

SUMMARY AND CONCLUSION

A renewed interest in the surgery for vaginal prolapse has developed in recent years with the use of the term "pelvic reconstructive surgery" helping to place the emphasis on the aim of prolapse surgery namely the restoration of structure, function and relief of symptoms.

The main cause of prolapse is the weakness of the supporting structures of the uterus and the vagina which are mainly achieved by the cardinal ligament, the uterosacral ligament, and the pelvic diaphragm mainly the levator ani muscle. The single most common etiologic factor of genital prolapse is parturition. Postmenopausal atrophy, increased intra-abdominal pressure, and previous surgery may play a role.

Genital prolapse may be symptomatic or asymptomatic by various symptoms depending upon the type and degree of the prolapse as sensation of fullness in the vagina or backache. It also may be presented by urinary symptoms as frequency, retention of urine, or stress incontinence. It may be also presented by rectal symptoms as constipation or sense of incomplete act.

A thorough pelvic examination is vital to delineate treatment options and should be performed in a standardized fashion.

The non surgical treatment of prolapse includes: physiotherapy, and vaginal pessaries. The surgical correction of prolapse should be tailored to the patient according to her parity and age.

Techniques for repair of vaginal prolapse have not changed significantly since Kelly's description in 1913. Recent studies have

demonstrated significant rates of morbidity and recurrence. These complications are thought to result, in part at least, from tissue tension created by the repair. Similar complications with abdominal hernia repair, promoted the development of the tension free technique using non absorbable mesh which has been proved to have fewer complications and lower recurrence rate.

Surgical approaches include: Anterior colporrhaphy, and posterior colpoperineorrhaphy.

The aim of this work was to evaluate the Tension-free Vaginal Mesh in the management of vaginal prolapse in Benha University, Department of Obstetrics and Gynecology. This work included thirty patients with symptomatic grade 2 to 4 cystocele and/or rectocele.

In conclusion, the TVM technique is a safe, easily performed procedure, and is associated with a low failure rate and morbidity. However, these initially encouraging anatomical and functional results must be confirmed over a long term follow up and a larger numbers of cases.