INTRODUCTION

Prolapse (from the Latin word prolapsus, a slipping forth) refers to falling or slipping out of place of a part or viscous. Pelvic organ prolapse is the descent of pelvic organs into the vagina often accompanied by urinary, bowel, sexual or local pelvic symptoms ***(Thaker & Stanton, 2004).***

Pelvic organ prolapse is common. Up to 50% of parous women have some degree of prolapse although only 10-20% is symptomatic ***(Beck, 1991)***. The first line of treatment is surgical repair. The life time of risk of having an operation for prolapse may be 11% and almost one-third of these cases require re-operation ***(Olsen, 1997).***

There are three goals for treatment of vaginal prolapse, restoration of normal function, anatomy, and prevention of recurrence ***(Mage, 1999).*** Many different operations have been proposed. However, long term follow-up reports on prolapse surgery are scarce and the rate of recurrence of anterior and posterior vaginal walls defects can range from 25% to 37% ***(Shull, 1992)***.

Traditional repairs consist of the anterior and posterior colporrhaphy which involve midline plication of the endopelvic fascia to reduce the prolapse and recreate support by strengthening the weakened fascial layer. It dose correct the underlying fascial defect when the defect

is in the midline. However, for lateral and transverse defects, traditional colporrhaphy leaves the defect uncorrected and may even create additional tension, resulting in recurrence ***(Weber & Walters, 1997).***

Considering pelvic organ prolapse as a hernia through the genital hiatus, prosthetic material has been advocated in gynecology from its use in general surgery for hernia repair ***(Smith, 1971).*** Recently, a new transvaginal procedure uses a polypropylene mesh that works like a sling to restore the prolapsed organs to their position.

This is called Tension-free Vaginal Mesh. The TVM technique for cystocele repair uses anterior mesh anchored transversally between arcus tendineus with two arms each side through the obturator foramen. Rectocele repair uses posterior mesh anchored transversally between the sacrospinous ligaments ***(Cosson, 2005)***.

Unlike the conventional techniques TVM group technique does not reconstruct pelvic floor by suturing tissues or sewing mesh into place thus making the technique tension free ***(De Tayrac, 2005).*** This typically require less tissue dissection, shortening recovery time and reducing current rate of recurrence between 20-30% associated with conventional technique ***(Cosson, 2005).***

Some studies have examined the efficacy of TVM technique. ***Migliari, et al. (2000),*** confirmed that in patients with moderate cystocele. A tension free mesh to support bladder neck and base

effectively treats the cystocele, it is particularly recommended in previous failure with traditional repair and when the quality of suspending tissue is poor or defective. ***Dewyer (2004),*** recommended the use of atrium polypropylene mesh for transvaginal repair of anterior and posterior compartment as it is showing promise in correcting pelvic organ prolapse.

De Tayrac (2005), concluded that vaginal repair of anterior vaginal wall prolapse reinforced with tension free polypropylene mesh is effective and relatively safe. ***Adamik, (2006)*** advised the new surgical technique for complex resolution of pelvic organ prolapse.