Pelvic Prolapse and Laparoscopic Enterocele and Cystocele Repair
Pelvic Prolapse is when pelvic supporting tissues weaken and fall down.
The traditional approach to this problem has been vaginal surgery where the vaginal walls are opened and the supporting tissues (fascia) are sewn together with absorbable sutures.
We now know that the vast majority of cystoceles (bladder dropping down) are due to the supporting tissues (fascia) separating from their normal attachment at the pelvic sidewalls. Through a laparoscope the space between the bladder and pubic bone is opened and using permanent suture the fascia is reattached to the pelvic sidewall. The upper end of the fascia is also pulled up and reattached to the uterosacral ligaments. This provides a more definitive, longer lasting, and anatomically correct repair of cystoceles.

When a woman has her uterus, then all the supporting tissues attach around the cervix. When a woman has had her uterus removed, then the supporting tissues (fascia) from between the bladder and the vagina (pubocervical fascia) should come together with the supporting tissues between the rectum and the vagina (rectovaginal septum) at the top of the vagina, and these supports should also be attached to the uterosacral ligaments. We know that enteroceles (top of the vagina falling down) are due to the absence of supporting tissues (fascia) at the top of the vagina. Using the laparoscope these spaces are opened and using permanent sutures the pubocervical fascia is brought together with the rectovaginal septum and the uterosacral ligaments. This provides a more definitive, longer lasting, and anatomically correct repair of enteroceles and vaginal vault prolapse.
Upper right: The uterosacral ligaments are isolated at the start of the surgical procedure.
Lower middle: The uterus and cervix have been removed and the top of the vagina closed.
Lower right: Permanent sutures bringing together the pubocervical fascia and uterosacral ligaments.
Upper left: Permanent sutures bringing together the pubocervical fascia (front wall of the vagina) with the rectovaginal septum (back wall of the vagina), with the uterosacral ligaments.
Upper middle: Retropubic space opened up. Pubic bone (white) seen at the top of the picture.
Upper right and lower left: Permanent sutures re-attaching the pubocervical fascia to the sidewalls. Lower middle: Completed Burch colpo-suspension, or “hammock”.
Lower right: Retropubic space closed at the end of the surgery.

When the uterus has been previously removed, the anterior and posterior fascia is not together, and the is a severe enterocoele, then suturing may not be enough and mesh is needed to augment the repair.

Laparoscopic Sacro-colpopexy with Polypropylene Mesh is a procedure where a Y-shaped mesh is used to support the upper vaginal canal and correct the cystocele and enterocoele. The arms of the mesh are attached with permanent sutures to the anterior and posterior vaginal walls, and the leg of the mesh is attached with permanent sutures to the ligament in front of the Sacrum. This provides a more definitive, longer lasting, and anatomically correct repair of enterocoele and vaginal vault prolapse.
This procedure gives excellent support and length to the vaginal canal.

Polypropylene mesh is secured to upper anterior vaginal wall with 2-0 Ethibond sutures.

Polypropylene mesh is secured to upper posterior vaginal wall with 2-0 Ethibond sutures.
The long leg of the Y-shaped Polypropylene mesh is secured to the anterior longitudinal ligament by the Sacral Promontory with 2-0 Ethibond sutures.

Peritoneum is closed burying the mesh at the completion of surgery.
Laparoscopic Sacro-cervicopexy with Polypropylene Mesh is a procedure where a Y-shaped mesh is used to support the cervix and upper vaginal canal and correct cystocele and enterocele. The arms of the mesh are attached with permanent sutures to the cervix, and the leg of the mesh is attached with permanent sutures to the ligament in front of the Sacrum. This provides a more definitive, longer lasting, and anatomically correct repair of enterocele and vaginal vault prolapse. This procedure gives excellent support and length to the vaginal canal.

Laparoscopic supracervical hysterectomy. Uterine manipulator through the cervix.
Polypropylene mesh secured to posterior aspect of cervix with permanent sutures.

Polypropylene mesh secured to anterior aspect of cervix with permanent sutures.

The long leg of the Y-shaped Polypropylene mesh is secured to the ligament by the Sacral Promontory with 2-0 Ethibond sutures. Peritoneum is closed burying the mesh at the completion of surgery. Colon enters pelvis in midline with no tension.