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

"First do no harm" and the emerging story of the vaginal reconstructive mesh implant. *Swift SE. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:983*

Patterns of technical error among surgical malpractice claims: an analysis of strategies to prevent injury to surgical patients. *Regenbogen SE, Greenberg CC, Studdert DM et al. Ann Surg. 2007;246:705.* To identify the most prevalent patterns of technical errors in surgery, surgeon reviewers analyzed 444 randomly sampled surgical malpractice claims. Most errors occur in routine operations with experienced surgeons, under conditions of increased patient complexity or systems failure. Commonly recommended interventions, including restricting high-complexity operations to experienced surgeons, additional training for inexperienced surgeons, and stricter supervision of trainees, are likely to address only a minority of errors. Safety should rather focus on improving decision-making and performance in routine operations for complex patients and circumstances.

Institutional academic industry relationships. *Campbell EG, Weissman JS, Ehringhaus S et al. JAMA. 2007;298:1779.* Relationships between academy and industry may create conflicts of interest. To date there are no empirical data to support the establishment and evaluation of institutional policies and practices related to managing these relationships. A total of 459 department chairs completed a survey, 60% of them having some form of personal relationship with industry, including serving as a consultant (27%), a member of a scientific advisory board (27%), a paid speaker (14%), an officer (7%), a founder (9%), or a member of the board of directors (11%). Institutional academic-industry relationships are then highly prevalent and underscore the need for their active disclosure and management.

1 – THE PELVIC FLOOR

Prevalence and risk factors for pelvic floor symptoms in women in rural El Salvador. *Ozel B, Borchelt AM, Cimino FM, Cremer M. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:1065.* Seventy-one percent of women reported urinary incontinence (UI); 49.3 and 61.1% of women reported urge UI and stress UI, respectively. Forty-one percent of women reported fecal incontinence (FI) of solid or liquid stool. Women with UI were significantly more likely to have had a hysterectomy compared to women without UI. Women with FI had significantly fewer years of education when compared to women without FI.

Gastrointestinal electrical stimulation for treatment of gastrointestinal disorders: gastroparesis, obesity, fecal incontinence, and constipation. *Lin Z, Sarosiek I, McCallum RW.Gastroenterol Clin North Am. 2007;36:713-34.*

2 – FUNCTIONAL ANATOMY

The Integral Theory of continence. *Petros PE, Woodman PJ. Int Urogynecol J Pelvic Floor Dysfunct. 2007 Oct 30; e-pub.* Pros and cons of a unitary view of the pelvic floor.

Effect of micturition on clitoris and cavernosus muscles: an electromyographic study. *Shafik A, Shafik AA, El Sibai O, Shafik IA. Int Urogynecol J Pelvic Floor Dysfunct. 2007 Oct 10; e-pub.* Decreased EMG activity of corpora cavernosa and increased activity of cavernosus muscles during micturition denotes corporal tissue relaxation and cavernosus muscles' contraction. These actions are mediated through the urethro-corporocavernosal reflex and effect a mild degree of clitoral tumescence.

Physiological considerations of the morphologic changes of the testicles during erection and ejaculation: a canine study. *Shafik A, Shafik AA, Shafik IA, El Sibai O. Urol Int. 2007;79:262.* During erection and ejaculation dogs testicles undergo changes in volume, position and temperature. This seems to serve the erectile and ejaculatory functions of the penis.

Physioanatomical relationship of the external anal sphincter to the bulbocavernosus muscle in the female. Shafik A, Shafik IA, el-Sibai O, Shafik AA. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:851. The bulbocavernosus muscle and external anal sphincter anatomically and physiologically constitute a single muscle in males. The study demonstrates a similar pattern in females, and this anatomical structure seems to play dual and yet synchronous roles in fecal control and sexual response.

Vaginal pressure during daily activities before and after vaginal repair. *Mouritsen L, Hulbaek M, Brostrom S, Bogstad J. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:943.* The measurement of vaginal pressure during various daily activities before and after vaginal surgery for pelvic organ prolapse showed that post-operative counselling should concentrate more on treating chronic cough and constipation than restrictions of moderate physical activities.

Vaginal pressure during lifting, floor exercises, jogging, and use of hydraulic exercise machines. *O'Dell KK, Morse AN, Crawford SL, Howard A. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:148.* Comparing exercise and cough pressure with urodynamic equipment it was concluded that vaginal pressure measurement is reproducible in women without prolapse and that exercises produce lower pressure than cough, but individuals varied in pressure exerted.

Evolving Concepts in the Cellular Control of Gastrointestinal Motility: Neurogastroenterology and Enteric Sciences. *Mazzone A, Farrugia G. Gastroenterol Clin North Am. 2007;36:499.* The enteric nervous system is independent, and it is integrated into several other complex systems (interstitial cells of Cajal, immune cells) for an effective coordination of motility, secretion, and blood flow in the gastrointestinal tract. Its complexity is comparable with the central nervous system.

3 – DIAGNOSTICS

Translabial ultrasound assessment of the anal sphincter complex: normal measurements of the internal and external anal sphincters at the proximal, mid-, and distal levels. *Hall RJ, Rogers RG, Saiz L, Qualls C. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:881.* Mean sphincter measurements are given for symptomatic and asymptomatic intact women and are comparable to previously reported endoanal MRI and ultrasound measurements.

Pelvic examination. *Kahwati LC. N Engl J Med. 2007;357:1778.*

The gastrointestinal motility laboratory. *Parkman HP, Orr WC. Gastroenterol Clin North Am. 2007;36:515.* This article addresses important concepts in setting up and running an efficient and practical gastrointestinal motility laboratory, an important area for patient evaluation in gastroenterology and an essential element in any comprehensive digestive disease program.

4 – PROLAPSES

Gene expression in the rectus abdominis muscle of patients with and without pelvic organ prolapse. *Hundley AF, Yuan L, Visco AG. Am J Obstet Gynecol. 2007 Nov 2; epub.* The gene expression in a group of actin and myosin-related proteins of the rectus muscle in 15 patients with pelvic organ prolapse and 13 controls was compared. Only one gene, MYH3, was 3.2 times overexpressed in patients with prolapse, therefore differential messenger ribonucleic acid levels of actin and myosin-related genes in patients with pelvic organ prolapse and controls may be limited to skeletal muscle from the pelvic floor.

Histological features of the rectovaginal septum in elderly women and a proposal for posterior vaginal defect repair. *Nagata I, Murakami G, Suzuki D et al. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:863.* To develop a novel surgical procedure for posterior vaginal defect repair, the rectum-vagina interface tissues obtained from cadavers were examined. The septum, an elastic fiber-rich plate, lines the posterior surface of the vein-rich zone of the vaginal wall, extending between the bilateral paracolpiums and being more evident in the lower half of the interface. Often thin and interrupted, it is not so clearly demonstrated in the upper vagina histologically, therefore augmentation using some implant is considered necessary for treating enterocele and high rectocele.

How accurate is symptomatic and clinical evaluation of prolapse prior to surgical repair? *Fayyad A, Hill S, Gurung V et al. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:1179.* To assess the accuracy of pre-operative evaluation of pelvic organ prolapse 104 patients admitted for prolapse surgery were enrolled in an audit. Examinations in theatre were different from clinic findings in 37% of the cases for degree of prolapse and the prolapse being in a different vaginal compartment. The operation performed was different from the one proposed in the clinic in 21% of the cases. Patients should be counselled about this when listed for surgery.

Is there a difference in patient and physician quality of life evaluation in pelvic organ prolapse? *Srikrishna S, Robinson D, Cardozo L, Gonzalez J. Int Urogynecol J Pelvic Floor Dysfunct. 2007 Oct 16;epub.* Quality of life assessment is important in the evaluation of women with urogenital prolapse, but using the Prolapse Quality of Life questionnaire the outcomes based on the physicians' perspective may not be valid compared to those completed by the patient.

Follow-up after polypropylene mesh repair of anterior and posterior compartments in patients with recurrent prolapse. *Gauruder-Burmester A, Koutouzidou P, Rohne J et al. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:1059.* In a total of 120 patients with recurrent cystocele and/or rectocele or with combined vaginal vault prolapse treated by either posterior (Apogee) or anterior (Perigee) mesh interposition depending on the defect, after 1 year 93% were free of vaginal prolapse, 7% had level 2 defects. Erosions occurred significantly more often in patients treated with the Perigee system.

Conservation of the prolapsed uterus is a valid option: medium term results of a prospective comparative study with the posterior intravaginal slingoplasty operation. *Neuman M, Lavy Y. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:889.* To evaluate the therapeutic significance of hysterectomy when vaginal apical prolapse is reconstructed with posterior intravaginal slingplasty (PIVS), 44 out of 77 underwent concomitant vaginal hysterectomy. The current results support the previously reported efficacy, safety, and simplicity of the PIVS procedure as well as the legitimacy of uterine preservation. Moreover, unstable bladder symptoms were found to be improved after this operation. However, long-term data are required to be able to draw solid conclusions concerning the superiority of the discussed operation.

Is hysterectomy or the use of graft necessary for the reconstructive surgery for uterine prolapse? *Jeon MJ, Jung HJ, Choi HJ et al. Int Urogynecol J Pelvic Floor Dysfunct. 2007 Oct 10; epub.* The use of graft, rather than hysterectomy, might be necessary for the reconstructive surgery for uterine prolapse. This was proven in 168 patients with abdominosacral colpopexy using mesh and hysterectomy (group l); abdominosacral uteropexy with mesh (group II), abdominal uterosacrocardinal colpopexy and hysterectomy (group III). After a 36 months follow-up recurrence in group III was 6.2 times higher than in group I.

Day case laparoscopic rectopexy is feasible, safe, and cost effective for selected patients. *Vijay V, Halbert J, Zissimopoulos A et al. Surg Endosc. 2007 Oct 18;epub. Since 2001,* 28 patients have undergone procedures for rectal prolapse and of 12 laparoscopic rectopexy patients, 5 were selected for day case, which appeared to be is safe, feasible, and acceptable for selected well-motivated patients. Compared with Delorme's procedure and inpatient laparoscopic rectopexy, savings of £1,000 per patient can be achieved because of an average 3-day decrease in bed occupancy.

Laparoscopic rectopexy without resection: a worthwhile treatment for rectal prolapse in patients without prior constipation. *Hsu A, Brand MI, Saclarides TJ. Am Surg. 2007;73:858.* Anterior resection with rectopexy is indicated in rectal prolapse for fear that sigmoid redundancy will cause disabling constipation. After treating 12 patients with rectopexy to the presacral fascia with Nurolon sutures and a 3-75 months follow up, the Authors believe that resection is not necessary in patients without preexisting constipation.

5 – RETENTIONS

Prevalence and associated risk factors of retention of urine after caesarean section. *Chai AH, Wong T, Mak HL. Int Urogynecol J Pelvic Floor Dysfunct. 2007 Oct 12; epub.* Caesarean section poses higher risk of postpartum urinary retention (PUR) than vaginal delivery with a prevalence of 3.38. Lack of progress of labor is a significant associated factor.

[Our experience with the urolume intraurethral prosthesis] *Garcia Penalver C, Parra Escobar JL et al. Arch Esp Urol. 2007;60:731.* Urolume is a stent type, non magnetic, self expanding urethral endoprosthesis indicated to keep the urethral lumen in cases of infravesical obstruction in 17 males, 10 with symptoms of BPH and 7 with bulbar urethral stenosis. This is a safe and simple technique, which may be performed under local anesthesia as outpatient surgery. It has a low complication rate. It significantly improves the flowmetry parameters and symptom questionnaire results. It is a very good option to be taken into consideration in older patients, with chronic urinary retention and high surgical risk or in patients with short bulbar urethral stenosis without previous skin flap urethroplasty.

Constipation: evaluation and treatment of colonic and anorectal motility disorders. *Rao SS. Gastroenterol Clin North Am. 2007;36:687.* The Rome criteria may be a useful guide for a clinical diagnosis of functional constipation that consists of three overlapping subtypes: slow transit constipation, dyssynergic defecation, and irritable bowel syndrome with constipation. An evidence-based approach considers specific drugs such as tegaserod and lubiprostone, and biofeedback for dyssynergia.

Constipation and Irritable Bowel Syndrome in the elderly. *Morley JE. Clin Geriatr Med. 2007;23:823.* Lifestyle changes, osmotic laxatives, and lubiprostone are the approaches of choice for the management of constipation in old age.

Idiopathic slow transit constipation is rare: But delayed passage of meconium is common in the constipation clinic. *Croaker GD, Pearce R, Li J. Pediatr Surg Int. 2007 Oct 31; epub.* There is no evidence for a supposed effect of social class in a population having truly idiopathic slow transit constipation which in itself is rare.

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6 – INCONTINENCES

Changes in urinary and fecal incontinence symptoms with weight loss surgery in morbidly obese women. *Burgio KL, Richter HE, Clements RH. Obstet Gynecol. 2007;110:1034.* In 101 women with BMI of 40 or more undergoing laparoscopic Roux-en-Y gastric bypass and followed to 6 and 12 months, presence, severity, and effect of UI were assessed using the Medical, Epidemiological, and Social Aspects of Aging Questionnaire, Urogenital Distress Inventory, and Incontinence Impact Questionnaire. Fecal incontinence was assessed by self-report of anal leakage. Mean BMI decreased from 48.9 to 30.2 at 12 months postsurgery. Prevalence of UI decreased from 66.7% to 37.0%, and fecal incontinence (solid or liquid stool) from 19.4% to 8.6%.

Hysterectomy and risk of stress-urinary-incontinence surgery: nationwide cohort study. *Altman D, Granath F, Cnattingius S, Falconer C. Lancet 2007;370:1494.* Hysterectomy for benign indications, irrespective of surgical technique, increases the risk for subsequent stress-urinary-incontinence surgery. Women should be counselled on associated risks related to hysterectomy, and other treatment options should be considered before surgery.

[Intravaginal device for the outpatient treatment of stress urinary incontinence: technique and preliminary results]. *Bouffier B. Prog Urol. 2007;17:983.* In 2005, a prospective study was conducted on 37 patients (pure stress, mixed, recurrent urinary incontinence associated with prolapse in 6 cases) with suburethral tape as an outpatient procedure, simplified to decrease the disadvantages of suburethral prostheses. Exclusively intravaginal it avoids skin incisions and the passage of needles. An umbrella is deployed behind each obturator foramen or behind the perineal membrane in order to maintain a fine tape, the other extremity of which is past through a 2 cm prosthesis, then folded on itself to allow tension-free maintenance of the prosthesis under the urethra without catheter. No postoperative complications were observed at 1 year. with 1 immediate failure and 36 cured patients; 9 out of 12 patients no longer experience any urgency.

The effect of mode of delivery, parity, and birth weight on risk of urinary incontinence. *Connolly TJ, Litman HJ, Tennstedt SL et al. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:1033.* The relationship between urinary incontinence (UI) and mode of delivery, parity, and birth weight was examined in a population sample of 3,205 women. Measures include UI symptoms [>or=3 (moderate/severe) Sandvik's severity index]; reproductive history [live birth(s), no live births, never pregnant]; mode of delivery for live births (>or=1 vaginal birth, cesarean delivery only); parity (1, 2, >or=3); and maximum birth weight of live births (<4,000 g, >or=4,000 g). Women with >or=1 vaginal delivery had twice the odds of UI compared to women with no pregnancies (P = 0.002) or only cesarean deliveries (P = 0.032). There was no difference in odds of UI between cesarean delivery only and never pregnant, by parity or birth weight.

Neobladder overactivity; an equivalent to spontaneous rectal contraction. *Sakakibara R, Awa Y, Naya Y et al. Int J Urol. 2007;14:1054.*

Is the role of Burch colposuspension fading away in this epoch for treating female urinary incontinence? *Ng S, Tee YT, Tsui KP, Chen GD. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:937.* The role of Burch colposuspension (BC) as the primary surgical treatment of stress urinary incontinence has been challenged by less invasive methods. To evaluate the long-term results of BC in terms of subjective self-reported outcomes, 159 women who underwent BC between 1993 were evaluated: 55.3% were dry, 36.2% women had improved, and 8.5% had failed; 82.2% were satisfied. BC is an effective alternative surgery for urodynamic proven stress incontinence.

Tension-free vaginal tape for stress incontinence in women with detrusor overactivity. *Basu M, Duckett JR. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:1097.* This is a case report which reviews the literature including the postulated mechanism by which stress leakage due to detrusor overactivity is cured by the TVT.

External iliac artery injury during insertion of tension-free vaginal tape: a case report and literature review. *Sivanesan K, Abdel-Fattah M, Ghani R. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:1105.* Serious vascular injuries after TVT insertion are rare but the clinician should be able to suspect them and patients have to be fully counselled about them. A case of external iliac artery injury was managed successfully by surgical intervention. The literature regarding major vascular injuries and their management is reviewed.

Late erosions of mid-urethral tapes for stress urinary incontinence--need for long-term follow-up? *Mesens T, Aich A, Bhal PS. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:1113.* There is a need for long-term follow-up of patients with TVT. Erosion of the synthetic mesh is a well-described complication where the mean time for the onset is 11.2 months, but there are case reports describing uncommon erosions after 18 and 28 months.

Symptom change in women with overactive bladder after extracorporeal magnetic stimulation: a prospective trial. *Choe JH, Choo MS, Lee KS. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:875.* A prospective evaluation of symptom change after discontinuation of extracorporeal 10 Hz magnetic stimulation was done in 48 women with overactive bladder (OAB) treated with a "magnetic chair" (20 min, twice weekly for 8 weeks). Compared with the baseline 56.3% patients were cured at 2 weeks, and 96.3% among these patients maintained improvement at 24 weeks. In 14 patients with detrusor overactivity the condition was no longer observed in four (28.6%).

A prospective randomised double-blind controlled trial evaluating the effect of trans-sacral magnetic stimulation in women with overactive bladder. *O'Reilly BA, Fynes M, Achtari C et al. Int Urogynecol J Pelvic Floor Dysfunct. 2007 Oct 12; epub.* Transcutaneous electrical nerve stimulation and neuromodulators have success in treating OAB but are expensive, invasive, and sometimes cumbersome. An alternative neuromodulatory technique involving electromagnetic stimulation of the sacral nerve roots with a portable electromagnetic device to produce trans-sacral stimulation of the S3 and S4 sacral nerve roots was tried, but resulted ineffective.

Efficacy, safety and tolerability of fesoterodine for overactive bladder syndrome. *Nitti VW, Dmochowski R, Sand PK et al. J Urol. 2007 Oct 13; epub.* Two 4 mg doses of fesoterodine, a new antimuscarinic agent, are well tolerated and statistically significantly improve overactive bladder symptoms.

Malone antegrade continence enema (MACE) for fecal incontinence in imperforate anus improves quality of life. *Mattix KD, Novotny NM, Shelley AA, Rescorla FJ. Pediatr Surg Int. 2007 Oct 16; epub.*

Fecal incontinence in older adults. *Tariq SH. Clin Geriatr Med. 2007;23:857.* Fecal incontinence is an underreported and underappreciated problem in older adults more common in women than in men. Risk factors that lead to the development of fecal incontinence include dementia, physical disability and fecal impaction. Treatment options include medical or conservative therapy for older adults who have mild incontinence, and surgical options can be explored in selected older adults if surgical expertise is available.

Outcome of primary repair of obstetric anal sphincter rupture using the overlap technique. *Molander P, Vayrynen T, Paavonen J et al. Acta Obstet Gynecol Scand. 2007;16:1.* In grade III and IV anal sphincter ruptures after vaginal delivery the primary overlap technique is highly successful after a median follow-up of 9.4 months (61 consecutive women from 2002 to 2004). Endoanal ultrasonography revealed intact external sphincter in 83% of the patients.

Is a morphologically intact anal sphincter necessary for success with sacral nerve modulation in patients with faecal incontinence? *Melenhorst J, Koch SM, Uludag O, van Gemert WG, Baeten CG Colorectal Dis. 2007 Oct 19; epub.* Two groups of patients were analysed retrospectively to determine whether sacral nerve modulation is as effective in patients with faecal incontinence associated with an anal sphincter defect as in those with a morphologically intact anal sphincter following anal repair, and it was concluded that an anal sphincter defect of <33% of the circumference can be effectively treated primarily with SNM without repair.

The artificial bowel sphincter for faecal incontinence: a single centre study. *Melenhorst J, Koch SM, van Gemert WG, Baeten CG. Int J Colorectal Dis. 2007 Oct 10; epub.* Large anal sphincter defects can be treated by sphincter replacement procedures: the dynamic graciloplasty and the artificial bowel sphincter (ABS). Among 33 patients (25 women) with an ABS followed-up for 0.8-106.3 months, and with a significant improvement of the incontinence score, 7 patients had an infection necessitating explantation. One patient was successfully reimplanted.

7 – PAIN

Short-term results of bilateral S2-S4 sacral neuromodulation for the treatment of refractory interstitial cystitis, painful baldder syndrome, and chronic pelvic pain. *Zabihi N, Mourtzinos A, Maher MG. Int Urogynecol J Pelvic Floor Dysfunct. 2007 Oct 10; epub.* In 30 consecutive patients (21 female, 9 male) with severe refractory symptoms undergone bilateral S2-S4 sacral neuromodulation there was a 42% improvement in symptoms. SF-36 scores did not improve significantly. In refractory patients, bilateral caudal epidural sacral neuromodulation is another possible mode of treatment, which appears to improve both pelvic pain and voiding symptoms.

Endometriomas are more frequent on the left side. *Sznurkowski JJ, Emerich J. Acta Obstet Gynecol Scand. 2007; 16:1.* A left lateral predisposition of endometrioma may be caused by the presence of the sigmoid colon in the left side of the pelvis, which decreases peritoneal fluid movement. These findings may support the transplantation theory of the origin for endometriosis. Ovarian cancer could accompany endometrioma.

Improvement in vulvar vestibulitis with montelukast. *Kamdar N, Fisher L, MacNeill C. J Reprod Med. 2007;52:912.* Montelukast was administered to a series of patients with vestibulitis over a period of 2.5 years. Subjects treated with montelukast showed an average of 52% in improvement in symptoms as compared to a 15% improvement in the controls. This finding implies that leukotrienes have a role in the pathophysiology of vulvar vestibulitis.

Irritable bowel syndrome: current approach to symptoms, evaluation, and treatment. *Videlock EJ, Chang L. Gastroenterol Clin North Am. 2007;36:665.* Symptoms, comorbidities, gender differences, measure of severity in irritable bowel syndrome, current and evidence-based approaches to evaluation and treatment, and the new symptom-based Rome III diagnostic criteria are reviewed and explained.

No difference in symptoms of irritable bowel syndrome between healthy subjects and patients with recurrent depression in remission. *Karling P, Danielsson A, Adolfsson R et al. Neurogastroenterol Motil. 2007;19:896.* There is bidirectional comorbidity between anxiety/depression and irritable bowel syndrome (IBS). To investigate the prevalence of IBS symptoms and factors associated with gastrointestinal symptoms in case of recurrent depressive disorder, 95 patients were investigated. Patients with recurrent depression had higher Gastrointestinal Symptom Rating Scale-IBS scores and showed a strong correlation between symptoms of IBS and anxiety-depression. IBS symptoms were also associated with multiple pain symptoms, higher health-seeking behaviour and selective-serotonin-reuptake inhibitor intake. Depressive patients in remission do not have more IBS symptoms than controls.

8 – FISTULAE

Congenital vesicovaginal fistula with transverse vaginal septum and ectopic ureter opening in proximal vagina: case report and brief review. *Kumar S, Mandal A, Acharya N. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:959.* Congenital vesicovaginal fistula is extremely rare. A 22-year-old woman with menouria and infertility was found to have congenital vesicovaginal fistula, a nonfunctioning right kidney with ectopic ureter and transverse vaginal septum. Abdominal repair of the fistula, right nephroureterectomy, and excision of the vaginal septum was performed.

Rectocutaneous fistula: a rare complication of the posterior intravaginal sling. *Yee YH, Lu CC, Kung FT, Huang KH. Int Urogynecol J Pelvic Floor Dysfunct. 2007 Oct 10; epub.* The posterior intravaginal sling (IVS) is a device used to correct apical vaginal prolapse; there are limited data on associated complications. A case of a rectocutaneous fistula after placement of a posterior IVS in a 59-year-old woman 2 months postoperatively is reported. The sling was resected during sigmoidoscopy with scissors, and the colon laceration was closed. The buttock wound underwent delayed healing 2 weeks later.

Anopenile urethral fistula (APUF). *Ohno K, Nakamura T, Azuma T et al. Pediatr Surg Int. 2007 Nov 1; epub.* According to the embryological studies of the anorectum, APUF could occur due to an incomplete descent of the urorectal septum, or a failed disappearance of the dorsal cloacal membrane, and excessive elongation of the urorectal septum in the phallus. Complete removal of the fistula in the corpus spongiosum penis is unnecessary.

9 – BEHAVIOUR, PSYCHOLOGY, SEXOLOGY

Psychological distress associated with colposcopy: Patients' perception. *Tahseen S, Reid PC. Eur J Obstet Gynecol Reprod Biol. 2007 Oct 31; epub.* To develop an understanding of factors associated with anxiety in relation to cervical screening and colposcopy, the advantages of information leaflet, video-screen display, nursing and medical intervention and exploration of medical terms, were evaluated. Prior to attendance 36% of patients felt they were very worried, 54% slightly worried and 10% not worried. All patients found the standardised NHS information leaflet helpful to a variable degree, 30% found watching on a video-screen display very helpful, whilst a significant number (18%) found it increased their worry. Women with pre-existing high level of anxiety were least satisfied with indices examined. Research should focus on the 'very anxious' women, as they are least satisfied with existing measures in place to reduce anxiety. However this may not be possible.

"You're not a victim of domestic violence, are you?" Provider patient communication about domestic violence. *Rhodes KV, Frankel RM, Levinthal N et al. Ann Intern Med. 2007;147:620.* Victims of domestic violence frequently seek care in an emergency department. The communication between emergency providers and female patients has been analysed. Nonverbal communication was not examined. Providers typically asked about domestic violence in a perfunctory manner during the social history. Provider communication behaviors associated with women disclosing abuse included probing (defined as asking > or =1 additional topically related question). Although hectic clinical environments present many obstacles to meaningful discussions, several provider communication behaviors seemed to facilitate patient disclosure of experiences with abuse.

Sexual function following surgery for urodynamic stress incontinence. *Jha S, Moran P, Greenham H, Ford C. Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:845.* Surgical correction of stress incontinence is associated with an improvement in sexual function. This was demonstrated comparing the Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ), the International Consultation on Incontinence Questionnaire (ICIQ) and the Patient Global Impression of Improvement sexual function in women before and after surgery for urodynamic stress incontinence in the absence of pelvic organ prolapse. Previous vaginal surgery, oestrogen status of respondents and hysterectomy status did not affect the PISQ.

Female sexual dysfunction. *Aslan E, Fynes M. Int Urogynecol J Pelvic Floor Dysfunct. 2007 Nov 1; epub.* Female sexual dysfunction is defined as disorders of sexual desire, arousal, orgasm, and sexual pain, which lead to personal distress, the etiology being frequently multifactorial and related to general physical and mental well-being, quality of relationship, past sexual functioning, social class, education, employment, life stressors, personality factors, presence of a sexual partner, partner's age and health. It is very important to adopt the most efficient approach to gather information, and this may be achieved via standardized questionnaires or open-ended questions. Therapy may involve a multidisciplinary team approach including psychosexual counselor/sexologist/therapist and the physician.

Sexual dysfunction associated with antidepressant therapy. *Segraves RT. Urol Clin North Am. 2007; 34:575.* When patients on psychiatric drugs, especially antidepressants, complain of sexual dysfunction, it is important that the clinician take a careful history and it is possible that simple interventions may maintain the desired effect of the drugs eliminating sexual side effects.

Coital urinary incontinence: impact on quality of life as measured by the King's Health Questionnaire (KHQ). *Espuna Pons M, Puig Clota M. Int Urogynecol J Pelvic Floor Dysfunct. 2007 Nov 1; epub.* Among 633 sexually active women seeking treatment for UI and/or overactive bladder in a gynecological clinic, aged between 24 and 83 years, prevalence of coital incontinence was 36.2%, classifying this impact on QoL (KHQ) score as low (59.8%), moderate (32.3%), and high (7.9%).

10 – MISCELLANEOUS

Development, standardization, and evaluation of NOTES cholecystectomy using a transsigmoid approach in the porcine model: an acute feasibility study. *Meining A, Wilhelm D, Burian M et al. Endoscopy. 2007;39:860.* Transluminal cholecystectomy is feasible but poorly standardized so far. A transsigmoid approach for cholecystectomy with minimal transabdominal assistance is performed in the porcine model in a relatively fast way with acceptable complication rates.

Implant infection after two-stage sacral nerve stimulator placement. *Washington BB, Hines BJ Int Urogynecol J Pelvic Floor Dysfunct. 2007;18:1477.* After stage II neurostimulator placement for refractory cases of urge urinary incontinence, urinary frequency, and non-obstructive urinary retention, 5 out of 37 (13.5%) women required device removal for culture positive wound infections occurring a minimum of 33 days, a median of 76 days, and a maximum of 461 days after implantation. The most common pathogen cultured was Staphylococcus aureus. After device removal, all infections resolved. Two patients underwent uncomplicated reimplantation in the contralateral buttock 14 and 16 days after stimulator removal.