

#617 Surgical management of apical prolapse in Flanders



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Introduction

- Apical prolapse can be managed with a **variety of different surgical techniques**. However, the level of evidence behind those different techniques is variable.
- **Practice variation¹** = important target for clinical systems improvement.
 - Some variation in clinical practice = justified
 - unwarranted variation = common; linked to suboptimal outcomes and to inefficient care.
- **No local guidelines** exist regarding the surgical management of apical prolapse.
- **Aim** of our study was to examine how apical prolapse is surgically managed in Flanders, Belgium.



Methods

- **Online questionnaire** (Qualtrics®) - all **Gynaecologists** practicing in Flanders, Belgium.
 - If never performing any urogynaecological surgery, survey = ended
- Results ~ **comparable** with the **MZG Database** (centrally collected registration data from the ministry of health) on ICD10-diagnosis and performed procedure at the time of hospitalization.



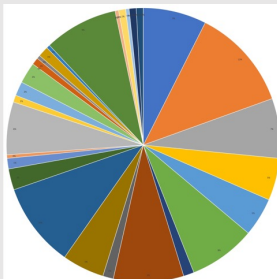
Results



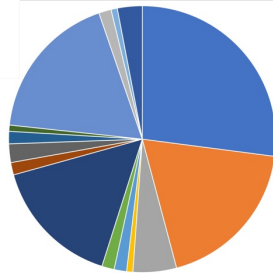
- Response rate = 28.4% (155/545)
- 74.2% ♀
- Mean age = 45y (SD 10.1)
- Mean years of expertise = 19y (SD 10.1)
- 78 (50.3%) performs pelvic floor surgery
 - mean 54 surgeries annually
 - 19 (24.4%) = Urogynaecology subspecialty training
 - 16 (20.5%) = tertiary center
 - 39 (50.0%) = multidisciplinary meeting preoperatively

Pie chart 1 and 2 reflect the variety of surgical techniques used. N= 78

1. Variety of surgical techniques used in uterus prolapse.
2. Variety of surgical techniques used in vault prolapse.



Pie chart 1 reflects the variety of surgical techniques used in uterus prolapse. N= 78



Pie chart 2 reflects the variety of surgical techniques used in vault prolapse. N= 78

Sacrospinous fixation (SSF): 39 (50.0%) participants.

Of those, 21 (53.8%) use an open technique, 8 (20.5%) use I-Stitch. Respectively 6 (15.4%), 6 (15.4%) and 4 (10.3%) participants use Cipro, Miya Hook and Anchorsure. Another device is used by 5 (12.8%) respondents.

Most surgeons (22, 56.4%) places 2 stitches on the SS ligament, the remainder 17 (43.6%) utilize 1 stitch.

Non-absorbable, delayed absorbable, absorbable and the combination of an absorbable with a non-absorbable suture was used by 20 (51.3%), 12 (30.8%), 5 (12.8%) and 2 (5.1%) participants respectively. Most participants use a suture size 1 (22, 56.4%), followed by size 0 (13, 33.3%) and 2-0 (4, 10.3%).

Uterosacral ligament suspension (USL): 20 (25.6%) participants.

Most surgeons (12, 60.0%) utilize absorbable sutures, while 4 (20.0%) use delayed absorbable sutures. Non-absorbable and the combination of a non-absorbable with an absorbable suture is used by 2 (10.0%) and 2 (10.0%) respectively. Suture size 0, 1 and 2-0 was used by 3 (15.0%), 16 (80.0%) and 1 (5.0%) participants respectively.

Sacral colpopexy (SCP): 28 (35.9%) participants.

13 (46.4%) use non-absorbable tackler for promontofixation. When performing SCP, 12 (42.8%), 11 (39.3%), 6 (21.4%) and 6 (21.4%) uses non-absorbable sutures, combination of non-absorbable and absorbable sutures, delayed absorbable and absorbable sutures, respectively. Suture size 0, 1 and 2-0 was respectively used by 8 (28.6%), 12 (42.8%) and 8 (28.6.0%).

"How confident are you about your answers"

Surgical technique 7.3/10 - suture choice 7.4/10 (mean confidence score). Respectively 31.5%, 41.6%, 10.7%, 3.6% and 12.6% stated that their answer was based on their own experience, education, hospital regulations, local guidelines, and research.

Choice of surgical technique: 78.3% by surgeon – 21.7% by patient.

MZG showed no data on the different surgical techniques, nor the correlation between the ICD10-diagnosis and the performed surgery.



Conclusion

- **Implementation of international clinical guidelines** might be recommended to ameliorate patient care and surgical outcomes.
- The need for Urogynaecological **subspecialty training** in Belgium might be considered.

References

1. Cook, D.A., et al., *Practice variation and practice guidelines: Attitudes of generalist and specialist physicians, nurse practitioners, and physician assistants*. PLoS One, 2018. **13**(1): p. e0191943.

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