

Urogynecology digest

Presented by Radhika Patnam

How do we define apical vaginal support loss?

Meister MRL, Sutcliffe S, Lowder JL. Definitions of apical vaginal support loss: a systematic review. *Am J Obstet Gynecol.* 2017; 216(3):232.e1–232.e14

This was a systematic review of the current literature regarding definitions of apical support loss utilized for inclusion, success, and failure in surgical trials for the treatment of apical vaginal prolapse. Apical support is often considered of paramount importance to overall female pelvic organ support; yet, there are no guidelines for when an apical support procedure should be performed. This systematic review sought to identify preoperative definitions of apical prolapse, and definitions for the success and failure of an apical prolapse procedure. A systematic review using eight search engines found 3,660 publications, and limiting the analysis to randomized controlled trials (RCTs), resulted in 35 studies for analysis. Twenty-five of these studies provided a definition of surgical success or failure, defined by anatomical criteria or anatomical and systems-based criteria. Definitions of surgical success varied, and included Pelvic Organ Prolapse Quantification (POPQ) stage 2 prolapse (29.4%), absence of prolapse beyond the hymen (5.9%), or using a form of comparison of apical support with total vaginal length, although again, this definition varied. Eight studies used an overall prolapse POPQ most dependent point to define surgical success, ≤ -1 or 0. Ten studies took symptoms into consideration, via validated questionnaire responses (40%), quality of life outcomes (10%) or

the presence or absence of symptoms (50%). The reviewers found that indications for performing apical support procedures and definitions of surgical success and failure were highly variable. Although all studies included a POPQ score as an indication for surgery, nearly 30% omitted a baseline apical support/loss of support score. In those who did include preoperative apical POPQ scores, the definition of prolapse varied significantly, showing a lack of consensus amongst surgeons. The reviewers, citing a normal vaginal length of 9–10 cm, found that some authors repaired prolapse when point C was -5 cm, whereas others deferred until point C reached the hymen or beyond. This often did not correlate with specific symptoms, despite symptoms being a major part of the reason why surgeons proceeded with surgery. On the other hand, those with significant anatomical apical prolapse but no symptoms were still undergoing an apical prolapse repair. Moreover, most lacked an anatomical outcome definition of success or failure for apical support. The strengths of this study are that it is the first to assimilate the RCT data available. With any systematic review, studies that were not included may have helped to further define apical prolapse and outcome of repair, but were not included because they were not part of the RCTs. Limitations include that the reviewers include their own “expert opinion,” but do acknowledge that this is not based on clear guidelines. The important conclusion is that clear standardization needs to be created for multiple values, both anatomical and symptomatic, to clearly see if an apical repair is necessary and to define whether or not it was successful.

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