DEBATE: HYSTERECTOMY VS. HYSTEROPEXY

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Learning Objectives

- Review options for surgical treatment of uterine prolapse
- Understand evidence pertinent to hysterectomy and hysteropexy
- Discuss best practice based on available information
Surgical Options

- Native tissue repairs
  - Sacrospinous Ligament Suspension (SSLF)
  - Uterosacral Ligament Suspension (USLS)
    - Vaginal approach; Laparoscopic approach

- Mesh-augmented repairs
  - Abdominal mesh (sacral colpopexy/hysteropexy)
    - Open; Laparoscopic/Robotic
  - Vaginal mesh
    - “Armed” mesh; “Single-incision”; custom
POP Surgery - Current Practice

- Vaginal Hysterectomy with native tissue repairs is most common approach for primary repair
  - Uterus is not cause of POP, loss of support mechanisms is primary pathology
  - Hysterectomy allows access to native tissue support structures (sacrospinous ligament, uterosacral ligament)

- Question of need for hysterectomy is not new – it periodically recurs in POP surgical practice
Review Articles

- **Diwan 2004**
  - Conclusion – “current literature suggests uterine preservation during surgery for uterovaginal prolapse may be an option in appropriately selected women who desire it; prospective, randomized trials are needed to corroborate this”

- **Dietz 2009**
  - Conclusion – “Data on symptomatic cure and quality of life are scarce. Because no randomized, controlled trials have been performed comparing these surgical techniques, we cannot conclude that one of the procedures prevails.”
Review Articles

Gutman 2013

Conclusion - “While uterine preservation is a viable option for the surgical management of uterine prolapse the evidence on safety and efficacy is currently lacking.”
Sacrosinuous Ligament Suspension

- Maher et al 2001 – IUJ
  - Vag hyst with SSLF vs. SSL Hysteropexy
  - Similar success rates
  - EBL less with hysteropexy (400ml vs. 200ml)
  - OR time less with hysteropexy (90 min vs. 60 min)
  - Similar return to activities of daily living (34 days vs. 32 days)
  - Reoperation: 5.5% in VH group; 8.8% in HP group
    - HP group – 1 case of abd hyst (?) for menorrhagia
Sacrosinuous Ligament Suspension

- Dietz et al 2010 – IUJ (RCT)
  - VH/USLS vs. SSL Hysteropexy
  - Failure rate: VH 3%; SSL HP 21% (at 1 yr F/U)
  - Return to work significantly shorter for HP group
    - But return to daily activities 33 days in VH group and 34 days in HP group

- Gutman 2013 – IUJ (pooled data/11 studies)
  - Objective success 93% for VH; 87% for SSL HP
Uterosacral Ligament Suspension

- Rosen et al 2008 JMIG – Lsc approach
  - Failure rate similar at 2 yr F/U
    - 22% in hysterectomy group; 21% in hysteropexy group
    - 7% in hysteropexy group required further surgery for cervical elongation
  
- Conclusion:
  - “Although prolapse outcomes did not differ at 2 years, our group would favor removal of the uterus and cervix in most instances to give a better and more complete reconstitution of the pericervical ring and reduce the incidence of reoperation for cervical prolapse/elongation in the future”
Uterosacral Ligament Suspension

- Bedford et al 2013 JMIG – Lsc approach
  - Apical failure at median 2.5 year F/U
    - 27% for hysteropexy group
    - 11% for hysterectomy group
  - 13% of hysteropexy group eventually underwent hysterectomy; “usually technically difficult because of pericervical adhesions, cervical elongation, and restricted descent of the uterus”

- Romanzi et al 2012 JMIG - Vag approach
  - Similar results at 2 year F/U
Sacral colpopexy/hysteropexy

- Roovers et al 2004 BJOG (RCT)
  - VH/USLS similar to ASHP, but more reoperations in ASHP group

- Costantini et al 2011 IUJ
  - Success rates similar: ASHP 91%; TAH/ASC 92%
  - Mesh erosion similar: ASHP 4%; TAH/ASC 8%

- Gutman 2013 IUJ (pooled data/11 studies)
  - Success rates: 91% ASHP vs. 94% TAH/ASC
Vaginal Mesh Hysteropexy

- Gutman 2013  IUJ (pooled data/7 studies)
  - Success rates:
    - VH/mesh - 98%
    - mesh HP – 86%
  - Erosion rates:
    - VH/mesh – 13% (was this reason to stop VH?)
    - Mesh HP – 8.8%

- Mesh hysteropexy erosion rates (case series):
  - Khandwala et al 2014  J Repro Med - 6.5%
  - Jirschele et al 2015  IUJ – 6.5%
Advantages of Hysteropexy?

- Desire to maintain fertility
  - "Standard practice at present suggests women undergo surgical repair of pelvic floor disorders after they have completed childbearing and use conservative methods, such as pessary, until that time"

- Avoid impact of hysterectomy on sexual function
  - No data to support this claim; multiple studies confirm hysterectomy (total and subtotal) does not result in impaired sexual function
Advantages of Hysteropexy?

- Decrease short-term morbidity
  - Some studies show decreased OR time, blood loss, post-op pain, hospital days, time to resume activities

- Decrease risks associated with mesh
  - Only relevant with mesh procedures
    - Mesh erosion rate remains 0% with non-mesh approaches
  - Similar erosion rates with ASC and ASHP
  - Similar erosion rates with vaginal mesh SC and HP
Advantages of Hysteropexy?

- Decrease risk of recurrent prolapse
  - No study showing better results with hysteropexy
  - Several studies report higher risk of recurrence
- Decrease risk of subsequent surgery
  - Risk of surgery for recurrent prolapse
  - Risk of surgery related to uterine/cervical issue
    - Cvach 2012 - 22% subsequent uterine pathology
    - Coskun 2014 J Urol – 13% subsequent hysterectomy
    - Hyakutake 2014 IUJ – SSL HP: 62.5% cervical elongation
Conclusions – Hyst Vs. HP

- **Success rates:**
  - Similar or worse with hysteropexy (not better)

- **Short-term morbidity:**
  - Similar or slightly better with hysteropexy; but clinical relevance questionable

- **Mesh-related complications:**
  - Similar with hysterectomy and hysteropexy

- **Risk of surgery for uterine/cervical pathology:**
  - Unique to hysteropexy
Final Question

Rank the following items in the correct order of importance:

- Patient preference
- Surgeon preference
- Scientific evidence