ISPP
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Short Abstracts

(key words underlined) **(Full abstracts at page 119)**

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Simultaneous surgical treatment of Pelvic Organ Prolapse with uterine leiomyoma: TFS minisling with laparoscopic myomectomy. HIROMI INOUE (*Kamakura, Japan*)

In the last decades requests for POP surgical correction have been increasing. Hysterectomy for leiomyoma induces a future risk of POP. Myomectomy instead of hysterectomy allows to conserve the 45° vaginal angle and the TFS tape allows to tighten normal pelvic tension and function. Simultaneous laparoscopic myomectomy and TFS surgery for POP with a fibroid represent a good option for all patients with POP and uterus leiomyoma to avoid hysterectomy.

If it bleeds we can kill it. BEVAN BROWN (*Sydney, Australia*)

Fibroids are a common cause of pelvic symptomatology. Hysterectomy is often used to manage patients with a symptomatic fibroid uterus. Uterine artery embolisation is a safe and highly effective method for treatment of women with symptomatic fibroids and adenomyosis. This approach permits preservation of pelvic structures, facilitating prolapse repair.

Laparoscopic rectopexy update. IAIN SKINNER (*Melbourne, Australia*)

Laparoscopic technique for rectal prolapse repair evolved in the early '90. Today it meets both anatomical and functional indication; the former includes a complete external rectal prolapse while the latter includes rectal intussusception, obstructed defecation and/or constipation, fecal incontinence and symptomatic rectocele. Ventral laparoscopic rectopexy seems to be efficacious for complete external rectal prolapse, while its role remains uncertain for rectocele, fecal incontinence, obstructed defecation or intussusception.

Designer vaginas in the context of the sexual revolution. BERNIE BRENNER (*Auckland, New Zealand*)

This presentation attempts to explain the relatively new phenomenon of cosmetic vaginal surgery. It reviews the history of feminism and the development of the sexual revolution in academic research, the lay literature through magazines and film and television. The types of cosmetic surgery are addressed.

Sacral neuromodulation in urology. GERARD TESTA (*Sydney, Australia*)

Sacral nerve stimulation (SNS) is an electric therapy based on a fully implantable system that delivers mild electrical impulses to sacral nerves influencing bladder, bowels, sphincters and pelvic floor muscles. Actual indications for Interstim therapy includes UI, OAB, constipation, fecal incontinence and pelvic pain both in male and female patients. Usually the definitive implant is preceded by a PNE test. Good results have been demonstrated at least in 50% of patients at short and mid term while long term results are uncertain.

Modern management of haemorrhoids. DARREN GOLD (*Sydney, Australia*)

Hemorrhoids are very common and symptoms include bleeding, pain and prolapse divided into 4 degrees. Outpatient techniques are based on sclerotherapy or rubber-band ligation. Although the most known procedure remains Milligan Morgan hemorrhoidectomy, in the recent past other notsurgical techniques have been performed. Stapled hemorrhoidopexy was firstly introduced by Longo in '90s. Recently doppler-guided hemorrhoidal artery ligation (HAL) has gained more and more favor as it allows minimal postoperative pain, early return to work and minimal complication rate.

Bladder pain- New perspectives. MAREK JANTOS (*Adelaide, Australia*)

Chronic pelvic pain (CPP) represents an increasing cause for medical visits but in 61% causes are unknown. Female patients make up 95% of these visits. Bladder is a common and important source for this kind of pain but its diagnosis is often based on exclusion criteria. Pelvic floor myofascial trigger points are not only source of pain but also a stimulation for neurogenic bladder via antidromic reflexes. Therapy includes not only medications: normalization of muscle function, postural correction, behavioral management of bladder and bowel function and anxiety management brought good results as well.

CR Mesh repair for posterior compartment prolapse. GIUSEPPE DODI (*Padova, Italy*)

The results of CR-Mesh repair in the treatment of Pelvic Organ Prolapses is satisfactory at middle and long term follow up. Complications are few and without consequences, the results in vaginal function are good. The correction of complete rectal prolapse and intussusception is possible only when the mesh blocks the bowel descent starting low enough in the pelvis. This study is a further demonstration that constipation depends on other causes than merely the posterior compartment prolapse when present.An open question remains the need for an overtreatment to prevent prolapses in the untreated compartment. Full abstract pag. 119.

Prolapse in Nepal. ANDREW BOOKER (*Sydney, Australia*)

According to WHOand UNFPA report, in Nepal 600.000 women are affected by POP and 200.000 require immediate treatment. Age rate is between 45 and 49 yrs old in 24% with a prevalence of more than 10%. Risk factors includes heavy workloads, early age at 1st birth, number and short birth intervals, malnutrition and unsafe termination of pregnancy. The project SAH Healthcare Outreach purpose is to give assessment, transportation, accommodation, surgery and convalescence to all women unable to access care due to poverty.

Urinary QOL after tensioned TFS minisling 1 year results. YUKI SEKIGUCHI (*Yokohama, Japan*)

A series of 54 patients were reviewed 1 year after a TFS minisling procedure for prolapse and urinary incontinence. A good objective success rate and improved urinary QoL confirm the efficacy and safety of this day surgery procedure for prolapse. Full abstract pag. 120.

Procedure selection in pelvic organ prolapse surgery, Science, art or luck of the draw. DAVID SHAKER (*Rockhampton, Australia*)

The decision of the pelvic surgeon to select certain procedures for treatment of uterovaginal prolapse is based on the evaluation of the prevalence of different defects, their impact, and the impact of the procedures as well on the other compartments, the meaning of the cervix, the experience with the failures, and the configuration ofthe meshes. Full abstract pag. 120.

The language of operative surgery. JOHN CARTMILL (*Macquarie University, Sydney, Australia*)

Classical (idealized) and actual examples of the operation "anterior resection of the rectum" are compared. The density of communication (verbal and non verbal) involved in mediating an episode of surgery are made explicit.

Surgery in the long term management of obstetric injury. TONY EYERS (*Macquarie University, Sydney, Australia*)

Colorectal surgeons are often asked to perform delayed repairs following obstetric sphincter injuries and close associated rectovaginal fistulas. Good results are usually obtained after the repair, but the function gradually deteriorates over a ten-year period, pudendal neuropathy being an additional factor. With sacral neuromodulation the results appear equivalent with an anatomical sphincter injury or not.Therefore surgical repair should be done whith a frank anal sphincter injury, but not repeated when the functional result deteriorates, preferring SNS. Full abstract pag. 121.

The Hospital by the River (Ethiopian fistula Hospital Update). GARY SYKES (*Sydney, Australia*)

According to WHO reports, 6,000 new obstetric fistula cases are estimated each year in Ethiopia. The Addis Abeba Fistula Hospital treats about 1000 women with fistulae each year without charge. Support services include urodynamic, radiology and ultrasonography, biochemistry, haematology, blood transfusion, microbiology, counselling and chaplaincy, literacy education, maternal health and women rights education and physiotherapy. Considering the 2010 outcome analysis, in 93% of patients the repair was successful while in 24% repair was successful but patients remained incontinent. The future target is obstetric fistula prevention.

Coital incontinence, female ejaculation and the G Spot revisited. BERNIE BRENNER (*Auckland, New Zealand*)

An overview in literature demonstrates two possible different origins: urinary and non urinary. If we accept that female ejaculation comes from non urinary origin we have to conclude that it's made up of pooled vaginal fluids. On the contrary, the urinary origin considers stress urinary incontinence and detrusor contraction. Skene's glands in female are analogous to male prostate. Moreover vaginal transudate may pool in the posterior fornix and be expressed at the orgasm. If urinary origin instead is admitted, urinary loss during sexual activity is common and is multi-factorial (23-34%). Ejaculation during orgasm may be pooled vagina secretion contaminated by Skene's fluid. However also urinary loss remains common during female orgasm. The G Spot is discussed.

Experience with Elevate mesh. MALCOLM FRAZER (*Gold Coast, Australia*)

Normal pelvic support is made up of 3 levels: apical (I), transverse (II) and perineal body (III). The elevate mesh is a system that include 4 fixation points (internal obturator muscle and sacrospinal ligaments) and that needs just one single anterior access but providing both anterior and apical support. According to recent FDA statement with vaginal mesh reclassification in class 3, mesh use should be almost always used in anterior wall prolapse although sacrocolpopexy is still considered the gold standard.

Management of post sling obstruction. VINCENT TSE *(Sydney, Australia*)

SUI is reported to be treated successfully with mid urethral sling in 80% of cases at 10 yrs FU. Anyway complications such as obstruction, de novo OAB, vessels and nerves injury and mesh erosion is described too. In case of obstruction an excessive urethral compress, a reduced Qmax, detrusor hypocontractility may represent risk factors. History, abdominal and vaginal examination, flowmetry and PVR are essentials tools for diagnosis but urodynamics and translabial US may be necessary too. Surgical treatment options include sling loosening, division and/or excision of sub-urethral segment and urethrolysis with Martius fat interposition graft. Anyway few protocols agree in timing of intervention. Full abstract pag. 121.

The next layer of anatomy. JOHN CARTMILL (*Macquarie University, Sydney, Australia*)

Surgery and anatomy have been inextricably linked through the millennia; advances in one supporting and enabling advances in the other. The traditional anatomy of internal corporeal relationships is now lagging behind the technical and intellectual advances that are occurring at the surgical interface. A new field of transactional (or penumbral) anatomy is in evolution; an anatomy mediated by information technology, engineering and the surgeon's imagination. An anatomy as essential and appropriate to its time as that of Galen, Vesalius and Harvey.

Do men know what women want? PHILIP KATELARIS (*Sydney, Australia*)

Do men know what women really want or they just wish to know what they want in fact? Sex relationships are a continuum of banding behaviors, implying communication at every level: intimacy, sensuality and sexuality. No good sex can exists without communication. Maybe men not always know what women want…because even women themselves don't know what they want too.

Technical aspects of Pelvic Surgery. RICHARD REID (*Sydney, Australia*)

The weakest point of pelvic floor is represented by levator hiatus and pelvic organs are suspended to axial skeleton by fibroelastic tissue. Delivery and hard labor damage muscles and pelvic fascia. The choice of biomaterial for pelvic defect repair should reflect the primary surgical objective. Polypropylene mesh provides high tensile strength but they are not suitable to be used near hollow organs because of their chronic inflammatory properties. Trocar mesh kits may be alternative to SCPx. What appears clear is that morbidity due to biomaterials implantation varies depending to the implantation site. In conclusion MUS are more effective and less morbid than the procedure they replaced but abdominal SCPx is still the gold standard for DeLancey level I prolapse.

Using Imaging to understand how slings work. LEWIS CHAN (*Sydney, Australia*)

Transperineal ultrasound is a good modality of imaging for demonstration of synthetic suburethral slings. Dynamic compression of the urethra by transobturator sling was demonstrated during Valsalva in patients with AdVance and Monarc slings suggesting that these slings may have a similar mechanism of action in restoring urinary continence in male and female patients with stress urinary incontinence. Full abstract pag. 121.

Minislings fashion or fabulous. MALCOLM FRAZER (*Gold-Coast, Australia*)

The evolution of surgery for urinary incontinence is presented: Kelly, Burch, antologous sling procedures...

Role of Injectables in managing urinary incontinence. JENNY KING (*Sydney, Australia*)

Preparations of injectables available in Australia: Contigen (bovine). Macroplastique silicone, Durosphere carbon coated zirconium oxide, Bulkamid. Not an alternative to mid urethral slings for stress incontinence with significant sphincter deficiency and lack of motility especially when previous surgery; combination therapy for impaired compliance, voiding dysfunction.

Urogynaecology in Indonesia: the change and the challenge. BUDI IMAN SANTOSO *(Djakarta, Indonesia*)

Indonesia is a large nation of 240 million people living on over 17000 islands. Despite considerable improvements in women's health great challenges remain to provide urogynecological services, as Indonesia strives to join the developed world. A rapid breakthrough in a very short period of time in the field of urogynecology is anyway expected. Full abstract pag. 122.

The pelvic floor reconstruction using CR Mesh: past, present and future. EMANUELA MISTRANGELO (*Ginteam, Turin, Italy)*

Since 2009 for pelvic prolapse stage POP-Q III-IV 312 pelvic floor reconstruction (PFR) have been performed using in 88 patients the A.M.I. CR-mesh. Complications*:* in 21 cases urinary retention resolved with indwelling catheter for 1 week, 6 hematomas spontaneously resolved in one month, in 37 perineal and lumbar-sacral pain (VAS > 6) resolved after 10-15 days, 18 difficult defecation resolved in 2 months with diet, 11 stress urinary incontinence de novo, 6 resolved in 6 months with rehabilitation, 5 whith TOT urethral suspension 6-9 months after the PFR. 61/88 patients had 1 year FU: none had recurrence of the prolapse > stage I; no mesh exposure was observed; 9 patients had deep dyspareunia. These results are considered excellent, however the technique is quite invasive due to the multiple passage of trocars, and causes dyspareunia associated to fibrosis and retraction. Full abstract pag. 122.

Role of physiotherapy in managing pelvic and perineal pain. SHERIN JARVIS (*Sydney, Australia*)

Physiotherapy manages pelvic and perineal pain disorders. All pelvic disorders and chronic pelvic pain (CPP) recognize a common theme: pelvic floor muscles (PFM) overactivity. PFM overactivity can be a primary cause of CPP or organ pathology or a second pain generator in response to CPP or pelvic organ pathology. Through a down-training program "contract-hold-relax" it's possible to regulate PFM overactivity. Biofeedback via manometry or EMG helps to modulate down-training. Also MFTP therapy had been reported to be successful in urgency-frequency syndrome.

The surgical anatomy of stress and non-stress non-urge urinary incontinence. PETER PETROS (*Sydney, Australia*)

The female urethra is closed by two distinct closure mechanisms, proximal ("bladder neck") and distal.

The anterior portion of pubococcygeus muscle stretches the suburethral vagina ("hammock") between pubourethral ligament PUL and the external urethral ligament (EUL) to close the urethra from behind. A lax EUL may lead to non-stress urine loss in patients who have been cured of USI. A diagnostic symptom is a "bubble" of air escaping concomitant with urine loss. This problem is best addressed with a "hammock suture" a Vicryl suture placed in the EUL. See also www.integraltheory.org. Full abstract pag. 124.

Lessons from over 4000 prosthesis implantations. MENAHEM NEUMAN (*Nahariya, Israel*)

POP is based on herniation concept and so therapeutic tools are to be based on the knowledge accumulated regarding any hernia repair: this include a correct patient selection with proper indication to surgery, the surgical centre selection that should be based on experienced pelvic unit. This allows to guarantee the right surgery for the right patient. Vaginal hysterectomy defects the endo-pelvic fascia integrity and, although worldwide performed, is often not necessary.

Laparoscopic hysterectomy with CR MESH. FERNANDO GARCIA MONTES (*Maiorca, Spain*)

The use of triple mesh in 39 patients for correction of POP gained good results for urinary continence, creating dyspareunia and bad fecal continence. Also severe complications may occur such as compartimental syndrome, bladder and rectal perforation or erosion. Moreover, as mesh doesn't cover lateral defect and fixation is not anatomical, prolapse recurrence can be possible. Subtotal laparoscopic hysterectomy performed in 31 patients provided good anatomical and functional results.

The easiest operation but the most litigation. GAB KOVACS (*Melbourne, Australia*)

The preferred procedure for female sterilization is represented by laparoscopic tubal occlusion and the commonest

way to perform it is Filshie clips application to the mid isthmus. This procedure, very popular in Australia, was criticized in early '90s because of risks for health women. Moreover a rate of "failure" was described. Today this failure rates accounts around 1%. Filshie clips remains the preferred method for sterilization. No procedure is 100% safe. The use of calibrated applicators, the record clip batch and applicator number are advisable and photograph should be taken whenever possible during the procedure.

Botox- more than just a pretty face. Paul Duggan (*Adelaide, Australia*)

Botulinum toxin is being increasingly used in the management of overactive bladder and idiopathic and neuropathic detrusor overactivity. A 60-70% response rate can be expected. Major impediments to its use include its unlicensed status and fear of prolonged urinary retention, which limits recruitment in trials and in clinical practice. Death following therapeutic use of Botulinum toxin has been reported in adults and children but not to date following intradetrusor injection. Full abstract pag. 124.

Miniarc versus transobturator. Anna Rosamilia (*Melbourne, Australia*)

Although RP and TO seem to be equivalent subjectively for SUI cure rates, objectively the trend appears more efficacious for RP than TO. In our study miniarc vs TO, preliminary results demonstrated that miniarc is safe having just 1 single patient with hematoma. Moreover no mesh exposure and no urinary retention was reported and 1 patient had pregnancy 8 months after miniarc procedure.

Incontinence and diabetic cystopathy in women. Tse Kiat Ng (*Singapore*)

Prevalence of UI in diabetic cystopathy rates from 25-87%. Causes are varying and include detrusor hyperriflexia, reduced detrusor contractility and areflexia. Both detrusor muscle and bladder urothelium play a role in cystopaphy. As the process is often insidious, a prompt diagnosis must include history, symptoms and signs such as decreased bladder sensation, increased bladder capacity and impaired emptying, increased bladder volume at 1st sensation to void. Urinalysis, urine culture, urodynamics ad dosage of serum glucose, HbA1c and urea/creatinine ratio are necessary. Therapy includes behavioural modalities and surgical procedure such as vescical neck resection, selective pudendal nerve block and SNS.

Finally a solution for the atonic bladder. Bill Lynch (*Sydney, Australia*)

Atonic bladder is defined as the inability of emptying bladder by detrusor contraction and recognizes neurogenic and myogenic mechanisms. Treatment options may be pharmacological, mechanical, inflow devices (just for women) and SNS. Self catheterization (CISC) remains the mainstay but inflow devices and especially SNS seemed to be good alternatives in selected patients

Neoligament repair in Pelvic reconstruction. Max Haverfield (*Melbourne, Australia*)

Our study purposed to assess safety and efficacy of Tissue Fixation System (TFS) neo-ligament site specific for restoration of pelvic floor anatomy with or without uterine preservation. All pts were worked up with POP-Q, QoL survey, urodynamics medical and surgical co-morbidity assessment, PISQ12 and bowel dysfunction. TFS creates neo-ligaments to mimicking those existing that are damaged or loose to regain resistance to muscle forces and support to stretch receptors and nerve bundles. A total of 105 TFS procedure were performed. From our preliminary results TFS seems to be safe, highly reproducible technique, minimally invasive without necessity of large tissue dissection, allows accurate anatomical and physiological restoration of POP and more efficacious with less usage of pelvic mesh.

Developing a new journal in pelvic medicine: history and future of "Pelviperineology". Giuseppe Dodi (*Padova, Italy*)

Pelviperineology is an open-access journal publishing original articles on scientific, clinical and experimental topics on physiology and pathology of the pelvic floor in urological, gynaecological and colo-rectal fields. It has a multidisciplinary and interdisciplinary perspective, it is open to different points of view, and pluralistic in its nature, and unconditionally agrees with the ethic principles of the World Association of Medical Editors (WAME) In 1982 it was founded in Padova as the Rivista Italiana di Colon-Proctologia. In 2006 it became the journal of the *Australasian Association of Vaginal & Incontinence Surgeons* (AAVIS), now the *International Society for Pelviperineology* (ISPP). Full abstract pag. 125.

Pelvic floor rehabilitation update. Sherin Jarvis (*Sydney, Australia*)

From 40 yrs old on even elite athletes suffers sarcopenia. Pelvic fiber muscles contraction (PFMC) and pelvic fiber muscle training (PFMT) helps to decrease sarcopenia related to ageing and to menopause. PFMC exercises before and during increased intra-abdominal pressure (IAP) decrease risk of SUI**.**

Functional Cine MRI in the evaluation of female pelvic floor dysfunction. Yasukuni Yoshimra (*Tokio, Japan*)

As POP is a dynamic phenomenon it requires a dynamic way of studying also because prolapse can't be clearly demonstrated although patients complain symptoms. Cine MRI allows to short acquisition time and also a functional evaluation under Valsava maneuver. This technique gives a global and panoramic view of the three pelvic compartments, visualizing soft tissue too and, even though expensive and a standardization of methodology is still lacking, it represent a powerful tool for research in clinical and anatomical studies.

Cosmetogynaecology: a new specialty? Oscar Horky (*Kiama, Australia*)

In spite of the negative views of conservative gynaecologists and certain female activists women have made their concerns regarding their genitalia known. They have demanded cosmetic genital procedures. Unfortunately faced with refusal by those they should trust most they have turned to practitioners often with poor knowledge of women and their anatomy. Encouraged by outrageous fees, inadequate and unskilled surgery has frequently been the result. There is a demand for aesthetic genital surgery and often in conjunction with cure of prolapse and incontinence. To this end aesthetic gynaecology should be done by suitably qualified gynaecologists with a special interest in this area.They could be called cosmeto-gynaecologists.The talk is illustrated by slides showing the development of cosmeto-gynaecology, a few techniques and pitfalls." horky609@live.com.au