AGES PELVIC FLOOR SYMPOSIUM & WORKSHOP V

15 | 16 OCTOBER 2004
ADELAIDE | HILTON
FLINDERS PRIVATE
HOSPITAL | ADELAIDE

PRIMARY VAGINAL REPAIR – GETTING IT RIGHT

Renowned USA Vaginal Surgeon
Professor Carl Zimmerman
Vanderbilt University
Nashville Tennessee

stryker® PLATINUM SPONSOR OF AGES
Saturday 16 October 2004

Ballroom A & B
Hilton Adelaide

0730 – 0800 Registration

0800 – 0810 Presidential Welcome
R. O’Shea

0810 – 0830 PR and CRM Session

0830 – 0845 Pearls on Pelvic Floor Defects
Including a video presentation
by C. Richardson
V. Lamaro

0850 – 0930 Debate: Endopelvic Fascia
Does Exist
Yes – A. Lam
C. Maher
No – P. Dwyer
O. Onuma

0930 – 1000 Current Concepts in Endopelvic
Fascial Anatomy
C. Zimmerman

1000 – 1030 Morning Tea & Exhibition

1030 – 1230 SESSION 1
SPONSORED BY STRYKER
Endopelvic Fascia –
is it the Holy Grail?
Chair:
(1) P. Maher
(2) C. Verco

0830 – 0845 Pearls on Pelvic Floor Defects
Including a video presentation
by C. Richardson
V. Lamaro

0850 – 0930 Debate: Endopelvic Fascia
Does Exist
Yes – A. Lam
C. Maher
No – P. Dwyer
O. Onuma

0930 – 1000 Current Concepts in Endopelvic
Fascial Anatomy
C. Zimmerman

1000 – 1030 Morning Tea & Exhibition

1030 – 1230 SESSION 2
SPONSORED BY OLYMPUS
Anterior Vaginal Reconstruction
– Moving on from mid-line
Plication
Chair:
(1) G. Burton
(2) J. Tsaltas
(3) O. Petrucco

1030 – 1050 Transvaginal Site-specific
Anterior Repair
C. Zimmerman

1050 – 1105 Laparoscopic Paravaginal Repair
R. O’Shea

1105 – 1120 Mesh Repair
M. Carey

1110 – 1130 Discussion

1130 – 1230 Challenging Complications –
Transponder Case Presentations
Chair:
(1) A. Yazdani
(2) P. Dwyer

1130 – 1150 Post-operative Vaginal Discharge
C. Zimmerman

1150 – 1210 Post-operative Oliguria
J. Cook

1210 – 1230 Dyspareunia and Vaginal
Discharge
G. Hamdorf

1230 – 1330 Lunch & Exhibition

1330 – 1500 SESSION 3
SPONSORED BY OLYMPUS
New Techniques & Complications
Chair:
(1) J. Taylor
(2) R. Garry

1330 – 1350 Site-specific Posterior
Vaginal Reconstruction
C. Zimmerman

1350 – 1405 Laparovaginal Mesh Repair of
Posterior Prolapse
G. Cario

1405 – 1425 Transobdurator Tape –
Where does it fit in?
A. Rane

1425-1440 What do you do when there
is no blue?
S. Evans

1440 – 1500 Discussion

1500 – 1530 Afternoon Tea & Exhibition

1530 – 1700 SESSION 4
SPONSORED BY STRYKER
Practical Problem Solving
Chair:
(1) E. Lombardi
(2) A. Lam

1530 – 1550 Panel: C. Zimmerman
M. Tudor
N. Rieger (Colorectal)
V. Gill (Physio)
M. McEvoy (Gynaecologist)

1550 – 1600 Dyspareunia & Difficult
Rectal Evacuation After
Posterior Repair

1630 – 1700 Chair:
(2) G. Reid
(2) R. Kuhn

How to Write a Legal Report –
Quantifying Disability
M. Byrnes (Lawyer)
M. McEvoy (Gynaecologist)

1700 – 1720 PR and CRM Points – Post Test

1720 Close – Conference Chairman

1930 for 2000 Conference Dinner
Sponsored by Stryker
Bridgewater Mill, Bridgewater
SITE-SPECIFIC COLPOCLEISIS WITH TOTAL VAGINECTOMY AND VAGINAL PARAVAGINAL REPAIR

Carl W. Zimmerman, M.D.
Professor of Obstetrics and Gynecology
Vanderbilt University School of Medicine
Nashville, Tennessee

Colpocleisis is an anatomically distorting operation useful in some patients with advanced and problematic prolapse. This procedure works best when loss of support and suspension is complete and is not useful in an incomplete prolapse. Candidates for this operation include those with failure of previous surgical and conservative treatments, advanced prolapse, compromised medical status, and a desire to minimize the possibility of recurrence while improving quality of life. An absence of desire for coital function is necessary in order to offer or perform the operation. Traditionally, this operation has been offered to very elderly patients with limited mobility and life-span. In fact, any patient who is properly informed and who places a premium on permanent reduction of an advanced prolapse is a candidate for the procedure.

The technique described in this presentation is more involved than the LeFort procedure; however, it can be successfully tolerated by the population of patients usually offered traditional colpocleisis. A complete midline incision is made, and the deep endopelvic connective tissue is separated from the vaginal epithelium all the way to the pelvic sidewall. A vaginal paravaginal paravesical repair is performed to restore midvaginal lateral support and to benefit urinary function. Any paravaginal pararectal defect is identified and repaired. The transverse proximal edges of the rectovaginal and pubocervical septa are then connected by a row of permanent sutures effectively obliterating the urogenital hiatus. Vaginal epithelium in the proximal vagina is removed to accomplish total vaginectomy, and a simple skin closure completes the operation. The result is a structurally sound reduction of all pelvic hernias with native endopelvic fascia.

UTEROUREDUCITIVE VAGINAL Hysterectomy

Carl W. Zimmerman, M.D.
Professor of Obstetrics and Gynecology
Vanderbilt University School of Medicine
Nashville, Tennessee

The methods used in vaginal removal of the enlarged uterus are described in this lecture. Surgical technique, instrumentation, and helpful tips are included in the presentation. The key concepts for successful vaginal hysterectomy are:

1. surgical transection of the uterosacral, cardinal, and pubourethral ligaments
2. ligation of the uterine artery
3. surgical entry into the peritoneal cavity

Once these steps are accomplished, progressive debulking of the uterine fundus may be accomplished using morcellation, coring, cervicectomy, or bivalving. Proper instrumentation, lighting, and the availability of experienced assistants are key requirements for this operation. Useful instruments include atraumatic hysterectomy clamps, vulsellum clamps, cartilage scissors, and myotomes.

When the proper anatomical steps are followed, significantly enlarged uteri may be removed vaginally with no increased morbidity to the patient.
Surgical techniques used in the removal of the adnexa at the time of vaginal hysterectomy without the use of abdominal endoscopy are described. Familiarity and comfort with this operation significantly increases the percentage of hysterectomies that can be performed by the vaginal approach. When compared to the abdominal approach, the patient benefits from the vaginal approach by lower cost, significantly shorter recovery time, and lower morbidity. When compared to the laparoscopically assisted approach, the vaginal operation is less costly while recovery and morbidity are equivalent.

A three-step anatomical approach to adnexectomy makes this operation considerably easier to perform. These steps are:

1. ligation of the round ligament and consequent entry into the broad ligament space
2. ligation of the mesovarium
3. ligation of the infundibulopelvic ligament.

When these steps are followed, the vast majority of adnexae may be removed successfully and safely. Division of the surgical process into three manageable steps allows the tube and ovary to be progressively released and safely removed.

CATHETERS - WHEN AND WHICH ONE?

John Taylor
Adelaide Women’s Pelvic Surgery Unit,
Modbury Hospital,
South Australia

This session will introduce the relationship between chronic and acute infections associated with short and long term catheterisation, and the indications for indwelling urinary catheters, suprapubic catheters, and intermittent clean catheterisation.

The incidence of infection in the presence of indwelling urinary catheters is 3-10% per day compared to suprapubic catheters that reduce this figure to 3-7% per week. The use of prophylactic antibiotic treatment only results in infection with resistant organisms.

Intermittent clean catheterisation should be accompanied by antibiotics for the first 2-3 weeks, and then ceased. Infection can be managed by regular emptying of the bladder, technique, and practice.

Postoperative bladder drainage by indwelling urethral catheters should be time limited to prevent infection and mucosal damage.

The use of fine indwelling urethral catheters past which micturition can occur may reduce infection rates, and mucosal irritation.

Bladder management strategy may need to be reviewed on a daily basis to ensure that retention is not a problem, and should be aimed at removing indwelling catheters as soon as possible.
DOES ENDOPELVIC FASCIA EXIST?

Introduction debate:
Christopher Maher, Brisbane

Gynaecology surgeons, anatomists and histopathologists have argued for decades about the nature of vaginal tissue and its relationship with pelvic floor muscles. Opinion can be roughly divided between those that believe the vagina is enveloped in connective tissue and those that do not.

The basic tenets of teaching the anterior and posterior colporrhaphy rely on the midline plication of “endopelvic fascia”. Histopathologists suggest that no such fascia exist and that this dissection is merely the separation of the layers of the vagina. They believe the fascia is an incorrect histological term and should be replaced as ligaments for level 1 support (uterosacral and cardinal), adventitia for rectovaginal or pubocervical fascia level II support and perineal body and membrane for level III support.

Today our debaters will describe anatomy, histology and outcomes of surgical repairs of the female pelvic floor so as to fully inform you of all aspects of the relevance of “endopelvic fascia”. Sit back, learn and enjoy.

References

ENDOPELVIC FASCIA. WHAT IS IT? WHERE IS IT? WHAT DOES IT DO?

Carl W. Zimmerman, M.D.
Professor of Obstetrics and Gynecology
Vanderbilt University School of Medicine
Nashville, Tennessee

Connective tissue in the pelvis consists of three types:
1. parietal fasciae
2. visceral fasciae
3. deep endopelvic connective tissue or endopelvic fascia.

The functions, named components, and location of each of these tissue types are described in this lecture. Particularly important to the pelvic surgeon are the structures of the endopelvic fascia. These structures are used in site-specific pelvic reconstructive surgery. They are distinct entities that are interconnected within a three-dimensional support and suspensory structure. The mechanical function of the deep endopelvic connective tissue is to prevent prolapse of the central pelvic organs and structures through the urogenital hiatus. When prolapse occurs, specific sites of damage to the endopelvic fascia can be identified and repaired through the processes of careful dissection and site-specific repair.
LAPAROSCOPIC PARAVAGINAL REPAIR

Robert O'Shea, Elvis Seman, Jenny Cook, Fariba Willison
Flinders Endogynaecology
Flinders University & Flinders Medical Centre
Adelaide, South Australia

The proposed aetiology of anterior compartment defects has changed little through the 20th century. Although the standard concept of thinning of supporting tissue has prevailed, White (1909) proposed repair of paravaginal defects in this situation. Richardson (1976) isolated pubocervical fascial defects although the standard approach to anterior compartment prolapse remains midline plication. Anterior colporrhaphy has produced symptomatic and objective failure rates of 3-20% and 54-70% respectively, whereas vaginal, paravaginal repair success rates are 1-4% and 20-24% respectively. The diagnosis of paravaginal defects is usually made on vaginal examination.

Repair of these defects has proved difficult vaginally. The laparoscopic approach offers unrivalled access and visibility. To date, 204 patients have undergone this procedure. All have been objectively scored preoperatively and annually followed-up postoperatively using POPQ, resulting in a 93% cure rate with an average follow-up of 48 weeks (1-212). When combined with midline plication, this improved to 94% (average follow-up 122 weeks [48-208]).

Paravaginal repair is an established approach to anterior compartment defects. The laparoscopic approach offers considerable advantages. Results to date are encouraging and offers improved cure rates for anterior compartment prolapse.

VAGINAL PARAVAGINAL REPAIR: A NECESSARY COMPONENT OF ANTERIOR VAGINAL RECONSTRUCTION

Carl W. Zimmerman, M.D.
Professor of Obstetrics and Gynecology
Vanderbilt University School of Medicine
Nashville, Tennessee

Traditionally, anterior vaginal reconstructions have been performed using a midline plication of endopelvic fascia. This operation was developed because of a perceived weakness in the pubocervical septum. High failure rates and significant anatomical distortion caused by this operation has led to a reassessment of the problem of anterior vaginal prolapse.

Careful dissection and identification of tissue types reveals a predominance of full-length paravaginal defects in combination with a transverse proximal separation of the pubocervical septum. Deducive reasoning applied to the cardinal movements of labor dictates that the majority of these paravaginal defects are on patient right. In a large prolapse, the detached edge of the septum is commonly retracted to the contralateral side of the midline from the site of paravaginal separation.

Dissection and surgical techniques are described that allow for site-specific anterior vaginal reconstruction. Full-length and full-width exposure of the vesicovaginal space is required. The fascial separations are repaired with permanent sutures. Anatomical distortion is minimized. Vaginal depth, axis, and caliber are maximized.
MESH REPAIR

Dr Marcus Carey
Royal Women's Hospital, Melbourne

Many different vaginal, abdominal and laparoscopic procedures have been described to treat pelvic organ prolapse and there is currently no consensus on the most effective operation. Approximately 200,000 women undergo surgery for pelvic organ prolapse in the United States each year (1). About 22,000 operations for pelvic organ prolapse are performed annually in Australia. Traditional vaginal surgery for pelvic organ prolapse is associated with a failure rate of 29.2% (2). In recent years surgeons have increasingly used mesh to augment vaginal repair procedures in order to obtain more durable results. However, most of the meshes currently in use have been designed for anterior abdominal wall hernia surgery and are too heavy-weight for vaginal surgery. Recently, meshes specifically designed for vaginal surgery have been released for commercial use (e.g. Gynecare Gynemesh PS*, Johnson & Johnson).

Advantages of using mesh
- Mesh provides durable support (reduces recurrence rates)
- Mesh avoids donor site incision (c.f. rectus fascia, fascia lata)
- Mesh avoids Viral/DNA/Prion transmission (c.f. dura, donor fascia lata, pig dermis)
- Mesh stabilizes tissues improves wound strength

Mesh Complications
- Infection and sinus tract formation
- Seroma
- Erosion and fistula formation
- Intestinal adhesions/obstruction
- Shrinkage, folding and crimpling
- Dyshpareunia
- Pain

Indications for using mesh (mesh does not replace good surgery)
- Research lacking on when to use and where to attach mesh for vaginal surgery
- Mesh should be used only when required:
  - Previous failed surgery
  - Poor "native tissue"
  - Other risk factors (obesity, level of physical activity, etc)
  - During abdominal or laparoscopic sacral colpopexy
  - Clinical trials in tertiary centres

References
DYSPAREUNIA AND VAGINAL DISCHARGE

Graham Hamdorf
Adelaide
M.B.B.B, FRANZCOG, FRCOG

The case I am presenting is a good example of a not uncommon problem we all see and will see more of in the future, in view of the increased use of synthetic mesh in vaginal surgery. The clinical scenario is aimed at trying to encourage the audience to respond to the various choices of management options, which are available in all of these cases.

The Cases:
1. Recurring prolapse and mesh erosion following previous prolapse surgery.
2. The choice of abdominal versus vaginal repair.
3. The use of the laparoscope in the repair and the question of involving other colleagues, e.g. colorectal surgeons in the management.

POSTERIOR VAGINAL RECONSTRUCTION USING BILATERAL VAGINAL UTEROSACRAL COLPOPEXY: THE NEW POSTERIOR REPAIR

Carl W. Zimmerman, M.D.
Professor of Obstetrics and Gynecology
Vanderbilt University School of Medicine
Nashville, Tennessee

Traditional repair of posterior vaginal prolapse has consisted of midline plication of the levator muscles to compensate for the perceived weakness in the rectovaginal septum. Because of surgical failures, anatomical distortion, and life-long dyspareunia, reexamination of this problem has occurred. Deductive reasoning can be applied to determine the effect of the cardinal movements of labor on the rectovaginal septum. A proximal transverse separation of the rectovaginal septum from the uterosacral ligaments and pericervical ring in the interspinous diameter is the routine result in patients who develop prolapse. The primary suspensory axis of the uterovaginal complex is located along the posterior vaginal wall. This axis consists of the perineal body, rectovaginal septum, pericervical ring, uterosacral ligament, and presacral periosteum. If this suspensory axis is reestablished through uterosacral colpopexy, the entire vaginal anatomical complex is supported and suspended. Full-length and full-width exposure of the rectovaginal space is required to complete this operation. The uterosacral ligaments should be identified within the pararectal spaces at the level of the interspinous diameter. The proximal edge of the rectovaginal septum should be connected to the ligaments with permanent sutures. Central reconnection of the septum to the pericervical ring or hysterectomy scar reduces the rectocele and enterocele. In a large prolapse, the rectovaginal septum is frequently retracted distally to the level of the perineal body. Dissection and release of any secondary adhesions that have affected the rectovaginal septum are important to successful reattachment. Bolsters are not commonly useful in posterior vaginal reconstruction when the technique of uterosacral colpopexy is used. Uterosacral colpopexy repairs perineal descent, vaginal prolapse, rectocele, and enterocele. Anatomical distortion is minimized. Vaginal depth, axis, and caliber are maximized.
LAPAROVAGINAL MESH REPAIR OF POSTERIOR PROLAPSE

Greg Cario
Sydney Women's Endosurgery Centre

The integrity of the posterior compartment depends on the rectovaginal septum and its attachments at the 3 levels of Delancey's support structure. It is anchored superiorly at its level 1 attachment to the pericervical ring and the uterosacral ligament. It is anchored laterally to the fascia of the levator ani muscles with secondary attachment to the fascial white line as its level 2 support. The attachment to the perineal body is crucial to the level 3 supports. The traditional posterior vaginal repair is carried out anterior to the damaged rectovaginal septum and addresses the perineal body and the levator fascia but is totally inadequate in its level 1 or upper rectovaginal support. It also relies on damaged endopelvic fascia which is by its nature a poor support structure. The laparoscopic posterior paravaginal repair is carried out posterior to the damaged rectovaginal septum and addresses the level 1 and 2 apical supports well but it can be difficult to access the level 3 perineal body attachment. It also relies on reconstituting endopelvic fascia and lots of often challenging curved needle suturing.

Mesh has been used increasingly in pelvic floor reconstructive surgery over the last 5 years following the success of the TVT suburethral slings. Previously the risk of mesh erosions and infections (which were reported to be as high as 25% in first generation meshes) severely limited its use to recurrent end stage prolapse. The type of mesh, the route of introduction and the technique used are all extremely important in the risk of rejection. The macroporous monofilament polypropylene flexible mesh used in the TVT appears to have many of the qualities of the ideal mesh and has proven to have a very low infection rate. Vaginal placement is said to have a 20% risk of rejection or erosion compared to a 4% risk when introduced abdominally. This makes the abdominal and indeed the laparoscopic approach the ideal way to introduce this new mesh.

I would like to present my new technique for laparoscopic mesh repair to the posterior compartment. I believe that by introducing and anchoring the mesh through a small horizontal incision at the fourchette at the level of the perineal body it addresses the level 3 problems of the Laparoscopic posterior paravaginal operation and it also simplifies the lateral dissection to the levators and the suturing dramatically. As well as this it allows for a perineorrhaphy that is often needed to complete the cosmetic result. This operation evolved from our work with Laparoscopic mesh sacrocolpopexy which replaced the worn out rectovaginal septum very well but was an operation for enthusiasts only and had little application to most laparoscopic surgeons looking for a "quick fix" procedure with minimal suturing. At SWEC we have developed a major interest in the uterosacral ligament which we believe is the simplest and best apical support structure available if it is located at its intact sacral end rather than its damaged cervical end. It is a superior and safer option than the sacral promontory or the sacrospinous ligament. In the long term this new laparovaginal mesh repair with attachment to the uterosacral ligament may be quicker, more effective and more anatomical than the traditional laparoscopic techniques of posterior paravaginal repair or mesh sacrocolpopexy.
**TRANSOBTURATOR TAPE – WHERE DOES IT FIT IN?**

Professor Ajay Rane  
MD FRCOG FRCS FRANZCOG CU  
Consultant Urogynaecologist, The Townsville Hospital,  
Chair and Head of Department, Ob-Gyn, James Cook University  
School of Medicine, VMO, The Mater Hospital, Townsville.

Sub urethral sling procedures have been successfully used in the treatment of urinary stress incontinence. Longitudinal studies on the TVT show a maintained success rate of around 80%. Retropubic slings however have been associated with serious complications like bowel perforation, major vessel trauma and retropubic haematomas. Other complications include bladder perforations, urethral perforations and sling erosions. Voiding dysfunction of up to 20% has been reported in some series post operatively and also de novo detrusor instability or OAB has been reported in up to 15% of cases after surgery.

The transobturator sling is another suburethral sling with a unique approach. It utilizes the principle of recreating a subfascial hammock. Early studies have shown similar success rates to the TVT. Cadaveric studies using the transobturator approach show that it is possible to eliminate serious complications like major vessel trauma and bowel trauma. Also tape placement visualised on 3D ultrasound suggest a ‘flatter’ placement thus reducing voiding dysfunction and may be even OAB.

The first Monarc sling procedure in Australia was performed in Townsville. Our unit has been part of the multicentre Monarc clinical study and to date our unit has performed over 250 procedures since March 2003. We have preceptored more than 50 surgeons in Australia and New Zealand.

**References**

**Questions**
1. Voiding dysfunction after retropubic sub urethral slings can be as high as 20%. True / False  
2. The transobturator tape attempts to recreate a sub fascial hammock underneath the mid urethra. True / False  
3. The average distance of the Monarc tape from the obturator vessels and nerves is less than 1 centimeter in cadaveric studies. True / False

---

**WHAT TO DO WHEN THERE IS NO BLUE?**

– And should cystoscopy to check ureteric patency be routine in gynaecological surgery?

Dr Susan Evans  
Adelaide

**How is ureteric patency checked?**
5mL ampoule indigo carmine injected iv/10 min before end of procedure. Excreted by kidney, appears in urine 5-20 min after injection 30 degree cystoscope and mild distension of the bladder only to allow good view. No need to over-distend the bladder. 100mL may be sufficient.

**Risks**
Transient mild hypertension. Return to baseline in 5-20 minutes with no treatment. Hypotension rarely described. Allergic reactions – rare but possible.

**No blue seen – Unilateral**
- Surgical obstruction? Were you operating near that ureter? What technique was used to secure pedicles? Could ureter be kinked or sutured?  
- Absent kidney (<1%).  
- Hypoplastic kidney (<1%).  
- Unilateral kidney disease. Presence and size of kidney can be checked with an USS.  
- Not looking at correct ureteric orifice i.e. duplex ureter (1% of women) with one poorly functioning ureter. Look medially or laterally along inter-ureteric bar.

**Management**
Go back and look at surgery. Undo sutures/dissect out ureter/release plicating sutures. Retrograde pyelogram. Requires an operating cystoscope and an operating bed suitable for image intensifier. Simplest is olive tip catheter just inside the ureteric orifice. Inject 3-5 mL of either Urograftin (is pre-diluted), or any angiogram contrast diluted 50:50 with saline. OR, 5 French open ended ureteric catheter instead of olive tip catheter (harder). Talk to a urologist at whatever stage you are uncomfortable.

**Is it OK to wait and see?**
Renal ultrasound the next day to look for hydronephrosis – allows early surgical repair, and won’t damage kidney, but two anaesthetics. Reasonable plan if no urologist available, can’t do retrograde pyelogram or believe the ureter to be intact.

Watching for flank pain, fever or unexplained rise in creatinine may lead to late diagnosis.
No blue seen – Bilaterally
- Dehydration? Bowel prep/blood loss.
- Inadequate time for blue to pass.
- Bilateral renal disease with slow passage of dye.

Things a post op cystoscopy won’t show
Diathermy damage without occlusion. Partial obstruction. Won’t prevent fistulas.

Which cases might benefit most?
Adhesions from endometriosis or PID. Risk of bladder perforation.

My Conclusions
Post procedure cystoscopy is not a perfect tool to exclude ureteric damage.
Benefit depend on the techique used. Less benefit with diathermy.
As gynaecologists we should all be able to do a cystoscopy.

References
OBSTRUCTED DEFECAITION AND RECTOCELE

Assoc Prof Nick Rieger
Colorectal Surgeon
University of Adelaide
The Queen Elizabeth Hospital

The aim of this presentation will be to discuss the common causes for obstructed defecation. This is one of the many syndromes of “constipation”. The principle symptom is the patient has the normal feeling or desire to defecate but can not “get it out”. Causes include rectocele, anismus and rectal intussusception. Rectocele is a form of herniation through the rectovaginal septum with protrusion of the hernial sac into the vagina. Anismus is paradoxical contraction of the pelvic floor which does not relax with defecation. Rectal intussusception is the rectum telescoping within itself and presenting at the anus as an intra-rectal lump. This may be complete with full thickness rectal prolapse. Investigations including defecating proctography and anal ultrasound will be discussed. Non-operative and operative management will be discussed.

DYSPAREUNIA AND DIFFICULT RECTAL EVACUATION AFTER POSTERIOR REPAIR

Virginia Gill
M App Science (Physio)
Pelvic Floor Physiotherapy, Hove, South Australia

Physiotherapy in gynaecology is most commonly considered to involve pelvic floor muscle strength training. Recent EMG and ultrasound evidence has identified patterns of coordinated muscle activity in the healthy abdominal wall and pelvic floor during pelvic floor contraction. Dysfunctional patterns of activity are recognised clinically in conditions including obstructed defaecation and dyspareunia. While change in levator ani strength may be one component in these conditions, it is unlikely to exist in isolation from changes in muscle and connective tissue length, and function of other pelvic structures, potentially giving rise to pain. Pelvic floor muscles may also function inadequately without being found to be weak. Thus physiotherapy management of pelvic floor dysfunction is likely to involve far more than muscle strengthening regimes.

Motor learning theory suggests that rehabilitation of motor dysfunction requires awareness of the nature and quality of the desired movement, as well as the development of new patterns of behaviour and inhibition of old patterns. This process requires time, a supportive learning environment, feedback and performance modification where necessary in the learning process. Achievement of the desired pattern of muscle movement precedes conventional muscle conditioning, i.e. strength and endurance training. These theories can be applied to pelvic floor rehabilitation.

The International Continence Society recommends physical rehabilitation as first line of therapy for stress urinary incontinence (SUI). Positive outcomes from training are reported, using various outcome measures, with attendant low risk and no prejudice against future management. Changes in muscle dimensions (resting and contracted positions, volume and thickness) have been clearly demonstrated in response to training, as have changes in behaviour i.e., speed of pre-contraction to prevent SUI. Similar symptom and sign changes have been shown for ano-rectal dysfunctions, including faecal incontinence and obstructed defaecation, especially where training has been assisted by sphincter biofeedback.

In view of the demonstrated changes to muscle dimensions and function in selected pelvic floor conditions, it may be assumed that rehabilitation of the pelvic floor has a role in management of other pelvic floor dysfunctions, including prolapse and dyspareunia, although direct evidence is currently lacking.

References

PROFILE
Virginia Gill is a physiotherapist who works exclusively with pelvic floor dysfunctions in private practice and in an Adelaide public hospital setting. She previously worked as a lecturer in women’s health in the School of Physiotherapy at the University of South Australia, with attendant study and research opportunities.
**DYSPAREUNIA AFTER POSTERIOR VAGINAL REPAIR – A SEX THERAPIST’S APPROACH**

Dr Marie Tudor  

The problem of dyspareunia is not limited to the pain experienced during sexual intercourse – it has significant consequences, particularly for the relationship, sexual desire and self-esteem. It is advisable to acknowledge the possible effects of dyspareunia with the couple as early as possible to enable them to address their individual emotional and relationship needs during and following the period of treatment. The sex therapist needs to address the concerns of the woman and her partner, the state of the relationship and the meaning the couple give to the problem.

The assessment of dyspareunia following posterior vaginal repair requires evaluation in the context of the overall health of the woman. This includes consideration of the pelvic anatomy & remaining/other pathology following surgery – e.g. examination of the pelvic musculature for trigger point tenderness/signs of pelvic floor myalgia. Screening for other possible medical conditions contributing to the symptom of dyspareunia is advisable. e.g. oestrogen deficiency (including vulvo-vaginal atrophy), co-existent symptoms or signs of vulvar vestibulitis and endometriosis.

The role of the sex therapist, whilst being mindful of the surgeon’s assessment and management plan is to encourage the couple to work together to bypass the experience of pain and to nurture the possibilities of connection and sexual intimacy. The beliefs and ideas about sexuality, the sexual desire levels, abilities of arousal and sexual styles of the couple can be discussed in order to enable choices that support the couple’s hopes of shared pleasure and sexual experience. There may be a place for relaxation training or self-hypnosis as a skill to modify or reduce the experience of pain. As with many medical conditions, the couple can be encouraged to view this problem as a challenge which may lead to possibilities of personal and relationship growth.

**References**

18. Tudor, M.Y. 1995:

**PROFILE**

Dr Marie Tudor  

Marie Tudor is a graduate of The University of Adelaide (1985) and trained in general medical practice. She has worked exclusively in the field of sexual, couples and individual therapy for the last 12 years. Interested in the many interconnections of the mind, body and spirit, she brings her medical knowledge and training in Narrative (Family) Therapy and Hypnosis to her work with people experiencing the many challenges and joys of sexual and intimate relationships.
HOW TO WRITE A LEGAL REPORT.
WHAT ARE YOUR RESPONSIBILITIES?
HOW TO QUANTIFY DISABILITY.

Ms Margaret Byrnes
Wallman’s Lawyers
173 Wakefield St.
Adelaide, SA 5000
LL.B
Specialist Legal Consultant
in area of Professional Indemnity

Dr Michael McEvoy
Obstetrician and Gynaecologist
41 Mann Terrace
North Adelaide, SA 5006
MBBS, RANZCOG, MBA
Member of RANZCOG expert witness panel.
Former MDASA Board Member

We will discuss the role of the expert witness in assisting the court rather than acting as an advocate for a party.
The expert is allowed (contrary to normal opinion evidence) to express an opinion to the court whereas ordinary witnesses can only give evidence of facts from personal knowledge. Generally the expert’s report will be considered the evidence in chief of the expert.
It is therefore crucial that the report complies with the rules of Court to that jurisdiction, is soundly reasoned, and referenced. There should be careful consideration of its contents before signing as any third-party that may consider the report to be deleterious to their cause may later question the expert, possibly in civil proceedings or in a professional review body. The expert must ensure that the factual basis for conclusions expressed is clearly set out. They should be clear that they have made all desirable enquiries. They should note any missing relevant material that they would consider to be useful to the material outcome of the case. They should also note where differences of opinions exist in the profession about some of their conclusions.
Whilst there are not uniform rules with respect to the form and content of legal reports, generally the various State codes of conduct and court rules cover the same issues. When an expert witness is contacted by a lawyer seeking a report, the appropriate State codes of conduct and court rules should be made available to the expert witness. At this point the witness should ensure that they have a good grasp of the extent of the case and what the specific requirements of the parties are. Should the expert witness not wish to be involved, or feels the matter lies outside their expertise, they can refuse to be involved at that point. We will compare and contrast the various statutory authorities in different states of Australia. We will discuss the assessment of disability by reference to the American Medical Association Guidelines for the Evaluation of Permanent Impairment, and the assistance such conclusions bring to the court.

References
RANZCOG Framework for the Continuing Education and Professional Development of Fellows on the Expert Witness Panel,
www.ranzcog.com.au
CONFERENCE FACULTY

International Faculty

Professor Carl Zimmerman
Vanderbilt University,
Nashville, Tennessee, U.S.A.

Australian Faculty

A/Prof. Gil Burton
Ms Margaret Byrnes
Dr Marcus Carey
Dr Greg Cario
Dr Jenny Cook
Dr Peter Dwyer
Dr Susan Evans
Prof. Ray Garry
Ms Virginia Gill
Dr Graham Hamdorf
Dr Raphael Kuhn
A/Prof. Alan Lam
Dr Vince Lamaro
Dr Enzo Lombardi

New South Wales
South Australia
Victoria
New South Wales
South Australia
Victoria
Western Australia
South Australia
South Australia
Victoria
New South Wales
New South Wales
South Australia

Dr Christopher Maher
A/Prof. Peter Maher
Dr Michael McEvoy
Dr Oseka Onuma
Dr Robert O’Shea
Prof. Ossie Petrucco
Prof. Ajay Rane
Dr Geoffrey Reid
A/Prof. Nicholas Rieger
Dr John Taylor
Dr Jim Tsaltas
Dr Marie Tudor
Dr Christopher Verco
Dr Anusch Yazdani

Victoria
Victoria
South Australia
South Australia
South Australia
Queensland
New South Wales
South Australia
South Australia
Victoria
South Australia
South Australia
Queensland

AGES EXECUTIVE COMMITTEE

Dr Robert O’Shea
A/Prof. Alan Lam
Dr Jim Tsaltas
Dr Geoffrey Reid
Dr Greg Cario
Dr Susan Evans
Prof. Ray Garry
Dr Raphael Kuhn
Dr Elvis Seman
Dr Anusch Yazdani

President
Vice President
Hon Secretary
Treasurer

CONFERENCE COMMITTEE

Dr Robert O’Shea
Dr Elvis Seman
Dr Jenny Cook
Dr Susan Evans
Dr Graham Hamdorf
A/Prof. Alan Lam
Dr Enzo Lombardi
Dr Michael McEvoy
Dr Oseka Onuma
Dr John Taylor
Dr Fariba Willison

Chairman
Scientific Chairman

AGES CONFERENCE ORGANISER

Michele Bender Director
Conference Connection
Phone: 02 9967 2928
Fax: 02 9967 2627
Mobile: 04 1111 0464
E-mail: michbender@aol.com
282 Edinburgh Road
CASTLECRAG SYDNEY NSW 2068

MEMBERSHIP OF AGES

Membership Application Forms are available from the AGES website or from:
AGES Secretariat
282 Edinburgh Road
CASTLECRAG NSW 2068

DELEGATES ATTENDING THIS CONFERENCE WILL BE AWARDED
• PR & CRM POINTS
• CPD MEETING POINTS
SPONSORSHIP

AGES gratefully acknowledges the following companies which have confirmed sponsorship at the time of printing.

Platinum Sponsor of AGES

stryker®

Major Sponsor of AGES

OLYMPUS

Sponsor

Johnson & Johnson Medical
American Medical Systems
B. Braun Australia
Cook Australia
Device Technologies
Excelray Australia
Fisher & Paykel Healthcare
Incision
Insight Oceania
Linvatec Australia
MD Solutions
N. Stenning & Co
Polartechnics
Tyco Healthcare