Stand up and walk!

Those familiar words are laden with consequences. The human species has been relieved of the quadruped stance, and assumed the upright posture.

It was the first footsteps of *Homo sapiens* that were decisive. By leaving Africa, humans lost, besides their millenial home, their collagen.

Reproduction, labor and deliveries were sometimes difficult but never without sequelae on the perineum. These facts were well known and documented throughout the ages.

In the XVIII<sup>th</sup> century, Dionis, chief surgeon of the spouses of the French crown princes, noted in *Study of Surgical Operations performed at the Royal Gardens* that “there are no afflictions more frequent than the descent and the fall of the womb, of which an infinite number of women are distressed. […] The womb ordinarily falls alone. […] We have nevertheless seen it more than once drag the bladder in its descent. […] At other times, the rectal sleeve falls to the outside following the excruciating pains of an extended labor… And the cause of these afflictions, in addition to the excessive pushing efforts, is the weakness or even paralysis of the levator ani muscles” [1].

Pelvic floor disorders have existed for a very long time. However, it took centuries to note that besides the visible and reparable anomalies, there are non visible alterations that lead to irreparable sequelae.

A phase of perineal wound healing follows the trauma of delivery, allowing a certain “stable equilibrium” of the pelvic floor that is frequently compatible with daily life. Unfortunately, this perineal equilibrium of variable duration can worsen progressively and lead to two major disabilities, viz., stress urinary incontinence and fecal incontinence, in addition to prolapse of the pelvic organs.

These genito-urinary prolapses are nothing less than hernias through weakened fascia around the vaginal wall.

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The vaginal opening is the major cause of this pathology, exacting a heavy toll from women due to their anatomy.

The vagina is a Trojan horse of sorts. Actually, there is evidence of cause and effect between these various disorders. All this makes “perineology” an entity by itself.

To use a very Lebanese analogy, the perineum is a “multiconfessional nation” that is subject to the same external forces. The evolution towards this concept of “perineology,” or pelvic floor medicine, occurred over the last two decades with the theories of DeLancey based on anatomic logic.

In this issue, Yiou and Delmas will update us on the anatomy and pathophysiology of pelvic organ prolapse [2]. These studies have changed our way of conceptualizing pelvic floor disorders and the way to treat them. Hence the necessity of a global rather than a compartmentalized approach by each specialist alone (urologist for the urethra, gynecologist for the uterus, proctologist for the posterior compartment).

Disappointments are the norm when each specialist manages “his own hole,” oblivious to what’s happening nearby, but in perineology, it is essential to look and see what is happening in other specialists’ holes! In such situations, acting like a peeping Tom would not be a nasty flaw.

Access routes for prolapse surgery have been the subject of long and intractable debates between the specialists of this pathology.

Proponents of the abdominal approach emphasized the solidity of their mesh fixations, whereas “vaginalists” considered their approach less invasive, more creative, and with less complications.

Certainly, a vaginal approach can be more direct than a traditional abdominal approach. Laparoscopy for treatment of prolase was not widely used twelve years ago, at the dawn of the new millennium. The first few published series go back to the previous decade.

In this issue, Nadine el Kassis et al. will detail the factors that determine the choice of the surgical route of access [3]. Robotic surgery is the “party pooper” in the decision-taking process of surgical route. However, the excessive costs associated with maintaining and operating a robot are its main limiting factors, and the democratization of this technique is not for the very near future.

The past two decades, which were decisive in how to approach the problem, have witnessed the birth of the concept of “lifting” rather than “traction.”

The term “tension free” has come to be used ubiquitously in pelvic floor repair. I remember the first sub-
urethral TVT (tension-free vaginal tape) mesh tapes for incontinence inserted by Richard Villet in France, in 1996 [4]. The technique was considered marginal at the time, even “extraterrestrial” and its practice condemned, yet it rapidly became the gold standard in the treatment of stress urinary incontinence.

Following the success of that particular suburethral mesh tape, other meshes were used for the treatment of prolapse. Here also, disappointments were frequent with occurrence of mesh erosions, rejection reactions and sexual dysfunction. Vaginal meshes have evolved to the “single incision” mesh to lower the risks of mesh erosion.

Exit the old techniques of repair by the vaginal route; almost no one remembers them nowadays. Patients will soon be asking for the mesh that will guarantee them the “definitive” cure of their problem.

Once third-party payers start routinely covering mesh surgeries, no one will want to perform the good old tried-and-true techniques any more.

It’s like the way hernia surgery evolved, starting with Shouldice versus non Shouldice debates, then meshes came along to plug that hole, leaving behind the older techniques and their proponents [5].

Who still practices the Shouldice technique or its variants nowadays, the McVay technique, or even the Burch technique? Very few.

I hope that the good old techniques by the vaginal route will not disappear from our therapeutic choices. They are always useful and have certainly less morbidity than vaginal meshes. Those techniques should retain their place in our surgical armamentarium, otherwise they’ll be forgotten. “Use it or lose it.”

REFERENCES

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