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A Study of 52 Cases of Uterovaginal Prolapse by New Procedure Sacro-Spinous Colpopexy in Rajshahi Bangladesh

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A Study of 52 Cases of Uterovaginal Prolapse by New Procedure Sacro-Spinous Colpopexy in Rajshahi Bangladesh

Monira Najnin [α] & Munima Haque [σ]

Abstract- The analysis intended to evaluate urogenital and defecatory signs, and life conditions ahead of and following a sacrospinous Colpopexy/hysteropexy for uterovaginal prolapse. To prevent recurrence of uterine prolapse and to maintain adequate vaginal length, a new surgical procedure Sacro-spinous Colpopexy was introduced in Rajshahi, Bangladesh. Fifty-two women with indicative uterovaginal prolapse were cured using sacrospinous Colpopexy/ hysteropexy. Ahead of and following surgery, urogenital and defecatory signs and life conditions were evaluated with a authenticated question form. Data were obtained using a Standardized questionnaires forms which were completed by the patients. Questionnaires were about their basic demographic information, complaint history, patient obstetric history, gynecological history, patient examination history, patient operations performed, and patient post-operations follow-up. Anatomical results were evaluated by examining the pelvic ahead of and following surgery. The average return sequel timing was 6 months. Grades of all areas of urogenital and defecatory signs, fecal incontinency and pain improved substantially. Additionally, on all areas there is betterment of life and no main difficulties were confronted.

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I. Introduction

For the last few eras, it has been observed from multiple observations that sacrospinous ligament fixation is a successful surgical technique to rectify post-hysterectomy vaginal vault prolapse [1, 2]. As it has attested its efficiency in vaginal vault prolapse operation, it can be utilized as a principal procedure to rectify descensus uteri, which is called sacrospinous hysteropexy. The anatomical result and difficulty amount of this surgery was elaborated in some studies, however, did not concentrate on urogenital signs and life quality proceeding sacrospinous Colpopexy/ hysteropexy [3–8]. Same research group in a former investigation, found that Sacrospinous Colpopexy/ hysteropexy is a favorable procedure for the modification of descensus uteri [9]. But, the average follow-up of the observation was comparatively brief, the postoperative anatomical conditions were obtained from the patients' medical files, and deviations inurogenital signs related to the anatomical results were not evaluated. This study analyzed the fulfillment, difficulties, urogenital warning signs, and life quality in a women faction proceeding a sacrospinous colpopexy [10].

Recently for obtaining the best surgical management of auterine descent, numerous vaginal and abdominal procedures have been illustrated. For a vaginal vault prolapse, the sacrospinous ligament fixation has established to be an efficient management [11]. The sacrospinous ligament fixation can additionally be achieved as major cure for a uterine descent, a procedure named as 'sacrospinous hysteropexy'. This technique has been labelled in females who desired to conserve the uterus to hold on to fertility [12, 13]. Numerous research works have illustrated that the sacrospinous hysteropexyis anatomically effective and secure and the majority of females are greatly contented regarding this technique [14–20]. Consequence in these analyses was primarily evaluated by anatomical end-results, and most of these investigations did not appraise urogenital signs and life quality with authenticated survey forms. Calculating this functional result before and after surgery was one of the suggestions for upcoming investigation from a current publication [21]. The primary goal of this analysis was to evaluate urogenital and defecatory symptoms and life conditions pre and post sacrospinous hysteropexy. Further, the anatomical results were evaluated [22].

Pelvic organ prolapse is a key health concern which can accelerate in the upcoming years because of increasing life expectancy. Richardson documented in 1989 about a method called sacrospinous hysteropexy which is utilized for auterine descent where the uterus can be conserved [23]. Currently it cannot be verified whether removing the uterus is essential or directs to improved outcomes. From numerous research it has been observed that sacrospinous hysteropexy is anatomically effective and secure, and maximum ladies are very fulfilled with this technique [23–28]. In about three nonrandomized research studies, the sacrospinous hysteropexy was contrasted with a vaginal hysterectomy relating toanatomical results [26–28]. The methods were equivalently applicable in terms of

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anatomical results. Time of recovery following a sacrospinous hysteropexy has been observed to be substantially smaller in contrast to vaginal hysterectomy in a retrospective analysis [26]. The one research analysis which was done related to sacrospinous hysteropexy and vaginal hysterectomy concentrated mainly on sexual performance 6-monthspreceding operation [29] [30].

Pelvic Organ Prolapse (POP) is the plunge of one or more of the pelvic organs. Anterior vaginal wall prolapse consists ofthe urethra (cystocele, urethrocele) or/and bladder. Apical prolapse consists of post-hysterectomy vaginal cuff or the uterus. Posterior vaginal wall prolapsed involves the rectum although can further consists of the large and small bowel (enterocele, rectocele). Women could prolapse with one or more than one kind.POP is a commonplace health issue involving nearly 40% of parous women who are more than 50years old [31]. The risk for lifetime of female to go through operation for the cure of POP is around 11%, and30% of these females will require further operation owing to the prolapse reappearance [32]. The risk of POP elevates along with the frequency of births by vagina and is greater in elder and overweight women. POP has substantial adverse influences on a woman's livelihood conditions, varying from bodily distress, sexual and mental ailments to professional and public restrictions.

Nowadays in the Netherlands vaginal hysterectomy is the major management procedure for patients having symptomatic uterine prolapse. The incidence of post-hysterectomy vaginal vault prolapsed fluctuates from 0.2 to 12% [33-35]. Hysterectomy for pelvicorgan prolapse seems to be a specific risk factor. The possibility of prolapse mending following hysterectomy was 4.7times greater in females whose primary hysterectomy was designated for pelvic organ prolapse and 8 times greater if prolapse grade 2 or more existed before surgery [36].

In numerous analysis studies, it has been presented that sacrospinous fixation for uterine or vaginal vault prolapse is a secure and successful remedy [37-41]. The technique has some difficulties. Buttock pain on the side where the sacrospinous sutures have been performed takes place in around 10 to 15% of the female which usually settles in days and within months. Three analysis relating vaginal hysterectomy to sacrospinous fixation revealed no substantial deviation in anatomical result, whereas hospital staying duration was brief, suffered less aching, and had swift recovery in the later faction [42-44]. However, until now only one randomized analysis relating both techniques is accessible. This multi-facility pilot experiment associated vaginal hysterectomy to sacrospinous fixation for 66 female with uterine descent and having a greater rate of reappearances following one year in patients with sacrospinous fixation (27% vs.3% reappearance in patients having vaginal hysterectomy)[45][46].

A cross-sectional study of 50 to 79 years age females registered in the Women's Health Initiative designated that 41% of these women had some type of POP at starting point, while Samuelsson et al. described that 31% of female in overall, and 44% of parous women specifically had POP in another analysis on Swedish women [47, 48]. Parity displayed the sturdiest link with risk of compelling operation for POP (4:1 for women having1 child and 8.4:1 for women having 2 children in contrastto nonparous women) of all risk factors that were assessed by Mantet al. In this analysis less than 1% of prolapse happened in nulliparous female [49]. Samuelsson et al. described that the highly notice able risk factors of etiologic significance for POP were pelvic floor muscle strength, parity, and age having greater birth weight additionally linked to elevated prevalence of POP amongst parous women [48] [50].

Sacrospinous colpopexy has been utilized for ages in the cure of uterovaginal prolapse [51-53]. Furthermore, numerous studies have described the effective utilization of sacrospinous fixation for remedy of uterine prolapse with preservation of the uterus.[54-56]Effective/fruitful pregnancies and vaginal deliveries following sacrospinous fixation have also been described[55][57].

Rising anxiety regarding the difficulty of pelvic support defects has been come upon recently and numerous surgeries have been promoted for the cure. The sacrospinous ligament fixation of the vaginal cuff is extensively believed as the regular cure for the restoration of vault prolapse and is progressively conducted simultaneously in patients during hysterectomy with acute uterovaginal prolapse [58]. The vaginal method to the pelvic floor faults permits the accompanying restoration of cystocele, rectocele, enterocele, urethrocele, and perineal body flaws that are linked with vault or uterine prolapsed in over 75% of patients [59]. Hanging the vaginal vault to the exact sacrospinous ligament in the duration of hysterectomy necessitates additional operation time, not exceeding15 to 20 minutes, and is deemed as a reliable technique if implemented correctly [60] [61].

II. Materials and Methods

a) Patients

The surgical operations were performed from April 2016 to October 2016 and involved 52 women patients with genital prolapse. All patients obtained an identical, authenticated survey form in 2016 that consisted of basic demographic information, complaint history, patient obstetric history, gynecological history, patient examination history, patient operations performed, and patient post-operations follow-up.

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b) Surgery/Sacro-spinous Colpopexy surgical procedure

At first all the patients under went vaginal hysterectomy. Then anterior Colpopexy was done. During post Colpoperineoraphy after vaginal hysterectomy, high ligation of enterocele sac was performed. In the duration of colpoperineorraphy, rectovaginal space was attained following parting of the vagina from rectum. Right rectal pillar was perforated with a finger, and right coccygeus muscle and right sacrospinous ligament were recognized utilizing ischial spine as marker. Two sacrospinous colpopexy stitches 1-1.5 cm apart were done around 2.5-3 cm medial to ischial spine with polypropylene no.1 on round body needle from below upwards. These were taken in the form of a pulley and fixed to vaginal apex 2,3. All patients were being operated using the PDS-1 thread. At the end of surgery, sufficient vault suspension was confirmed, and vagina was packed for 24 hours. On the 6th postoperative day patients were evaluated and discharged. They were followed up after 1 month.

Nine patients went through vault repair operations. Vault repair consists of three operations performed consecutively: Anterior colporrhaphy, Posterior colporrhaphy and then Sacro-spinous colpopexy.

c) Measurements/Data collection

The Study is conducted with the data which was collected from the patient history questionnaire forms supplied to the patients undergoing uterine prolapse diagnosis and consequent surgery using the new surgical procedure Sacro-spinous Colpopexy. In addition, follow ups were done on these patients after completion of the surgery. The analysis of this paper comprises the information of 52patients of various diagnosis aged 35-55 years. Excel software (version 16.0) was used for doing the statistical analysis of the patient data.

For this analysis, some demographic characteristics of patients i.e. Age (various categories from 35-74years), living place (urban, rural), religion (Muslim, Hindu, Christian, Buddhism, others) are considered as outcomes variables. Obstetric history was taken on patients present with complaints, parity, age of first delivery, mode of deliveries (No. of spontaneous vaginal deliveries, No. of assisted vaginal deliveries, No. of caesarean sections) as outcome variables. In addition, Patient Gynecological history are taken on post-menopausal info, sexually active/not, other operations as outcome variables. Patient Examination history included variables as uterus present, weight, height, blood pressure (BP), Stage of prolapse (POP-Q staging, most distal portion of prolapse), Investigations. Various types of operations were taken as variables Patient Operations performed (Vaginal hysterectomy, Anterior colporrhaphy, Posterior colporrhaphy, Sacro-spinous colpopexy, Sacro-spinous hysteropexy). In post-operation follow-up, outcome variables were taken as Total vaginal length (cm), vaginal caliber, Any evidence of recurrence of prolapse (Cystocoele, Rectocoele, Uterine descent, Vault descent), existence or nonexistence of any warning signs, complains were noted. Also, existence or nonexistence of urinary incontinence, any bowel symptoms, Lump protruding from vagina were monitored during the post-operation follow-up.

III. Results

There were 52 women that went under Sacro-spinous Colpopexy surgery. All of them completed the standardized questionnaire forms. Basic demographic information is listed in table-1. Age of the patient was categorized from 35-74 years in 5 years interval. Amongst the patients, maximum patients were of40 to 64years of age. Amongst them, 46 (88.5%) patients are residing in rural areas, while the rest 6 of them (11.5%) lived in urban area. Amongst the patients, 48 (92.3%) are Muslims, and 4 (7.7%) are Hindu. There were none found from Christian, Buddhist or other religions.

Table 1: Key demographics on the respondents ($n = 52$)

	Category	Numbers	Percent %
Age (years)	35-39	3	5.8
	40-44	6	11.5
	45-49	13	25
	50-54	12	23.1
	55-59	7	13.5
	60-64	6	11.5
	65-69	3	5.8
	70-74	2	3.8
Living place	Urban	6	11.5
	Rural	46	88.5
Religion	Muslim	48	92.3
	Hindu	4	7.7
	Christian	0	-
	Buddhist	0	-
	Others	0	-

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Complaint history are recorded in table 2. Lump protruding from vagina symptom were present in 52 (100%) of the patients. Two patients had it for 1-11 months, while 19 of them had this medical condition for 1-5 year, 7 for 6-10 years, 3 patients for 16-20 years and 2 for 21-25 years. Vaginal pain/discomfort were present in 13 (25%) of the patients. Nine of them for 1-6 months duration and 4 of the patients were having this symptom for 1-5 years period. Urinary incontinence was present in 7 (13.5%) of the patients. Two of them had this complaint for 3 months while 5 had for 1-12 years duration. Sixteen (30.8%) of the patients had difficulty passing urine, while the duration ranged from months leading up to 15 years. Nine (17.3%) of the patients under study had difficulty passing bowel motion and the symptom ranged from 1 month to 5 years. Vaginal discharge or bleeding were present in 18 (34.6%) of the patients: 8 of them had for 1-11 months, 6 had it for 1-5 years, 3 for 6-10 years while 1 of them had this symptom for 11-15 years range.

Table 2: Patient complaint history

Presenting complaints	Percent % Yes	Percent % No	If yes, how long? (years)
Lump protruding from vagina	52 (100%)	0 (0%)	1-11 months: 2 1-5 years: 19 6-10 years: 19 11-15 years: 7 16-20 years: 3 21-25 years: 2
Vaginal pain/discomfort	13 (25.0%)	37 (71.2%)	1-6 months: 9 1-5 years: 4
Urinary incontinence	7 (13.5%)	42 (80.8%)	3 months: 2 1-12 years: 5
Difficulty passing urine	16 (30.8%)	34 (65.4%)	1-6 months: 5 1-5 years: 7 5-10 year: 3 11-15 years: 1
Difficulty passing bowel motion	9(17.3%)	41 (78.8%)	1-6 months: 4 1-5 years: 5
Vaginal discharge or bleeding	18 (34.6%)	34 (65.4%)	1-11 months: 8 1-5 years: 6 6-10 years: 3 11-15 years: 1

Patient Obstetric history are given in table 3. Of the patients, 6 (11.5%) of them had parity 2, 16 (30.8%) had parity 3, 8of them (15.4%) had parity 4, 7 of them (13.5%) had parity 5, and others ranging from 1-4 number of patients had parity 1, 6-10. Age at first delivery was highest from women of 15-19 years (32 number of patients, 61.5%), while the lowest (1, 1.9%) from 25-29 years of age. All the patients under study had their first delivery within 10-29 years of age, none from 30-44-year ranges. From the category of mode of deliveries, no. of spontaneous deliveries was most for 3 (15 of them) while the lowest were from 1 and 9 deliveries (2 of the patients). No. of assisted vaginal deliveries were 3 for only 1 patient found under study. Number of caesarean sections were none amongst the patients in this study.

Table 3: Patient Obstetric history

Variables	Category	Number of patients	Percent %
Parity	1	2	3.8
	2	6	11.5
	3	16	30.8
	4	8	15.4
	5	7	13.5
	6	3	5.8
	7	4	7.7
	8	4	7.7
	9	1	1.9
	10	1	1.9
Age at first delivery	10-14	9	17.3
	15-19	32	61.5

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	20-24 25-29 30-34 35-39 40-44	5 1 0 0 0	9.6 1.9 0 0 0
Mode of deliveries			
No. of spontaneous vaginal deliveries	0 1 2 3 4 5 6 7 8 9	- 2 6 15 8 7 3 4 4 2	0 3.8 11.5 28.8 15.4 13.5 5.8 7.7 7.7 3.8
No. of assisted vaginal deliveries	1 2 3 4 5	- - 1 - -	0 0 1.9 0 0
No. of caesarean sections	1 2 3 4 5	- - - - -	0 0 0 0 0

Patient Gynecological history are given in table 4.It was determined whether the patient was post-menopausal or not. Forty 40 (76.9%) patients were found to be post-menopausal. For those who were post-menopausal) specify age, their age of menopausal was noted and it fell between the range of 40-50 years. Five of the patients had surgical menopause. In case of sexual activity, if the patient responded to yes, then it was found if she had dyspareunia or not. Only 7 of the sexually active patients had dyspareunia, while 28 of them did not. Among the patients that were sexually inactive, 11 of them were widowed, 2 were divorced, while 15 were married. Twenty-one (21) patients responded to have previous operations: Total Abdominal Hysterectomy (TAH) 9 of them, 3 of patients mentioned to have Vaginal Hysterectomy (VH), while 14 patients had other previous operations (9 had BLTL, 3 had BL.SO and 2 of the patients had Cholecystectomy).

Table 4: Patient Gynecological history

Variables	Category	Number		Percent %	Yes (post-menopausal) specify age	Yes (Sexually active) Dyspareunia		No (Sexually active)		
Post-Menopausal	Yes No	40 12 (MC-R)		76.9 23.1	40-50 years: 21 >50 years: 9 Surgical menopause: 5	Yes	No	Widow	Divorced	Married
						7	28	11	2	15
Sexually active	Yes No	34 18								
Any previous operations	Yes 21 No31	TAH	VH	BLTL: 9 BL.SO: 3 Cholecystectomy:2						
		9	3							

- TAH- Total Abdominal Hysterectomy
- VH- Vaginal Hysterectomy
- BLTL- Bilateral Tubal Ligation
- BL.SO- Basic Life Support in Obstetrics
- Cholecystectomy-Surgical removal of gallbladder
- MC-R- Menstrual Cycle Regular
- UTI- Urinary Tract Infection

Patient Examination history are given in table 5.Of the 52 patients, 40 (76.9%) patients responded to having uterus present, while the rest (23.1%) do not. Eight (15.4%) patient weight ranged from 35-69 kgs, most patients 15 (28.8%) were in the weight range of 45-49 kgs, while the least 1 (1.9%) were of weight range65-69 kgs. Most of the patients weighted within 40-59 kgs. BP was within range of normal for most patients 49 of

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them (94.2%). Stage of prolapse (POP-Q staging, most distal portion of prolapse): One patient (1.9%) was in stage 1, 2 (3.8%) were in stage 2, 15 (28.8%) were in stage 3, while 22(42.3%) in stage 4. Vault prolapse occurred in 11 (21.2%) of the patients, while 1 (1.9%) patient had Cervix 3 cm outside introitus.

Table 5: Patient Examination history

Variables	Category	Numbers	Percent %
Uterus present	Yes	40	76.9
	No	12	23.1
Weight (kgs)	35-39	2	3.8
	40-44	8	15.4
	45-49	15	28.8
	50-54	13	25.0
	55-59	10	19.2
	60-64	3	5.8
	65-69	1	1.9
BP	Hypertensive (>140/90)	3	5.8
	Normotensive	49	94.2
Stage of prolapse (POP-Q staging, most distal portion of prolapse)	Stage 1 (> 1 cm above hymen)	1	1.9
	Stage 2 (to +/- 1 cm of hymen)	2	3.8
	Stage 3 (> 1 cm below hymen)	15	28.8
	Stage 4 (complete vaginal eversion)	22	42.3
	Vault prolapse	11	21.2
	Cervix 3 cm outside introitus	1	1.9

Patient Operations performed are given in table 6.Amongst the patients, 32(61.5%) went through vaginal hysterectomy operation, 47 (90.4%) patients had Anterior colporrhaphy operations, 46 (88.5%) patients had Posterior colporrhaphy, 41 (78.8%) of them had Sacro-spinous Colpopexy, 8 (15.4%) of the patients had Sacro-spinous hysteropexy. None of the patients under study needed Abdominal sacro-spinous Colpopexy, Perineorraphy, Le Fort, Utero sacral sling, Abdominal hysterectomy, or other operations.

Table 6: Patient Operations performed.

Operations performed	Category	Numbers	Percent (%)
Vaginal hysterectomy	Yes	32	61.5
	No	20	38.5
Anterior colporrhaphy	Yes	47	90.4
	No	05	9.6
Posterior colporrhaphy	Yes	46	88.5
	No	06	11.5
Sacro-spinous colpopexy	Yes	41	78.8
	No	11	21.2
Sacro-spinous hysteropexy	Yes	8	15.4
	No	44	84.6

Patient Post-operations follow-up are given in table 7. In post operation follow-up, total vaginal length was 8 cm for 48 (92.3%) patients, 5 cm for 4 (7.7%) patients; no patients had between 5-8 cm, smaller than 5 cm or other categories. Vaginal caliber was narrow for 3 (5.8%), and normal for 49 (94.2%) patients. None of the patients had wide vagina. For indication of recurrence of prolapse, Cystocele was seen in 1 (1.9%) of the patients in stage 1, 3 (5.8%) of the patients in stage 2, none of the patients were in stages 3, and 4. Rectocele was seen in 2 patients in stage 2, none of the patients were in stages1, 3, or 4.Uterine descent and Vault descent recurrence were not seen in any of the patients. Cervical descent was found in 1 patient each for stage 2 and stage 3 recurrence. It was noted whether the patients were still showing symptoms. Amongst the operated patients, one patient was found to having one of the symptoms in each category: having the Bulge in vagina (1), Buttock pain (improving) in 1 patient, vagina problem short following original hysterectomy (1), and shortened vagina in 1 patient. 5 patients were sexually active, while 6 patients were not sexually active (was pre-op). Some patients showed complains as infected vaginal Haematoma postop-UTI (1), some pain after Micturation(1), dryness in vagina (1), some dyspareunia postop (3), vaginal pain (1), lower abdominal pain (3), atrophic vagina (1), Dyspareunia (1) and some stress-incontinence postop in (1) patient.

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Table 7: Patient Post-operations follow-up

Variables	Category	Numbers	Percent (%)
Total vaginal length (cm)	8 5 Between 5-8 >5 Others	48 4 - - -	92.3 7.7
Vaginal calibre	Narrow Normal Wide	3 49 -	5.8 94.2
Any evidence of recurrence of prolapse		-	
Cystocele	Stage 1 Stage 2 Stage 3 Stage 4	1 3 - -	1.9 5.8
Rectocele	Stage 1 Stage 2 Stage 3 Stage 4	- 2 - -	3.8
Uterine descent	Stage 1 Stage 2 Stage 3 Stage 4	- - - -	
Vault descent	Stage 1 Stage 2 Stage 3 Stage 4	- - - -	
Cervical descent	Stage 1 Stage 2 Stage 3 Stage 4	- 1 1 -	1.9 1.9
Is the patient symptomatic?	Bulge in vagina Buttock pain (improving) Vagina prob short following original hysterectomy Shortened vagina Sexually active Not sexually active (was preop)	1 1 1 1 5 6	1.9 1.9 1.9 1.9 9.6 11.5
Any complains?	Infected vag. Haematoma postop-UTI Some pain after Micturation Dryness in vagina Some dyspareunia postop Vaginal pain lower abdominal pain Atrophic vagina Dyspareunia Stress-incontinence postop	1 1 1 3 1 3 1 1 1	1.9 1.9 1.9 5.8 1.9 5.8 1.9 1.9 1.9
Urinary incontinence	Yes 2 No 50	- -	3.8 96.2
Any bowel symptoms	Yes 2 No 50	- -	3.8 96.2
Lump protruding from vagina	Yes 2 (due to elongated cervix) No 50	- -	3.8 96.2

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IV. Discussion

There are a couple of limitations in this study. First, there could be some selection bias in the collection of patients' attendances for gynecological inspection. Not all the patients were chosen, only the ones that qualified for this project. Second, there could be a sign bias. Women who picked particularly this operation as an alternative to the more usual vaginal hysterectomy possibly had high anticipations of this technique. This could have had affected their respond choices. Further, there can be a bias of the gynecologist who chose the females for the technique. Third, while an average 2 years of followup is acceptable, maybe some reappearances were not until now progressed in the duration of gynecological inspection or exploration of medical records. Nevertheless, females being cared for their recurrent prolapse were analyzedby6 months following primary operation. Fourth, this data on the revival time following operation were assembled in retrospect and patients can have problematic recall bias. Fifth, pad testing or urodynamics were not carried out following operation to verify urinary incontinency and detrusor hyperactivity. Still, these processes are identified for relating reasonably with the stated symptoms [62, 63] [64].

Vaginal vault prolapse is an unusual difficulty which can happen following any vaginal or abdominal hysterectomy [65,66]; however, larger life expectancy will establish an actual elevation of occurrence of this condition in the future. It is recommended that transvaginal sacrospinous fixation procedure could be applied as an addition to vaginal hysterectomy and mending for noticeable uterovaginal prolapse in the attendance of poor uterosacral and cardinal ligaments. The minimal illness and the brief timing needed for suitable anatomic partition into the proper pararectal space, conception and trans fixation of the sacrospinous ligament inspires the utilization of this technique as a precaution during vaginal hysterectomy in patients having acute uterovaginal prolapse [67].

In summary, sacrospinous fixation of the vaginal vault is a suitableprocedure for the remedy of vault prolapse, permitting instantaneous effortless restoration of coexistent cystocele, enterocele and rectocele. It could be utilized prophylactically in patients with acute uterovaginal prolapse, is linked by superior anatomic outcomes and subtle during operation illness. The supervision of stress incontinency in these patients frequently necessitates a retropubic or a united vaginoabdominal technique [68].

Hope for Life undertakes free Genital Prolapse surgery for low income women in rural communities. Genital Uterine Prolapse occurs when ligaments and pelvic floor muscles elongate and wear off, offering insufficient support for the uterus. The uterus then slides down into or extends exterior to the vagina. It is an extremely common ailment that, untreated, often has devastating consequences. It can lead to chronic backpain, urinary difficulty, sexual intercourse pain, and pregnancy complications. It impacts on the ability of women to carry out household chores and earn a living and to sustain a functioning public association. It dramatically alters the life quality of the concerned female. The psychosocial and physical changes in women suffering from this disability has been indicated to influence spouse bonds, and the society: often leading to social seclusion, marriage split-up, constraints on religious performance, and denial by their own families and acquaintances.[69].

V. Conclusion and Future Works

This work was performed in Rajshahi and is still an ongoing process. This same project is being sponsored in other parts of Bangladesh. In 2014-2015, there were 2,500 free operations performed by 15 Hope for Life surgeons. In 2017, there is expectation of this many patients to have a free operation by Hope for Life surgeons. If this project can be extended to all places in Bangladesh, then it can serve the whole population.

Because of their shyness, most of the patients do not inform their symptoms at an early stage. Also because of socio-economic background and also surrounding environment forces them not to come out and inform their symptoms to health care professionals. If it can be diagnosed and treated early, then these problems can mostly be prevented. There needs to be a door to door campaign regarding this for awareness in Bangladesh.

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