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Editorial

Pelvic Reconstructive Surgery

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EDITORIAL

Pelvic organ prolapse is growing more widespread as our population ages. A woman's lifetime chance of pelvic organ prolapse surgery is at least 11.1 percent, and nearly one in every three will require recurring prolapse repair [1]. Traditional repair procedures for anterior vaginal wall prolapse have a high failure/recurrence rate of 40% to 60%, and they are based on surgical expertise from a century ago. The purpose of pelvic organ prolapse surgery back then was to minimize the bulge, not to correct the prolapse's source. According to a survey conducted by the American Urogynecology Society, 80 percent of urogynecologists still use this 100-year-old procedure, despite its low success rate.

Why is repairing anterior vaginal wall prolapse so difficult? Isn't it possible that midline flaws and paravaginal defect fixes aren't the roots of anterior vaginal wall prolapse? If that's the case, why do midline plications and paravaginal repairs fail so often? Recurrences account for 30% to 40% of the 300,000-400,000 pelvic organ prolapse surgeries performed each year in the United States, with 60% recurring in the same region [2]. This is the location of the Achilles' heel.

Mesh kits were developed by modern gynecologists who were dissatisfied with the recurrence rates of Kelly, White, and Richardson procedures [3,4]. Unfortunately, instead of repairing the faults, these kits embraced a new "industrial" notion for constructing a mesh bridge for the centrally prolapsed bladder. Mesh kits' focus shifted from reconstructive surgery utilizing long-accepted theories of vaginal abnormalities to simply reconstructive surgery using a mesh bridge marketed by industry but mostly untested in the pelvis.

The surgeon simply opened the vaginal epithelium, lay down the bolster, and closed the epithelium using these kits, ostensibly eliminating the need to identify the facial abnormalities. The notion that a permanent repair necessitated a permanent biomaterial was pushed to surgeons by industry. When mesh-related complications became more common, the industry pulled the product off the market, leaving gynecologic surgeons with no choice but to revert to traditional midline placation, despite its poor recurrence rates, to avoid erosions, pain, dyspareunia, and possible legal issues caused by the vaginally inserted mesh.

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