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Cardinal and uterosacral ligaments

Uterosacral ligament vs cardinal ligament. What is uterosacral ligament.

Address for reimpressions: S.H. Cruikshank Department of Obstetricia and Gynecology Hennepin County Medical Center 701 Park Avenue Sul Minneapolis, MN 55415, USA. OBJECTIVE: To determine the surcetic anatomy of the ureter during vaginal hysterectomy. METHOD: Sixty patients submitted to vaginal hysterectomy were studied. All patients had moderate or severe uterovaginal prolapse or complete prociones. The ureteral position was observed after the traction and cutting each complex of the uterosacral cardinal ligament. Result: In 40 patients with moderate or severe uterovaginal prolapse, the ureter is not significantly moved when the trablet was applied to the lap of the tube and there was no upward to the bladder. When the uterosacral-cardinal ligament complex was cut, with vigorous traction in the colo of the underter and the upward bladder retraction, the ureter was high from the operating field. The same happened with those 20 patients with Procidian after cutting the cardinal ligaments. CONCLUSION: The tracing and cutting of cardinal ligaments are the main factors that affect the movement of the ureter during vaginal hystery; This action protects the ureter. The protection added by the cardinal ligament occurs with the bladder retraction. Preventing the prolapse of vaginal safe, supporting the vaginal cuff is an essential part of hysterectomy, whether abdominal or vaginal. Incidence of vaginal prolapse of Posthysterectomy ranges from 0.2% to 43 %.1, 2 preventing complications from being a sine surgery. In transvaginal or transabdominal hysterectomy, it is necessary to use the pane (uterosacral and cardinal ligament) support structures to support vaginal fist. Any successful repair will restore normal anatomy and an operating vagina. In this chapter, several principles of vaginal fixation during hysterectomy are discussed, including attaching the vagina to Ivico support structures, correcting or preventing a potential or potential enterocele, and performing a colpopexia, vaginal and abdominal. The normal vaginal axis is almost horizontally and higher to the lift plate.3 The vagina is parallel to the Ani Levator, not directly on the genital hiatus. In the poca of intra-abdominal pressure increase, the alvency plate and endelvic fans (especially the cardinal-uterosacral complex) keep the color of the building and the upper vagina in their suitable positions. Stretching and laceration of support structures can result in uterine or vaginal prolapse. The ethiological factors include trauma, atrophy and attenuation of menopause, and possibly pudendal neuropathy, with loss of lifting and endopic intopic integrity of Fascia. The TTERTER and VAGINA then overcome the genital hiatus, which leads to the prolapse of the agriculures. Discussions of all to help prevent the prolapse of pomsacular afterwards. These steps are routinely performed and adjuvants. They require strict attachment to attach the uterosacral and cardinal ligaments to the vaginal membrane. Also they are discussed the techniques to close the douglas alley that are used - to avoid the formation of a enterocele and prevent apical descendancy. During transvaginal hystery, The uterosacral cardinal ligament complex should be replaced for the vagina. The following steps can be performed at the beginning or at the end of the procedure. We carry out these steps in the beginning of a transvaginal hysterectomy so that the sutures are not cut by mistake later in the procedure, and so that these steps are not forgotten if the procedure becomes difficult or complicated. If the support is defective at the beginning of the case, I use a more proximal annex of the uterosacral ligament to the cuff at the end of the procedure. fig. 1. Uterosacral cardinal ligaments connected to vaginal membrane. (CRUIKSHANK SH: Preventing the prolapse of vaginal safe of Pós-Insacia and Enterocele during vaginal hysterectomy. AM J Installed Ginecol 156: 1433, 1987.) After prior and subsequent alleys are inserted, the uterosacral and and Ligations are cut and connected. If these support structures are not fragile or attenuated, the pedicles are sutured to the vaginal membrane (Fig. 1). Fixing the pedicles to the sidewalks of the vagina, the abah is supported and the sidewalks of the vaginal culpule are easily sutured. Care should be taken, because these are common sources of pole-operative bleeding. These steps are completed during any transvaginal hysterectomy. If hysterectomy indication includes uterovaginal prolapse, these ligaments should be shortened to eliminate any loop which is present. Shortening can be performed at the beginning of the process, provided that the previous Cul-de-SAC has been introduced and the bladder retracted. This step raises the bladder and urethers out of the way of evil. If uterosacro-cardinal ligaments need shortening but hysterectomy should be performed without entering the previous cul-de-sac, shortening steps should be performed after the building is removed and the bladder and urethers are high. A recent study showed that in all patients, except those with severe uterovaginal prolapse or procidency, the ureter, actually, is protected by cutting the cardinal ligaments at the beginning of procedure.4 This step allows urethers to fall laterally and retract For Side Ivica Sidewall fig. 2. Modified Culmplasty McCall at the time of abdominal hysterectomy. Sacro-uterine ligaments are identified at the beginning of the hysterectomy course before the use was removed. This is assisted by traction up the speech through Kocher's use of arms (arrows). Permanent tag sutures are placed through each uterosacro ligament, about 2 cm from the lateral wall wall. (Wall LL: a technique for culmplasty McCall modified at the time of abdominal hysterectomy J A am Coll Surg. 178: 507, 1994.) Culllasty McCall or a modification of this procedure is another means of support from the culpula Vaginal during transvaginal hysterectomy.5, 6,7 This process incorporates uterosacros and cardinal ligaments to the peritoneal surface. The sutures are linked so that when tied up, the uterosacro-cardinal ligaments are attracted to the middle-day line, thus contributing to close the cul-de-sac. In addition, when the suture is turned on, it extracts the back vaginal inexcure to the support structures, raising it for a normal position. This maneuver can be performed with one or more sutures (Fig. 2). The only disadvantage of this kind of culmplasty is possible an increase in the ureter torch or connection incidence, because it is so close to the ligament modification. Any uterosacro of these procedures to arrest The support structures (uterosacros cardinals) for the vagina will work. The important point is to perform these steps during transvaginal hysterectomy. During an abdominal hysterectomy, the cardinal and sacral-uterine ligaments should also be connected to the vaginal codula. As soon as the survey and cervix are removed, the urchinacrosal pedals are sewn from the sidewalks of the vagina. They can be incorporated as part of the side angle or separately. There is no need to incorporate the round ligaments to the fist, because they do not help with the balonete suspension and, in fact, can draw the ovaries for a position that is overlapping Vaginal. Ritec, which predisposes the patient to dyspareunia. emphasis should be given to prevent prolapse of posthysterectomy culpula. Prolapse of normal Ivico loss loss vagina results or occurs as a result of omitting the steps using these fabrics of pale Ivico support during hysterectomy. This complication may occur after any transvaginal or transabdominal hysterectomy; Hysterectomy alone will not cure uterovaginal prolapse. Hysterectomy allows the surgeon to visualize and use the support structures, attaching them to the Membrane. Several vaginal fixing vaginal moment of hysterectomy are currently recognized. Surgeons should try to prevent preventing Prolapse using the complex cardinal-uterosacro as described. Another step that helps prevent complications after transvaginal or transabdominal hysterectomy is to take care for Douglas's cul-bag. If normal cul-de-sac, a deep cul-de-sac, or a self entocle is found, an attempt must be made for future enterocele to avoid or identify and correct a Enterocele. Closure the peritá "Abdominal may be held during vaginal hysterectomy as part of an attempt to prevent enterocele formation. Closing of the former peritécio is unnecessary for proper healing. However, if a cul-de-sac or the deep enterocele is not repaired, future formation enterocele and vaginal culpule prolapse can occur. fig. 3. Closing the cul-de-sac and peritoneal cavity during vaginal hysterectomy. (CRUIKSHANK SH: Prolapual pap-hysterectomy prevention of vaginal and enterocele culpula during vaginal hysterectomy am J Other Gynecol. 156: 1433, 1987.) At the time of transvaginal hysterectomy, the Cul-de-sac can be closed as it follows. Beginning in the position of 12 hours, one full length, prolonged action absorbable or permanent suture is placed through the superior peritoneum (Fig. 3). In the hourly direction, running on the bag is placed to the left if the surgeon is left-handed. At the level of uterosacros and cardinal ligaments, a bite is done through each of these proximal ligaments to the ligation of the pedestrian for the vagina. The suture wire is passed through the previous rectal serous approximately 3rd, 4 centimeters above the peritoneal reflection level. Suture is brought around to meet the free end of the draw. It is drawn and attached to ensuring the appropriate and elevated abdominal peritoneal closure (Fig. 4). The suture wire is performed and sewn for the vagina at the level of the cardinal ligaments as the vaginal culpula is closed. Compared with simple peritoneal closure and a clasp of McCall-type, this procedure only closes the de-cul-bag; It does not effectively prevent a Enterocele.7 Fig. 4. Portioneal closure is complete. (CRUIKSHANK SH: Posthysterotomy prevention Vaginal prolapse of the ababic enterocele and during vaginal hysterectomy am J Other Gynecol. 156: 1433, 1987.) Many have been described to take care of Douglas's posterior cul-de-sac. In both transvaginal and transabdominal hysterectomy, 5, 6, 7, 8, 9, 10, 11 These methods vary slightly in the case, but the objectives remains the same: to prevent or repair a enterocele. However, only one McCall-type suture has been demonstrated that truly prevent enterocele formation.7 The Halban Cul-de-sac Closure11 is a vertical clasp of the peritoneum that was first described by abdominal procedures (Figs 5 and 6). By incorporating these peritoneal sutures vertically, ureteral damage is avoided while closing surgeons out of a potential, SAC enterocele deep, or obvious. This process is effective for transvaginal surgery as well as (Fig. 7). It closes the des-CUL-SAC without the need to placing sutures near the urethers. He also performs high peritoneal ligature, which is an important step in closing a deep cul-de-sac. If intact uterosacros ligaments can be picked up in the suture type halban, this will add force to Closure. fig. 5. Cul-de-sac Halban (Abdominal, Sóthero Removed). A. Side view attaching sigmoid the vagina. Vista B. Douglas Cul-de-sac. C. Side view of completed closing. (Nichols DH: Vaginal surgery, P 348. Baltimore, Williams Wilkins, 1996.) Fig. 7. Vaginal Halban-Clasp type. (Nichols DH: Vaginal surgery, P 347. Baltimore, Williams & Wilkins, 1996.) Fig. 8. Double transvaginal close. The first suture of the purse rope was tied, closing the peritoneal cavity. A second suture of purse rope was placed 1 cm distal for the first, also to be tied. (Nichols DH: Vaginal surgery, P 346. Baltimore, Williams & Wilkins, 1996.) The MoschCovitz procedure was first described as a method to close a deep outdable alley in conjunction with the prolapse of the rectum. It has been modified and now it is announced as a subject to close the alley-free alley during the course of different abdominal procedures (ie hysterectomy, abdominal sacroplexia, abdominal procedures for genuine stress incontinence). A circumferential suture (Fig. 8) is used to close the alley without exit. The anterior part of the ligation is attached to the back side of the lower uterine segment if the omters is left in situ or for the peritemy of the vaginal wall subsequently after hysterectomy. The method of Cul-de-SAC closing previously described for transvaginal hysterectomy is a modification of the abdominal Moschcovitz suture. Be performed abdominally or vaginal, should be taken to avoid the ureter because it is so close to uterosacral ligaments. However, prevent urethers from not impeding to grab uterosacral ligaments as an integral part of this repair. The surgeon can prevent this area with the use of direct palpation and identification12 of these structures during the placement of the alley without exit - plicating links. Of all the above mentioned procedures, only the McCall type point is effective in the prevention and healing of a formation of enterocele. Enrocele is more common than the recognized frequency. Ranny8 reported an incidence of 18.1% in patients submitted to large gynecological operations. The lack of closing a deep no-exit alkka at the time of hysterectomy or another procedure can result in hence formation. Be repairing or preventing a self or potential enterocele, the objectives are the same: to restore the function and anatomy, prevent recorency and use an appropriate procedure. Hysterectomy and transperitoneal abdominal procedures allow the surgeon to evaluate Cull-de-sac and avoid the formation of a enterocele. Most transvaginal hysterectomies have some degree of uterovaginal descent. In some cases, the main indication for hysterectomy is symptomatic pale relaxation. In patients who have stage I for the uterovaginal prolapse IV, the adjunct support of the vaginal Apex may be required. Estágio I Uterovaginal Prolapse is defined as the presentation of the colo of the underter past the mid part of the vagina, Phase II for the Hmic as a result of the Valsalva maneuver. Estágios III and IV uterovaginal prolapse are defined as the presentation of the color of the use of at least 1 cm after the hymen with Valsalva maneuver (Figs 9 and 10). 13, 14 patients with these degrees of Relaxation before surgery can be candidates for more than the uterosacral - complex cargo-casual-casual for the vaginal membrane. In addition, in some patients, the presentation-operate will be different; However, after the support of the safe and the vaginal plastic repair procedures were performed, the vaginal safe can still be pulled into or in addition to the hm. This condition, although intraoperative diagnosed, should be repaired. Pronoratory evaluation and intraoperatory of legal support should be performed to repair all defects that are gifts, 9. Estágios I II Uterovaginal Prolapse. (CRUIKSHANK SH, COX DW: sacroxy fixing at the time of transvaginal hysterectomy. AM J Instantated Gynecol 162: 1611, 1990.) Fig. 10. Estágio III Uterovaginal prolapse. (CROIKSHANK SH, COX DW: Sacrospinal fixing at the time of transvaginal hysterectomy AM J Other Gynecol. 162: 1611, 1990.) Traditionally, the sacrospinal fission of the sacrocolpopexy vagina and abdominal were considered suitable for repair of vaginal prolapse or abobbed certain types of 16 However, these processes can also be used as an auxiliary procedure for preventing Posthysterectomy prolapse ababic. All That suffers hysterectomy is a candidate for these procedures. If the loss of Ivico support structures (uterosacral cardinal ligament complex) is observed in hysterectomy, an attempt to use its remnants should be made. However, the use of sacrovenominal fixing as adjunct procedure will prevent further safe prolapse. If the abdominal hysterectomy is indicated in a patient with uterovaginal prolapse, the abdominal sacroplexy can be performed as an adjunct procedure. If an evaluation prond or intraoperatory in a patient submitted to transvaginal hystery shows the need for support Deputy vaginal, a sacrovenous colpopexia is easy to perform hystery. The secretion attachment procedure is performed as follows. The posterior vaginal wall is open to the grave and retrovaginal space is inserted. This space is dissected with the surgeon's finger to the level of the ischial spine. The descending rectal septum (pillar) is pierced, opening the spacing space (Fig. 11). With further defense dissection, the ischy spine and the skills - complex of the sacroxy ligament are palpated and visually identified. Abservising long durability or permanent monofilament sutures are placed through the ligament. These sutures are performed and left untied until any additional reconstructive procedures are concluded. The attachment of the ligament is performed with safety points and pulleys (Fig. 12). In a recent study of 695 ligament fixation procedures 695, this procedure was effective in the vaginal item cure to 97.0% of the prolapse of the space.17 If the abdominal hysterectomy was indicated despite the presence A of the otteropagnal prolapse, the abdominal sacroplexy can be performed. 11. Dissecting the retrovaginal and similar spaces. (Cruikshank Sh, Cox DW: Sacroxy fixing at the time of transvaginal hysterectomy. AM J Instantal Gynecol 162: 1611, 1990.) Fig. 12. Fixing with pulley and security points. (Cruikshank Sh, Cox DW: Sacroescent fixing at the time of transvaginal hysterectomy. AM J Instantated Gynecol 162: 1611, 1990.) Various modifications in the abdominal sacroxy were proposed, but this discussion is limited to a single modification of two of them. 18, 19 An incision is made in Peritónio in the sacral hollow of the sacral promontory down, more later as possible. The alley is obliterated. Three to five permanent sutures are placed in the peri-estheus of approximately 1 cm distance. These sutures are used to hold one end of the graft (synthetic non-absorbable material or homophage) to the sacrum. The other end of the graft is sutured to the posterior wall of the exposed vaginal safe. The graft is sewn to the vaginal safe and peri-ésteo of the sacral promontory. The graft is fixed for the underlying serous of the sigmoid with two or three non-absorbable sutures 2-0 (Fig. 13) (Fig. 13). Abdominal sacroplexia. (Thompson JD, Rock Ja, [EDS]: Telinde's operative gynecology, P 883. FiladÁ © Lfia, JB Lippincott, 1992.) Thus, the literature is full of an attempt to manage not surgical and surgical of prolapse genital. More than 1500 articles were written in management or prolapse. Before the XX season, most treatments were partial or had serious inconveniences. This abstract involves only some of the anatomically corrective operations to support vaginal safe. Several principles of vaginal fixation during hysterectomy are currently recognized. It is crucial for the surgeon to observe the loose of support structures and try to repair this loop in the initial operation. Hysterectomy offers a good opportunity to evaluate all the anatomical aspects of pale Ivico support and avoid the future vaginal prolapse. Attaching the feet support structures to the vagina, repairing a self or potential enterocele, and the use of appropriate deputy procedures are some of the surgical approaches to provide support to the cuff Safe Prolapse Safe For gynecological surgeon, as evidenced by the many historical attempts to repair this condition surgically. Although more than 40 procedures were proposed, few have been able to rebuild the vagina in its normal anatomical position. This objective is of extreme importance so that the anatomy is not distorted, the patient is not predisposed to the formation of enterocele, and the vagina has the normal function. With any reconstructive procedure, some operational failures will occur. Some of the factors that cause the failure Operatory are unpredictable, but age, condition of poor tissue, cicatricial tissue, increase of abdominal pressure, and neuropathies can prevent the ideal reconstruction of taking place and lead to a less-perfect result. Every effort should be done to restore the anatomy to its normal position. Vagina's placing with a abdominal or vaginal sacrocolpopexy through sacrospinal fixation usually results in good patient restoration. each Anatomical should be treated individually. If a good support and functure of the vagina are the desired results of operative repair of prolapse Posthysterectomy, surgical techniques can vary considerably from patient to patient. However, the result remains restoration of the vagina for its normal anatomical position. Incidental prevention is one of the objectives in reconstructive surgery for vaginal prolapse of vaginal culpule. Recorences often have the following causes: (1) a sack of enterocele was ignored; (2) The vaginal cucula was suspended in a position that was too far before, possibly for the anterior wall of the rectum, thus predisposing the patient for a rapid recroction of enterocele; (3) Both these factors may be present; and (4) the procedure was performed incorrecly. An important consideration in the selection of a process is if the patient will continue to be sexually active. SUMBER importance to verify if a woman is sure that she will not be sexually active if an obliterating ethics is to be realized. Recent Studies from the procedure20 Neugebauer-Le Fort for the vaginal prolapse reported good results. However, all efforts should be made to preserve vaginal function, length, and axis of more than 40 procedures for the prolapse of the vaginal cucula described along the last season, three large categories have evolved: (1) complete obliteration (Colpocleise); (2) abdominal sacrocolpopexy or vaginal sacrospinal fixation, or a modification of it; and (3) anterior fixation on the ventral abdominal wall, which is rarely used because of normal anatomy is not restored. Prolapses for the prolapse of the vaginal culpulum that offer the best anatomic result are those that have already been described: sacrospinal transvaginal fixing, sacrocolpopexy transabdominal with the use of an artificial or a fascial graft, and A high uterosacro attachment ligament for the vagina (or a high modified McCall Culmplasty). This section does not attempt to describe each type of repair that has been reported for this hysterectomy complication. However, a partial review of the different types of abdominal and vaginal impairments can be found in the Section reference.13,14,15,16,17,18,19,20,21,22,23,24,25 The most important consideration is that normal anatomy is restored and the location or local damage sites are reconstructed properly. it has been shown, both clinically and anatomically, that damages to the suspension fibers Connect with vaginal vaginal codper results on vaginal abah prolapse.26 These include the fibers that compose the endopic fission of the complex cardinal-uterosacro ligament. When these fibers are destroyed, they are surgically relaxed, or are not used. Therefore, every effort must be done to replace these For the vaginal cucula at the time of hysterectomy to avoid Posthysterectomy Prolapse.27 Theoretically, this approach must prevent prolapse in almost all cases. However, reduction of the suspensive suspension The atrophy of menopause, or loss of neural supply to this area can result in vaginal safe prolapse, and one of the anthathy repair of safe prolapse will be necessary. The numerous attempts in the literature to repair the safe prolapse suggest that this condition is a significant problem for the gynecological surgeon. The careful reconstruction of the anatomy at the time of hysterectomy will prevent many prolapses of éctemic. However, if the prolapse occurs, the restoration of normal anatomic relationships should be tempted, transvaginally or transablabely. In addition, any other gift defect must be corrected at the same time. Limiting the treatment to repair the vaginal prolapse of the safe, without a correction of a cistocole, enterocele, retecele or paravaginal defect may result in recroction of other anthathy and failure of the initial repair. Vaginal or anatomical abdominal repair can be performed in this group of patients without reduction in vaginal depth, diameter or function. FUNCTION.

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