Pelvic Floor Digest

*This section presents a small sample of the Pelvic Floor Digest, an online publication (**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

Google obstetrics: who is educating our patients? *Kaimal AJ, Cheng YW, Bryant AS et al. Am J Obstet Gynecol. 2008;198:682.* Internet becomes a frequently used source of health information, and obstetrician-gynecologists should consider how this forum can be more effectively used to disseminate educational information.

Bladder tissue engineering through nanotechnology. *Harrington DA, Sharma AK, Erickson BA, Cheng EY. World J Urol. 2008 Jun 7; epub.* Initially "inert" biomaterials to act as replacement structures in the body were searched. Then biodegradable scaffolds-both naturally derived and synthetic-for the temporary support of growing tissues were explored. A third phase has developed through the subcategory of regenerative medicine. By operating at the size regime of proteins themselves, nanotechnology gives us the opportunity to directly speak the language of cells, through reliable creation of nanoscale features. Understanding the synthesis of nanoscale materials, via "top-down" and "bottom-up" strategies, research in urology allows to assess the capabilities and limits inherent in both, in particular to reach the end goal of functional bladder restoration.

1 – THE PELVIC FLOOR

Learning curve and preliminary experience with da Vinci-assisted laparoscopic radical prostatectomy (RALP). *Artibani W, Fracalanza S, Cavalleri S et al. Urol Int. 2008;80:237.* RALP is a feasible and reproducible technique, with a short learning curve and low perioperative complication rate. Even during the initial phase of the learning curve, good results were obtained with regard to postoperative complications and oncological outcome.

Graphic integration of causal factors of pelvic floor disorders: an integrated life span model. *Delancey JO, Low LK, Miller JM et al. Am J Obstet Gynecol. 2008 Jun 2; epub.* Causal factors for symptomatic pelvic floor disorders include pelvic organ prolapse and urinary and fecal incontinence and are affected by a myriad of factors. Unraveling the complex causal network of genetic factors, birth-induced injury, connective tissue aging, lifestyle and comorbid factors is challenging. We describe a graphical tool to integrate the factors affecting pelvic floor disorders. It plots pelvic floor function in 3 major life phases: (1) development of functional reserve during an individual's growth, (2) variations in the amount of injury and potential recovery that occur during and after vaginal birth, and (3) deterioration that occurs with advancing age.

The effect of early removal of indwelling urinary catheter on postoperative urinary complications in anterior colporrhaphy surgery. *Sekhavat L, Farajkhoda T, Davar R. Aust N Z J Obstet Gynaecol. 2008;48:348-52.* Early removal of an indwelling catheter immediately after anterior colporrhaphy was not associated with adverse events and increased rate of re-catheterisation. In this group, symptomatic urinary tract infection was significantly lower. Moreover, early removal of indwelling catheters immediately after operation seemed to decrease the ambulation time and hospital stay.

Pelvic floor fitness using lay instructors. *Brubaker L, Shott S, Tomezsko J, Goldberg RP. Obstet Gynecol. 2008;111:1298.* Non medical pelvic fitness classes are promising for pelvic symptom improvement in self-selected participants.

2 – FUNCTIONAL ANATOMY

Pelvic Nerve Stimulation evokes nitric oxide mediated distal rectal relaxation in pigs. *Moller FV, Buntzen S, Rijkhoff NJ, Laurberg S. Dis Colon Rectum. 2008 May 31; epub.* In the distal rectum the smooth muscle response is mediated by nitric oxide.

Combined estrogen and ghrelin administration decreases expression of p27(kip1) and proportion of isomyosin type I in the striated urethral and anal sphincters and levator ani of old ovariectomized rats. *Rizk DE, Hassan HA, Al-Marzouqi AH et al. Int Urogynecol J Pelvic Floor Dysfunct. 2008 May 22; epub.* Estrogen/ghrelin administration reversed pelvic floor muscle ageing changes in old ovariectomized rats through growth hormone production.

Ballooning of the levator hiatus. *Dietz HP, Shek C, De Leon J, Steensma AB. Ultrasound Obstet Gynecol. 2008;31:676.* The levator hiatus defines the 'hernial portal' through which female pelvic organ prolapse develops. Based on the ROC curves (receiver-operating characteristics), it is suggested that a hiatal area of > 25 cm(2) on Valsalva be defined as abnormal distensibility or 'ballooning' of the levator hiatus.

3 – DIAGNOSTICS

Discrepancies between physician interview and a patient self-assessment questionnaire after surgery for pelvic organ prolapse. *de Boer TA, Gietelink DA, Vierhout ME. Int Urogynecol J Pelvic Floor Dysfunct. 2008 May 29; epub.* The use of validated questionnaires besides physician interview to evaluate surgical outcome is recommended because they provide a more realistic (objective) view of the functional results. There is poor to slight agreement between the interview score and the self-reported responses to the questionnaire on all items.

The urethral motion profile: a novel method to evaluate urethral support and mobility. *Shek KL, Dietz HP. Aust N Z J Obstet Gynaecol. 2008;48:337.* Urethral hypermobility is one of the theories developed to explain stress urinary incontinence. Traumatic damage to urethral supports during vaginal childbirth may be an important contributor. The study of urethral mobility using 3D/4D translabial ultrasound shows an increase in urethral mobility after childbirth, especially after instrumental delivery, suggesting an alteration in urethral support.

Perineal ultrasound in the study of urethral mobility: proposal of a normal physiological range. *Di Pietto L, Scaffa C, Torella M et al. Int Urogynecol J Pelvic Floor Dysfunct. 2008 May 10, epub.*

Brain responses during the first desire to void: A positron emission tomography study. *Takao T, Tsujimura A, Miyagawa Yet al. Int J Urol. 2008 Jun 2; epub.* To identify the brain regions activated during the first feeling that would lead the patient to pass urine, positron emission tomography (PET) scans were analyzed and the regional cerebral blood flow variations were accurately located.

Evaluation of outcome of anorectal anomaly in childhood: the role of anorectal manometry and endosonography. *Keshtgar AS, Athanasakos E, Clayden GS, Ward HC. Pediatr Surg Int. 2008 May 30; epub.* In continence outcome following repair of anorectal anomalies the internal anal sphincter quality is a vital in absence of neuropathy and megarectum.

4 – PROLAPSES

Sacrocolpopexy without concomitant posterior repair improves posterior compartment defects. *Guiahi M, Kenton K, Brubaker L. Int Urogynecol J Pelvic Floor Dysfunct. 2008 May 22; epub.* In 1-year follow-up sacrocolpopexy without concomitant posterior repair restores posterior vaginal topography in the majority of women.

Laparoscopic sacrocolpopexy for uterine and post-hysterectomy prolapse: anatomical results, quality of life and perioperative outcome-a prospective study with 101 cases. *Sarlos D, Brandner S, Kots L, Gygax N, Schaer G. Int Urogynecol J Pelvic Floor Dysfunct. 2008*

Jun 7; epub. After a median follow-up of 12 months in both groups the subjective and objective cure rate was 93% and 98%. The main site of objective recurrence (6%) was the anterior compartment. No apical recurrences and no vaginal mesh erosion occurred. Postoperatively overall quality of life and sexual quality showed significant improvement with less than 1% de-novo dyspareunia. The procedure is recommended for experienced laparoscopic surgeons because of severe intraoperative complications like bladder or rectal injuries.

The contractile properties of vaginal myofibroblasts: Is the myofibroblasts contraction force test a valuable indication of future prolapse development? *Meyer S, Achtari C, Hohlfeld P, Juillerat-Jeanneret L. Int Urogynecol J Pelvic Floor Dysfunct. 2008 May 30; epub*. Using a specific myofibroblast contraction test, we tried to predict future utero-vaginal prolapse development in young primiparae women. Vaginal myofibroblasts of young women show better contraction forces than young women with severe utero-vaginal prolapse. The latter have a myofibroblast contraction factor similar to those of older post-menopausal women operated for the same condition.

Symptoms of female pelvic organ prolapse: correlation with organ descent in women with single compartment prolapse. *Blain G, Dietz HP. Aust N Z J Obstet Gynaecol. 2008;48:317.* A vaginal lump correlates strongly with the degree of female pelvic organ prolapse as ascertained on clinical and ultrasound examination that perform very well as tests for predicting symptomatic prolapse, provided that the confounding effect of other compartments is accounted for.

Transobturator mesh for cystocele repair: a short- to medium-term follow-up using 3D/4D ultrasound. *Shek KL, Dietz HP, Rane A, Balakrishnan S. Ultrasound Obstet Gynecol. 2008 Jun 10; epub*. Since anterior colporrhaphy has limited medium-term success rates in cystocele repair, mesh implants have been proposed, but their safety and efficacy are controversial. In 46 women undergone transobturator mesh anterior repair using the Perigee(TM) system, at 10-month follow-up cystocele recurrence (Stage 2 or 3) was observed in six (13%) patients. There were three (6.5%) cases of mesh erosion, with a satisfaction rate of 78%. In some women recurrence may occur due to dislodgment of the superior anchoring arms.

[Treatment of recurrent rectal prolapse.] *Gravie JF. Gastroenterol Clin Biol. 2008 May 12; epub*.

[Management of hemorrhoid disease in the pregnant woman.] *Abramowitz L. Gastroenterol Clin Biol. 2008 May 22; epub*.

Overt rectal prolapse and fecal incontinence. *Siproudhis L, Eleouet M, Rousselle A et al. Dis Colon Rectum. 2008 Jun 11; epub*. Rectal prolapse is frequently associated with fecal incontinence; however, the relationship is questionable. Continent and incontinent patients do not differ with respect to occurrence of dyschezia, and digital help to defecate. Age and previous hemorrhoid surgery are causative factors and anal weakness and sphincter defects are also frequently observed.

Evaluation of rectal sensory and motor function by means of the electronic barostat after stapled hemorrhoidopexy. *De Nardi P, Corsetti M, Passaretti S et al. Dis Colon Rectum. 2008 May 10; epub*. Rectal distensibility and volume thresholds for sensations decrease after stapled hemorrhoidopexy. These impairments persist for at least six months after surgery.

Postoperative complications after procedure for prolapsed hemorrhoids (PPH) and stapled transanal rectal resection (STARR) procedures. *Pescatori M, Gagliardi G. Tech Coloproctol. 2008;12:7.* PPH and STARR carry the expected morbidity following anorectal surgery, such as bleeding, strictures and fecal incontinence. Particular complications are rectovaginal fistula, chronic proctalgia, total rectal obliteration, rectal wall hematoma and perforation with pelvic sepsis often requiring a diverting stoma. A higher complication rate and worse results are expected after PPH for fourth-degree piles. Enterocele and anismus are contraindications.

5 – RETENTIONS

Sacral neuromodulation for the dysfunctional elimination syndrome: a single center experience with 20 children. *Roth TJ, Vandersteen DR, Hollatz P et al. J Urol. 2008;180:306*. Neuromodulation with the InterStim implantable device has demonstrated promise in treating children with the dysfunctional elimination syndrome refractory to medical management. Urinary incontinence, urgency and frequency, nocturnal enuresis and constipation were improved or resolved in 88% (14 of 16), 69% (9 of 13), 89% (8 of 9), 69% (11 of 16) and 71% (12 of 17) of the patients, respectively. Urinary retention requiring intermittent catheterization persisted in 75% of the patients (3 of 4). Complications requiring operative treatment occurred in 20% of the patients (4 of 20). Following marked symptomatic improvement 2 devices were explanted at 20 and 19 months following placement, and both patients have remained symptom-free.

Vesico ureteral reflux (VUR) and elimination disorders. *Alova I, Lottmann HB. Arch Esp Urol. 2008;61:218*. Two kinds of elimination disorders can be associated with VUR: pure bladder elimination disorders or combination of bladder and bowel elimination disorders. The management of urinary and intestinal elimination disorders is based on the prevention of infections, the suppression of the post voiding residual urine and the treatment of an associated constipation. If surgical treatment of VUR is needed, it must be associated to the management of elimination disorders in the peri operative period.

Detrusor acontractility in urinary retention: detrusor contractility test as exclusion criteria for sacral neurostimulation. *Bertapelle P, Bodo G, Carone R. J Urol. 2008;180:215.* Results of sacral neurostimulation in urinary retention are reported in the literature without distinction between the 2 functional disorders causing this condition, detrusor acontractility and functional outlet obstruction. We suggest a stimulation test to differentiate irreversible bladder myopathy (or complete neurogenic lesion) from potential bladder contractility eligible for sacral neurostimulation.

Postoperative course and long term follow up after colectomy for slow transit constipation - is surgery an appropriate approach? *Stefan R, Tudor B, Friedrich H, Anton S. Colorectal Dis. 2008 May 29; epub*. Patients with slow transit constipation who do not respond satisfactorily to common medical treatment are considered candidates for colectomy. Between 1996 and 2004 20 consecutive patients were treated by colectomy: 3 (15%) died perioperatively, 10 (50%) needed further operations after colectomy: Three patients (15%) had surgery during the early postoperative period, seven patients (35%) during follow up. The median Wexner constipation score was 11.5 (range 8-23). The median Vaizey incontinence score was 7.5 (range 0-22). The median GIQLI showed 80 points (range 32-129). Therefore this approach cannot recommended.

Laparoscopic caecodivision ACE (antegrade continence enema) procedure. *Thomas K, Bassuini M. Tech Coloproctol. 2008;12:65*. The laparoscopic caecodivision method of the ACE procedure combines the advantages of laparoscopic technique with those of not using the appendix.

A placebo-controlled trial of prucalopride for severe chronic constipation. *Camilleri M, Kerstens R, Rykx A, Vandeplassche L N Engl J Med. 2008;358:2344.* Over 12 weeks, prucalopride, a selective high-affinity 5-hydroxytryptamine4 receptor agonist, significantly improved bowel function and reduced the severity of symptoms in patients with severe chronic constipation. Larger and longer trials are required to further assess the risks and benefits.

6 – INCONTINENCES

Muscle derived stem cell therapy for stress urinary incontinence. *Smaldone MC, Chancellor MB. World J Urol. 2008 May 10; epub* Cell-based therapies often use autologous multipotent stem cells, such as bone marrow stromal cells. However their harvesting requires a general anesthetic, can be painful, and has variable yield of stem cells upon processing. In contrast alternative autologous adult stem cells such as muscle-derived and adipose-derived stem cells can be obtained in large quantities with minimal discomfort.

Sphincter contractility after muscle-derived stem cells autograft into the cryoinjured anal sphincters of rats. *Kang SB, Lee HN, Lee JY et al. Dis Colon Rectum. 2008 Jun 7; epub.* The injection of muscle-derived stem cells into the anal sphincter can improve functional properties in a fecal incontinence rat model.

Transobturator tape in the management of female stress incontinence: clinical outcomes at medium term follow-up. *Kocjancic E, Crivellaro S, Oyama IA et al. Urol Int. 2008;80:275.* TOT is a safe procedure with a good efficacy: 70 patients with type II urinary stress incontinence treated between 2003 and 2006 with a 32-month follow-up. Vaginal erosion occurred in 4 patients.

Are there any UPP changes in women with stress urinary incontinence after pelvic floor muscle exercises? *Zahariou A, Karamouti M, Georgantzis D, Papaioannou P. Urol Int. 2008;80:270.* This study examined the effect of pelvic floor muscle exercises after 12 months of successful treatment for stress urinary incontinence based on subjective (incontinence episodes and pad test) and objective outcome variables (urethral closure pressure, UCP, functional profile length and pressure transmission ratio, PTR) in 50 women. Apart from the mean PTR no other urodynamic parameter reflected the continence improvement of pelvic floor exercise program.

Seeking care: women's narratives concerning long-term urinary incontinence. *Bradway C, Strumpf N. Urol Nurs. 2008;28:123.* Women who seek care for UI are more likely than those who do not seek care to 1) tell a story, 2) describe UI as having a negative impact on sense of self, 3) be older, Caucasian, in good general health, suffer for a longer period of time. Some relate UI to sexuality, intercourse, and intimacy.

Early results of transobturator sling suspension for male urinary incontinence following radical prostatectomy. *Gozzi C, Becker AJ, Bauer R, Bastian PJ. Eur Urol. 2008 May 6; epub.*

Obesity and urinary incontinence. *Khong SY, Jackson S. Menopause Int. 2008;14:53.* Obesity is growing at an alarming rate worldwide. This article reviews the current literature to see whether: (1) obesity predisposes to urinary incontinence; (2) weight loss improves urinary incontinence and (3) obesity affects the surgical outcome.

Why do stress and urge incontinence co-occur much more often than expected? *Minassian VA, Stewart WF, Hirsch AG. Int Urogynecol J Pelvic Floor Dysfunct. 2008 Jun 5;epub.* Assuming stress and urge urinary incontinence (UI) are independent, mixed UI prevalence is 17 times higher than expected. Longitudinal studies are needed.

Neuromodulation for the treatment of urinary incontinence. *Yamanishi T, Kamai T, Yoshida KI. Int J Urol. 2008 Jun 2; epub.* Neuromodulation has been reported to be effective for the treatment of stress and urgency urinary incontinence with cure and improvement rates in 30-50% and 60-90%, respectively. However, the superiority to other conservative treatments, such as pelvic floor muscle training has not been confirmed. A long-term effect has also been reported. For urgency and mixed stress plus urgency incontinence, neuromodulation may also be the treatment of choice as an alternative to drug therapy.

Relationships between improvements in symptoms and patient assessments of bladder condition, symptom bother and health-related quality of life in patients with overactive bladder treated with tolterodine. *Coyne KS, Elinoff V, Gordon DA et al. Int J Clin Pract. 2008;62:925.* Tolterodine extended release -related improvements in overactive bladder symptoms (assessed by diary variables) and patients' perceptions of the changes in symptom bother, bladder-related problems and health-related quality of life (assessed by Patient Perception of Bladder Condition and Overactive Bladder Questionnaire) were significantly correlated. The questionnaires provide a relevant and important patient perspective for OAB treatment evaluation.

Refractory idiopathic urge urinary incontinence and botulinum A injection. *Brubaker L, Richter HE, Visco A et al. J Urol. 2008 Jul;180(1):217.* Local injection of 200 U botulinum toxin A was an effective and durable treatment for refractory overactive bladder. However, a transient post-void residual urine increase was experienced in 43% of patients. Botulinum toxin A for idiopathic overactive bladder is still under investigation.

Fecal incontinence. *Hannaway CD, Hull TL. Obstet Gynecol Clin North Am. 2008;35:249.* An interesting overview.

Relation of bowel habits to fecal incontinence in women. *Bharucha AE, Seide BM, Zinsmeister AR et al. Am J Gastroenterol. 2008;103:1470.* Though most women with fecal incontinence (FI) have anorectal dysfunctions, a majority have intermittent symptoms. Variations in bowel habits and daily routine may partly explain this. Bowel patterns, rectal urgency, and daily routine influence the occurrence of FI. Stool characteristics explained 46% of the likelihood for incontinence episodes, emphasizing that anorectal sensorimotor dysfunctions must also contribute to FI in women.

Sacral nerve stimulation for fecal incontinence: external anal sphincter defect vs. intact anal sphincter. *Chan MK, Tjandra JJ. Dis Colon Rectum. 2008 May 17; epub.* Sacral nerve stimulation for fecal incontinence is as effective in patients with external anal sphincter defects as those with intact sphincter and the result is similar for defect size up to 120 degrees of circumference.

Clinical characteristics and quality of life in a cohort of 621 patients with faecal incontinence. *Damon H, Siproudhis L, Valancogne G et al. Int J Colorectal Dis. 2008 May 28; epub.* A self-questionnaire was filled in by 621 patients (114 men), mean age 58 +/- 15 years (range: 20-92), with FI (mean Jorge and Wexner score 11 ± 4), 27 with IBS, 38 associated constipation, UI in 48% women and 25% men. QL was significantly altered, and anxiety and depression were frequent. The frequent association with other digestive and perineal symptoms argue in favour of a multi-disciplinary management of FI.

7 – PAIN

Treatment of interstitial cystitis with hydrodistention and bladder training. *Hsieh CH, Chang ST, Hsieh CJ et al. Int Urogynecol J Pelvic Floor Dysfunct. 2008 May 22; epub.* From 1997 to 2006, 361 patients were treated by HD. The implementation of HD and bladder training is crucially important for long-term remission.

Urinary tract infection and inflammation at onset of interstitial cystitis/painful bladder syndrome. *Warren JW, Brown V, Jacobs S, Horne L et al. Urology. 2008;71:1085.* The retrospective data suggest that a proportion, probably a minority, of women at interstitial cystitis/painful bladder syndrome (IC/PBS) onset had evidence of acute urinary tract infection (UTI) or inflammation. This might reveal clues to IC/PBS pathogenesis.

Detection of nanobacteria infection in type III prostatitis. *Zhou Z, Hong L, Shen X et al . Urology. 2008;71:1091.* This study shows that nanobacterial infection might be an important etiologic factor of type III prostatitis. Anti-NB treatment could be an effective therapy against refractory type III prostatitis.

Surgical treatment of endometriosis: a 7-year follow-up on the requirement for further surgery. *Shakiba K, Bena JF, McGill KM et al. Obstet Gynecol. 2008;111:1285.* Local excision of endometriosis is associated with good short-term outcomes but on long-term follow-up there is a high reoperation rate. Hysterectomy is associated with a low reoperation rate. Preservation of the ovaries at the time of hysterectomy remains a viable option.

A search for Helicobacter pylori in localized vulvodynia. *Geva A, Sabo E, Levy J et al. Gynecol Obstet Invest. 2008;66:152.* This study did not found immunohistochemical evidence of H. pylori infection in the vestibule but suggests a possible role for anti-H. pylori treatment in localized vulvodynia.

Small intestinal bacterial overgrowth in irritable bowel syndrome: association with colon motility, bowel symptoms, and psychological distress. *Grover M, Kanazawa M, Palsson OS et al. Neurogastroenterol Motil. 2008 May 15; epub.* Bacterial overgrowth in the small intestine (SIBO) has been implicated in the pathogenesis of irritable bowel syndrome (IBS), although the issue is still under debate. This study concludes that SIBO is unlikely to contribute significantly to the pathogenesis of IBS. Methane production is associated with constipation.

Candidate genes and sensory functions in health and irritable bowel syndrome. *Camilleri M, Busciglio I, Carlson P et al. Am J Physiol Gastrointest Liver Physiol. 2008 May 29; epub.* Adrenergic and serotonergic (ADR-SER) mechanisms alter gut (GI) function; these effects are mediated through G protein transduction. Candidate genetic variations in ADR-SER were significantly associated with somatic scores in IBS and gastric emptying, but not small bowel or colonic transit. Our aim was to assess in 122 IBS patients whether candidate ADR-SER genes are associated with motor and sensory GI functions in IBS and subgroups based on bowel dysfunction. The results suggest that the endophenotype of visceral hypersensitivity in IBS may be partly related to genetic factors.

Anal fissure; surgery is the most effective treatment. *Nicholls J. Colorectal Dis. 2008;10(6):529.*

Intradermal injection of methylene blue for the treatment of refractory pruritus ani. *Sutherland AD, Faragher IG, Frizelle FA. Colorectal Dis. 2008 May 29; epub.* Effective and generally well tolerated.

Gastrointestinal microbiota in irritable bowel syndrome: their role in its pathogenesis and treatment. *Parkes GC, Brostoff J, Whelan K, Sanderson JD. Am J Gastroenterol. 2008;103:1557.*

Tegaserod for female patients suffering from IBS with mixed bowel habits or constipation: a randomized controlled trial. *Chey WD, Pare P, Viegas A et al. Am J Gastroenterol. 2008;103:1217.* Tegaserod provided significant improvement in satisfactory relief of IBS symptoms over 4 wk in both IBS-Mixed and IBS-C patients.

The efficacy of probiotics in IBS. *Quigley EM. J Clin Gastroenterol. 2008 Jun 5; epub.* Although clinical evidence of efficacy is now beginning to emerge, a review of available trials emphasizes the importance of clear definition of strain selection, dose, and viability. The possible roles of cotherapy or sequential therapy with antibiotics, probiotics, prokinetics, or other agents, also deserve further study.

8 – FISTULAE

Management of radiation-induced vesicovaginal fistula. *Pushkar DY, Dyakov VV, Kasyan GR. Eur Urol. 2008 Apr 30; epub.* The Martius labial flap is a safe and effective procedure for these cases. Latzko upper colpocleisis is preferable when the risk of ureteral damage during surgery is present.

Management of acquired rectourinary fistulas: how often and when is permanent fecal or urinary diversion necessary? *Nunoo-Mensah JW, Kaiser AM, Wasserberg N et al. Dis Colon Rectum. 2008 May 10; epub.* Surgical treatment for acquired rectourinary fistulas can successfully avoid permanent fecal and/or urinary diversion in a large number of patients if locally curative cancer treatment can be achieved.

Outcomes after repair of rectovaginal fistulas using bioprosthetics. *Ellis CN. Dis Colon Rectum. 2008 May 14; epub.* The fistula recurred in 34% of anodermal flap repair, 19% of bioprosthetic sheet and 14% of bioprosthetic plug repair.

Surgical management of anal fistulae: a systematic review. *Malik AI, Nelson RL. Colorectal Dis. 2008;10:420.*

Treatment of complex anal fistulas with the collagen fistula plug. *Christoforidis D, Etzioni DA, Goldberg SM et al. Dis Colon Rectum. 2008 Jun 3; epub.* In an experience 43 % of patients with complex anal fistulas were successfully treated. Patients with less external sphincter involvement were more likely to heal.

9 – BEHAVIOUR, PSYCHOLOGY, SEXOLOGY

Female sexual function and dysfunction. *Kammerer-Doak D, Rogers RG. Obstet Gynecol Clin North Am. 2008;35:169.* Some of the questionnaires used to evaluate sexual function are discussed.

Use of brief tools to measure depressive symptoms in women with a history of intimate partner violence. *Bonomi AE, Kernic MA, Anderson ML et al. Nurs Res. 2008;57:150.* Two brief question subsets were effective in identifying depression and can be used by nurses to assess depression in women with histories of abuse.

[Results of sacral posterior neuromodulation on voiding disorders and impact on sexuality based on a single-centre study.] *Ferhi K, Miaadi N, Tanneau Y et al. Prog Urol. 2008;18:160.*

Older victims of sexual assault: an underrecognized population. *Eckert LO, Sugar NF. Am J Obstet Gynecol. 2008;198:688.* Sexual assault in older women has distinct characteristics, which may be useful in planning intervention and prevention strategies.

10 – MISCELLANEOUS

Penetrating external genital trauma: a 30-year single institution experience. *Phonsombat S, Master VA, McAninch JW. J Urol. 2008;180:192.* Conservative debridement of penetrating injuries should maximize tissue preservation. Testicular salvage rates are significantly higher in gunshot wound injuries (75%) compared to stab wounds/lacerations injuries (23%). A select group of patients with penile and scrotal injuries (ie those with injuries superficial to Buck's or dartos fascia) may undergo nonsurgical treatment of the penetrating external genital injury with minimal morbidity.

Recommendations for probiotic use-2008. *Floch MH, Walker WA, Guandalini S et al. J Clin Gastroenterol. 2008 Jun 5; epub.* After a Yale University Workshop in 2005 and a similar one in 2007, the updated recommendations are graded into: "A" (acute childhood diarrhea, antibiotic-associated diarrhea, pouchitis, cows milk allergy), "B" (inflammatory bowel disease and irritable bowel syndrome with limited or negative studies), "C" (recommendations significant but short of receiving stronger ratings).

Enteric autoantibodies and gut motility disorders. *Kashyap P, Farrugia G. Gastroenterol Clin North Am. 2008;37:397.* This review focuses on the types of circulating antibodies associated with gastrointestinal motility disorders and their significance. Increasing evidence suggests that a subset of gastrointestinal motility disorders is associated with these antibodies directed against various molecular targets, the best known being anti-neuronal nuclear antibody.

Robotic colorectal surgery: first 50 cases experience. *Spinoglio G, Summa M, Priora F et al. Dis Colon Rectum. 2008 May 17; epub.*

Tracking outcomes of anorectal surgery: the need for a disease-specific quality assessment tool. *Hyman NH, Cataldo PA, Trevisani GT et al. Dis Colon Rectum. 2008 May 30; epub.* Complications after anorectal procedures are infrequent, typically minor, and occur after hospital discharge. Major complications reflect concomitant illness, not surgical quality. Meaningful outcome measures are needed to assess the quality of anorectal surgery.