Sacrosinous ligament
vs:
Uterosacral Ligament suspension

Magnus Murphy FRCSC
Clinical Assistant Professor
Department of Obstetrics and Gynecology
University of Calgary
Division of Urogynecology
www.pelvicfloor.com
Apical Prolapse

- Vagina is a continuum
- Apex is always involved in higher stage prolapse
- Symptoms could be:
  - Bulge (anterior/posterior/global)
  - Urinary
  - Defecatory
  - Sexual dysfunction
Apex correlation
- anterior prolapse: High
- Posterior prolapse: Moderate

Key message:
- Apical fixation should almost always be done

What are you trying to achieve?
- Objective success
- Patient’s subjective improvement
- Expectation management
- Avoidance of complications
- Avoiding unnecessary difficulty
- Avoiding extra dissection
- Precision, consistency
- Efficiency
What Is Success?

- Your opinion is not that important
- Patient satisfaction, goal achievement is all that counts

Vaginal Apical Suspensions: Not much new

- McCall Culdeplasty
- SSLS
- Iliococcygeus suspension
- Prespinous fixation/suspension

The honest truth:

It doesn’t matter – it’s a wash
- Landmark study 1998
  - Retrospective case control
  - 62 patients per arm
  - Results were reported as objective impressions

- Results
  - No difference in Apical support failure (15%)
  - Significant difference in anterior failures
    - McCAll: 6%  SSLS: 21%
No difference in outcome
Both SSLS and USLS have less than 5% serious complications

USLS: mostly ureteric obstruction
SSLS: mostly buttock pain

After 2 years: Equivalent

Optimal’ Outcomes

- Apical failure: Average study finding 15%
  - Success defined as both objective and subjective success at 2 years postop
  - USLS/McCall: 59.2% (N=154)
  - SSLS: 60.5% (152)
  - Recurrent objective prolapse beyond hymen: 15.5% (no difference)
  - Subjective outcomes: no difference

Perceived Success

- Depends on definitions, choices of measurement and completely arbitrary decisions
- There does seem to be higher risk of anterior recurrence with SSLS vs USLS and McCall

Morgan, Daniel M., Mary A. M. Rogers, Markus Huebner, John T. Wei, and John O. Delancey. “Heterogeneity in Anatomic Outcome of Sacrospinous Ligament Fixation for Prolapse: A Systematic Review.” *Obstetrics and Gynecology* 109, no. 6 (June 2007): 1424–33
Studies bedeviled by additional procedures and lack of standardization

USLS and SSLS equivalent

– Depends on definitions

  ▪ Strict anatomical success based on POPQ, is low (37-64%)
  ▪ Clinically relevant success (not below hymen) better (82-94%)
Why I don’t like USLS/McCall

- Ureter obstruction up to 11% (more common than studies will have you believe)
- TEN fold increase risk if anterior colporrhaphy is done as well
- This is difficult/impossible to prevent
- Not easy to do extra-peritoneally

To me and my patients, the rate with USLS/McCall is unacceptable
  — Too much hassle, stress, waste of time, undoing of hard work
  — I don’t want to have to call urologist

Procedure less ‘specific’ than SSLS
- Much more ‘vague’
- More difficult to teach
- More difficult to be consistent
- More difficult than usually admitted
  - Just watch someone struggle
  - Just watch them take ‘shortcuts’
    - Euphemistically called ‘modified’ procedure
What/Where Are the Uterosacral Ligaments Anyway?
Good luck finding such obvious ligaments in real life!
Let me make this perfectly clear

If you are simply tying the cut end of the USL to the vault (in a patient with prolapse)
– you are not doing a proper Level I support!
SSLS Benefits

- More specific
- Easier to mitigate risk
  - Direct palpation of landmarks
  - Use of device to prevent deep stitches
- Possible ways to prevent anterior recurrence
- Easy intra-and extra-peritoneal approaches
- Apical success equivalent to USLS
  - Objective failure 2.4-19%
- Anterior failure more common
  - However mostly asymptomatic
- No difference in subjective satisfaction with degree of support, as long as at or above hymen

- Buttock pain
- Sacral/pudendal neurovascular injury

- Review of 1,229 SSLS
  - 0.2% severe hemorrhage
  - Transfusion rate 2%
  - Buttock pain 3% (resolved by six weeks)

SSLF vs SCP

- Studies are conflicting
- No hard evidence that one is superior
- Cost effectiveness studies conflicting and dependent on input parameter modeling
- Seems to be consensus that SCP better long term

Summary: Why SSLS?

- Strong anchor point
- Very low ureteral obstruction
- Easy to do with or without hysterectomy
  - Trans-peritoneal or extra-peritoneal
- Consistency, in contrast to USL
  - Can be more specific with *exact* position
- Easier and quicker!
Thank You