Guidelines forPrivileging and Credentialing Physicians for Sacrocolpopexy for Pelvic Organ Prolapse

American Urogynecologic Society’s Guidelines Development Committee

EXECUTIVE SUMMARY

The adoption of new technology or procedures into a clinician’s surgical armamentarium is driven by multiple factors. Patient safety and anticipated long-term improvement in outcomes should be the primary objective that guides a surgeon’s decision to deliver care involving new procedures. Surgically complex procedures require a balance of knowledge, surgical skills, and experience as well as an appropriate ongoing surgical volume, an adequately trained and equipped surgical team, and the ability to monitor outcomes and adverse events. Sacrocolpopexy is a complex procedure used to treat apical vaginal prolapse. Clinical outcome studies support its effectiveness in managing apical prolapse. Serious adverse events have been noted in several of these studies (hemorrhage, sacral infection, mesh erosion, bowel obstruction, and injury to the urinary tract). This document provides guidelines for the privileging and credentialing of physicians planning to implement or continue the use of sacrocolpopexy in clinical practice.

KEY POINTS

- Sacrocolpopexy should only be performed by surgeons with board certification or active candidacy for board certification in obstetrics and gynecology or urology who also have requisite knowledge, surgical skills, and experience in reconstructive pelvic surgery.
- Outcomes and complications of sacrocolpopexy and other prolapse procedures should be monitored by annual internal audit or other mechanism at the local institution.
- Informed consent should highlight the following:
  - Potential benefits and complications of sacrocolpopexy.
  - Alternatives including nonsurgical options (eg, pessary) and other surgical treatments.
  - Potential complications of mesh used in sacrocolpopexy including but not limited to mesh exposure/extrusion through vaginal epithelium or erosion into vasa, possibly requiring repeat surgery, and other known complications.

BACKGROUND

Sacrocolpopexy is a procedure used to treat apical pelvic organ prolapse (POP) including uterine prolapse and posthysterectomy vaginal vault prolapse. It involves placement of a graft or mesh from the anterior and posterior walls of the vagina to the anterior longitudinal ligament of the sacrum. Sacrocolpopexy can be performed via laparotomy, or endoscopically with or without robotic assistance. This procedure is considered a highly effective and durable treatment for POP. However, major complications such as intraoperative hemorrhage, bowel and bladder injury, postoperative bowel obstruction, sacral discitis and osteomyelitis, and other serious mesh-related complications can occur.

Training to perform sacrocolpopexy is not included in the currently published goals of general urology or obstetrics and gynecology residency programs. Many practitioners learn sacrocolpopexy as part of a fellowship in Female Pelvic Medicine and Reconstructive Surgery (FPMRS). This fellowship training includes didactic and clinical training in the sacrocolpopexy procedure. Some clinicians who have not completed an FPMRS fellowship may request privileges for sacrocolpopexy.

The purpose of this guideline is to provide recommendations to assist health care institutions when considering granting privileges to perform sacrocolpopexy. Sacrocolpopexy for POP should be performed by surgeons with board certification or active candidacy for board certification in obstetrics and gynecology or urology who also have requisite knowledge, surgical skills, and experience in reconstructive pelvic surgery.

Minimally invasive sacrocolpopexy refers to sacrocolpopexy performed endoscopically with or without robotic assistance. Additional training will be required to perform sacrocolpopexy via a minimally invasive approach in addition to the aforementioned requisite knowledge, surgical skills, and experience in reconstructive pelvic surgery. A surgeon should possess the skills and privileges to perform sacrocolpopexy via laparotomy before requesting minimally invasive privileges for sacrocolpopexy should conversion to an open procedure become necessary. Most health care institutions have privileging and proctoring guidelines for advanced laparoscopic and robotic procedures. These institutional privileging guidelines for laparoscopic and robotic surgery should be followed in addition to the privileging guidelines for sacrocolpopexy outlined in this document. This document does not apply to POP surgery performed solely through a vaginal or perineal incision but does apply to combined vaginal and endoscopic or open sacrocolpopexy procedures.

For Surgeons Requesting New Privileges to Perform Sacrocolpopexy

Documenting Knowledge

A surgeon planning to perform sacrocolpopexy for POP should acquire and document general knowledge of pelvic anatomy and the fundamentals of pelvic reconstructive surgery as well as specific knowledge about sacrocolpopexy. Graduation from an FPMRS fellowship program provides adequate...
evidence of both general and specific knowledge required for this purpose. Credentialing committees should review privilege requests from surgeons who have previously performed the procedure. Surgeons who have privileges to perform sacrocolpopexy may use that experience at another institution to qualify for privileges at the new institution. Surgeons who have not graduated from a fellowship training program should provide documentation of both general and specific knowledge through continuing medical education (CME) programs to their local institution’s credentialing committee.

A core curriculum for general knowledge acquisition fundamental to all pelvic reconstructive surgery generally includes all of the items listed below. It is recommended that surgeons document general knowledge acquisition through satisfactory completion of CME programs.

- Preoperative evaluation
  - a. Bothsomes prolapse symptoms and objective evaluation of POP
  - b. Evaluation of bowel function
  - c. Assessment of bladder function including risk of postoperative incontinence and/or voiding dysfunction
  - d. Documentation of sexual activity and possible dysfunction
- Relevant pelvic surgical anatomy
- Perioperative management including discussion of methods to prevent, identify, and treat common complications of pelvic reconstructive surgery
- A discussion of the strengths and weaknesses of the existing comparative effectiveness studies of POP procedures
- A description of differences in biomechanical properties of marketed synthetic mesh or other grafts

To demonstrate specific knowledge of sacrocolpopexy, surgeons should do as follows:
1. Demonstrate understanding of relevant pelvic anatomy; specific attention should be paid to the anatomy of the paravesical space, the rectovaginal and vesicovaginal planes, the pelvic sidewall, the pararectal space, and the presacral space.
2. Observe steps involved in the procedure via animation, video, or live surgery.
3. Undergo hands-on experience specific to sacrocolpopexy using simulated models, animal or cadaveric models, or other learning models.
4. Consider specific intraoperative conditions that may require conversion to an alternate therapy or approach.
5. Be able to identify and manage postoperative complications of sacrocolpopexy.
6. Acknowledge the requirements for adequate informed consent for sacrocolpopexy, including the following:
   - a. Specific indications for the choice of graft material (synthetic, autologous, allograft, and xenograft)
   - b. Relative contraindications to the procedure (eg, inflammatory bowel disease)
   - c. Alternatives including nonsurgical options (eg, pessary) and other surgical treatments such as vaginal prolapse repairs.
   - d. Potential benefits of sacrocolpopexy with review of available outcome data.
   - e. Potential complications of graft materials including mesh exposure/erosion through the vaginal epithelium or erosion into pelvic viscera, fistula formation, sinus tract formation, dyspareunia, infection, and/or pelvic pain, which may require additional intervention and may not be completely resolved with mesh removal.
   - f. Potential complications of the procedure including wound infection, bowel and bladder injury, vascular injury, ileus or small bowel obstruction, and sacral discitis or osteomyelitis.

**Documenting Surgical Skills**

A surgeon who does not currently have privileges for and is planning to practice sacrocolpopexy should be proctored to demonstrate adequate skills for performing a procedure independently. Graduates of a fellowship training program in urogynecology, FPMRS, or female urology may meet this requirement by providing documentation of specific training in sacrocolpopexy during their fellowship of no fewer than 10 cases. 

Surgeons who have not graduated from an FPMRS fellowship training program should be proctored on 10 cases or as many cases as is necessary to demonstrate that they can independently perform the specific procedure safely without supervision.

Surgical proctors should have unrestricted credentials to perform the operation via the same route as the proctored procedure. The proctor must have significant experience with sacrocolpopexy and should be able to perform an independent evaluation of the candidate surgeon. The surgical proctor must have the right to require or recommend more proctored procedures as needed to ensure that the surgeon in training has met the requirements. At the time of proctoring, the surgeon in training must demonstrate the following:

- Appropriate patient selection.
- All patients offered conservative management with a vaginal pessary as an option.
- The ability to explain the procedure, potential outcomes, and potential complications at the time of informed consent.
- Knowledge of appropriate pelvic anatomy and potential areas of safety/danger associated with the procedure.
- Ability to perform the procedure safely and efficiently.
- Capacity to track outcomes and complications.

**Documenting Experience**

Surgeons planning to perform sacrocolpopexy in their practice must demonstrate previous experience in the care and management of women with pelvic floor disorders, specifically POP. Graduation from an FPMRS fellowship training program provides adequate evidence of the experience required for this procedure. Surgeons who have not graduated from a fellowship training program must provide evidence of previous experience with reconstructive surgical procedures for POP (eg, case lists) including documentation that surgery for female pelvic floor disorders, particularly POP, represents a significant portion (≥50%) of their current surgical practice. Surgeons should demonstrate experience in vaginal repair of prolapse, including anterior colporrhaphy, posterior colporrhaphy, or vaginal colpopexy. Experience and privileges to perform intraoperative cystoscopy to evaluate for bladder and ureteral integrity are necessary. It is strongly recommended that credentialing committees require this documentation from all surgeons, even those who have previously performed sacrocolpopexy.

**Internal Audits**

Maintaining quality assurance after the implementation phase through ongoing annual internal audits at the local institutional level is recommended of all surgeons performing sacrocolpopexy. Surgeons should follow their patients undergoing sacrocolpopexy postoperatively. Considerations should
be given to tracking the following preoperative evaluation and postoperative outcomes.7

- Preoperative evaluation including the following:
  a. All patients offered conservative management with a vaginal pessary as an option.
  b. Objective evaluation of POP [for example, Pelvic Organ Prolapse Quantification (POPQ) system].

- Postoperative monitoring including the following:
  a. Subjective symptoms of POP (patient-oriented improvement and satisfaction).
  b. Objective measures of prolapse.
  c. Short- and long-term complications.
  d. POP recurrence requiring additional surgical or non-surgical intervention.

- Perioperative events:
  a. Injury to the genitourinary tract
  b. Injury to the gastrointestinal tract
  c. Need for blood transfusion
  d. Documentation of mesh or graft complication
  e. New-onset vaginal or pelvic pain lasting greater than 6 weeks
  f. Fistula formation
  g. New-onset or worsening dyspareunia
  h. Persistent neurologic injury
  i. Other procedural related complications

For Surgeons Who Currently Have Privileges for Sacrocolpopexy

Sacrocolpopexy is a complex procedure. High-volume surgeons have lower complication rates when performing complex procedures.6 A minimum number of 30 surgical procedures for POP a year with at least 5 being sacrocolpopexy (CPT code 57280 and/or 57425) should be considered for surgeons to remain proficient in the technique. Exceptions can be considered for surgeons with extensive prior experience in POP surgery.

**SUMMARY**

Surgically complex procedures require a balance of knowledge, surgical skill, and experience with appropriate ongoing surgical volume and monitoring of outcomes and adverse events. Sacrocolpopexy has the potential to improve patient outcomes. These guidelines are meant to provide guidance for privileging and credentialing of physicians planning to implement or continue to use this procedure in their clinical practice.

**TABLE 1. Summary of Pathways for Privileges to Perform Sacrocolpopexy**

<table>
<thead>
<tr>
<th>New Privileges, No Prior Fellowship Training</th>
<th>New Privileges, Prior Fellowship Training</th>
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<tr>
<td>Satisfactory completion of residency in ObGyn or Urology</td>
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<tr>
<td>CME in pelvic reconstructive surgery AND CME specific to sacrocolpopexy training</td>
<td>Satisfactory completion of fellowship in FPMRS</td>
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<td>Experience with other pelvic reconstructive surgery procedures (≥50% of practice) AND proctoring recommended for 10 cases or as many as necessary to demonstrate competence</td>
<td>Case list documenting at least 10 sacrocolpopexy procedures during fellowship training</td>
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<tr>
<td>Cystoscopy privileges</td>
<td>Cystoscopy privileges</td>
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Summary of Recommendations

1. For surgeons who do not have privileges to perform sacrocolpopexy but wish to begin performing this procedure.
   a. General knowledge should be documented either by completing a fellowship training program in FPMRS or by completing adequate CME in pelvic anatomy and reconstructive pelvic surgery.
   b. Specific knowledge for sacrocolpopexy should be obtained.
   c. Skill may be documented by surgeons who have completed an FPMRS fellowship program via case lists showing experience. Surgeons who do not have documentation of such prior training with sacrocolpopexy should be proctored on 10 procedures or as many as is necessary to demonstrate that they can independently perform the specific procedure.
   d. Experience in treating women with pelvic floor disorders should be documented either by completion of a fellowship training program in FPMRS or by demonstrating that they offer a full spectrum of surgical options for pelvic floor disorders and that pelvic reconstructive surgery represents a substantial portion (>50%) of their practice.

2. For surgeons who currently have privileges to perform sacrocolpopexy.
   a. Continuing medical education in female pelvic reconstructive surgery should be documented annually.
   b. A minimum of 30 prolapse procedures should be performed each year, with at least 5 being sacrocolpopexy.
   c. Recommend tracking of surgeon outcomes through performance of annual internal audits.

The 2 Training Pathways Are as Follows:

1. Surgeons who have not completed a fellowship in FPMRS (Table 1):
   a. Satisfactory completion of a residency training program in obstetrics and gynecology or urology.
   b. Documentation of CME in pelvic reconstructive surgery.
   c. Experience with other procedures in reconstructive pelvic surgery documenting that surgery for female pelvic floor disorders represents a significant portion (>50%) of their practice.
   d. Surgeon should have experience and privileges to perform cystoscopy.
   e. Documentation of CME with specific training in sacrocolpopexy.
   f. Surgeon should be proctored on 10 cases or as many as is necessary to demonstrate competence in the procedure.
2. Surgeons who have completed a fellowship in FPMRS.
   a. Satisfactory completion of a residency training program
      in obstetrics and gynecology or urology.
   b. Satisfactory completion of a fellowship training pro-
      gram in Female Pelvic Medicine and Reconstructive
      Pelvic Surgery.
   c. Surgeon should have experience and privileges to per-
      form cystoscopy.
   d. Case list documenting at least 10 sacrocolpopexies
      during their fellowship training period.

**Reappointment (Renewal) Criteria**

For reappointment, the individual must do the following (Table 2):

1. Perform a minimum of 30 surgical procedures for POP annually.
2. Perform a minimum of 5 sacrocolpopexy procedures annually.
3. Annual CME in female pelvic medicine and recon-
   structive pelvic surgery.
4. Maintain quality assurance through internal audits.

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