

34. Marinkovic SP, Stanton SL. Triple compartment prolapse: sacro-colpopexy with anterior and posterior mesh extension. *BJOG* 2003; 110: 323-6.
35. Bensinger G, Lind L, Lesser M et al. Abdominal sacral suspension: analysis of complications using permanent mesh. *Am J Obstet Gynecol* 2005; 193: 2094-8.
36. Reisenauer C, Kirschniak A, Drews U, Wallwiener D. Anatomical conditions for pelvic floor reconstruction with polypropylene implant and its application for the treatment of vaginal prolapse. *Eur J Obstet Gynecol Reprod Biol* 2007; 131: 214-25.
37. Debodinance P, Amblard J, Fatton B, Cosson M and Jacquetin B. The prosthetic kits in the prolapse surgery: is it a gadget? *J Gynecol Obstet Biol Reprod (Paris)* 2007; 36: 267-75.
38. Altman D, Vayrynen T, Enhe ME et al. Short term outcome after trans vaginal mesh repair of pelvic organ prolapse. *Int Urogynecol J Pelvic Floor Dysfunc* 2008; 19: 787-93.
39. Caquant F, Collinet P, Debodinance P et al. Safety of trans vaginal mesh procedure: retrospective study on 684 patients. *J Obstet Gynecol Res* 2008; 34: 449-56.
40. D'Hoore A, Vanbeckvoort D, Penninckx F. Clinical, physiological and radiological assessment of recto-vaginal septum reinforcement with mesh for complex rectocele. *Br J Surg* 2008; 95: 1264-72.
41. Pacquee S, Palit G, Jacquemyn Y. Complications and patient satisfaction after trans obturator anterior and/or posterior tension free polypropylene mesh for pelvic organ prolapse. *Acta Obstet Gynecol Scan* 2008; 87: 972-4.
42. Alperin M, Sutkin G, Ellison R et al. Peri-operative outcome of the Prolift® pelvic floor repair system following introduction to an urogynecology teaching service. *Int Urogynecol J Pelvic Floor Dysfunc* 2008; 19: 1617-22.
43. Lucioni A, Rapp DE, Gong EM et al. The surgical technique and early post-operative complications of the Gynecare Prolift® pelvic floor repair system. *Can J Urol* 2008; 15: 4004-8.
44. Gauruder-Burmester A, Koutouzidou P, Rohne J et al. Follow up after polypropylene mesh repair of anterior and posterior compartments in patients with recurrent prolapse. *Int Urogynecol J Pelvic Floor Dysfunc* 2007; 18: 1059-64.
45. Maher C, Baessler K, Glazener CM et al. Surgical management of pelvic organ prolapse in women. *Cochrane Database Syst Rev* 2004; (4): CD004014.
46. Silva WA and Karram MM. Scientific basis for use of grafts during vaginal reconstructive procedures. *Curr Opin Obstet Gynecol* 2005; 17: 519-29.
47. Schultz DG. FDA public health notification: serious complications associated with trans-vaginal placement of surgical mesh in repair of pelvic organ prolapse and stress urinary incontinence 2008.
48. Wu MP. The use of prostheses in pelvic reconstructive surgery: joy or toy? *Taiwan J Obstet Gynecol* 2008; 47: 151-6.
49. De Ridder D. Should we use meshes in the management of vaginal prolapse? *Curr Opin Urol* 2008; 18: 377-82.
50. Neuman M, Lavy Y. Reducing mesh exposure in Posterior Intra-Vaginal Slingplasty (PIVS) for vaginal apex suspension. *Pelvipereineology* 2007; 26: 117-21.
51. National institute for health and clinical excellence guideline CG40 Urinary incontinence: NICE guideline 2006.

Correspondence to:

MENAHM NEUMAN, MD  
7 Te'ena st,  
Carmei-Yosef - Israel, 99797  
Tel. +972-546-444-033 - Fax +972-8-9287983  
E-mail: mneuman@netvision.net.il

## Pelvic Floor Digest

*This section presents a small sample of the Pelvic Floor Digest, an online publication ([www.pelvicfloordigest.org](http://www.pelvicfloordigest.org)) that reproduces titles and abstracts from over 200 journals. The goal is to increase interest in all the compartments of the pelvic floor and to develop an interdisciplinary culture in the reader.*

### FORUM

**Do we see what we think we see? The complexities of morphological assessment.** *Hamilton PW, van Diest PJ, Williams R, Gallagher Ag. J Pathol. EPUB: 2009-03-18.* There is a paucity of research in the field of decision-making. Understanding the complex processes involved in it is the starting point to improve both diagnostic reproducibility and the definition of diagnostic groups that underpin all our experiments. Reliable pathological interpretation for instance is vital to so many aspects of tissue-based research as well as being central to patient care. Work in this area should be encouraged since there are many opportunities and technologies available to support this type of research.

### 1 – THE PELVIC FLOOR

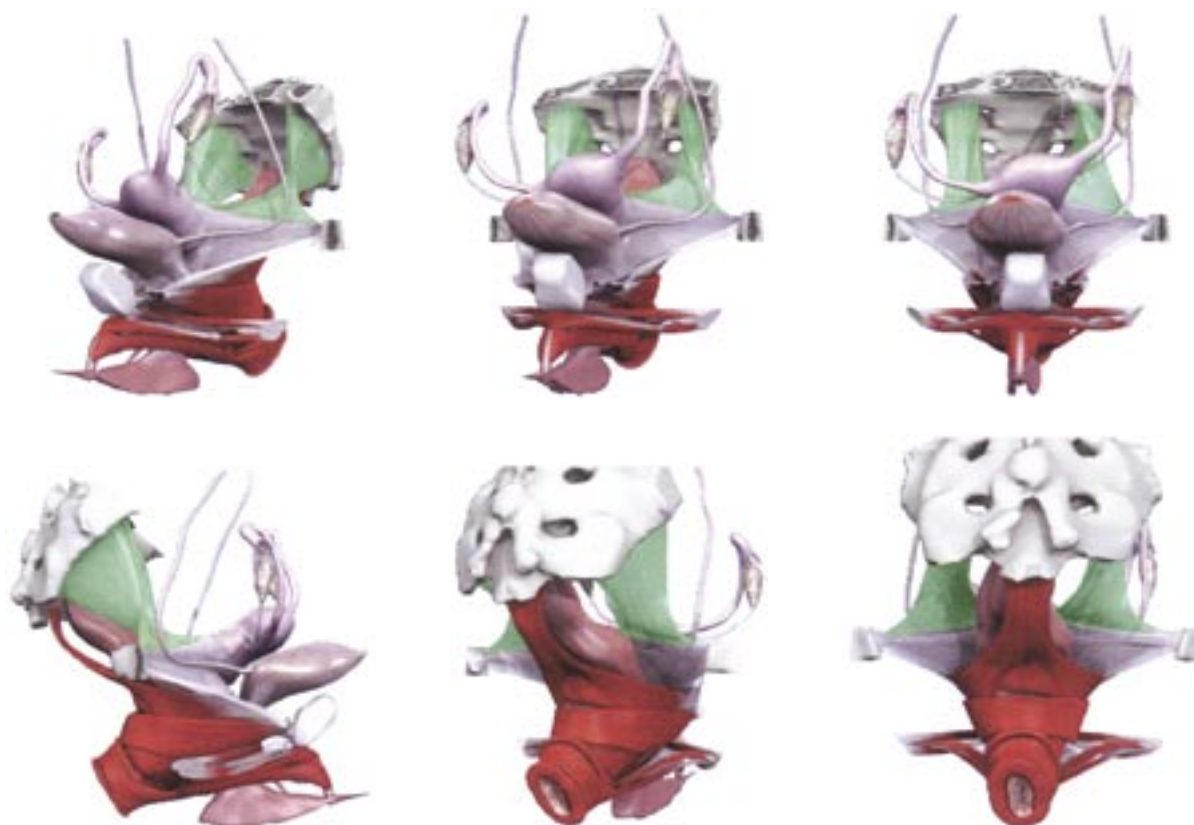
**Pelvic reconstructive surgery in renal transplant recipients.** *Shveiky D, Blatt A, Sokol AI et al. Int Urogyn J Pelvic Floor Dysf. EPUB: 2009-02-12.* This study describes an experience with pelvic reconstructive surgery in renal transplant recipients. Vaginal hysterectomies with vault suspension, anterior and posterior repairs, synthetic midurethral slings were safely performed without intraoperative or postoperative complications.

### 2 – FUNCTIONAL ANATOMY

**Increased colonic transit in rats produced by a combination of a cholinesterase inhibitor with a 5-HT(4) receptor agonist.** *Campbell-Dittmeyer K, Hicks GA, Earnest DL et al. Neurogastroenterol & Motil. EPUB: 2009-02-13.* The acetylcholinesterase inhibitor neostigmine and the 5-HT(4) receptor partial agonist tegaserod have a prokinetic activity and increase ACh at cholinergic synapses innervating intestinal smooth muscle. In combination, low doses of the two agents which did not produce significant effects alone, cause, as a synergistic effect, significant increase in fecal pellet output in rats. Combinations of higher doses did not display synergy. This may be a useful therapeutic approach to treat conditions associated with slow GI transit.

**Influence of naloxone on rectal sensorimotor function in health.** *Geeraerts B, V Oudenhove L, Vos R, et al. Neurogastroenterol & Motil. EPUB 2009-02-19.* Endogenous opioids are involved in both the regulation of gut motility and the processing of sensory information. Abnormal rectal motor physiology and visceral hypersensitivity are implicated in the pathogenesis of irritable bowel syndrome. The suppression of endogenous opioid function by naloxone on rectal sensorimotor function was studied in 18 healthy subjects with a rectal barostat. Naloxone does not alter rectal sensitivity but abolishes rectal adaptation in response to repeated balloon distention. These observations suggest that the endogenous opioid system is involved in control of rectal tone rather than rectal sensitivity.

*The PFD continues on page 100*



A *Getting Start Guide* allows training through the product by getting used to the images and their visualizing options, saving, printing and the DVD contents. A technical support staff can be contacted for assistance at [techsupport@primapictures.com](mailto:techsupport@primapictures.com).

*Minimum requirements* are: operating systems: Microsoft® Windows XP or Vista and MAC OSX 10.3-10.5. Processor speed: 1.5GHz with 512MB of RAM,

200MB free disk space for all platforms. Screen display: 1024x768 screen. DVD-ROM drive.

Primal Pictures has a range of other DVDs available: Radiological Cross Sectional Interactive Anatomy with multi-detector CT: Thorax, Abdomen and Pelvis; Anatomy for Urology; Interactive Functional Anatomy 2nd Edition - 2009 release; Interactive Complete Human Anatomy Series. Full details can be found at [www.primapictures.com](http://www.primapictures.com) and online trials are available at [www.anatomy.tv](http://www.anatomy.tv).

## Pelvic Floor Digest

*continued from page 96*

### 3 – DIAGNOSTICS

**Validation of Spanish versions of the Pelvic Floor Distress Inventory (PFDI) and Pelvic Floor Impact Questionnaire (PFIQ): a multicenter validation randomized study.** *Omotoshio TB, Hardart A, Rogers RG et al. Int Urogyn J Pelvic Floor Dysf. EPUB: 2009-02-14.* Valid and reliable Spanish versions of the PFIQ and PFDI have been developed using back translation and by randomizing 44 bilingual women to complete the Spanish or English versions of the questionnaires (weighted kappa statistics assessed agreement for individual questions, interclass correlation coefficients (ICC) compared primary and subscale scores, and Cronbach's alpha assessed internal consistency of Spanish versions).

**Three-dimensional endoanal ultrasonography: intraobserver and interobserver agreement using scoring systems for classification of anal sphincter defects.** *Norderval S, Dehli T, Vonen B. Ultrasound in Obst & Gyn. EPUB: 2009-02-19.* To determine the degree of intraobserver and interobserver agreement for an experienced and an inexperienced sonologist using an endoanal ultrasound defect score system and the Starck score for ultrasonographic assessment of anal sphincter defects, datasets of 55 women were included and their sphincter defects were classified. Intraobserver and interobserver agreement was acceptable for both scoring systems. The experienced sonologist obtained a higher degree of intraobserver agreement than did the inexperienced sonologist.

### 4 – PROLAPSES

**Multiple perineal abscesses and sinus tracts as a complication of vaginal mesh.** *Lewicky-Gaupp C, McGuire EJ, Fenner DE. Int Urogyn J Pelvic Floor Dysf EPUB: 2009-02-21.* A 54-year-old woman with constant perineal pain, and copious, foul-smelling vaginal discharge after anterior and posterior placement of a synthetic mesh and mid-urethral sling 3 months earlier, was found to have two vaginocutaneous sinus tracts (to the left ischioirectal fossa and to the left labia majora), as well as bilateral abscess cavities within the ischioirectal fossae. The posterior mesh was completely excised, the tracts were opened, and the wound was packed and allowed to heal by secondary intention.

**Clinical, physiological and radiological assessment of rectovaginal septum reinforcement with mesh for complex rectocele.** *Zbar AP, Ansari A. Brit J Surg. EPUB 2009-02-19.*

*The PFD continues on page 103*

8. Rossberger J, Fall M, and Peeker R. Critical appraisal of dimethyl sulfoxide treatment for interstitial cystitis: discomfort, side-effects and treatment outcome. *Scand J Urol Nephrol* 2005; 39: 73.
9. Webster DC and Brennan T. Use and effectiveness of physical self-care strategies for interstitial cystitis. *Nurse Pract* 1994; 19: 55.
10. Weiss JM. Pelvic floor myofascial trigger points: manual therapy for interstitial cystitis and the urgency-frequency syndrome. *J Urol* 2001; 166: 2226.
11. Yamada T, Murayama T, and Andoh M. Adjuvant hydrodistension under epidural anesthesia for interstitial cystitis. *Int J Urol* 2003; 10: 463.
12. Chancellor MB and Chartier-Kastler EJ. Principles of Sacral Nerve Stimulation (SNS) for the Treatment of Bladder and Urethral Sphincter Dysfunctions. *Neuromodulation* 2000; 3: 16-26. Ref Type: Abstract.
13. Hassouna MM, Siegel SW, Nyeholt AA et al. Sacral neuromodulation in the treatment of urgency-frequency symptoms: a multicenter study on efficacy and safety. *J Urol* 2000; 163: 1849.
14. Jonas U, Fowler CJ, Chancellor MB et al. Efficacy of sacral nerve stimulation for urinary retention: results 18 months after implantation. *J Urol* 2001; 165: 15.
15. Siegel SW, Catanzaro F, Dijkema HE. et al. Long-term results of a multicenter study on sacral nerve stimulation for treatment of urinary urge incontinence, urgency-frequency, and retention. *Urology* 2000; 56: 87.
16. Elhilali MM, Khaled SM, Kashiwabara T et al. Sacral neuromodulation: long-term experience of one center. *Urology* 2005; 65: 1114.
17. van Voskuilen A, van Kerrebroeck PE, Dijkema H, Maastricht Bemelmans B, Lycklpa A, Nijeholt AA, Fall M, Jonas D, Fowler C, Das AK, Milam DF, Siegel J, and van den Hombergh U. Lasting improvement is demonstrated in patients with voiding disorders treated with sacral nerve stimulation. *Journal of Urology* 2004; 171 (4, Suppl.): 328. Ref Type: Abstract.
18. Chai TC, Zhang C, Warren JW et al. Percutaneous sacral third nerve root neurostimulation improves symptoms and normalizes urinary HB-EGF levels and antiproliferative activity in patients with interstitial cystitis. *Urology* 2000; 55: 643.
19. Comiter CV. Sacral neuromodulation for the symptomatic treatment of refractory interstitial cystitis: a prospective study. *J Urol* 2003; 169: 1369.
20. Feloney MP and Culkin DJ. Neuromodulation Treatment for Refractory Severe Interstitial Cystitis. *Journal of Urology* 2001; 165 (5, Suppl.): 66. Ref Type: Abstract.
21. Maher CF, Carey MP, Dwyer PL et al. Percutaneous sacral nerve root neuromodulation for intractable interstitial cystitis. *J Urol* 2001; 165: 884.
22. Peters KM. Neuromodulation for the treatment of refractory interstitial cystitis. *Rev Urol* 2002; 4 (Suppl 1): S36.
23. Peters KM, Carey JM, and Konstandt DB. Sacral neuromodulation for the treatment of refractory interstitial cystitis: outcomes based on technique. *Int Urogynecol J Pelvic Floor Dysfunct* 2003; 14: 223.
24. Peters KM and Konstandt D. Sacral neuromodulation decreases narcotic requirements in refractory interstitial cystitis. *BJU Int* 2004; 93: 777.
25. Whitmore KE, Payne CK, Diokno AC et al. Sacral neuromodulation in patients with interstitial cystitis: a multicenter clinical trial. *Int Urogynecol J Pelvic Floor Dysfunct* 2003; 14: 305.
26. Gillenwater JY and Wein J. Summary of the National Institute of Arthritis, Diabetes, Digestive and Kidney Diseases Workshop on Interstitial Cystitis, National Institutes of Health, Bethesda, Maryland, August 28-29, 1987. *J Urol* 1988; 140: 203.
27. O'Leary MP, Sant GR, Fowler FJ, Jr. et al. The interstitial cystitis symptom index and problem index. *Urology* 1997; 49: 58.
28. Propert KJ, Payne C, Kusek JW et al. Pitfalls in the design of clinical trials for interstitial cystitis. *Urology* 2002; 60: 742.
29. Jepsen JV, Sail M, Rhodes PR et al. Long-term experience with pentosan polysulfate in interstitial cystitis. *Urology* 1998; 51: 381.
30. Hwang P, Auclair B, Beechinor D et al. Efficacy of pentosan polysulfate in the treatment of interstitial cystitis: a meta-analysis. *Urology* 1997; 50: 39.

*Correspondence to:*

MICHAEL P. FELONEY, M.D.  
 Section of Urologic Surgery  
 University of Nebraska Medical Center  
 982360 Nebraska Medical Center  
 Omaha, Nebraska 68198-2360  
 (402) 559-4292  
 Fax: (402) 559-6529  
 e-mail: mfeloney@unmc.edu

**Pelvic Floor Digest** *continued from page 100*

**5 – RETENTIONS**

**Oral mucosal grafts urethroplasty for the treatment of long segmented anterior urethral strictures.** *Xu YM, Sa YL, Fu Q et al. World J Urol. EPUB: 2009-02-14.* Combined two oral mucosal grafts substitution urethroplasty is an effective technique for the treatment of long, complex segmented urethral strictures. In 25 patients followed-up for 6-72 months, urethrocutaneous fistulas developed in 2, and urethral stricture in 1 who needed urethral dilations, after which he voided well with a urinary peak flow of 26.4 ml/s.

**Decreased colonic transit time after transcutaneous interferential electrical stimulation in children with slow transit constipation.** *Clarke MC, Chase JW, Gibb S. et al. Journal of Pediatric Surgery EPUB: 2009-02-24* Idiopathic slow transit constipation is diagnosed by demonstrating delayed colonic transit on nuclear transit studies and describes a clinical syndrome characterised by intractable constipation. A possible new treatment is interferential therapy, which is a form of electrical stimulation that involves the transcutaneous application of electrical current and in children can speed up colonic transit significantly compared to placebo.

**6 – INCONTINENCES**

**Sacral Nerve Modulation and other treatments in patients with faecal incontinence after unsuccessful pelvic floor rehabilitation: a prospective study.** *Koch SM, Melenhorst J, Uluda O, Baeten CG et al. Colorectal Dis. EPUB: 2009-02-18.* Patients with faecal incontinence were included in a multicenter study and treated with standardized pelvic floor rehabilitation. Those with an unsuccessful result who were eligible for sacral nerve modulation were included in the present study while failures at test stimulation received another treatment. Clinical outcome, Vaizey scores and quality of life (EQ-5D and HAQL) indicated a 49% overall success rate in patients with SNM with a significant improvement disease specific quality of life compared to other treatment.

37. D'Hoore A, Vanbeckvoort D, Penninckx F. Clinical, physiological and radiological assessment of recto-vaginal septum reinforcement with mesh for complex rectocele. *Br J Surg* 2008; 95: 1264-72.
38. Pacquee S, Palit G, Jacquemyn Y. Complications and patient satisfaction after trans obturator anterior and/or posterior tension free polypropylene mesh for pelvic organ prolapse. *Acta Obstet Gynecol Scan* 2008; 87: 972-4.
39. Alperin M, Sutkin G, Ellison R et al. Peri-operative outcome of the Prolift pelvic floor repair system following introduction to a urogynecology teaching service. *Int Urogynecol J Pelvic Floor Dysfunc* 2008; 19: 1617-22.
40. Lucioni A, Rapp DE, Gong EM et al. The surgical technique and early post-operative complications of the Gynecare Prolift pelvic floor repair system. *Can J Urol* 2008; 15: 4004-8.
41. Gauruder-Burmester A, Koutouzidou P, Rohne J et al. Follow up after polypropylene mesh repair of anterior and posterior compartments in patients with recurrent prolapse. *Int Urogynecol J Pelvic Floor Dysfunc* 2007; 18: 1059-64.
42. Silva WA and Karram MM. Scientific basis for use of grafts during vaginal reconstructive procedures. *Curr Opin Obstet Gynecol* 2005; 17: 519-29.
43. Wu MP. The use of prostheses in pelvic reconstructive surgery: joy or toy? *Taiwan J Obstet Gynecol* 2008; 47: 151-6.
44. De Ridder D. Should we use meshes in the management of vaginal prolapse? *Curr Opin Urol* 2008; 18: 377-82.
45. Neuman M, Lavy Y. Reducing mesh exposure in Posterior Intra-Vaginal Slingplasty (PIVS) for vaginal apex suspension. *Pelviperrineology*, 2007; 26: 117-21.
46. Von Theobald P, Labbe E. Three-way prosthetic repair of the pelvic floor. *J Gynecol Obstet Biol Reprod (Paris)* 2003; 32: 562-70.
47. Smadja S, Vanormelingen L, VandeWalle G et al. Trans levator posterior intra vaginal slingplasty: anatomical landmarks and safety margins. *Int Urogynecol J Pelvic Floor Dysfunc* 2005; 16: 364-8.
48. Siegel AL, Kim M, Goldstein M et al. High incidence of vaginal mesh extrusion using the intravaginal slingplasty sling. *J Urol* 2005; 174: 1308-11.
49. Schultz DG: FDA public health notification: serious complications associated with trans-vaginal placement of surgical mesh in repair of pelvic organ prolapse and stress urinary incontinence 2008.
50. National institute for health and clinical excellence guideline CG40 Urinary incontinence: NICE guideline 2006.

Correspondence to:

MENACHEM NEUMAN, MD

7 Te'ena st,

Carmei-Yosef - Israel, 99797

Tel. +972-546-444-033 - Fax +972-8-9287983

E-mail: mneuman@netvision.net.il

## Pelvic Floor Digest

continued from page 103

**Triple therapy in refractory detrusor overactivity: a preliminary study.** *Natalin R, Reis LO, Alpendre C et al. World Journal of Urology. EPUB: 2009-03-18.* To prospectively evaluate the impact of the "three-drug therapy" (antimuscarinic, alpha-blocker and tricyclic antidepressants) on the treatment of refractory detrusor overactivity, data from 27 consented patients were collected through a daily urinary chart and an urodynamic evaluation before and 60 days after treatment with a mean follow-up of 15 months. There was a significant increase on bladder capacity and decreases on urgency, urge-incontinence and frequency. Main side effects comprised dry mouth and constipation (40%). More studies are necessary to achieve more consistent data on the matter.

### 7 – PAIN

Treatment of endometriosis of uterosacral ligament and rectum through the vagina: description of a modified technique. *Camara O, Herrmann J, Egbe A et al. Human Reprod. EPUB: 2009-02-19.* The optimum way to diagnose endometriosis is by direct visualization of the implants. Four patients with a uterosacral ligament and rectal endometriosis, average tumour diameter 3.5 cm, complaining of rectal bleeding and lower abdominal pain in relation to their menstrual cycle were successfully treated with combined laparoscopic-transvaginal resection.

**Adequate relief in a treatment trial with ibs patients: a prospective assessment.** *Passos MC, Lembo AJ, Conboy LA, Drossman DA et al. Am J Gastroenterol. EPUB: 2009-03-19.* Adequate relief of irritable bowel syndrome symptoms as an end point in randomized controlled trials is inversely related to baseline symptom severity. However, if patients who report adequate relief at screening are excluded from study participation, baseline symptom severity is no longer confounded with a report of adequate relief at the study end point.

### 8 – FISTULAE

**Fournier's gangrene: population based epidemiology and outcomes.** *Sorensen MD, Krieger JN, Rivara FP et al. J Urol. EPUB: 2009-03-17.* A national database was used to investigate the epidemiology of Fournier's gangrene. Inpatients diagnosed with Fournier's gangrene who underwent genital/perineal débridement or died in the hospital were identified in 1,641 males and 39 females the cases representing less than 0.02% of hospital admissions. The overall incidence was 1.6/100,000 males, which peaked in males 50 to 79 years old with an overall case fatality rate of 7.5%.

**Hidradenitis suppurativa.** *Buimer MG, Wobbles T, Klinkenbijn JH. Br J Surg. EPUB: 2009-03-14.* is a. Despite its incidence, optimal medical or surgical treatment hidradenitis suppurativa remains unclear. On the basis of histological findings, this chronic, recurrent, suppurative cutaneous disease is considered inflammatory and originating from the hair follicle; therefore it is called also acne inversa. but Smoking seems to be a major triggering factor though the exact aetiology remains obscure. Treatment should be individualized according to the site and extent of the disease. Absolute cessation of smoking is essential. Management with antibiotics or other medications may relieve early symptoms, but radical surgery may be necessary for control and to prevent recurrence.

The PFD continues on page 111

a drainage tube. The subsequent output of pus mixed with hair suggested the hypothesis of a disembryogenic infected cyst. TRUS is a sensitive method for analysis of the rectal wall and the perirectal space, helping to distinguish solid from liquid lesions. In our case the position of the cyst, its extension and size and its relationship with the rectal wall were determined. Because of its better definition of the soft tissues, MR allowed to evidence the longitudinal cyst of 7x2x2 cm with an air fluid level and a gross fistulous tract directing to the perineal skin. Because of the vertical development of the cyst with its superior pole at the sacral promontory, an abdominal operation became necessary to remove the cyst remnant combined with a perianal fistulectomy. Laparoscopy allows a good vision of the deepest part of the pelvis preserving nerves, vessels, ureters and providing less discomfort for the patient and a shorter and less expensive hospital stay. Furthermore, rectum mobilization necessary to reach the retrorectal space, results easier and less time-expensive when performed through a laparoscopic dissection. Contemporary anal fistula excision allowed to complete the procedure without necessity of other surgical operations.<sup>7,8</sup>

For this reasons, when possible, the combination of laparoscopic and pelvic procedure represents the best alternative to classic laparotomy for high presacral infected cysts, avoiding long hospital stay and reducing patient's discomfort.

## REFERENCES

1. Tampi C, Lotwala V, Lakdawala M, Coelho K. Retrorectal cyst hamartoma (tailgut cyst) with malignant transformation. *Gynecol Oncol* 2007; 266-68.
2. Jang SH, Song YS, Min KW et al. Unusual prerectal location of a tailgut cyst: a case report. *World J Gastroenterol* 2006; 12: 5081-83.
3. Hobson KG, Ghaemmaghami V, Roe JP et al. Tumors of the retrorectal space. *Dis Colon Rectum* 2005; 48: 1964-74.
4. Jao SW, Beart RW, Spencer RJ et al. Retrorectal Tumors: Mayo Clinic experience, 1960-1979. *Dis Colon Rectum* 1985; 28: 644-52.
5. McCune WS. Management of sacrococcygeal tumors. *Ann Surg* 1964; 159: 911-18.
6. Glasgow SC, Birnbaum EH, Lowney JK et al. Retrorectal tumors: a diagnostic and therapeutic challenge. *Dis Colon Rectum* 2005; 48: 1581-87.
7. Piura B, Rabinovich A, Silnelnikov I, Delgado B. Tailgut cyst initially misdiagnosed as an ovarian tumor. *Arch Gynecol Obstet* 2005; 272: 301-303.
8. Buchs N, Taylor S, Roche B. The posterior approach for low retrorectal tumors in adults. *Int J Colorectal Dis* 2007; 22: 381-85.

*Correspondence to:*

ENRICO BELLUCO MD

Department of Clinica Chirurgica 2, Policlinico di Padova  
via Giustiniani 2, 35128, Padova (Italy)  
enrico.belluco@unipd.it

---

## Pelvic Floor Digest

*continued from page 108*

**Anastomotic-vaginal fistula (AVF) after anterior resection of the rectum for cancer - occurrence and risk factors.** *Matthiessen P, Hansson L, Sjødahl R, Rutegård J. Colorectal Dis. EPUB: 2009-02-18.* To assess recto-vaginal fistula after anterior resection of the rectum for cancer with regard to occurrence and risk factors, 20 female patients who developed a symptomatic fistula were compared with 32 who developed conventional symptomatic leakage and 338 who did not leak. Patients with AVF had lower anastomoses and decreased BMI compared with those with conventional leakage. Risk factors for AVF in multivariate analysis were anastomosis < 5 cm above the anal verge, preoperative radiotherapy and UICC cancer stage IV. Previous hysterectomy was not a risk factor. The need for abdominal reoperation and defunctioning stoma is not different from patients with conventional leakage.

## 9 – BEHAVIOUR, PSYCHOLOGY, SEXOLOGY

**Ageing, mate preferences and sexuality: a mini-review.** *Oberzaucher E, Grammer K. Gerontology. EPUB: 2009-02-21.* Sexuality never ceases to be part of a relationship. With increasing age, reproduction loses importance, while pair bonding functions remain relevant. The evolutionary constraints that lead to the evolution of sexual reproduction are framed by the better repair mechanisms of fatal mutations, as well as the need for variable immune systems imposed on large organisms by parasites, such as viruses and bacteria. These factors affect mate choice, especially as regards the gene complex that encodes the immune system. The need to increase both the likelihood of gametes to encounter each other as well as sufficient provision of nutrition for the offspring then leads to the evolution of two sexes: large numbers of small mobile sperms ensure that gametes meet, whereas large egg cells full of energy provide for the zygote, thus leading to a developmental advantage. The asymmetric investment in the offspring affects also cognitive strategies. Men place more importance on youthfulness and fertility than women, who regard resource holding potential as a more relevant criterion. Consequently, jealousy is connected in females to endangered access to resources, in males to paternal uncertainty.

## 10 – MISCELLANEOUS

**Endoscopic closure of the natural orifice transluminal endoscopic surgery (NOTES) access site to the peritoneal cavity by means of transmural resorbable sutures: an animal survival study.** *von Renteln D, Eickhoff A et al. Endoscopy. EPUB: 2009-02-14.* Endoscopic closure of the transgastric access site is still a critical area of active research and development into NOTES. Endoscopic gastrostomy closure by means of resorbable sutures was performed in 10 female domestic pigs in an animal survival study. Mean suturing time was 26 minutes (range 14 - 35 minutes). One case of gallbladder perforation occurred during peritoneoscopy and the pig was sacrificed due to peritonitis.

## Erratum

*In Vol 28, issue 2, pag. 50 (Complex pelvic problems - a multidisciplinary perspective), corresponding Author: Marco Soligo Servizio di Uroginecologia, U.O. Ginecologia e Ostetricia, Ospedale San Carlo Borromeo, Milano, add  
E-mail: marcosoligo@fastwebnet.it*