

## Pelvic floor prolapse mesh reconstruction-mesh choice

(Presented at the 12<sup>th</sup> Annual AAVIS/ISPP Scientific Meeting, 2010, Vienna)

*Accurate diagnosis of all the prolapse features and site specific support requirements identification are mandatory for proper mesh choice. It is the presence of isolated apical supportive defect only at the central pelvic floor compartment or any additional anterior and/or posterior compartments prolapse that determine the requested mesh shape. It is the coexistence of urinary stress incontinence that indicates the need for additional mid-urethral support. The elected mesh or combination of meshes should be providing support for all the prolapsed pelvic floor sites. One must bear in mind that some commercially available anterior compartment meshes are designed for cystocele repair only while others provides the possibility to suspend the prolapsed uterus by cervical ring attachment, thus permitting it to be preserved. Other meshes provide support the mid urethra, concomitantly with anterior compartment reconstruction, hence avoiding the need for additional tape to support the mid-urethra separately. The later ones cure not only the anterior compartment prolapse but the uterine prolapse and/or stress urinary incontinence simultaneously with the cystocele repair. Other meshes are designed for posterior compartment reinforcement, some of provides the possibility to support the prolapsed uterus or vaginal apex at the same time. Whenever there is a need to treat several sites of pelvic supportive defects more than one mesh might be needed. There should be a dissent and convincing published body of evidence to prove the safety and efficacy of the specifically chosen mesh. The surgeon must be properly trained with any new mesh by an experienced trainer and familiar with potential hazards including their prevention and management. The mesh texture need to be as soft and light as possible, none shrinking, small in dimensions, yet sufficient for complete replacement of all defected parts of the endo-pelvic fascia and pelvic floor herniation. Thorough defected endo-pelvic fascia substitution with the artificial fascia is crucial for insuring long lasting support. Host against graft and graft against host reaction formation should be ruled out according with any particular mesh prior to usage, so should any mesh related bacteria nesting or harboring. This is generally the case with type 1 mono-filament macroporous knitted meshes, not interfering with macrophages migration. Long lasting anchoring method were reported to involve ligament through passing mesh arms, thus the particular mesh attachments to the pelvic chosen supportive points should be proved before hands for long lasting support, preferably with mesh arms through ATFP or SS ligaments anchoring. Mesh and arm delivery systems for mesh individually prepared or pre-cut kits should be proven to yield the desired correct mesh and arms placement at the pelvic floor. Some pre-cut meshes might be too small to provide the necessary complete coverage of the whole fascial defects, thus easier to place because less dissection is required. Others might provide relatively easy arm placing devices, but at the price of improper arm passage at the deep ligaments of the pelvis for appropriate high support. These meshes might be prone to operative failure and recurrent prolapse. One should not be tempted for these easy to apply kits but rather go for the highly curative ones. Bio meshes were not proven to yield any advantage over the synthetic ones and one should not endanger his patients with bio-hazards. Smilingly, the absorbable meshes were not reported to entail any superiority and one should ask himself is there any potential benefit of a vanishing mesh in herniation repair at all. The list of available commercially manufactured products expends fast and the existing ones are regularly re-shaped, thus there is no point in referring to any particular currently available mesh. With this atmosphere of many newly designed meshes popping up almost monthly, one must be extra couches when choosing his own mesh. Of huge importance is solid clinical data, proving high cure rate and low rate of complications of mild nature. One should seek for proper training before adopting any new operation and maintain his skills with frequent operation performance.*

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