



STOP using synthetic mesh for routine repair of pelvic organ prolapse

START performing native tissue repairs and reserve mesh for selective cases

► **EXPERT COMMENTARY**



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► **CASE** Stage 2 prolapse to the hymenal ring

A 54-year-old Para 3 woman presents with stage 2 prolapse to the hymenal ring. The prolapse predominantly involves the anterior vagina, with her cervix prolapsing to 2 cm within the hymenal ring. The patient is bothered by the bulge and stress urinary leakage. She does not want to use a pessary and prefers to have definitive surgical correction, including hysterectomy.

The first surgeon she consulted recommended a vaginal hysterectomy, anterior colporrhaphy, anterior synthetic mesh vaginal colpopexy, and synthetic midurethral sling. The patient was concerned about mesh placement for prolapse and the sling after seeing ads on the Internet about vaginal mesh. She presents for a second opinion about surgical alternatives.

Stop routinely offering synthetic vaginal mesh for prolapse

Advantages to the use of synthetic vaginal mesh include improved subjective and objective cure rates for prolapse (especially

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for the anterior compartment) and fewer repeat surgeries for recurrent prolapse. However, **disadvantages** include:

- mesh exposure and extrusion through the vaginal epithelium
- overall higher reoperation for mesh-related complications and de novo stress urinary incontinence.¹

Synthetic vaginal mesh should be reserved for special situations.

Currently, experts agree that synthetic vaginal mesh is appropriate in cases of recurrent prolapse, advanced-stage prolapse, collagen deficiency, or in cases with relative contraindications to longer endoscopic or abdominal surgery, such as medical comorbidities or adhesions.^{2,3} Other indications for synthetic vaginal mesh include vaginal hysteropexy procedures.

Mesh is likely not necessary in:

- primary repairs
- prolapse < POPQ (pelvic organ prolapse quantification system) stage 2
- posterior prolapse
- patients with chronic pelvic pain.

Start offering, learning, and mastering native tissue repairs

For the patient in the opening case, who has symptomatic stage 2 uterovaginal prolapse and stress urinary incontinence, surgery, including a transvaginal hysterectomy, anterior colporrhaphy, uterosacral ligament




If you are offering synthetic mesh for POP repair, be trained on each device, track outcomes, and enroll in the national registry

suspension, and synthetic midurethral sling, is a reasonable alternative and has a high subjective and objective cure rate—81.2% rate for anterior prolapse and 98.3% rate for apical prolapse. Better outcomes are noted with stage 2 compared with stage 3 prolapse (92.4% vs 66.8%, respectively).⁴

Final note

If you are offering selective transvaginal synthetic mesh for prolapse repairs:

- Undergo training specific to each device.
- Track your outcomes—including objective, subjective, quality of life, and reoperation for complications and recurrence.
- Enroll in the national pelvic floor disorders

registry, which is scheduled to debut in Fall 2013. 

References

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