Australasian Gynaecological Endoscopy & Surgery Society Limited

XX PELVIC FLOOR SYMPOSIUM 2019

DARE TO BE *Different*

PROGRAM BOOKLET

1st & 2nd November 2019

Sheraton Grand
Sydney Hyde Park

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SHERATON GRAND SYDNEY HYDE PARK
Friday 1st November

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LETTER OF INVITATION

Dear Colleague,

It is with great pleasure that we welcome you to the 20th Annual AGES Pelvic Floor Symposium 2019, ***'Dare to be Different'***

We are excited to be joined by the joint 2018 Noble Peace Prize winner, Dr Denis Mukwege. This inspirational Congolese doctor has devoted his life to the repair of women who have been brutalised and violated. The son of a pastor who was prepared to shift the focus of his career from pediatrics to obstetrics and then gynecological surgery to respond to local needs, Denis will share stories and experiences not to be missed.

'Mukwege has earned the moniker "the man who mends women" for the work he and his colleagues at Panzi Hospital have done to treat tens of thousands of women and girls, survivors of rape and sexual violence, which has been used as a weapon of war since conflict began in the east of the DRC in 1995'. Rumours had circulated for years that he was in the running for the Nobel Peace Prize, and in 2018 he was awarded the highest of honours for his work.

Dr Mukwege will be joining our other international faculty members such as Dr Lynsey Hayward, the stellar immediate past president of IUGA and Prof Sayeba Akhter, a visionary woman who has transformed hundreds of lives in Bangladesh and who works tirelessly for the Rohingya women. They are charged with the task of guiding you along a different surgical pathway, a task they are ably equipped for. Back by popular demand, Lorimer Moseley joins us once again to explain pain. We can't pass by an opportunity to extend our knowledge of this ever-expanding area, presented in such a beguiling way!

Let our local faculty dare you to innovate with more controversial surgical options and new technology updates. We then move into another realm and join our invited international physiotherapist, Professor Kari Bø, a woman of immense achievements. In 2015, Prof Bø was awarded the Mildred Elson Award, the most prestigious award from the World Confederation of Physiotherapy, for her contribution to research and education in pelvic floor dysfunction and women's health. In 2016 Prof Bø was awarded the International Continence Society Lifelong Achievement award. Prof Bø will bring us into the world of physiotherapy and its intersection with the pelvic floor.

Everything about the 2019 program is different. We explore obstetric and gynaecological issues, and even venture into politics, exploring the plights of different groups, including a foray into the Rohingya Crisis… now that is different! We also continue with our discussions on different strategies in obstetrics to prevent pelvic floor disorders.

Outside of the Symposium make the most of the November weather. You can see the Jacaranda trees in full bloom by visiting one of Sydney's many parks, visit the world-class beaches, or even take a stroll around the Harbour. Sydney is also hosting the Sydney Open, where the city unlocks the doors of over 60 of their iconic, intriguing and inspiring buildings and spaces on Sunday 3rd November.

We promise that this year's program will challenge your thinking and take you on a journey of difference. As specialist gynaecologists we need to be leaders in elevating the care that we offer the women who rely on us. Joining your colleagues to discuss and debate the latest ideas and innovations will help make a difference to the lives of these women.

We hope you enjoy the coming days in Sydney as we explore "Dare to be Different".

Kind regards,

Dr Stuart Salfinger
President, AGES

Prof Ajay Rane OAM
Co-Chair

Dr Emma Readman
Co-Chair

INTERNATIONAL FACULTY

Prof Sayeba Akhter

Sayeba Akhter is the Professor and CEO of MAMM'S Institute of Fistula and Women's Health(MIFWOH), member of FIGO fistula committee, President Elect of International Society of Obstetric Fistula Surgeon, Chair of South Asian Group of Fistula and other morbidities, president of Obstetrics and Gynaecology Society of Bangladesh(2008-2010) and member of many national and international professional associations. Prof Akhter was Head of dept of OBGYN, Dhaka Medical college, has conducted countrywide program on ARH, VAW and PPH. Prof Akhter has dedicated her lifetime to eliminate obstetric fistula from Asia and the globe. Her innovation 'Condom Uterine Balloon Temponade'(Sayeba's Method) for control of massive PPH in resource poor settings & is used in of Asia and Africa . Prof Akhter has more than 50 publications, author/co-author of 4 books including book on fistula management. Prof Akhter has received several awards including "Fellows Honorius Causa" by RCOG, honorary FCPS(PAK), FICMCH(IN), and FIAOG(IN).

Prof Kari Bø

PhD in 1990. Appointed professor 1997. Vice president of the International Organization of Physical Therapists in Women's Health, WCPT 1999-2007, vice president of the Norwegian Council for Physical Activity for 8 years, vice president of The Norwegian Sport Physiotherapy Association 2003-2007, elected rector of the NSSS 2013-2017. Published > 260 scientific papers, given > 270 invited international keynote presentations. RCT awarded of 15 top trials among >25.000 studies in the PEDro database. Awarded with the most prestige's award in physiotherapy 2015. Awarded ICS Lifelong Achievement award 2016.

Dr Lynsey Hayward

Lynsey is the Immediate Past President of the International Urogynaecological Association, a founding board member of the UGSA and a committee member of the FIGO urogynaecological committee. Lysney is passionate about education and lectures nationally and internationally and is also involved in undergraduate medical education and is an examiner for the RANZCOG. Having graduated from Bristol University, Lynsey undertook her postgraduate training in the UK and NZ, she has been working at Middlemore Hospital for the last 20 years where she is lead urogynaecologists. She is a member of the Auckland University Bioengineering Department pelvic floor research group conducting research into the biomechanics of the pelvic floor in relation to childbirth and exercise.

Dr Denis Mukwege

Son of a Pentecostal pastor, Denis Mukwege completed primary school at the Royal Athenaeum in Bukavu and secondary school at the Bwindi Institute in Bukavu, where he obtained his diploma with a specialty in biochemistry in 1974. After two years of study at the University of Kinshasa (UNIKIN) in Polytechnics, he found his calling when in 1976 he enrolled in Medical School in Burundi. He received his medical degree in 1983, and then began his professional career in the hospital in Lemera, a village south of Bukavu. In 1984, he received a scholarship from the Swedish Pentecostal Mission to study to become a specialist in gynecology at the University of Angers in France. Along with another person from Anjou, France, he founded the organization "Esther Solidarity France-Kivu" to help the province of his birth. On September 24, 2015, he received the advanced degree of Doctor of Medical Sciences at the Free University of Brussels following the defense of his doctoral thesis, entitled "Etiology, classification and treatment of lower genital and genito-digestive trauma fistulas in eastern DRC."

FRIDAY 1ST NOVEMBER 2019

0700 - 0800	Conference Registration	
0800 - 1000	**SESSION 1: DIFFERENT SURGERY** *Session Chairs: Ajay Rane & Emma Readman*	*Grand Ballroom 1*
	Welcome - **Stuart Salfinger**	
	Is the sacrospinous ligament optimal for vaginal vault prolapse repair? - **Lynsey Hayward**	
	"There will be no fistulas in 2030"... Dream or reality? - **Ajay Rane**	
	Apical support by robot or straight stick laparoscope - a balanced view - **Joseph Lee**	
	Obliterative procedures for vault prolapse - **Sayeba Akhter**	
	How do we approach the necessity of high-volume surgery? - **Gil Burton**	
	To stent or not to stent? ... That is the question! - **Vincent Tse**	
	Panel Discussion	
1000 - 1030	MORNING TEA, DIGITAL COMMUNICATIONS & TRADE EXHIBITION	*Level 2 Foyer & Ballroom 2*
1030 - 1240	**SESSION 2: DIFFERENT PAINS** *Session Chairs: Rachel Green & Gil Burton*	*Grand Ballroom 1*
	Pain - please explain? - **Lorimer Moseley**	
	Painful bladder syndrome - is surgery ever indicted? - **Lucy Bates**	
	Pain outside the pelvis - is it important ? - **Charles Brooker**	
	Pathophysiology of pelvic pain post mesh and native tissue surgery - **Thierry Vancaillie**	
	Botox infiltration of the bladder, pelvic floor & bowel - A "how & why" instructional video - **Erin Nesbitt-Hawes**	
	KEYNOTE: The weighty issue and the pelvic floor - **Lynsey Hayward**	
	Panel Discussion	
1240 - 1340	LUNCH, DIGITAL COMMUNICATIONS & TRADE EXHIBITION	*Level 2 Foyer & Ballroom 2*
1340 - 1440	**FREE COMMUNICATIONS A** *Session Chairs: Stephen Lyons & Anna Rosamilia* *Grand Ballroom 1*	**FREE COMMUNICATIONS B** *Session Chairs: Jason Abbott & Lucy Bates* *Hyde Park Room*
1440 - 1510	AFTERNOON TEA, DIGITAL COMMUNICATIONS & TRADE EXHIBITION	*Level 2 Foyer & Ballroom 2*
1510 - 1730	**SESSION 4: DARE TO INNOVATE** *Session Chairs: Helen Green & Michael Wynn-Williams*	*Grand Ballroom 1*
	Urogynae current affairs - **Stefaan Pacquée**	
	The vaginal mesh debate exposed us... Where are our databases? - **Lynsey Hayward**	
	Does the laparoscope have a place in urogynaecology? Prove it! - **Marcus Carey**	
	Paradise lost? Is there still a role for vaginal mesh? - **Alan Lam**	
	Big data, grand plans and the pelvic floor - **Elvis Šeman**	
	Autologous grafts - back to the future? - **Fariba Behnia-Willison**	
	New wave technology and the pelvic floor - is it the way? - **Christopher Maher**	
	Pain after sexual violence - **Denis Mukwege**	
1730	Close of Day One	
1915 - 2300	**GREAT GATSBY DINNER & AWARDS** *Sheraton Grand Sydney Hyde Park*	*Grand Ballroom 1*

SATURDAY 2ND NOVEMBER 2019

0730 - 0800	Conference Registration	
0800 - 1000	**SESSION 5: DIFFERENT COLLABORATIONS** *Session Chairs: Bassem Gerges & Jennifer King*	*Grand Ballroom 1*
	Are physios all the same? Physiotherapy philosophies - **Kari Bø**	
	Myotherapists - muscular magicians?! - **Taryn Hallam**	
	Colorectal collaboration - **Shahrir Kabir**	
	Getting it going - the GP's role in pelvic floor management? - **Sara Yousaf**	
	Help! The urologist and urotrauma - **Justin Vass**	
	Urogynae nurses nurturing the service - **Wendy Allen**	
	Let's talk about sex therapy - **Rosie King**	
	Panel Discussion	
1000 - 1030	MORNING TEA & TRADE EXHIBITION	*Level 2 Foyer & Ballroom 2*
1030 - 1210	**SESSION 6: DIFFERENT OBSTETRIC ISSUES** *Session Chairs: Kirsten Connan & Martin Ritossa*	*Grand Ballroom 1*
	Physiotherapy and the post-partum patient - the evidence - **Kari Bø**	
	Scarab and UR choice - **Harsha Ananthram**	
	Assisted vaginal delivery and pelvic trauma - the green top guideline - **Jennifer King**	
	Towards normal birth? - **Jason Mak**	
	Australian Birth Trauma Association - **Jessica Caudwell-Hall & Amy Dawes**	
	The Pacific and training - are we on track? - **Amanda Noovao-Hill**	
	Panel Discussion	
1210 - 1310	LUNCH & TRADE EXHIBITION	*Level 2 Foyer & Ballroom 2*
1310 - 1445	**SESSION 7: DIFFERENT PLIGHTS** *Session Chairs: Krish Karthigasu & Rachel Collings*	*Grand Ballroom 1*
	Re-constructive pelvic surgery after gender-based violence - **Denis Mukwege**	
	KEYNOTE: Is physical activity good or bad for the pelvic floor? - **Kari Bø**	
	Different surgeries - dare we do it? - **Gregory Cario, Jay Iyer & Stephen Lyons**	
1445 - 1510	AFTERNOON TEA & TRADE EXHIBITION	*Level 2 Foyer & Ballroom 2*
1510 - 1710	**SESSION 8: CHANGE, DIFFERENCE & POLITICS** *Session Chairs: Fariba Behnia-Willison & Stuart Salfinger*	*Grand Ballroom 1*
	Rohingya crisis - challenges for women - **Sayeba Akhter**	
	Challenges for a urogynaecologist in a developed world - **Anna Rosamilia**	
	Far from the city - bush urogynaecology - **Elizabeth Gallagher**	
	Medical interventions in the developing world. Can we help? Should we help? - **Sayeba Akhter**	
	KEYNOTE: How to truly make a difference - **Denis Mukwege**	
	Panel Discussion	
1710	Close of Day Two and Symposium	

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ART PRIZE - 2019/20



LUCILA ZENTNER

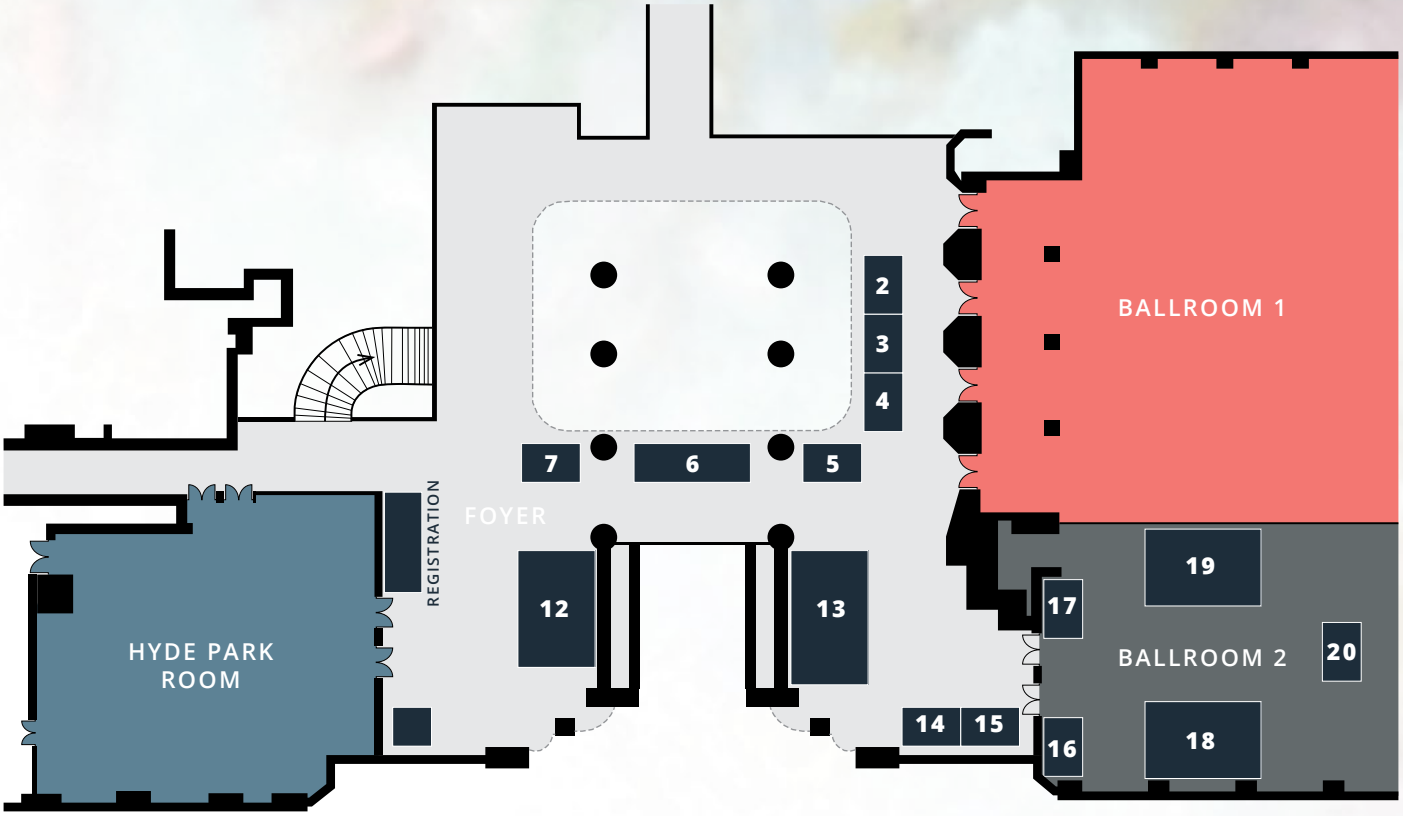
Lucila Zentner is an Australian artist working predominantly in oils. Lucila combines a love and practice of fine art with a career in medicine, practicing as a Radiologist and Nuclear Medicine specialist.

She has lived and worked in Regional Victoria and NSW over the last 10 years and has now moved studio to Sydney. Lucila paints private commissions as well as for private and public institutions ranging from professional medical suites/hospitals to cafes.

ARTIST STATEMENT

I paint to hold onto a moment, to thrill the senses, to delight, to mourn and to live. My paintings are oil on canvas or linen, representational, mildly abstracted, expressionistic. All are of people, places or ideas. I enjoy gestures, light and form and shadows. My muses are my family, my friends and the Australian landscape. My styles are diverse, but the brush strokes are always solid, definite and final.

FLOOR PLAN



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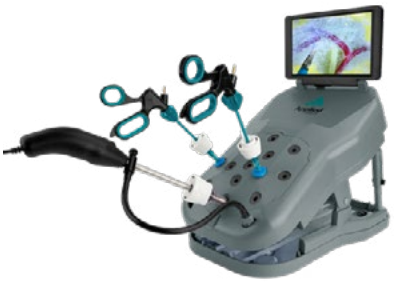

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AGES XXX
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Hyatt Regency, Sydney
5th - 7th March 2020

MARCH 5 | MARCH 6 | MARCH 7

Australasian Gynaecological Endoscopy & Surgery FOCUS MEETING

AGES/AAGL Affiliated Society
Focus Meeting 2020
Bangkok, Thailand
17th & 18th July 2020

JULY 17 | JULY 18

Australasian Gynaecological Endoscopy & Surgery PELVIC FLOOR SYMPOSIUM

AGES XXI Pelvic Floor Symposium 2020
Adelaide Convention Centre
30th & 31st October 2020

OCTOBER 30 | OCTOBER 31

AGES TRAINING

AGES/RANZCOG
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RACS, Melbourne
13th & 14th June 2020

JUNE 13 | JUNE 14

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MERF QUT, Brisbane

2019
Dissection Workshop:
30th November 2019

NOVEMBER 30

2020
Dissection Workshop:
4th April 2020
28th November 2020

Advanced Dissection Workshop:
5th April 2020

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29th August 2020

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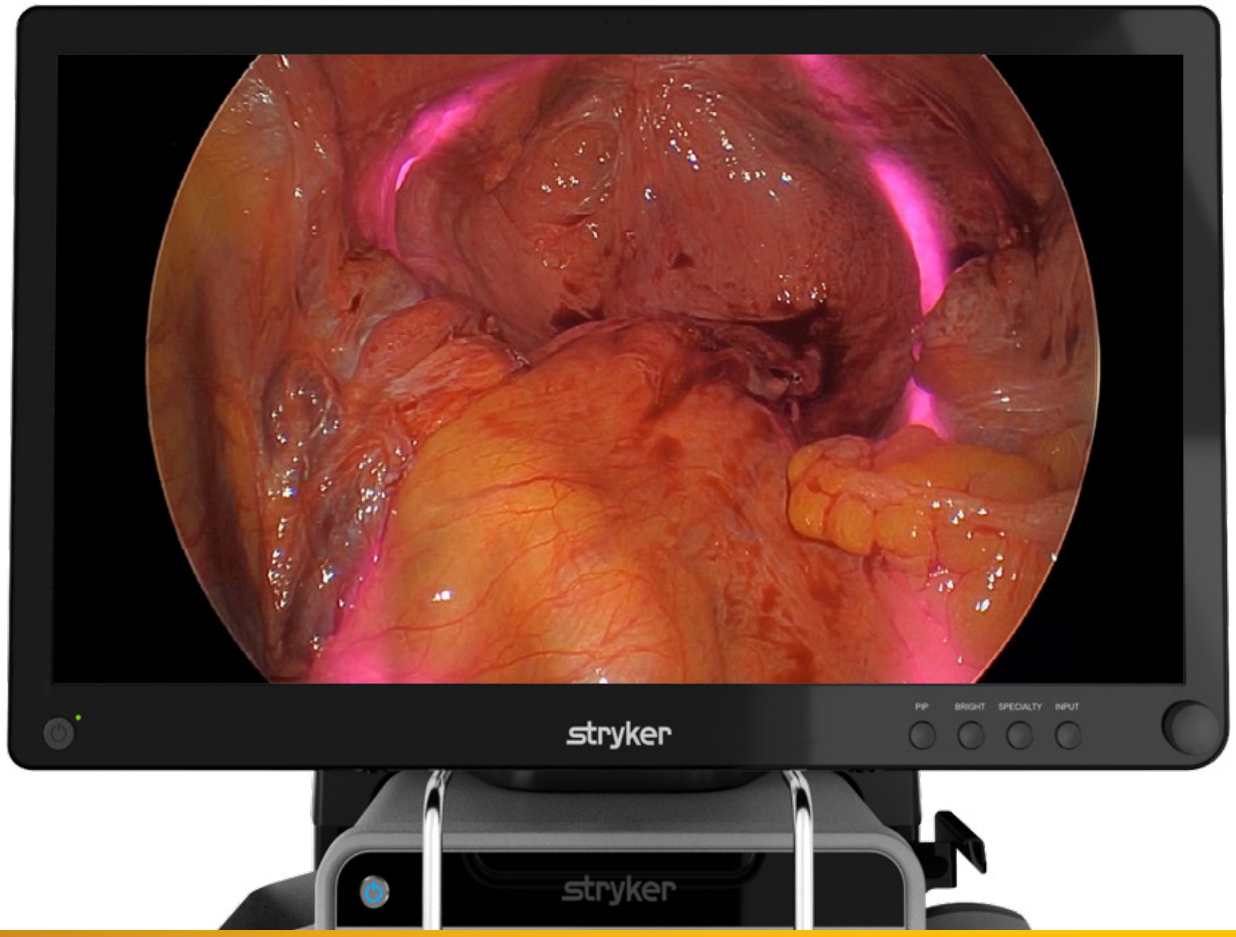

PROGRAM ABSTRACTS

FRIDAY 1ST NOVEMBER 2019

SESSION ONE: DIFFERENT SURGERY / 0800 -1000

BALLROOM 1

Is the sacrospinous ligament optimal for vaginal vault prolapse repair?

Lynsey Hayward

Abstract not yet received.

"There will be no fistulas in 2030"... Dream or reality?

Ajay Rane

Abstract not yet received.

Challenges and Accomplishments in the Conduct of Modern MIS Trials

Joseph Lee

Sacrocolpopexy seemed to have undergone a renaissance of sorts in recent times, co-inciding with the decline of transvaginal mesh use. its inevitable conventional laparoscopic approach - so called straight stick because most instruments dont "bend", will be compared to robotics for sacrocolpopexy, an operation requiring substantial dissection and suturing. this presentation will compare/contrast these approaches, drawing on evidence from literature, as well as discussing learning curve data and credentialing issues.

Obliterative procedures for vault prolapse

Sayeba Akhter

Pelvic organ prolapse (POP) is one of the most commonly occurring gynecological problems in women, developed either due to improper/absence of care during childbirth or due to aging. With increase in life expectancy globally, more women are suffering from it. So, the need of treatment of POP is increasing enormously and at the same time become more challenging due to development of co-morbidities among old women. After both abdominal and vaginal hysterectomy, apex or vault of vagina may get prolapsed and need to refixed. Though prolapse can occur in young women also, vault prolapse usually developed in comparatively more older women. When developed it can be corrected either by reconstructive surgery like sacrocolpopexy, sacrocolpo suspension or sacrospinous colpopexy. All of them are complex procedure and need expertise. Vault prolapse can be corrected by less invasive/simple procedure called colpocleisis or obliterative Procedures (OP).

Objectives of the presentation:

To describe the OP, its types and historical background

To emphasize on its indications, advantages/disadvantages and challenges related to it

To focus on evidences on this procedure,

To share the situation of women in Bangladesh and our experiences

Evidences and discussion:

Reconstructive surgery for vault prolapse aims to cure women by restoring normal anatomy but obliterative procedure (OP) correct prolapse by reducing viscera back into pelvis by making partition /occluding vagina and preventing it coming down. OP can be partial or complete and can be done alone or with concomitant incontinence surgery. OP has a long history. Nicolas Geradin (Frence) 1823 came up with the idea of re-approximation of denuded vaginal mucosa to obliterate the vaginal canal, Le

Fort in 1877 described the most popular partial colpocleisis, the Le Fort operation and Martin A in 1899 described the total colpocleisis with levator plication.

OP is an effective surgical treatment option for elderly women who do not wish to have vaginal sex any more and does not want prolonged surgery or high risk for it. With global trend of advancing age of women, OP become an increasingly popular treatment option, because it is a quick surgery, less intra/postoperative complications, faster recovery, can achieve better satisfaction of women, improved quality of life with high success rate (90%) and low rate of regrate. It is very easy to operate and can be done even under local anesthesia. But still, study shows, 8-30% women developed de novo SUI.

In 2016, a study in Bangladesh found that the prevalence of POP is 8/1000 among ever married women, aged 15-49 years and estimated that approximately half a million women are suffering from stage III and IV POP. Most of the surgeons do the reconstructive procedures to treat vault prolapse, which sometime not appropriate, gets complicated and may fail to achieve proper satisfaction of women. Sometime, this surgery can not be done in women due to associated co-morbidities. Only few surgeons do it. In MAMMS Institute, OP is done and junior gynecologist are trained and encouraged to perform it, where it is indicated.

Conclusion:

Among the surgical treatment of vault prolapse, OP, being a simple surgery with less complications but comparable/better outcome, is not in practiced by many surgeons. Reconstructive surgeries needs to be done by experienced/expert surgeons and may not be appropriate/possible in very old women with co-morbidities. It is not justifiable to refuge surgery to old women with some complications and let her continue to suffer. We need to explore and practice alternate safe and simpler options for them and give them some comfort in remaining life.

How do we approach the necessity of high-volume surgery?

Gil Burton

It is intuitive that "Practice makes perfect" and there is low to moderate level evidence that this applies to surgery. Land mark papers in 1979 (Luft et al) and 2003 (Birkmeyer et al) looked at this issue and individual surgical groups have studied it as well and there is certainly a trend to high volume surgeons and hospitals having less complications. However, there is almost no evidence supporting an actual number defining low and high volume surgeons. Three major hospitals in the USA took "the low Volume pledge" in 2015 and in 2018 Australian Commission for Health Quality and Safety released a credentialing requirement for midurethral slings that the surgeon perform at least ten operations a year.

In 2019 there is now only one hospital out of about 6000 hospitals in the USA that has continued the low volume pledge. Better analysis of the data now questions Volume being used as a quality metric. Other factors such as experience, individual types of surgery, hospital and operating systems, total surgical numbers , excessive surgery rates, better medium and long term outcome measures and the role of tight guideline governance seem to play an important or possibly more important role in quality outcomes. Providing realistic equitable access to high volume surgeons and hospitals continues to be very problematic for all health systems.

If volume is seen as important for surgical quality then systems to improve patient selection (eg electronic second opinions), in house and virtual practice, validated and accepted guidelines, fly -in fly out mentoring teams and very senior post operative management all could play a role in managing this issue.

To stent or not to stent? ... That is the question!

Vincent Tse

Abstract not yet received.

SESSION TWO : DIFFERENT PAINS / 1030-1230

BALLROOM 1

Pain - please explain?

Lorimer Moseley

Developments in pain science point to characteristic patterns of pain and change in pain over time that will increase the precision with which we understand mechanisms that are contributing to persisting pain. Interpreting these patterns is made easier if the patient is viewed through a contemporary lens that captures both the protective nature of pain and the complexity of the 'unified

human'. In this talk I will both present a contemporary view of brain focussing on several key concepts and how one might present them to the person in pain, and I will outline common patterns of pain that can inform both clinician and patient about the biological processes likely to be underpinning their pain.

Painful bladder syndrome - is surgery ever indicted?

Lucy Bates

An update on the painful bladder syndrome, what is it, basic management, and what is new? When is surgery indicated and what surgeries are available?

Pain outside the pelvis - is it important ?

Charles Brooker

Chronic pain as a complication after careful patient selection and technically competent surgery is very common. It may occur despite best efforts to prevent and fix it and may occur as a side effect of surgery in patients with no prior pain in the pelvis. Chronic pain is not just a psychological phenomenon and has achieved the status of a disease entity in its own right in ICD 11 soon to be adopted by the WHO. Underlying factors include pain in other parts of the patient. Prior chronic pain e.g. migraine, back pain and pelvic pain predict chronic pain as does post traumatic stress disorder, anxiety and depression. Substance use disorder is an obvious risk factor for severe preoperative pain. Poorly controlled perioperative pain is associated with chronic pain. Prior opioid use is an independent risk factor. Catastrophic thought processes in regard to pain symptoms can be measured as can depression, anxiety and other pain symptoms via questionnaires and can give a warning to surgeons about patients who might be at risk of chronic pain as an outcome.

Pathophysiology of pelvic pain post mesh and native tissue surgery

Thierry Vancaillie

Post-surgical pain is defined as pain persisting after a surgical procedure for more than three months. The pain is due to damage to the peripheral nervous system which has not healed properly, a process defined as maladaptive healing.

Post-surgical pain can occur after any surgery, whether there were complications at the time or not. The issue of consent prior to surgery is beyond the scope of this presentation.

There are a number of pre-disposing factors, one of which is the existence of chronic pain prior to surgery. There is an ongoing debate whether persistent post-surgical pain is preventable or not and which methods should be used to achieve prevention.

The use of mesh may influence the occurrence of post-surgical neuropathy. Special attention will be paid to the onset of delayed postoperative pain after insertion of mesh.

Botox infiltration of the bladder, pelvic floor & bowel - A "how & why" instructional video

Erin Nesbitt-Hawes

Botulinum toxin has been used for treatment of pelvic floor muscle overcontraction and it's contribution to pelvic pain since the early 2000's. This presentation will outline the existing evidence for the use of botulinum toxin to the pelvic floor as well as overactive bladder and other applications.

KEYNOTE: The weighty issue and the pelvic floor

Lynsey Hayward

Abstract not yet received.

SESSION THREE A: FREE COMMUNICATIONS / 1400-1500

BALLROOM 1

The mesh removal experience: a clinical audit of a 40 mesh removal surgeries by a single operator

Karen K Chan[3, 1, 2], Elizabeth Howard[1], Thierry V Vancaillie[1, 2]

1. Women's Health and Research Institute of Australia, Sydney, NSW, Australia

2. University of New South Wales, Randwick, NSW, Australia

3. Royal Hospital for Women, Randwick, NSW, Australia

World-wide there are a large number of women who have reported transvaginal mesh-related complications including pain, erosion, recurrent infections and bowel or bladder dysfunction. Mesh removal surgery has been performed as part of the management of complications, however, there is little information on the outcomes of mesh-removal surgery (Crosby et al 2014, Danford et al 2015).

The aim of this retrospective audit was to provide data on the pain, psychological, bladder and bowel outcomes of women who have undergone transvaginal mesh removal surgery.

Methods:

The records of forty women who underwent transvaginal mesh removal surgery as part of their multimodal management were retrospectively reviewed. Data included mesh type, number of mesh insertion surgeries and clinical symptoms. An online survey was sent via email and text to obtain patient reported symptoms, quality of life, mental and general health measures since removal.

Results:

From October 2017 to February 2019, forty women underwent transvaginal mesh removals. A total of 46 mesh devices were removed including 34 suburethral slings and 11 vaginal prolapse mesh devices. Pain was the main indication for mesh removal (25/40), followed by voiding dysfunction. Surgical complications include six wound infections, one urinary tract infection and one post-operative urinary retention.

Thirty-three women responded to the online survey. Of these, pain was reported to have improved in 17/33 of respondents (51.5%) however 3/33 (9%) reported worsening of pain and 11/33 (33.3%) reported no change in pain. Mental health was worse in 15/33 (45.5%) after removal.

Conclusion:

Transvaginal mesh complications have significantly impacted on some women's quality of life. However, the results of this audit demonstrate that some complications are not always surgically correctable. This should be discussed with women before they make the decision to proceed with surgery.

1. Crosby, E. C., Abernethy, M., Berger, M. B., DeLancey, J. O., Fenner, D. E., & Morgan, D. M. (2014). Symptom resolution after operative management of complications from transvaginal mesh. Obstetrics and gynecology, 123(1), 134.
2. Danford, J. M., Osborn, D. J., Reynolds, W. S., Biller, D. H., & Dmochowski, R. R. (2015). Postoperative pain outcomes after transvaginal mesh revision. International urogynecology journal, 26(1), 65-69.
3.

The Utility of Australian Pelvic Floor Questionnaire as an Diagnostic Tool for Urinary Incontinence and Prolapse

susana mustafa[1], Zhuoran Chen[1], Gunter Hartel[2], Christopher Maher[1]

1. Royal Brisbane Women's Hospital, Heston, QLD, Australia

2.QIMR Berghofer Medical Research Institute, Brisbane, QLD , Australia

Background and aims:

Pelvic floor dysfunction (PFD) affects as many as 50% of parous women and commonly includes stress urinary incontinence (SUI), overactive bladder (OAB) or pelvic organ prolapse (POP). A variety of self-completed validated questionnaires have been developed to facilitate clinical assessment, but their diagnostic value has not been established. Thus the aim of this study was to establish the utility of Australian Pelvic Floor Questionnaire (APFQ) as a diagnostic tool for common PDF.

Methods:

A model that evaluated 52 possible predictors of clinical diagnosis including: all 42 questions from AFPQ, tabulated scores for bladder, bowel, prolapse and sexual function domains, total score and demographics (age, parity, mode of delivery and BMI) was developed. Using the model we retrospectively evaluated a cohort of 3502 women, of whom 3034 were referred to tertiary a Urogynaecology unit between 2014-2017 and had self-completed the APFQ. Their clinical diagnoses SUI, OAB or "other", were recorded by an experienced Urogynaecologist based upon dedicated history, examination and review of ancillary investigations.

The other 468 patients were healthy female volunteers aged 42-80 who completed the APFQ as part of another longitudinal study of ageing.

The accuracy of the model in differentiating between healthy volunteers and refereed patients was evaluated and internally validated. The model's accuracy in differentiating between various PFD diagnoses was also evaluated. Predicted diagnosis were compared with the clinical diagnosis and quantitated using the Bootstrap Forest analysis. The fit of models was evaluated using area under the Receiver Operating Characteristic-ROC curves (AUROC). The importance of the predictors in the models were ranked by their relative contribution to the model. A confusion matrix of the predictions provided estimated sensitivity, specificity and classification errors.

Results:

The model accurately identified 2703/3034 referred patients (sensitivity 89%) and 398/468 healthy volunteers (specificity 85%) with AUROC=0.94. Of the 2703 predicted patients, POP was identified with a sensitivity of 84%, specificity of 79% and AUROC=0.89. OAB patients with a sensitivity of 75%, specificity of 73% and AUROC=0.81. SUI patients were identified with a sensitivity of 79%, specificity of 86% and AUROC=0.89.

Conclusion:

The predictive model using the APFQ accurately differentiates between healthy volunteers and referred patients and between common pelvic floor dysfunctions. The inclusion of condition-specific and qualitative assessments of bladder, bowel, prolapse and sexual function in APFQ may account for the diagnostic accuracy as compared to alternative tools.

1. Barber MD, Maher C. 2013; 24(11): 1783-90.

Pilot Evaluation of 3D printed medical grade Polycaprolactone (mPCL) scaffold for the surgical treatment of pelvic organ prolapse in the sheep model

Chris Maher[1], Alex Mowat[1], Mairim Serafini[2], Flavia Savi[2], Onur Bas[2], Tara Shabab[2], Siamak Saifzedeh[2], Nicholas O'Rourke[1], Zhuoran Chen[1]

1. Royal Brisbane Women's Hospital, Heston, QLD, Australia

2. Queensland University of Technology, Brisbane, QLD, Australia

Objective:

To compare 3D printed medical grade polycaprolactone mPCL scaffolds with polypropylene (PP) mesh for tissue regeneration in vaginal host environment of parous Ewes.

Methods:

mPCL is FDA-approved and CE-marked biodegradable polymer that has been evaluated as a tissue engineered scaffold in rat models for hernia but not within the sheep model or the vaginal environment. Six parous ewes were implanted with 3D printed mPCL scaffolds enriched with Plasma Rich Protein (PRP) in the rectovaginal space (20x20mm) and anterior abdominal wall (30x30mm) and compared to same size light-weight polypropylene (PP) mesh implant. Explants were retrieved at 3 months (4 ewes) and remainder at 6 months with a control sample of tissue from the anterior abdominal wall also retrieved. The mechanical properties and deformation characteristics were investigated via biaxial mechanical tests (plunger test). Histological and immunohistochemical evaluation was assessed by haematoxylin and eosin (H&E), Masson Trichrome and Von Willebrand factor (vWF).

Results:

There was no unexpected Ewe morbidity or graft exposure. The stiffness of the mPCL scaffold explant was greater than control tissue and less than PP a change that was significant in the abdominal explants ($p < 0.001$).

On histology there were no markers of acute inflammation in any treatment groups. The H&E and Masson trichrome staining of the vaginal explants demonstrate integration of fibrous tissue within both implants with the collagen being more densely and uniformly packed around the PP group. The vWF stain confirms equitable vascular response to both groups and reflects the architectural arrangement of the fibrous response seen in the H&E and Masson Trichrome stains.

Conclusions:

In preliminary results the mPCL has equitable collagen and vascular ingrowth when compared to PP with stiffness that is greater than control and less than PP. Further evaluation of mPCL as scaffold for prolapse surgery is warranted.

Hysterectomy or Uphold Uterine Conservation in Women with Apical Prolapse: Medium term follow up.

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1. Monash Health, Melbourne, VIC, Australia

2. Urogynaecology, University of New South Wales, Sydney

Introduction:

There is increasing recognition that women may wish to avoid hysterectomy at the time of pelvic organ prolapse (POP) surgery.

Objective:

To compare objective and subjective outcomes between Uphold and vaginal hysterectomy.

Methods:

This study was designed as a multicentre RCT, due to poor recruitment it was changed to patient preference study. Women with symptomatic uterine descent referred for prolapse surgery were included. Routine clinic follow-up was scheduled at 6 weeks, 6 & 12 months, involving a review, examination with symptom & quality of life questionnaires. Primary outcome was the absence of stage 2 prolapse in apical compartment and a composite cure of no leading edge beyond the hymen, absence of bulge symptoms on questionnaire and no retreatment. Secondary outcomes were quality-of-life measures and complications (PFDI-20, PFIQ-7, PISQ, Patient Global impression of improvement, EQ5D and a health score).

Results:

We performed 50 VH from August 2011 and November 2013 and 51 Upholds from August 2011 to June 2016, a long recruitment period for Uphold as it coincided with transvaginal mesh FDA notification. Median follow up was 25(23-96) months.

Five women from the VH (10%) and 7 from the Uphold (14%) group were lost to follow-up. There were balanced demographics between the two groups at recruitment. Incidence of stage 2 prolapse in apical compartment was 0%in VH and 2.2%in Uphold (p=0.50). The composite cure rate was 52% in VH and 60% in Uphold (P=0.51). Any compartment stage 2 prolapse in VH was 73% and 50% in Uphold (P= 0.04). POPDI was significantly better in VH compared to Uphold (p=0.04), however clinical significance of this is unknown.

There was no significant difference in surgical complication (p=0.33), assessed using Clavien-Dindo classification.Two cases of mesh exposure were noted, 1 requiring mesh excision and other treated conservatively. Incidence of stress urinary incontinence (SUI) on follow up was 27% and 37% in VH and Uphold respectively (p=0.37).

Conclusions:

Uphold uterine suspension and VH appear to have equivalent objective and subjective cure at medium term follow up with no significant difference in surgical complications. Two percent surgery rate for mesh exposure in the Uphold group. There was a trend to more re-operation for stress urinary incontinence in the Uphold group. Longer-term follow-up is in progress.

Acute severe uterine bleeding in reproductive-age women with recent initiation of non-vitamin-K oral anticoagulants - a case series

Vanessa Tatham[1]

1. Hunter New England Area Health Service, Adamstown Heights, NSW, Australia

Introduction:

Increased community use of non-vitamin-K oral anticoagulant (NOAC) medications coincided with a cluster of admissions and consultations of reproductive-age women with acute heavy uterine bleeding.

Methods:

Emergency room consultations and admissions to the gynaecology service of a tertiary facility between 2015 and 2017 were identified and reviewed. Descriptive statistics were performed.

Results:

Ten women with a mean age of 33 years (range 17 - 56 years) were admitted for large-volume uterine bleeding after initiation of rivaroxaban in the context of known or suspected venous thromboembolism (VTE). Mean haemoglobin drop was 23 mg/dL (8 – 42 mg/dL), and 40% received a blood transfusion. Eight women (80%) were not on hormonal suppression when admitted, of

whom six had ceased contraception during the past month. Management included a change to enoxaparin in 60%, change to apixaban in 20%, and two had cessation of anticoagulation due to negative imaging. Eight women commenced or augmented their hormonal suppression, one did not require ongoing hormonal medications, and two had surgical management with ablation and hysterectomy.

Conclusions:

Acute severe uterine bleeding episodes associated with NOAC initiation in women of reproductive-age are usually avoidable. Clinical strategies to avoid this situation include using enoxaparin rather than a NOAC if the diagnosis of VTE is under investigation, initiation of hormonal contraception to coincide with the use of NOAC, and preference of apixaban over rivaroxaban in reproductive-age women.

Intravesical Botox - Patient Satisfaction - Experience from a single practice

Lisa Doble[1]

1. Mater Pelvic Health - Mater Hospital, Pimlico, Pimlico, QLD, Australia

Fifty-one patient's had a total of 56 intravesical Botox injections at Mater Pelvic Health in 2018. These procedures were performed under general anaesthetic in a day surgery setting or an inpatient hospital unit depending on patient co-morbidities. The procedure generally takes 10-15 minutes to perform.

Of the encounters above, 32 have completed post-op questionnaires. In terms of satisfaction on a scale of 1 to 10, 13 procedures (40.625%) were rated by patients as a satisfaction level of 9 or 10. A further 14 procedures (43.75%), were rated at 7-8. Of those that did not complete the post-op questionnaire, a reasonable proportion had comments in the doctor's notes such as Botox 'worked a treat' or 'fantastic, changed my life'.

The main complication as expected was UTI. It is difficult to estimate this accurately as many patients only reported this at the follow-up visit or saw their GP so that urine culture results were unavailable to verify. There do not appear to have been any readmissions for post-op complications. As all patients would be expected to attend the same emergency department, we believe that we would have detected any readmissions.

In summary, Intravesical Botox injections are a

quick procedure with few complications that gives patients relief from their symptoms leading to high patient satisfaction scores in >80% of patients.

SESSION THREE B: FREE COMMUNICATIONS /1400-1500

HYDE PARK ROOM

Treatment of Severe Vaginal Mesh Exposure with Regenerative Medicine

Fariba Behnia-Willison[1, 2], **Robert Carey**[1, 2], **Tran Nguyen**[1, 2], **Robert Thomas T O'Shea**[1, 2]

1. Flinders Medical Centre, Eden Hills, SOUTH AUSTRALIA, Australia

2. FBW Gynaecology Plus, Ashford, SA, Australia

Objective:

To present our experience of treating patients with severe symptoms relating to vaginal mesh complications

Study Design:

There were 10 who were referred to FBW gynaecology practice for treatment of mesh complications.

Background:

Mesh exposure can occur in up to 10% of women with vaginal mesh surgery. Current management is topical oestrogen treatment (E2); however due to severity of atrophic changes and inflammatory reaction between the vaginal mucosa and mesh, E2 treatment is not adequate. Platelet rich plasma is used for treatment of damaged tissue as well as tissue remodelling in multiple disciplines such as orthopaedics, plastic/reconstructive surgery, sports medicine, dermatology and recently in gynaecology (atrophic vaginitis, lichen sclerosis). The growth factors released by the activated platelets promote tissue remodelling by stimulation, migration, proliferation of local and peripheral stem cells to regenerate new and healthy tissue.

Results:

The 10 women referred had all previously undertaken surgery for mesh exposure and excision and were still symptomatic. All women were refractory to treatment with topical vaginal oestrogen 8 (80%) of patients suffered from mesh exposure >5cm in size 2 (20%) of patients suffered from severe vaginal fibrosis. Following unsuccessful standard treatment with topical oestrogen, the group were individually treated with CO2 Vaginal laser and Platelet rich plasma.

All patients treated became asymptomatic in view of pain, bleeding and dyspareunia. These women did not required further surgery. 6/8 had no further mesh erosion evident on examination. 2/10 had ongoing mesh exposure but were asymptomatic and able to participate in intercourse.

Conclusion:

The treatment of severe vaginal mesh exposure is challenging. In recurrent cases, multi-modal treatment may be required. Regenerative medicine in the form of PRP and CO2 laser women with mesh exposure.

The anatomy of stress urinary incontinence: a laparoscopic perspective

Dean H Conrad[1], Praveen De Silva[1], Samuel Daniels[1], Mansour Al Shamari[1], Sarah Choi[1], Danny Chou[1], David Rosen[1], Gregory Cario[1]

1. SWEC, Sydney

Stress Urinary Incontinence (SUI), defined as involuntary leakage of urine with increased intra-abdominal pressure, is a prevalent condition with significant medical, social and psychological burden. Contrary to popular belief, SUI predominantly affects younger women, with peak prevalence occurring between the ages of 35 and 44 (1). The aetiology of SUI is thought to be due to a combination of urethral hypermobility (UHM) and intrinsic sphincter deficiency (ISD), with pregnancy and childbirth being leading contributing factors. Although pelvic floor physiotherapy and continence pessaries are excellent first line options, when conservative measures fail, surgery is the mainstay of treatment.

The choice of surgery for SUI is ideally determined by the underlying pathophysiology. Traditionally, UHM is managed with a bladder neck suspension and ISD with a sling, bulking agent or artificial sphincter. However, despite numerous questionnaires, examination techniques, urodynamic investigations and imaging modalities, there are no standardised tests which can precisely diagnose UHM and ISD. This provides significant challenges for surgeons, who must rely on experience and clinical acumen to guide surgical decision. With the development of the synthetic midurethral sling (MUS) by Ulmsted et al in 1996, a simple, minimally invasive and effective treatment for both UHM and ISD became available. It was widely adopted and for nearly 20 years, became the gold standard approach for the treatment of SUI (2). Despite long term data confirming effectiveness and safety of the MUS, the rise of the "mesh controversy" has seen numerous MUS withdrawn from the market. A future without MUS is fast becoming a reality.

Gynaecologists performing surgery for SUI require an in-depth knowledge of the pathophysiology of UHM and ISD as well as an understanding of the corresponding surgical anatomy. The aim of this educational video is to provide a unique laparoscopic perspective of the anatomy and pathophysiology of SUI. The pelvic nerves responsible for maintaining urethral sphincter tone will be identified, providing practical tips for performing nerve sparing surgery. The fascial supports of the urethra and bladder neck within the retropubic space will be presented in the context of DeLancey's "hammock hypothesis" and Petros' "integral theory" (3). The mechanism of urethral support provided by the MUS and colposuspension sutures will be demonstrated, identifying essential anatomical landmarks necessary for safe dissection and minimising operative complications.

1. Australian Institute of Health and Welfare 2013. Incontinence in Australia. Cat. No. DIS 61. Canberra: AIHW.
2. Ulmsten U, Henriksson L, Johnson P, Varhos G. An ambulatory surgical procedure under local anesthesia for treatment of female urinary incontinence. Int Urogynecol J Pelvic Floor Dysfunct. 1996;7(2):81-86.
3. DeLancey JO. Structural support of the urethra as it relates to stress urinary incontinence: the hammock hypothesis. Am J Obstet Gynecol. 1994;170(6):1713.

Conservative versus radical bowel surgery for endometriosis: A systematic review of complications and outcomes

Sean Heinz-Partington[1], Walter Costa[2], Wellington Martins[3], George Condous[1]

1. Gynaecology, Nepean Hospital, Penrith, NSW, Australia

2. Gynaecology, Reproductive Medicine, Goiânia, Brazil

3. Gynaecology, Reproductive Medicine, Ribeirao Preto, Brazil

Study question:

Is conservative surgery superior to radical surgery in the treatment of bowel endometriosis?

Summary answer:

Conservative surgery is superior to radical surgery in the treatment of bowel endometriosis.

What is known already:

Radical surgery is associated with significant morbidity. Symptomatic and functional outcomes may be similar to conservative surgery.

Participants/materials, setting, methods: We considered eligible any cohort, observational or randomized control trial (RCT) study of at least ten women per arm comparing conservative versus radical bowel surgery for endometriosis. In particular, we analysed moderate shaving or discoid resection versus radical segmental resection surgery, regarding intra-operative, and postoperative complications and outcomes.

Main results and the role of chance: 3,041 studies were screened. Ultimately, 11 studies were included (n=1648; 601 patients in the resection group and 1047 patients in the shaving and discoid resection group). The risk ratio of major complications for shaving and disc excision versus segmental resection is 0.31 (95% confidence interval (CI) 0.21-0.46) (Tau^2 = 0.15, Chi^2 = 18.04, df = 10 (P = 0.05), I^2 = 45%, Z = 5.68 (P < 0.00001)). The risk difference of major complications for shaving and disc excision versus segmental resection is -0.25 (95% CI -0.41--0.10) (Tau^2 = 0.07, Chi^2 = 244.33, df = 10 (P < 0.00001), I^2 = 96%, Z = 3.15 (P = 0.002)). The risk ratio of minor complications for shaving and disc excision versus segmental resection is 0.63 (95% CI 0.36-1.09) (Tau^2 = 0.46, Chi^2 = 27.81, df = 10 (P = 0.002), I^2 = 64%, Z = 1.65 (P = 0.10)). The risk difference of minor complications for shaving and disc excision versus segmental resection is -0.03 (95% CI -0.12-0.05) (Tau^2 = 0.02, Chi^2 = 67.32, df = 10 (P < 0.00001), I^2 = 85%, Z = 0.73 (P = 0.47)). An RCT was also qualitatively describe with results that match the results of this review, which brought the total studies analysed to 12.

Wider implications of the findings: These results confirm previous findings that more conservative shaving or disc excision surgery is associated with a reduced complication rate. This applies to both major and minor complications. Previous studies demonstrated a trend towards this finding, but suffered from relatively low participant numbers, increasing the risk of type 1 statistical error. The significant difference demonstrated here allows surgeons to make informed choices about potential complications when deciding how to approach bowel endometriosis.

Success Rate of Vaginal Pessary Self-Management in Women with Pelvic Organ Prolapse

Pattaya Hengrasmee[1], Maneenin maneeninx2@hotmail.com[1], Asumpinwong chutata@hotmail.com[1], Leerasiri pichai.lee@mahidol.ac.th[1]

1. Female Pelvic Medicine and Reconstructive Surgery Unit, Dept of Obstetrics and Gynaecology, Faculty of Medicine, Siriraj Hospital, Bangkok, Thailand

Introduction:

Pelvic organ prolapse (POP) has become more prevalent in older women who may have more surgical risks and perioperative complications when undergoing surgery for POP repair. Vaginal pessary is considered an effective treatment choice, carrying no surgical risks with low complication rates. Woman's ability to manage the pessary is an important factor predicting success and failure of pessary use.

Objective:

To determine the success rate of self-management of vaginal pessaries for POP and to find out associated predictors for the success and failure of pessary use

Materials and methods:

We conducted a cross-sectional descriptive study of women with symptomatic stage 2-4 who attended Urogynecology Clinic, Siriraj Hospital from August to December 2018. POP stage and location were identified according to POP-Q system. All women diagnosed with stage 2 to 4 prolapse. Appropriate pessary type and size were defined by one urogynecologist. Women were provided with self-educating video and supervised training session demonstrating techniques for pessary self-insertion/removal. Women who were able to self-insert and remove the pessary were defined as 'success' group whereas those who failed either of the process were categorized as 'non-success' group. Factors predicting success and failure of pessary self-management were recorded and analyzed.

Results:

Twenty-four women were found to successfully manage the pessary while 21 failed either of the process, yielding an overall success rate of 53.33%. Women in the success group were significantly younger and had lower BMI ($p = 0.029$ and $p = 0.012$, respectively). Advanced stage apical prolapse was the significant factor in predicting the failure of pessary ($p = 0.002$) whereas ring with support pessary was the significant predictor for the successful outcome. Overall rate of continuing pessary use was 55.6% and the most important reason to continue pessary use was the relief of POP and POP-related symptoms.

Conclusion: Pessary self-management has been confirmed to provide both personal benefits and cost-effectiveness to the hospital and the nation's healthcare system. However, factors predicting the success and failure of the self-management should be identified to optimally select the patients suitable for this option.

1. Adams E, Thomson A, Maher C, Hagen S. Mechanical devices for pelvic organ prolapse in women. Cochrane Database Syst Rev 2004;(2):CD004010.
2. Abdool Z, Thakar R, Sultan AH, Oliver RS. Prospective evaluation of outcome of vaginal pessaries versus surgery in women with symptomatic pelvic organ prolapse. Int Urogynecol J Pelvic Floor Dysfunct 2010;22:273-8.
3. Komesu YM, Rogers RG, Rode MA et al. Pelvic floor symptom changes in pessary users. Am J Obstet Gynecol 2007;197:620-6.

Dare to be Different - Hysterectomy by vaginal natural orifice transluminal endoscopic surgery (VNOTES) an evolution of the original minimally invasive approach to hysterectomy

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2. University of Sydney, Sydney

3. Gyneoncology Department, Westmead Hospital, Westmead, NSW, Australia

4. Sydney West Area Pelvic Surgery Unit, Sydney

Complex surgical procedures are now being performed using smaller and fewer incisions, improving recovery time and reducing post-operative pain, length of stay, allowing appropriate patients to be discharged within 24 hours. Like the advent of anaesthesia and anti-sepsis, emerging minimally invasive surgical techniques are revolutionizing our day to day practice.

Hysterectomy is one of the most common gynaecological procedure performed in Australia. The current trend in the approach to hysterectomy is such that the rate of laparoscopic hysterectomy (LH) is at an all-time high, with a stagnant rate of abdominal hysterectomy (AH) and a dwindling rate of vaginal hysterectomy (VH). Factors contributing to this trend of lower rates of VH include diminishing appropriate case numbers, difficult access and visualization due to patient factors such as previous caesarean section, obesity and other comorbidities as well as challenges encountered while teaching vaginal surgery.

The most recent Cochrane review demonstrated that VH as compared to LH was associated with reduced length of stay, shorter operating time and was more economical, with no difference in short term or long-term complications (1). Another systematic review and meta-analysis comparing TLH to VH revealed lower cost (non-significant), shorter operative times and lower rate of vaginal dehiscence in the VH group (2). Given the benefits of VH, it is imperative to maintain these skills and continue to develop vaginal approach to surgery for the appropriate patient.

Vaginal natural orifice transluminal endoscopic surgery (vNOTES) allows vaginal access (natural orifice) to the intra-abdominal and pelvic cavity to perform procedures including adnexal surgery, myomectomy and hysterectomy. The ability to visualize and magnify using the laparoscope helps to overcome some of the traditional pre-requisites and limitations faced with conventional vaginal surgery. The vNOTES approach has certain advantages in a wide range of situations where it is risky or unsuitable to enter the abdominal cavity and also allow for specimen extraction without an abdominal incision or laparotomy. This is particularly important with the current patient population who are generally more obese and or have multiple co-morbidities. Recent outcomes of a randomized control trial also demonstrated that the vNOTES approach to be non-inferior to total laparoscopic hysterectomy (3).

We will review the evolution of this procedure, the current evidence, appropriate case selection, perioperative care and a single surgeons' operative outcomes. A video presentation of vNOTES hysterectomy will also be demonstrated to highlight the step by step approach and strategies to overcome common challenges.

1. 1. Aarts JWM, Nieboer TE, Johnson N, Tavender E, Garry R, Mol BJ, Kluivers KB. Surgical approach to hysterectomy for benign gynaecological disease. Cochrane Database of Systematic Reviews. 2015 ; 8 Art. No.: CD003677. DOI: 10.1002/14651858.CD003677.pub5
2. 2. Sandberg EM, Twijnstra ARH, Driessen S, Jansen F. Total Laparoscopic Hysterectomy Versus Vaginal Hysterectomy: A Systematic Review and Meta-Analysis. Journal of Minimally Invasive Gynecology. 2016 ; 24(2). DOI: 10.1016/j.jmig.2016.10.020
3. 3. Baekelandt JF, De Mulder PA, Le Roy I, Mathieu C, Laenen A, Enzlin P, Weyers S, Mol B, Bosteels J. Hysterectomy by transvaginal natural orifice transluminal endoscopic surgery versus laparoscopy as a day-care procedure: a randomised controlled trial. BJOG. 2019 Jan;126(1):105-113. doi: 10.1111/1471-0528.15504.

Ten year trend of urinary incontinence and pelvic organ prolapse surgery in Australia

Mounika Penmethsa[1], Mugdha Kulkarni[1], Anna Rosamilia[1]
1. Monash Health, Melbourne, Victoria, Australia

Objective:

To identify the trends in urogynaecological surgical practices for pelvic organ prolapse (POP) and urinary incontinence within Australia from January 2009 to July 2019, and to identify rates of mesh removal since July 2018.

Materials and Methods:

Age specific data regarding the number of urodynamic studies (UDS), female urinary continence and prolapse surgeries, mesh removal surgeries performed in total, are collated from Medicare Australia Statistics over the period of January 2009 until July 2019 and projected till end of 2019.

Results:

Between 2008 and 2015 more than 6700 SUI surgical procedures were performed annually. By 2018, there was a 36% reduction in all SUI procedures (7,593 and 4,247 in 2008 and 2018 respectively), with a specific 51% drop in mid urethral sling (MUS) procedures, whereas urethral bulking agent use increased by 103% between 2008 and 2018.

Management of overactive bladder with intravesical Botox use increased 5 fold in 5 years (176 procedures in 2014 to 985 in 2018 due to Medicare funding for this indication), and 64% increase in sacral neuromodulation between 2014 and 2018. Urodynamic study numbers have remained stable over the 10 year period.

There was a gradual 16% rise in total number of POP surgeries between 2008 and 2014, followed by a steeper decline to near baseline by 2018. The decline included a 15% reduction in vaginal prolapse procedures and 23% in sacrocolpopexy. Of note, there was a rise in Colpocleisis by 24%, possibly due to ageing population trends. Laparoscopic suture suspension procedures increased in that period by 21%; it is not known what proportion of these procedures were performed for POP or prophylactically at the time of laparoscopic hysterectomy.

New Medicare codes were introduced in July 2018 for vaginal or abdominal mesh removal. So far a total of 176 mesh removal procedures were performed in Australia with 43% of performed in Queensland.

Conclusion:

There is overall decline in midurethral sling and mesh based sacral colpopexy surgery in Australia in the last 10 years. Other suture based surgery such as colpocleisis and laparoscopic suspension has increased as has the use of bulking agents and the surgical treatment of refractory overactive bladder. The decrease in surgery for stress urinary incontinence can be due to multiple reasons such as rising Caesarean section rates, lower overall vaginal parity, media attention regarding mesh complications and the withdrawal of transvaginal mesh and single incision slings from Therapeutic Goods Administration (TGA).

SESSION FOUR: DARE TO INNOVATE / 1530-1700

BALLROOM 1

Urogynae current affairs

Stefaan Pacquée

We have seen a number of significant developments in the field of urogynaecology during the past few years. Without doubt, the biggest controversy has been related to the role of mesh. This lecture will elaborate on the challenges and breakthroughs in the management of pelvic floor disorders anno 2019. Is it time to change management of delivery to prevent pelvic floor dysfunction later in life? Is personalised medicine the future and can statistical modelling and machine learning help us in making clinical predictions for our individual patients?

The vaginal mesh debate exposed us… Where are our databases?

Lynsey Hayward

Abstract not yet received.

Does the laparoscope have a place in urogynaecology? Prove it!

Marcus Carey

For 25 years minimal access surgery (MAS) has become an essential component of urogynaecology surgery with some laparoscopic pelvic floor procedures now considered routine such as sacral colpopexy and Burch colposuspension. More recent indications for laparoscopic and robot-assisted pelvic floor surgery include removal of pelvic mesh, non-mesh uterosacral ligament vault suspension, uterus-conserving prolapse surgery and selected urogenital fistulae. Laparoscopy has a number of advantages over laparotomy, including reduced blood loss, fewer perioperative complications, reduced post-operative pain, earlier recovery, shortened hospital stay, reduced adhesions and improved anterior abdominal wall cosmetic appearance. However, laparoscopic urogynaecology surgery is complex and technically demanding with a long learning curve. This is due to a range of limitations of conventional laparoscopy such as non-wristed instruments (*straight stick*), difficulty performing accurate suturing, unfavorable ergonomics for both surgeon and assistant, and two-dimensional vision. These limitations have contributed to the relatively low adoption of laparoscopy by Australian pelvic floor surgeons for selected prolapse and anti-incontinence procedures. This in turn has a negative knock-on effect for trainees in training centres not routinely offering laparoscopy pelvic floor surgery.

To improve the adoption rates of minimal access surgery (MAS) for selected urogynaecology procedures, trainees will need to undertake dedicated MAS training. Robotic-assisted laparoscopic pelvic floor surgery will overcome the main limitations of conventional laparoscopy allowing more pelvic floor surgeons to adopt MAS in urogynaecology.

Paradise lost? Is there still a role for vaginal mesh?

Alan Lam

Abstract not yet received.

Big data, grand plans and the pelvic floor

Elvis Šeman

Objective:
Review the background to the establishment of the Australasian Pelvic Floor Procedure Registry (APFPR), it's development and implementation, and examine some practical questions it raises. Assess the strengths and limitations of existing urogynaecological databases.1,2

Design:

Review of the relevant literature, and discussion with gynaecological database managers and other stakeholders.

Method:

A review of editorials on the Australasian and other pelvic floor procedure registries, interview of managers of the Urogynaecological Society of Australia (UGSA) and Surgical Performance databases, and a review of the Flinders Medical Centre experience of the UGSA database. Reflection on the subject matter in relation to the conference theme.

Results:

There is substantial public and political pressure to establish an Australasian Pelvic Floor Procedure Registry. There are key practical questions about the registry which remain unanswered. Of the 2 Australasian gynaecological databases, Surgical Performance respects surgeon ownership of the data and appears to have greater potential to be a future tool for the APRPR than UGSA.

Conclusion:

Our specialty should maintain control of the process to establish the APFPR so as to minimise the risk of an administrative Pandora's box.

Autologous grafts - back to the future?

Fariba Behnia-Willison

Objective:

To present our experience of utero-vaginal prolapse repair augmentation with autologous platelet rich plasma (PRP) graft.

Design:

Prospective cohort study of women who underwent primary or secondary utero-vaginal prolapse surgery augmented with autologous PRP graft. Women were enrolled into the study at FBW Gynaecolology Plus, a private practice in Adelaide, Australia, during August 2018 to October 2019. In Australia and other countries, such as Ireland, vaginal mesh and biological implants have been withdrawn from the market. Therefore, there is a need for safe, innovative, and minimally invasive technology to perform pelvic floor reconstruction. There is an increasing demand and acceptance of autologous procedures used in other specialties, such as musculoskeletal medicine, orthopaedics, and plastic reconstructive surgery, globally. Hence our study that looks into alternatives to enhance the vaginal repair success rate.

Method:

Women with symptomatic pelvic organ prolapse who opted to undergo vaginal repair were recruited to this study for PRP graft augmentation of their vaginal repair at the time of surgery. Intraoperatively, PRP tubes, fibrin, and calcium gluconate were used to create the graft, which required sequential centrifugation. The PRP graft was sutured onto the endopelvic fascia after site-specific vaginal repair with V-lock sutures. Follow-up was planned at six weeks, six months, and 12 months. Patient assessment included Pelvic organ prolapse quantification (POPQ), degree of vaginal atrophy, and Australia Pelvic Floor Questionnaire (APFQ).

Results:

There have been 59 anterior, posterior, or combined cases of PRP-graft-augmented vaginal repairs in 38 patients. There were no major complications. There were five cases of minor complications and one failure at the apical support, needing colpocleisis. Follow-up of 12 months has been obtained for some cases, results of which will be presented.

Conclusion:

PRP graft appears to be a safe and feasible treatment to augment repair of symptomatic utero-vaginal prolapse, especially in recurrent pelvic floor repair. However, the efficacy requires longer follow-up studies and RCTs to assess the role of this method in pelvic floor repair.

New wave technology and the pelvic floor - is it the way?

Christopher Maher

Abstract not yet received.

Pain after sexual violence

Denis Mukwege

Abstract not yet received.

SATURDAY 2ND NOVEMBER 2019

SESSION FIVE: DIFFERENT COLLABORATIONS / 0800-1000

BALLROOM 1

Are physios all the same? Physiotherapy philosophies

Kari Bø

Abstract yet to be received.

Myotherapists - muscular magicians?!

Taryn Hallam

With extensive randomised controlled trials and systematic reviews now available, there is now little conjecture as to whether pelvic floor muscle training can be effective in the management of urinary incontinence. However, in other urological, gynaecological and colorectal conditions the role of a 'muscle based' approach is more controversial.

Early clinical science research provides some evidence there could be a link between pelvic pain syndromes and pelvic floor muscular dysfunction (particularly pelvic floor hypertonicity), through viscerosomatic convergences and antidromic facilitated neural inflammatory processes. However, does this necessarily indicate that physiotherapists can influence muscle function through peripheral muscular release techniques?

This presentation will aim to look at what we currently know and don't know about pelvic floor dysfunction and pelvic pain, explain the difficulties we face in attempting to design research to answer these questions, and provide an overview of the theoretical principles that both suggest and refute that a muscle based approach has validity in this complex area.

Colorectal collaboration

Shahrir Kabir

This will be a two part talk. The first will broadly cover the topic of intra-operative bowel related injuries, how to prevent them, steps in identification and management. The second part will focus on the role of the colorectal surgeon as part of a multidisciplinary team in management of both endometriosis and pelvic floor disorders.

Getting it going - the GP's role in pelvic floor management?

Sara Yousaf

Abstract yet to be received.

Help! The urologist and urotrauma

Justin Vass

Complications after any type of surgery is inevitable. Iatrogenic Urological injuries during gynaecological surgery can have devastating consequences with significant long term sequelae. We will discuss the risk factors that may predispose patients to urological injury and how possibly we can minimise the risk preoperatively. How to recognise injuries to the urinary tract intra-operatively and post-operatively will be discussed. Options for repair to Ureteric, Bladder and Urethral injuries will be discussed and advice on how you can help your Urologist help you when disaster strikes.

Urogynae nurses nurturing the service

Wendy Allen

Urogynae Nurses Nurturing the Service: Nurses are an integral part of the team in caring for patients with prolapse and incontinence issues. The role is a varied one including patient care, assisting with procedures, research, education and everything in between! This talk will discuss the ever changing and growing role nurses play in an Urogynaecology service.

Let's talk about sex therapy

Rosie King

Sexual dysfunctions constitute a heterogenous group of disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure. Causes of sexual dysfunction include organic, sociocultural, psychological, relationship and cognitive factors thus sex therapy takes a bio-psycho-social approach. Sexual dysfunctions are common - in sexually active 18 to 59 year olds 31% of men and 43% of women report sexual dysfunction but only a minority seek help. Patients don't tend to volunteer sexual information – it is important to ask an open-ended rather than a closed question to address issues. Ignorance and unrealistic expectations about sex are common and education and reassurance may be all that is needed. There are several modalities of treatment available depending on the presenting issue.

SESSION SIX : DIFFERENT OBSTETRIC ISSUES / 1030-1210

BALLROOM 1

Physiotherapy and the post-partum patient - the evidence

Kari Bø

Abstract not yet received.

Scarab and UR choice

Harsha Ananthram

Abstract not yet received.

Assisted vaginal delivery and pelvic trauma - the green top guideline

Jennifer King

This topic was planned to look at whether the RCOG guidelines are adequate to the task – do they sufficiently explain and inform about the risks of pelvic floor trauma associated with instrumental vaginal delivery? The assumption would appear to be that we aim to give such information (antenatally or intrapartum) so the fully dilated patient, faced with failure to progress or foetal distress, can decide whether she prefers to have an operative vaginal delivery or a Caesarean section.

Is this really ethical behaviour? Do we really believe this type of management decision is a matter of patient autonomy and that we can be absolved of responsibility after quoting percentages - because it is the patient's right to choose? "Informed consent" may be adequate for a patient deciding whether or not to proceed with a very elective procedure such as incontinence surgery. But for major intrapartum management decisions surely it remains our clinical duty to explain, to recommend and to proceed with the safest and most expeditious mode of delivery.

Towards normal birth?

Jason Mak

In Australia approximately one third of infants are delivered via caesarean section. The rising Caesarean delivery rate is seen by many as a problem that requires a solution and government strategies both here and around the globe have aimed at curbing the number of caesarean sections performed. Here in NSW the archetypal "Toward Normal Birth" policy set the benchmark caesarean delivery rate at 20% and included a range of measures designed to achieve this target. What is not clear is why caesarean delivery is inferior and why the rate needs to change at all. No supporting evidence is provided anywhere in the policy document. In this session we will attempt to bridge this gap in evidence by addressing the following questions: What evidence is there for lowering the caesarean delivery rate? What are the comparative risks of planned caesarean delivery and planned vaginal delivery? What evidence is there for the strategies outlined in the policy? What would be the impact on women and babies of attempting these strategies and achieving a caesarean delivery rate of 20%?

Australian Birth Trauma Association

Jessica Caudwell-Hall & Amy Dawes

Abstract not yet received.

The Pacific and training - are we on track?

Amanda Noovao-Hill

The scale of pelvic floor disorders in Fiji is unknown. We are seeing significant issues with urinary incontinence but many women do not complain and access care. Pelvic organ prolapse is a growing issue particularly with obesity being endemic. An unpublished paper in 2011 reported that almost 24% of women attending O&G clinics in two of three of the Fiji divisional hospitals had urinary incontinence; of these 44% were unaware this was a gynaecological problem. One third of these women felt their condition was not significant enough to seek medical assistance while the remaining two thirds believed it was a normal part of aging that they just had to accept and live with.

Currently there is no local Fijian Gynaecologist trained in the subspecialty of Urogynaecology. Recent retirements and planned future retirements will result in the little expertise that currently exist, being lost. Sporadic ad hoc training has been available through Ajay Rane and his teams visits to Fiji for the last four years. This has raised awareness and encouraged some level of competency development. There is a significant gap in care and expertise in the Pacific. There is no formal strategy to meet the gap. Local health services do not see pelvic floor disorders as an urgent priority. The women continue to suffer their symptoms

Suggestions for a way forward include raising community awareness, advocacy with health providers, identifying two or three people for training, and buy in for annual short-term workshops by the clinical services networks and training institutions.

SESSION SEVEN: DIFFERENT PLIGHTS / 1310-1445

BALLROOM 1

Re-constructive pelvic surgery after gender-based violence

Denis Mukwege

Abstract not yet received.

KEYNOTE: Is physical activity good or bad for the pelvic floor?

Kari Bø

Abstract not yet received.

Different surgeries - dare we do it?

Gregory Cario, Jay Iyer & Stephen Lyons

In the aftermath of the worldwide hysteria regarding mesh used in the pelvis, the Burch Colposuspension first described in the 1960s has re-emerged as a significant force in incontinence surgery in its Laparoscopic and less so its Robotic form. The SWEC unit is about to publish in ANZJOG an article entitled "Long term patient reported outcomes after Laparoscopic Burch Colposuspension" by a single surgeon over 6 years with a successful outcome in 90.7% of cases. As the TVT was involved as collateral damage particularly in the UK, many gynaecologists are keen to offer this minimally invasive operation to patients and health authorities who are averse to any type of mesh. This video presentation looks at the surgical anatomy of the retropubic space followed by a step by step look at the Tanagho modification of this technique which I learnt from Stuart Stanton at St Georges hospital in London in 1982.

SESSION EIGHT: CHANGE, DIFFERENCE & POLICITCS / 1510-1710

BALLROOM 1

Rohingya crisis - challenges for women

Sayeba Akhter

Introduction:
"Forcibly displaced people" are labelled as "Refugee" and refugee crisis has been on a constant rise in past few years due to increasing political and ethnic conflicts around the globe. Since generation after generation, there has been deliberate persecution against "Rohingya population" in the Northern Rahkhain state of Myanmar with a view to eliminate the minority Muslims from the state. The Myanmar government denied their citizenship, violated their rights to education, health care and social security and allowed the ruthless army to do physical, sexual and emotional violence upon the Rohingyas rendering them rootless, stateless and homeless. Consequently, there has been fleeing of Rohingyas for decades from Myanmar to Bangladesh in bouts. Since August 2017, the massive influx of Rohingyas in Bangladesh has given rise to the fastest growing refugee crisis in the world. Such a crisis not only poses threat to humanity but also brings countless challenges to the survivors, particularly the women and children.

Objectives:

1. To analyze the challenges faced by the Rohingya women.
2. To overview the situation of the refugee camps in Bangladesh, particularly highlighting the perspective of women.
3. To ascertain the supports provided to the Rohingya community to overcome the crisis.
4. To figure out what more can be done to improve their quality of life.

Overview:
The history of hosting displaced Rohingyas in Bangladesh dates back to 1948. Since then, there has been influx of persecuted Rohingyas in installments. The largest invasion occurred in August 2017, when around 7,00,000 people fled from Myanmar, crossing border on boats or on feet to escape the brutal killing and destruction by Myanmar army. Now the number has crossed

over one million, 45.8% of them are women of reproductive age. These women are the victims of "Conflict related sexual violence" and did not receive any post assault medical care, emergency contraception and prophylaxis against HIV. Due to loss of livelihood, decreased economic opportunity, heightened insecurity and absence of education, there is a high prevalence of childhood marriage and dowry exchange in the camps. The contraceptive prevalence rate is 34% and there is inadequate availability and accessibility to SRH services. Only 22% of birth take place in facility. Women and especially adolescent girls are susceptible to sexual abuse and GBV in the form of sexual harassments, child marriage, women and child trafficking etc. In the camps 57% women feel unsafe in simply using latrines. There are reported incidents of "Survival sex" among Rohingya women. In addition to the scarcity of food, shelter, wash facilities, safe water and sanitation, out breaks of communicable diseases, these are the additional obstacles that the Rohingya women are facing every single day. 21 HIV cases have been reported.

The situation demands intensive, organized and global support to overcome such humanitarian crisis. Bangladesh Govt. has allocated 6000 acres of land to host the Rohingya community despite squeezing up the allocations for the host population. The Govt along with its health ministry and armed forces, the UN agencies and more than 150 national and international development partners are working together to provide humanitarian assistance to these stateless refugees. The camps have been extended. More than 5,00,000 Rohingyas are provided with ID cards. The supply of food and safe water is there, though not adequate to meet the necessity. Women are getting "Dignity kits" containing sanitary napkins and other necessary items to maintain personal hygiene. Health facilities are established inside camps to provide ANC, delivery services, PNC, emergency obstetric care and contraceptive services. There are "Women friendly spaces" for safe gathering of women inside camps. But there are fundamental needs like ensuring safety and security, providing education and empowering women that still lag far behind.

Conclusion:
Rohingya crisis is not a crisis of Bangladesh alone. It is the crisis of the whole humanity. Effective efforts of repatriation must be materialized through national and international collaborative efforts. The Rohingya women's sexual and reproductive health rights must be recognized and established.

Challenges for a urogynaecologist in a developed world

Anna Rosamilia

Abstract not yet received.

Far from the city - bush urogynaecology

Elizabeth Gallagher

Women living out of major centres still have the same issues as women in the cities, although don't have the same access to help and facilities. This talk will look at options for managing some problems in the rural and remote areas of Australia, including apps, and the future of telemedicine.

The provincial fellows need to be able to manage many gynaecological problems and triage those that do need referral as travelling for health care takes time, a cost, and disruption to family and work. Limited opportunities for surgical experience means that many trainees are not going to be equipped to manage all aspects of gynaecology and obstetrics that earlier generations of trainees did. Therefore there may be a need for the support and development of "special interest" generalists in rural areas.

This talk will explore the current and future barriers to equitable management for rural and remote women and how we can support them and the specialists who care for them and their community.

Medical interventions in the developing world. Can we help? Should we help?

Sayeba Akhter

Abstract not yet received.

KEYNOTE: How to truly make a difference

Denis Mukwege

Abstract not yet received.
