Case Report

Laparoscopic Hysterosacropexy: Is it A Safe Option for Fertility Spearing?

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Abstract

Objective: In case of uterine prolapse, hyseroxacropexy, a conservative surgical approach, which allows the sparing of body image and sexuality, could be the choice in fertile women. Few information are reported on subsequent pregnancy after surgery.

Case report: A 33 years-old women with symptomatic prolapse underwent a laparoscopic hysterosacropexy. Subsequently she expressed her pregnancy desire and she got pregnant. A scheduled caesarean section was performed without complication. The subsequent follow-up was regular: the patient was asymptomatic and presented no sign of prolapse recurrence.

Conclusion: In motivate and well counselled patient, informed about the risk of prolapse recurrence, pregnancy could be considered after hysterosacropexy.

Keywords: Hysterosacropexy; Laparoscopy; Pelvic Pain; Pregnancy; Prolapse Recurrence Risk

Introduction

The uterine prolapse is common in post-menopausal women (1), however, few cases are reported also in fertile-age patients (2). In case of symptoms not responsive to conservative management, surgery is indicated after an accurate urogynaecological evaluation, which allowed the identification of anatomical and functional defects (3). The treatment of choice is hysterectomy with a colpopexy. Indeed, a more conservative surgical approach, which allows the sparing of body image and sexuality, could be the choice in fertile women. Abdominal hysterosacropexy, the most studied technique, is a safe and efficient surgery (2).Even if there is not a conclusive opinion, it seems that also laparoscopic hysterosacropexy could allow good clinical outcomes (4).

Few information are reported on subsequent pregnancy after surgery: they seem not to influence conservative repair (5).

We faced with a patient in pregnancy after laparoscopic hysterosacropexy. Considering that only few cases were described, due to the rarity of this event, and that the management was not univocal, we would like to share our experience thinking that also a single case could be of contribute.

Case report

A 33 years old women firstly come to our attention in January 2018 for a gynaecological prolapse. She is normal weighted (BMI: 22.9 kg/m^2), without any disease. Her obstetric history reported two previous

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vaginal delivery without complication, one intrauterine death at 6 months, 1 caesarean section for breech presentation, 1 hydatiform mola treated with hysterosuction, and 1 miscarriage. At gynaecological visit she reported II degree cystocele, hysterocele and rectocele. She referred difficulties in evacuation, with necessity of digital pression; she presented urodynamic stress incontinence and hyperactive bladder. She underwent pelvic rehabilitation and solifenacin 5 mg/daily. She come back 5 months later requiring surgery due to therapy intolerance. After an accurate counselling, the patient confirmed the desire of surgical therapy and required a conservative approach. In July 2019, at 34 years-old she underwent laparoscopic hysterosacropexy. A "Y" propylene band was used to fix the cervix to the sacral promontory. The post-surgical course was uncomplicated. She was followed-up and remained asymptomatic after surgery. In September 2021 she expressed her pregnancy desire, therefore she was counselled about the risk of prolapse and symptoms recurrence. However, she presented some months later in pregnancy. The pregnancy course was regular, without prolapse or urinary symptoms, until 32 weeks when pelvic pain started. This pain was challenging, considering that she was at risk also for uterine rupture, due to big multiparity and previous caesarean section. She came three times to Emergency room complaining this continuous and not responsive to pain killer symptom. For this reason, at 34 weeks she was hospitalized and posed under a strict control. Serial cardiotocographies were always reassurance (ACOG category 1). No sign or symptoms of uterine rupture were reported. Other causes of pain were excluded. However, at 35.1 weeks a scheduled caesarean section was performed, after corticosteroid course, for worsening pelvic pain. At surgery no complication was reported, and the post-operative course was uneventful. After caesarean section the pain disappeared. The subsequent follow-up was regular: the patient was asymptomatic and presented no sign of prolapse recurrence at gynaecological visit (Figure 1); also transvaginal ultrasound examination was regular (Figure 2).

Discussion

This case could be of support to the counselling in case a patient requires pregnancy after prolapse surgery. Even if other cases are required to pose conclusive indications, we can support the possibility to underwent pregnancy in motivate and well counselled patient, informed about the risk of prolapse recurrence, as in the other two similar cases reported in literature (6, 7).

Moreover, nowadays the patient presented excellent results of urogynaecological correction with no sign of recurrence. Therefore, we think that a follow-up is mandatory, to identify an initial recurrence and trying a prevention thanks to pelvic rehabilitation.

In the aftermath, we hypnotized that the worsening pelvic pain in the third trimester could be correlated to a tension due to the presence of the propylene band and adherences in contest of uterine enlargement and uterine inferior segment preparation, typical of the third part of pregnancy.

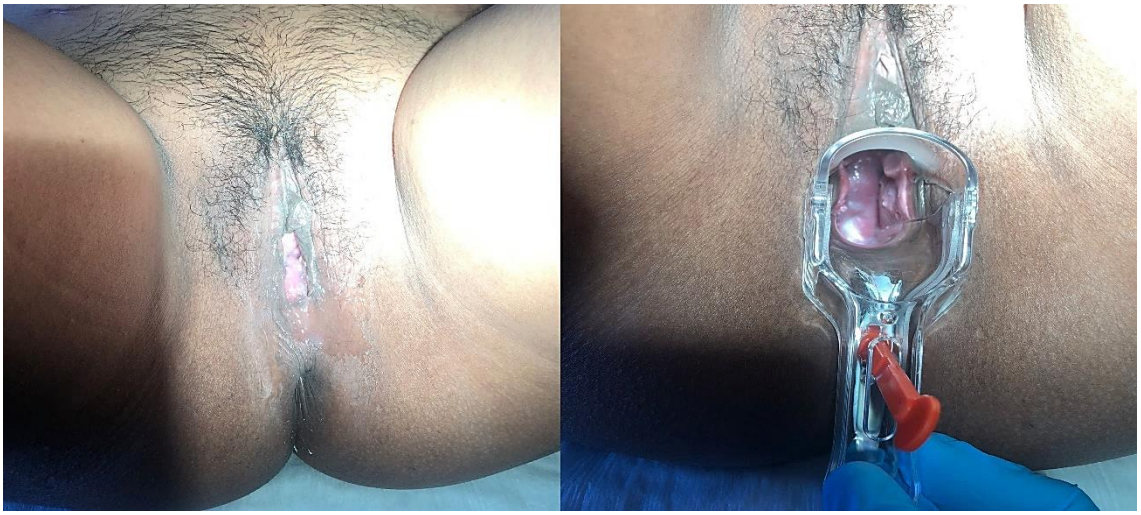

Figure 1: Clinical evaluation at gynaecological visit for the follow-up after caesarean section: no sign of prolapse recurrence was reported.

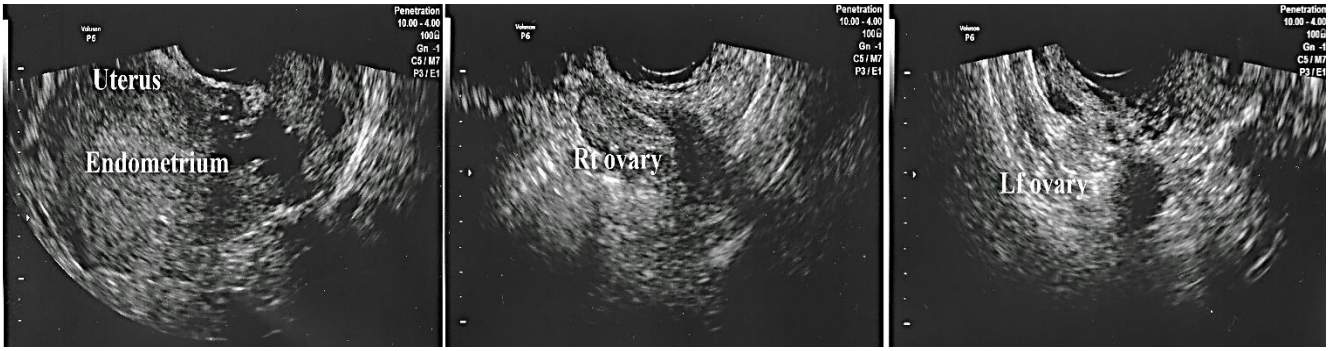

Figure 2: A regular ultrasound examination performed at the scheduled follow-up after pregnancy

We opted to share our case to underline that the presence of pelvic pain in patient with previous laparoscopic hysterosacropexy could be correlate to this surgery, and this cause should be posed in differential diagnosis with other motivation.

Considering delivery, our suggestion opted for C-section, as in the other case reports (6, 7), considering the previous gynaecological surgery with the presence of a non-elastic band.

Conclusion

In motivate and well counselled patient, informed about the risk of prolapse recurrence, pregnancy could be considered.

Conflict of Interests

Authors declare no conflict of interests.

Acknowledgments

None.

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