in 2 publications), 2 case series and 1 case report, and is presented in table 2 of the interventional procedures overview.

3.2 The specialist advisers and the committee considered the key efficacy outcomes to be: repair of prolapse and reduction of symptoms.

3.3 The specialist advisers and the committee considered the key safety outcomes to be: pain, infection and mesh erosion into the vagina, bladder, urethra or bowel.

3.4 Patient commentary was sought but none was received.

Committee comments

3.5 There is more than 1 mesh available for use in this procedure.

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Endorsing organisation

This guidance has been endorsed by Healthcare Improvement Scotland.

Accreditation



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