



ABSTRACT BOOKLET

AGES PELVIC FLOOR
SYMPOSIUM &
WORKSHOP XVI 2015
THE 3 C'S:

Choices, Chances, Changes.

7-8 August 2015

Sheraton on the Park - Sydney, Australia

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Program

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Day 1 Friday 7 August 2015

7.30am - 8.00am	Conference Registration
7.30am - 8.00am	Arrival tea and coffee
Session 1 8.00am - 10.00am	<p>Pelvic organ prolapse – What choice do I have? What chance do I have? What change should I make?</p> <p>CHAIRS: Ajay Rane & Jason Abbott</p> <p>Surgical management of primary utero-vaginal prolapse: How to make an informed choice <i>Catherine Matthews</i></p> <p>Mesh or no mesh in pelvic / vaginal reconstructive surgery <i>Jan-Paul Roovers</i></p> <p>Medicine and Healthcare Products Regulatory Agency (MHRA) report on the benefits and risks of vaginal mesh implants <i>Stephen Jeffery</i></p> <p>Where are we in Australia on mesh litigation <i>Peter Henderson</i></p> <p>What chance do I have... <i>Alan Lam</i></p> <p>Discussion <i>Panel</i></p>
10.00am - 10.30am	Morning Tea & Trade Exhibition
Session 2 10.30am - 12.30pm	<p>Choices, Chances, Changes to control your bladder</p> <p>CHAIRS: Alan Lam & Harry Merkur</p> <p>Overactive bladder (OAB) <i>Jenny King</i></p> <p>Recurrent cystitis <i>Anna Rosamilia</i></p> <p>Bladder pain syndrome <i>Audrey Wang</i></p> <p>Dealing with complications in urinary stress incontinence surgery <i>Greg Cario</i></p> <p>How best to avoid fistula <i>Jay Iyer</i></p> <p>Discussion <i>Panel</i></p>
12.30pm - 1.30pm	Lunch & Trade Exhibition
Session 3 1.30pm - 2.00pm	<p>Keynote Lecture</p> <p>CHAIR: Anusch Yazdani</p> <p>Future trends for the management of pelvic organ prolapse <i>Catherine Matthews</i></p>
Session 4 2.00pm - 3.00pm	<p>FREE COMMUNICATION SESSION</p> <p>CHAIRS: Stephen Lyons, Stuart Salfinger & Rachel Green (See page 9 for full listing)</p>
3.00pm - 3.30pm	Afternoon Tea & Trade Exhibition
Session 5 3.30pm - 5.30pm	<p>Choices, Chances, Changes of Sexuality</p> <p>CHAIRS: Krish Karthigasu & Robert Ford</p> <p>What's normal? <i>Ajay Rane OAM</i></p> <p>Assessment of female sexual dysfunction <i>Lesley Yee</i></p> <p>Physiologic measurements of the vagina to study effects of surgery on pelvic floor function <i>Jan-Paul Roovers</i></p> <p>Male and female sexual dysfunction after repair surgery <i>Catherine Matthews</i></p> <p>Gender – Choices, Chances, Changes <i>Stephen Jeffery</i></p> <p>Discussion <i>Panel</i></p>
7.30pm	Gala Dinner

Day 2 Saturday 8 August 2015

7.30am - 8.00am	Conference Registration
7.30am - 8.00am	Arrival tea and coffee
Session 6 8.00am - 10.00am	<p>Real live surgical experience – Pearls & Pitfalls</p> <p>CHAIRS: Alan Lam & Ajay Rane</p> <p>PANEL: Anna Rosamilia, Greg Cario, Marcus Carey, Catherine Matthews, Jan-Paul Roovers & Stephen Jeffery</p>
10.00am - 10.30am	Morning Tea & Trade Exhibition
Session 7 10.30am - 12.30pm	<p>Taking chances with new choices</p> <p>CHAIRS: Haider Najjar & Emma Readman</p> <p>Non-surgical choices for management of pelvic organ prolapse <i>Gil Burton</i></p> <p>A radical change in management of fecal incontinence: Introduction of an innovative vaginal bowel control device <i>Catherine Matthews</i></p> <p>A simple device with profound results <i>Ajay Rane OAM</i></p> <p>I want surgery, but can I do crossfit? <i>Taryn Hallam</i></p> <p>Sacral modulation – role, benefits, limitations <i>Marcus Carey</i></p> <p>Discussion <i>Panel</i></p>
12.30pm - 1.30pm	Lunch & Trade Exhibition
Session 8 1.30pm - 2.00pm	<p>Keynote Lecture</p> <p>CHAIRS: Alan Lam & Anusch Yazdani</p> <p>Development of a new material to treat pelvic organ prolapse <i>Jan-Paul Roovers</i></p>
Session 9 2.00pm - 2.40pm	<p>Interactive session – “Help!!! I’m in deep trouble”</p> <p>Chair/MC: Ajay Rane</p> <p>PANEL: Catherine Matthews, Jan-Paul Roovers, Stephen Jeffery, Alan Lam, Greg Cario, Robert O’Shea, Anna Rosamilia, Salwan Al Salihi</p>
2.40pm - 3.10pm	Afternoon Tea & Trade Exhibition
Session 10 3.10pm - 4.50pm	<p>Obstetrics and Urogynaecology</p> <p>CHAIRS: Salwan Al Salihi & Simon Edmonds</p> <p>Does mode of delivery affect sexual function? <i>Alison DeSouza</i></p> <p>Changes in obstetric practice, choices of mode of delivery, chances of placenta accreta <i>Stephen Lyons</i></p> <p>Placenta etcetera - don't worry, I'm here <i>Greg Gard</i></p> <p>I'm incontinent and I've got prolapse, but I want another baby <i>Stephen Jeffery</i></p> <p>Discussion <i>Panel</i></p>
4.50pm - 5.00pm	<p>Awards</p> <p>CHAIRS: Ajay Rane & Alan Lam</p>
Session 11 5.00pm - 5.30pm	<p>Debate</p> <p>CHAIRS: Ajay Rane & Alan Lam</p> <p>Go 'Brazilian' if you want to protect your pelvis Yes: <i>Catherine Matthews & Stephen Jeffery</i> No: <i>Jan-Paul Roovers & Anna Rosamilia</i></p>

Choices, Chances, Changes.

AGES PELVIC FLOOR SYMPOSIUM & WORKSHOP XVI 2015 – THE 3 C'S: 7-8 August 2015

Program Abstracts

Friday 8 August 2015

Session 1 / 8.00am – 10.00am

Pelvic organ prolapse – What choice do I have? What chance do I have? What change should I make?

Surgical management of primary utero-vaginal prolapse: How to make an informed choice

Catherine Matthews^{1,2}

1. *Carolinas Institute for Pelvic Health, Winston Salem, North Carolina, USA*
2. *University of Cape Town, Cape Town, South Africa*

The primary surgical management of uterine prolapse is controversial and well-designed comparative trials are lacking. Women with this diagnosis face several important questions including uterine preservation versus removal, native tissue versus mesh augmentation, vaginal versus laparoscopic versus open approach, and which procedure optimizes a personalized risk/benefit ratio. For example, a 40 year-old sexually active woman with Stage III multi-compartment prolapse may tolerate a higher risk profile to achieve better long-term efficacy compared to a 75 year-old medically infirm patient in whom surgical morbidity must be minimized. It behoves every pelvic surgeon to recognize that risk aversion is paramount as we are treating elective, quality of life conditions. In addition, before considering uterine preservation or a supracervical hysterectomy with morcellation, surgeons must understand the potential risk of unanticipated uterine pathology in this patient population.

The primary objectives of this lecture are to discuss the:

- Rate of unanticipated uterine pathology in women undergoing surgery for POP
- Risks and benefits of uterine preserving surgery
- Outcomes of native tissue vs sacrocolpopexy repair
- Primary risk factors for surgical failure

Following this talk, surgeons will be better equipped to conduct an informed discussion regarding the preferred treatment choice for any individual patient with uterine prolapse.

Mesh or no mesh in pelvic / vaginal reconstructive surgery

Jan-Paul Roovers

The working mechanism of vaginal mesh is to reinforce weakened tissue by inducing a host response that results in production of new collagen and elastin by fibroblasts. Whereas conventional surgery relies on connective tissue that has been proven to be weak, mesh procedures rely on newly developed support.

After the FDA reports in 2008 and 2011, and especially after a very critical public opinion, physicians have stepped away from vaginal mesh. The interesting aspect of this observation is that this happened at the moment that strong evidence came out, providing evidence that mesh generates better objective and subjective cure, as compared to conventional surgery.

The truth is: vaginal mesh was too fast and too wide, implemented, but it was criticized in an unbalanced way, resulting in a situation that our patients do not benefit from.

In this talk the evidence on vaginal mesh will be presented, as well as the status of the debate between those who favour mesh and those who defeat its use.

Medicine and Healthcare Products Regulatory Agency (MHRA) report on the benefits and risks of vaginal mesh implants

Stephen Jeffery¹

1. *University of Cape Town, Cape Town, South Africa*

Ask ten experts on pelvic organ prolapse about their ideal choice of intervention for prolapse surgery and you will receive ten perfect but different options. Most surgeons feel that their patients have an excellent chance of cure and of course you should change your approach to adopt their technique.

The most complex issue in pelvic floor reconstructive surgery is the interplay between the broad range of options available to us, the chances of recurrence and complications and then also trying to decide on whether a new technique should be learnt.

Surgical outcomes after prolapse surgery are often disappointing. This not only includes recurrences but complications as well, not only for mesh but also for native tissue surgery. In the recently published OPTIMAL trial comparing uterosacral ligament suspension to sacrospinous fixation, 16% of women had serious adverse events. This included ureteric injury and persistent pain. Recurrence rates were 5%.

The surgical choices for pelvic organ prolapse have expanded substantially over the past century. It remains unclear as to whether these have been associated with substantial improvements in outcomes. . The mesh kit devices made the biggest impact on surgery for prolapse. These were associated with large-scale controversy and many surgeons are still faced with the dilemma of whether these should be part their armamentarium.

The decision to use vaginal mesh in pelvic organ prolapse (POP) surgery is controversial. This was highlighted on 29 April 2014 when the U.S. Food and Drug Administration issued two proposed orders to address the health risks associated with surgical mesh used for transvaginal repair of POP. If finalized, the orders would reclassify surgical mesh for transvaginal POP from a moderate-risk device (class II) to a high-risk device (class III) and require manufacturers to submit a premarket approval (PMA) application for the agency to evaluate safety and effectiveness. The UK MHRA (Medicines & Healthcare products Regulatory Agency) in October 2014 also issued a statement on the role, indications and contra-indications to mesh in vaginal surgery.

The safest surgical approach to using a vaginal mesh graft is to consider whether it is indeed necessary to use a prosthetic material in the planned procedure. While a large number of high-volume pelvic floor surgeons completely avoid using vaginal mesh in prolapse pelvic floor surgery, there is good long term data to support the use of these products in selected cases.

Every surgeon embarking on a vaginal mesh operation has to consider a number of important issues before proceeding. Studies have shown that re-intervention rates for vaginal mesh based techniques are higher than for both native tissue surgery and abdominal mesh procedures. Complications are also much higher in the hands of low-volume surgeons and in those inexperienced in the use of mesh. It is also prudent to review the guidelines on mesh of the individual societies and associations before proceeding.

A robust indication to use mesh is mandatory. Most surgeons who have continued to use mesh reserve it for women who have a high risk for recurrence in the anterior or apical compartment. These include women with a recurrent cystocele and women with a vault prolapse with a large anterior compartment component. It is never indicated for posterior compartment surgery.

It is essential to counsel the patient thoroughly pre-operatively. This discussion should include the increased risks of re-intervention, exposure, erosion and most importantly, the risk of post-operative pain. The women should also be informed of the alternatives, including conservative measures, native tissue surgery and abdominal sacrocolpopexy if appropriate.

In order to minimise the risk of post-operative complications, it is essential to select an appropriate mesh device. It is essential to use a device that has intra-operative adjustability and that provides adequate apical support. The anterior single-incision mesh kits that attach onto the sacrospinous ligament are the procedures of choice. It is safer to opt for the product with the lightest mesh and smallest surface area. It is also essential to prescribe pre-operative estrogen cream.

The following procedural steps ensure the safest placement of the mesh:

- Start with a completely empty bladder and retain the catheter with bag attachment so that the urine can be monitored for haematuria.
- Inject a large amount of hydrodissection (between 150 and 200ml), this ensures an adequate depth of dissection.
- Perform a good full thickness vaginal dissection.
- Get into the right plane using sharp dissection, before resorting to blunt dissection. This decreases the risk of bladder injury.
- During dissection, constantly monitor the urine for haematuria.
- If blood is noted in the urine, either do a dye test or perform a cystoscopy before proceeding to mesh placement.
- If the bladder is injured during the dissection, it would be prudent to proceed with a native tissue repair instead of a mesh procedure.
- Secure the mesh to the vaginal apex with two sutures.
- Make sure that the mesh attachment is well clear of the Pudendal nerve (ie 2cm from the Ischial Spine)
- Once the mesh is deployed ensure that it is completely tension-free. Using a mesh with post-insertion adjustability ensures that this is possible.
- It is prudent to perform a cystoscopy after every vaginal mesh procedure.

It is essential to monitor the patient carefully for the development of post-operative complications.

Where are we in Australia on mesh litigation

Peter Henderson¹

1. *Avant Mutual Insurance, Koombalah, QLD, Australia*

The current claims experience at Avant with regard to pelvic floor reconstruction operations will be presented. What are your chances of a civil claim of a complaint?

Are there medico-legal considerations to consider when choosing a procedure for your patient?

An illustrative case will be used to highlight the practice procedures and policies you can adopt to protect yourself.

What chance do I have...

Alan Lam

Given the complex environment marked by a myriad of surgical techniques, diverse and conflicting opinions, lack of high-quality evidence, rapid technological changes, what chance do we have of:

- Obtaining adequate surgical skills
- Providing patients with adequate information
- Overcoming media hysteria and legal hype
- Helping patient choose the 'right' option
- Improving functional outcomes
- Resolving prolapse
- Fulfilling expectations
- Avoiding complications
- Mitigating malpractice risks

These fundamental questions are systematically explored in this practical presentation aimed to stimulate discussion and provide answers to the many issues which concern everyone in day to day practice.

Session 2 / 10.30am – 12.30pm

Choices, Chances, Changes to control your bladder

Overactive bladder (OAB)

Jenny King¹

1. *Westmead Hospital, Westmead, NSW, Australia*

Are there any new medications and how effective are they? What is the place for botulinum toxin injections and sacral neuromodulation? Plus an overview of the new USANZ / UGSA Australian guidelines on OAB.

Recurrent cystitis

Anna Rosamilia¹

1. *Cabrini Medical Centre, Malvern, VIC, Australia*

Recurrent urinary tract infections are defined as 2 or more episodes in the last 6 months or 3 or more in the last 12 months. There is a greater than 50 % lifetime risk for a woman to acquire a UTI with about 25% of these having a recurrence. A recurrence can either be a relapse or a reinfection; the latter if it occurs > 2weeks after treatment or sterile urine. Risk factors vary between premenopausal and post menopausal women; in the former; sexual activity, diaphragm use, history of childhood UTI's , family history and in the latter; oestrogen deficiency, incontinence; cystocele and elevated post void residual are often implicated. The investigations including imaging, cystoscopy will be discussed. In addition, the role of preventive measures such as cranberry, vitamin c, methenamine salts, prophylactic antibiotics will be discussed. Newer preventive strategies under trial include D-mannose, vaccinations and probiotics.

Bladder pain syndrome

Audrey Wang¹

1. *Westmead Hospital, Sydney, NSW, Australia*

IC/BPS is a chronic condition which is characterised by an unpleasant sensation (pain, pressure, discomfort), perceived to be related to the urinary bladder and is associated with lower urinary tract symptoms of more than six weeks duration, in the absence of infection or other identifiable causes. Its definition has been updated a number of times to better reflect our improved understanding of this condition. Currently the aetiology of IC/BPS is not fully elucidated and there is no cure. Patient education, therapeutic trials and multimodal therapy are often needed to achieve effective symptom control. The aim of this lecture is to provide an update and examine the effectiveness of new therapeutic interventions.

Dealing with complications in urinary stress incontinence surgery

Greg Cario¹

1. *Sydney Women's Endosurgery Centre, Kogarah, NSW, Australia*

Urinary stress incontinence is a very distressing problem and generally surgery results in excellent outcomes. Surgical options include urethral slings, transvaginal tapes, retropubic suspensions, electrical stimulation and urethral bulking agents. The surgery is sometimes very simple but dealing with the complications can be very challenging. These complications and their management will be discussed with particular reference to TVT and Laparoscopic colposuspension.

Complications include:

1. Bleeding
2. Infection including the operation site and the urinary tract
3. Bladder injury
4. Urethral injury
5. Fistula
6. Neurological injury and pain
7. Mesh related complications including exposure and perforation of the urethra and bladder
8. Bladder outlet obstruction and voiding dysfunction and retention
9. Overactive bladder symptoms
10. Failure and reoperation
11. Sexual function and dyspareunia.

How best to avoid fistula

Jay Iyer^{1, 2, 3}

1. *Townsville Hospitals, Townsville, QLD, Australia*
2. *Mater Hospital, Townsville, QLD, Australia*
3. *James Cook University, Townsville, QLD, Australia*

The talk highlights simple tips and tricks to avoid urological injury and subsequent formation of urogenital fistulae in surgical practice. Postoperative urinary tract fistulae are one of the many risk factors associated with pelvic surgery. It is estimated that the risk of injury to the urinary tract is about 1% and many of these injuries are occult at the time of surgery. Occult injuries of either the bladder or ureters may subsequently result in the leakage of urine outside of the urinary collection system, tracking eventually to the vaginal cuff to spontaneously drain as a vesicovaginal fistula or a ureterovaginal fistula. While fistulae can result in an anatomically normal surgical field, the most common risk factor associated with urinary fistulae after pelvic surgery is the presence of anatomical distortion. Preventive strategies like adequate preoperative imaging, optimal surgical exposure, sharp dissection, use of devices to better define anatomy like stents and appropriate use of energy sources are also discussed in the talk. Clues to detecting intra-operative urological injuries are touched upon as are the immediate measures one could undertake to prevent fistula formation. Finally a brief discussion of the investigations and management of urogenital fistulae is covered in the talk.

1. *Prog Urol. 2015 Jun;25(8):474-81. doi: 10.1016/j.purol.2015.03.002. Epub 2015 Apr 10. [Evolution aspect of anatomy clinical lesions of urogenital fistula (UGF) in Cocody Teaching Hospital urological unit from 1990 to 2011]. [Article in French] Konan PG1, Dekou AH1, Gowé EE2, Vodi CC1, Fofana A1, Kramo N1, Diomandé FA3, Nigie L4, Ouegnin GA1, Manzan K1.*

Session 3 / 1.30pm – 2.00pm

Keynote Lecture

Future trends for the management of pelvic organ prolapse

Catherine Matthews^{1,2}

1. Carolinas Institute for Pelvic Health, Winston Salem, North Carolina, USA
2. University of Cape Town, Cape Town, South Africa

The rate of pelvic floor disorders will increase exponentially in the next 50 years due to the expanding geriatric population. As age is the greatest risk factor for the development of urinary incontinence, prolapse and fecal incontinence, we expect to treat 44 million women in 2050 compared to only 28 million today in the US alone. We recently confirmed that rates of surgery for prolapse or urinary incontinence have increased from 11.5% to almost 20%. Therefore, 1 in 5 women will undergo surgery for a pelvic floor disorder. Small improvements in surgical technique or materials could have a dramatic population effect.

Currently, outcomes of surgical intervention including both native tissue and mesh-augmented repairs are suboptimal. Up to 40% of women demonstrate recurrence within 2 years of surgery. The primary risk factors that have been identified for surgical failure include young age at time of first surgery, multi-compartment advanced prolapse, wide genital hiatus and levator avulsion.

While strong suspicions exist for a genetic basis for POP, no conclusive evidence exists yet. If a specific gene defect is identified, the potential exists for gene therapy and creation of a more aggressive plan for surgical intervention with augmented graft materials.

The available evidence suggests that the use of autologous muscle-derived cells, fibroblasts, or mesenchymal stem cells seeded on biocompatible, degradable, and potentially growth-promoting scaffolds could be an alternative to surgical reconstruction of native tissue or the use of conventional implants in treating POP. However, the vagina is a complex organ with great demands of functionality, and the perfect match of scaffold, cell, and trophic factor has yet to be found and tested in preclinical studies. Important issues such as safety and economy must also be addressed before this approach is ready for clinical studies.

Surgical tools and materials will continue to evolve. Robotic surgery will likely become more nimble and affordable with introduction of competitors to the market place.

The primary objectives of this talk are:

1. To discuss current rates of prolapse and incontinence surgeries
2. Review outcomes of native tissue versus mesh-augmented repairs
3. Discuss evolution of surgical materials that will impact efficiency and cost
4. Present evolving options include gene therapy, stem cell utilization, and new materials

Session 4 / 2.00pm – 3.00pm

Free Communication Session A

Risk factors for obstetric anal sphincter injuries –OASIS in Western Sydney

Emma Inglis, Jennifer King

Risk factors for obstetric anal sphincter injuries (OASIS) have been well documented and include maternal, foetal and obstetrical factors as well as administrative and personnel factors (1,2,3).

As part of a program to reduce OASIS at our tertiary unit we performed a retrospective review of all cases of OASIS over 6 years from 2009 to 2015 to determine risk factors and their impact on OASIS. In total 23,824 vaginal deliveries were reviewed. There were 739 cases of OASIS a rate of three percent.

In all cases of OASIS risk factors were determined. Primiparity, instrumental delivery and ethnicity were all independently significant risk factors in our population of women sustaining OASIS.

In women experiencing OASIS 76.7% were primiparous and 23.3% multiparous.

Ethnicity was a significant risk factor for OASIS in our population. Women from India, Pakistan, Sri Lanka and Bangladesh constitute 25-30% of our delivery population. 55-65% of OASIS at our institution occurred in this group of women. 13% of OASIS occurred in women from China and South East Asia and 10% in Caucasian women.

OASIS has been shown to occur more commonly with instrumental delivery (1,2,3). In our population the incidence of OASIS in women having a normal vaginal delivery ranged from 1.4% in 2009 to the highest rate of 2.4% in 2013. The rate of OASIS in those women having an instrumental delivery ranged from 6.5-9.2% of all instrumental deliveries.

We have noted an increasing rate of the use of forceps compared to vacuum for instrumental delivery over the course of the study. The ratio of forceps to vacuum delivery was 1.6 by 2015. The risk of OASIS in forceps delivery was 10.6% overall and 5.6% of vacuum deliveries. This trend in increased forceps deliveries has resulted in an overall rise in the rate of OASIS with instrumental delivery.

The highest rate of OASIS occurred in deliveries performed on night, evening and weekend shifts compared to deliveries performed within 'office hours'. This is likely as a result a less experienced accoucher.

As a result of our study we have instituted education sessions for trainees on forceps technique and prevention of OASIS and have ongoing review of all OASIS cases. We are planning subsequent research to identify additional in our population of women from India, Pakistan, Sri Lanka and Bangladesh and possible preventative strategies that can be implement to decrease OASIS.

1. Royal College of Obstetricians and Gynaecologists. 2015. Third- and Fourth-degree Perineal Tears, management. Greentop Guideline No. 29.
2. Handa VL, Danielsen BH, Gilbert WM. Obstetric anal sphincter lacerations. *Obstet Gynecol* 2001;98(2):225-230.
3. Baghestan E, Irgens LM, Bordahl PE, Rasmussen S. Trends in risk factors for obstetric anal sphincter injuries in Norway. *Obstet Gynaecol* 2010;116(1):25-34.

Long Term Efficacy of Anterior-Apical Elevate® Approach for Prolapse Repair

Harsha Ananthram¹, Ajay Rane¹, Jay Iyer¹, Mrinal Pawar²

1. *Mater Pelvic Health, Douglas, QLD, Australia*
2. *Reproductive & Neonatal Health, James Cook University, Townsville, Queensland, Australia*

This retrospective, non-randomised study of women with vaginal vault prolapse evaluated symptomatic, functional and subjective quality-of-life outcome four years post surgery. Outcome measures include symptomatic relief from, and recurrence of prolapse, improvement in sexual function, rate of mesh extrusions or surgical revisions and sequelae of operative complications. 61 of 63 eligible patients with grade 4 cystocele, were assessed at a median follow up of 4.4 years. Overall post-operative anatomical success rate was 95.2%. Of the 79.5 % (n=50) patients that reported pre-operative vaginal lump/dragging sensation, 94% (n=47) patients reporting a marked improvement in the symptoms of prolapse and 56% (n=28), improved sexual function. 4.9 % (n=3) of procedures resulted in mesh extrusions. Data analysis reported no significant correlation between age and improved outcomes. Our data assessment suggests this single-incision technique to result in improved symptomatic and functional outcomes. Subjective cure rates propose the long-term efficacy of the Elevate Anterior System to be promising, with sustained therapeutic benefit for POP correction.

1. D. Sinhal, J. Iyer, M. Mous, R. Mullerc, A. Rane, Anterior-Apical Mesh Repair System in an ambulatory setting, *Ambulatory Surgery*, November 2013 (19.4) : pp. 130-133

Surgery for pelvic organ prolapse: a survey of practice.

Brendan Miller¹, Robert O'Shea², Elvis Seman², Fariba Behnia-Willison², Yogender Yadav²

1. *St Vincent's Medical Centre, Toowoomba, Qld, Australia*
2. *Obstetrics and Gynaecology, Flinders Medical Centre, Bedford Park, SA, Australia*

Objective: To compare the current practice in the treatment of pelvic organ prolapse in Australia and New Zealand with the practice of gynaecologists in Australia and New Zealand who completed a postal survey in 2007.

Methods: An email was sent to 2506 members of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists on the 6th March 2015 inviting them to participate in an online survey (via SurveyMonkey). A second email was sent on the 20th March 2015. The results were compared with a postal version of the survey sent out in mid-2007.

Results: The response rate was 17% as 418 online surveys were completed. This compares with a response rate of 13% in the 2007 survey. 33% of respondents had completed the previous questionnaire. As a result of the recent mesh controversies 58% of respondents did not feel it had changed their practice. 6% had changed to another mesh. 10% had ceased all mesh kit surgery and returned to native tissue repair. 2% used alternative grafts instead. 30% refer all potential mesh cases on.

For primary anterior vaginal prolapse the number who repair with a graft was 20% in 2007. In 2015 it was 4%. For recurrent anterior prolapse the number using a graft has decreased from 75% in 2007 to 45% in 2015 while the use of paravaginal repair has increased from 11% to 16%.

For primary posterior vaginal prolapse a graft was used by 13% in 2007 versus 5% in 2015. For recurrent posterior vaginal prolapse a graft was used by 61% in 2007 versus 26% in 2015.

For apical prolapse the procedure of choice was sacrospinous fixation with anterior and posterior colporrhaphy among 37% of respondents in 2007 versus 83% in 2015. Use of the vaginal mesh kit was 33% in 2007 and 5% in 2015.

Conclusion: Since 2007 there has been a fall in the use of grafts for both primary and recurrent prolapse.

1. Vanspauwen R, Seman E, Dwyer P. Survey of current management of prolapse in Australia and New Zealand. *Aust NZ J Obstet Gynaecol* 2010; 50:262-267.
2. Jha S, Moran PA. National survey on the management of prolapse in the UK. *Neurourol Urodyn* 2007; 26:325-331.
3. Maher C, Feiner B, Baessler K, Schmid C. Surgical management of pelvic organ prolapse in women. *Cochrane Database of Systematic Reviews* 2013, Issue 4. Art. No.: CD004014. DOI: 10.1002/14651858.CD004014.pub5.

Laparoscopic and robotic sacral cervico-colpopexy with subtotal hysterectomy for advanced pelvic organ prolapse

Salwan Al-Salihi, Marcus Carey, Felicity Gould

Introduction: Sacral colpopexy is often considered the gold standard surgical procedure for advanced pelvic organ prolapse (POP).¹ Sacral colpopexy can be combined with subtotal hysterectomy (sacral cervico-colpopexy) in order to provide optimal apical support.² This surgery suspends the cervical stump, and upper anterior and posterior vaginal walls from the sacral promontory using a prosthetic material, usually surgical mesh. Surgery is optimally performed via laparoscopy with or without robotic assistance.

Objective: To assess the anatomic and functional outcomes 6-months following laparoscopic and robotic sacral cervico-colpopexy with subtotal hysterectomy. Complications of surgery were also assessed.

Methods: A prospective observation study of consecutive women undergoing laparoscopic or robotic sacral cervico-colpopexy with subtotal hysterectomy for POP. All subjects required power morcellation of the uterus +/- adnexa. Upsilon Y-Mesh (Boston Scientific, US) and Ultrapro mesh (Ethicon, US) customized into a Y-shape was used for 29 cases and 12 cases respectively for the sacral cervico-colpopexy. The mesh was sutured onto the ligament. Concomitant trans-vaginal repair and anti-incontinence surgery was performed in 25 (60%) and 18 (44) subjects respectively. Baseline and 6-month assessments included clinical examination and administration of EQ-5D, PFDI-20 and PISQ-12 questionnaires. An IRB waiver to conduct this surgical audit was obtained.

Results: Between 1 August 2013 and 30 July 2014, 41 women (mean age 51) with symptomatic POP underwent laparoscopic (33) or robotic (8) sacral cervico-colpopexy with subtotal hysterectomy. Anatomic and functional outcomes are detailed in table 1. The mean change in the POP-Q C point from baseline to 6-months was 7cm (SD 3.4) and was a significant improvement ($t_{40}=12.8$, $P<0.001$). There was significant improvement in all 3 questionnaires (EQ-5D, PFDI-20 and PISQ-12) at 6-months compared to baseline.

No intra-operative complications occurred. At 6-months no mesh exposures were identified and no subject had undergone further POP surgery.

Conclusions: Our study demonstrates that laparoscopic and robotic sacral cervico-colpopexy with subtotal hysterectomy are safe and effective procedures for utero-vaginal prolapse. At 6-months there were significant improvements in anatomic and function outcomes compared to baseline. No major complications or mesh exposures occurred. However, further studies, including comparison studies, are required to establish the role laparoscopic and robotic sacral cervico-colpopexy with subtotal hysterectomy for utero-vaginal prolapse.

Controversy surrounding the use of a power morcellator during hysterectomy underscores the need for careful preoperative uterine assessment and patient counseling. Furthermore, we believe that this surgery should be undertaken only by surgeons experienced in advanced reconstructive pelvic floor and laparoscopic/robotic surgery.

Do paravaginal sutures improve outcomes for cystocele repair? Results from an RCT at 1-year

Ruchi Singh, Ann Cornish, Marcus Carey

Introduction: Repair of the anterior vaginal compartment remains an ongoing challenge for reconstructive pelvic surgeons because it is the most common site of recurrence. Paravaginal sutures and vaginal mesh have been used to improve anatomic outcomes for cystocele repair.¹

Objective: To compare success rates, anatomic and functional outcomes at 1-year for women undergoing mesh augmented cystocele repair with and without trans-vaginal paravaginal sutures.

Methods: This was a prospective superiority RCT of women with advanced symptomatic cystocele (POP-Q \geq Stage III; Ba $>$ +1cm) requiring anterior vaginal repair. Participants were randomised to no paravaginal sutures (control group) or trans-vaginal paravaginal sutures (2/0 Prolene, Ethicon). Randomization was computer-generated with allocation concealment. Cystocele repair was reinforced with polypropylene mesh in all patients. An independent assessor, blinded to the intervention, reviewed participants who presented for the 1-year review with a clinical examination and administration of EQ-5D, PFDI -20 and PISQ-12 questionnaires.

The primary outcome was "clinically relevant" success as defined by the leading edge of the anterior vaginal wall (POP-Q site Ba) being situated at or above the hymen (Ba \leq 0cm) with absence of a "bulge symptom" and no re-intervention (i.e. no further POP surgery or pessary). Secondary outcomes included anatomic success in the posterior and apical vaginal compartments, QoL measures, sexual function, peri-operative outcomes and complications.

Results: 100 participants were randomised, 44 control and 56 with paravaginal sutures. Baseline characteristics of both groups were comparable. 84% of participants returned at 1-year.

The primary outcome was similar in both groups with a 66.7% success rate in the control group and 71% in the paravaginal suture group. There were significant improvements in EQ-5D, PFDI -20 and PISQ-12 at 1-year compared to baseline but no difference between the two groups. There were two mesh exposures. There were no re-interventions in either group.

Conclusion: The role of paravaginal sutures for cystocele repair is unclear. Some authors have reported improved outcomes with the use of mesh and paravaginal sutures when compared to native tissue repair² whereas other authors report no benefit with paravaginal sutures compared to native tissue repair.³

In our study, the addition of the paravaginal sutures during anterior vaginal repair with mesh augmentation for women with advanced cystocele did not improve success, anatomic and functional outcomes 1-year following surgery. The routine use of trans-vaginal paravaginal sutures in treatment of advanced cystocele is not recommended.

Comparative Study Of Abdominal Sacrocolpopexy Versus Anterior Elevate® In Women With Post Hysterectomy Apical Prolapse – 6 month Results

Joseph Lee^{1,2}, Anna Rosamilia^{2,3}, Meirav Braverman²

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2. Monash Medical Centre Moorabbin, Melbourne, Vic, Australia
3. University of Melbourne, Melbourne, Vic, Australia

BACKGROUND:

Apical prolapse post hysterectomy is a challenging problem in pelvic floor surgery. Systematic review showed transvaginal mesh kits use gives high anatomical results in restoring apical prolapse (1). Maher et al, showed laparoscopic sacrocolpopexy had a higher satisfaction rate and objective success rate than a total vaginal mesh with lower perioperative morbidity and reoperation rate (2), but it takes longer to perform and has a significant learning curve (3). This trial compared the efficacy of laparoscopic sacrocolpopexy and Anterior Elevate® vaginal mesh kit.

OBJECTIVE:

The aim of this study was to evaluate subjective and objective cure and surgery related complications following the two procedures. Methods:

The design was a prospective cohort trial. The current follow-up represents the first 6 months. Women with symptomatic apical prolapse post hysterectomy were allocated to each arm. Baseline and follow-up assessments included a pelvic examination, Patient Global Impression of Severity (PGI-S) questionnaire, Pelvic Floor Distress Inventory – Short Form 20 (PFDI20) questionnaire, Pelvic Floor Impact Questionnaire – Short Form 7 (PFIQ7) and Pelvic organ prolapse / Urinary incontinence Sexual Questionnaire (PISQ12). Primary outcome was incidence of apical POP> stage 2. Secondary outcomes were incidence of overall POP>stage 2 and an improvement on the Patient Global Impression of Improvement (PGI-I) questionnaire or improvement in relation to baseline questionnaires.

RESULTS:

This trial was prematurely ceased due to very slow recruitment. Sixteen women from the Anterior Elevate® group and 15 women from the sacrocolpopexy group have completed 6 month follow-up. The objective cure rate was 100% for apical prolapse, cystocele and rectocele in both groups. No significant difference was found between the two groups in regard to the post-operative questionnaire scores, except for the PFDI20, which was significantly higher in the sacrocolpopexy group ($p=0.04$). Both groups demonstrated significant improvement ($p<0.009$) in PFDI-20 score post-operatively. There was significant difference ($p=0.004$) in the PFIQ7 score post-operatively only in the sacrocolpopexy group. The improvement in the PISQ12 scores before and after surgery in both groups did not reach significance. The median PGI-I score was 1 (= very much better) in both groups. After 6 months follow up there were no mesh complications or repeat surgery. Only one patient from the sacrocolpopexy group had surgical complication.

CONCLUSIONS:

At 6-months follow-up, results of comparison between Anterior Elevate® and sacrocolpopexy were similar in respect to overall cure rate and surgical complications.

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2. 2. Laparoscopic sacral colpopexy versus total vaginal mesh for vaginal vault prolapse: a randomized trial. Maher CF, Feiner B, DeCuyper EM, Nichlos CJ, Hickey KV, O'Rourke P. Am J Obstet Gynecol. 2011 Apr;204(4):360
3. 3. The challenge of implementing laparoscopic sacrocolpopexy. Deprest J, Krofta L, Van der Aa F, Milani AL, Den Boon J, Claerhout F, Roovers JP. Int Urogynecol J. 2014 Sep;25(9):1153-60.

Session 4 / 2.00pm – 3.00pm

Free Communication Session B

The rise and fall of mid-urethral slings in Australia.

Supuni Kapurubandara^{1,2,3}, **Amani Harris**^{1,3}, **Jenny King**^{1,4}

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2. Western Clinical School, Sydney University, Sydney, NSW, Australia
3. SWAPS, Sydney West Area Pelvic Surgery Unit, Sydney, Australia
4. Director, Pelvic Floor Unit, Westmead Hospital, Westmead, NSW, Australia

Background:

Since its introduction to Australia in late 1998, the mid-urethral sling (MUS) very quickly superseded all other continence procedures and essentially became the gold standard for urinary stress incontinence surgery. The majority of mid-urethral slings have been shown to be effective with minimal complications (1). However this rapid adoption of a radically different technique is unprecedented in surgical history so we wanted to track the pattern of usage and assess possible factors involved in this.

Methods:

Population data was obtained from the Australian Bureau of Statistics website and data on numbers of continence procedures for 1998 to 2014 from Department of Human Services Medicare Australia Statistics. This is private patient data only. Data was separately analysed for ten year age groups from 25-34 years to greater than 85 years.

Results:

The rate of MUS rose sharply from late 1998 to almost 50 procedures per 100,000 women by 2002. The fall in the other continence procedures, predominantly colposuspension, was more gradual. This meant an absolute increase in urinary incontinence procedures over 1998 rate (73.3 per 100,000 women) totalling 10,600 women in the next fifteen years. These increased procedures were almost all performed by gynaecologists - from 70.8% of continence procedures in 1998 to 95.1% in 2004.

Age group analysis shows the greatest rise was in the 45-54 years, 55-64 years and 65-74 years age groups. These groups were also the most frequently operated prior to introduction of MUS. While numbers are small, there was an almost 50% increase in the numbers of women \geq 85 years having a MUS.

From 2009 there has been a plateauing and then a decline in overall numbers of MUS without a corresponding return of other continence procedures. In 2009 the figures were 77.5 per 100,000 women falling to 66.6 per 100,000 in 2014 ($P=0$).

Conclusions:

MUS has rapidly gained momentum since 1998 to be the standard of care for surgical management of female SUI in all age groups. It is important to note the rapid uptake of this surgical procedure occurred prior to the first published randomized control trial (2). Aggressive marketing and patient awareness very likely contributed to the popularity of the MUS. However the enthusiasm of surgeons not previously concentrating on continence procedures was also a major factor. The decline after 2011 may represent consumer confusion and concern over the FDA vaginal mesh statements.

References:

1. Ford AA, Rogerson L, Cody JD, Ogah J. Mid-urethral sling operations for stress urinary incontinence in women. Cochrane Database of Systematic Reviews, 2015 (7). <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006375.pub3/pdf/standard>
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Analysis of biofilm on vaginal ring pessaries used for the treatment of pelvic organ prolapse: results from a pilot study

Felicity Gould¹, Sepehr Tabrizi¹, Suzanne Garland¹, Lucy Pizzo¹, Ann Cornish¹, Marcus Carey¹

1. Royal Women's Hospital Melbourne, Prahran, VIC, Australia

Introduction: Bacteria have the potential to colonize the surfaces of any material introduced into the body and to form a biofilm layer. There is growing evidence of the clinical significance of biofilm formation on many medical devices used in vivo. Pathogenic bacteria can become incorporated into biofilms resulting in clinical sepsis and microbial biofilms are widely implicated in chronic infection.¹ Additionally, biofilm bacteria may be difficult to cultivate in the laboratory, leading to false negative reports.² Vaginal pessaries used for pelvic organ prolapse are often associated with a malodorous discharge and this may be secondary to biofilm build up on the pessary. To our knowledge the detection and characterization of biofilm formation on vaginal pessaries has not previously been studied.

Objective: To detect the presence or absence of bacterial biofilm on vaginal ring pessaries after at least three months of use. Additionally we aim to diagnose the bacterial makeup of any biofilm that may be found.

Methods: This was an observational pilot study of 16 consecutive vaginal PVC ring pessaries examined after routine removal from participants who are regular vaginal pessary users. All pessaries had been in situ for between 3 and 6 months. One pessary was fixed immediately after removal from the vagina with 2% Glutaraldehyde and then analysed via electron microscopy (EM). Fifteen pessaries underwent swabbing for molecular microbiological examination in the form of 16s rRNA gene sequencing.

Results: The one pessary that underwent fixation showed clear biofilm matrix formation when examined under EM. The matrix like formation of the biofilm can be seen at high and low magnification. Fifteen pessaries were swabbed and underwent 16s RNA gene sequencing. A picture of polymicrobial colonization was shown in twelve of the fifteen pessaries. Three distinct patterns of colonisation were identified. Of the 12 pessaries that were colonised, 6 displayed predominantly Lactobacillus species, 2 pessaries showed a predominance of Gardnerella vaginalis and 5 pessaries displayed a low yield of mixed flora.

Conclusions: This study demonstrated that biofilms develop on PVC vaginal pessaries, and that there is a predominance of distinct biofilm phenotypes. The results of the gene sequencing reveal three distinct phenotypes comprising of a Lactobacillus type, Gardnerella type, and mixed vaginal flora type.

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2. J Clin Invest 2003; 112:1466-1477

Hands off my anal sphincter

Amani Harris¹, Jenny King¹, Supuni Kapurubandara¹

1. Urogynaecology, Western Sydney Pelvic Floor Unit, Sydney, NSW, Australia

Publish consent withheld

1. Balchandra P & Marsh F. Hands on v hands off approach: a survey. Int Urogynecol J 2013;24(Suppl 1):S1-S152

2. Laine K et al Decreasing the incidence of anal sphincter tears during delivery. Obstet Gynecol 2008;111:1053-7

3. Jansova M et al. Modelling manual perineal protection during vaginal delivery. Int Urogynecol J 2014;25(1):65-71

Is there still a place for anterior vaginal wall mesh?

Elizabeth SG Luxford¹, Jenny King¹

1. Urogynaecology, Western Sydney Pelvic Floor Unit, Sydney, NSW, Australia

Background: The 2013 Cochrane review on use of anterior wall mesh reported a similar reoperation rate for prolapse compared with fascial repair, an 11.4% reoperation rate for mesh erosion, increased operating time & blood loss plus increased de novo stress incontinence (1). Other authors report no difference in QOL outcomes or in some cases in subjective outcome with a higher complication and reoperation rate (2). Clinically our outcome was felt to be more positive than this so we reviewed our last 100 cases of vaginal mesh repair for major prolapse.

Method: Case records were retrospectively reviewed for 102 patients with Stage 3 or 4 anterior wall and uterine / vault prolapse who underwent a sacrospinous ligament fixation or hysteropexy with anterior vaginal wall mesh reinforcement. These patients have a recurrence rate of up to 30% (3). Follow-up period is 6 months to 3 years. All meshes were individually shaped with four anchor points - bilaterally through the transobturator membrane and to the sacrospinous ligaments.

Results: Two demented patients were not returned for follow up so data is available on 100 patients. 68% had stage 3 prolapse and 32% stage 4. Over half, 57% had a previous failed fascial repair. The decision for mesh reinforcement in the other 43% was made due to a combination of failed repair in other compartments, severity of prolapse and serious co-morbidities likely to prohibit further surgery. Surgery was performed by a single consultant and by multiple registrars under that consultant's supervision (35%).

There were no intraoperative mesh complications. Post-operatively no patient experienced de novo or worsening urinary incontinence while there were no cases of chronic pelvic pain or dyspareunia. Superficial mesh extrusion occurred in 20% and was symptomatic in 9%. Nine patients had trimming of the mesh exposure - rooms or day surgery. Subjective and objective success were seen in 96% of

patients (no awareness of a bulge, no further treatment required and point Ba \geq 0.) Two patients had further surgery and one a vaginal ring pessary.

Conclusion: Mesh reinforcement is effective in patients with advanced prolapse, including recurrent prolapse, even if medically complex. Failure or reoperation rate is lower than following fascial repair.

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2. Jonsson Funk M et al Long term outcomes of vaginal mesh versus native tissue repair for anterior vaginal wall prolapse. Int Urogynecol J 2013;24(8):1279-85
3. Dietz V et al Functional outcomes after sacrospinous hysteropexy for uterine descensus. Int Urogynecol J. 2008;19(6):747-752

Performance of MiniArc® single-incision sling system at 4 years post-insertion

Harsha Ananthram¹, Ajay Rane¹, Jay Iyer¹, Lucy Brodnik², Michelle Ward

1. Mater Pelvic Health, Douglas, QLD, Australia
2. Reproductive & Neonatal Health, James Cook University, Townsville, Queensland, Australia

This is a qualitative retrospective longitudinal study of 112 women at our centre, who underwent a MiniArc single-incision sling insertion over a consecutive 12 month period, and were then followed up with a survey at 4-years post-insertion. In the 4-year follow-up questionnaire we were able to survey 61 out of 112 eligible cases using independent telephone interviewers. Improvements were shown in the subjective experience of stress incontinence with 51 patients (83.6%) reporting improvement, and 40 patients (65.6%) reporting nil current symptoms of SUI. This is an improvement on the 5-year follow-up data (66 patients surveyed out of 87 eligible cases) where only 44 patients (66.7%) reported improvement, and only 28 patients (42.4%) reported nil symptoms. The subjective success rate was 77% which is improved from the 5-year follow-up data, in which the subjective success rate was 68%. Both 4- and 5-year follow-up data showed improvement or stasis of urgency symptoms post-operatively and there was no significant occurrences of post-operative complications.

1. Hsiao Y, Rane A, Iyer J, Brodnik L, Ward M. Performance of MiniArc® single-incision sling system at 5 years on. Poster session presented at: International Urogynecological Association 40th Annual Meeting 2015; June 9 – 13, 2015; Nice, France

Cystourethrocele (Grade 3 and 4) repair using the Elevate™ Anterior kit in a tertiary urogynaecology centre: A 2-year outcome

Wei Shung Koh, How Chuan Han

BACKGROUND

The Elevate™ Anterior mesh is designed to correct anterior vaginal wall defects by providing level one and two support, via single-incision trans-vaginal approach.

METHODS

A retrospective review was conducted of 153 patients with grade 3 and 4 cystourethrocele who underwent repair with the Elevate™ Anterior kit from 1 October 2011 to 31 July 2013 performed by a single surgeon. Peri-operative and post-operative complications were recorded. Follow up was arranged at 1 month, 6 months, 1 year and 2 years with a physical examination and a standardized questionnaire directed at both urinary and pain symptoms. The primary outcome was to assess the cure rate (patients with cystourethrocele \leq grade 1). The secondary outcome was to assess its complications.

RESULTS

153 patients were included in the study. The mean age of patients was 65.1 years. Concurrent vaginal hysterectomy and pelvic floor repair (PFR) were done in 131 (85.6%) patients and concurrent mid-urethral sling inserted in 53 (34.6%) patients. The mean duration of surgery was 72.4 minutes. 5 patients had intra-operative complications (3.3%) – 2 had excessive bleeding, 1 had bladder perforation and 2 had rectal perforation. The mean duration of hospital stay was 3.2 days.

At 1 month, there were 2 (1.3%) patients with complaints of de novo urgency/urge incontinence (U/UI) and 1 (0.7%) patient had pelvic pain. At 6 months, the same 2 (1.4%) patients had de novo U/UI and 4 (2.9%) patients had stress urinary incontinence (SUI).

At 1 year, only 2 (2.2%) patients had SUI and at the 2 year follow up, 1 (3.7%) patient was reported with SUI. The subjective and objective cure rates at 6 months were 96.4% and 100% respectively with 1 year subjective and objective cure rates of 97.8% and 100%. The 2 year post-operative follow up had subjective and objective cure rates of 96.3% and 100% respectively.

CONCLUSION

Our experience with the Elevate™ Anterior kit showed good objective and subjective outcomes, high patient satisfaction rates and few complications at up to 2 years of follow-up.

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3. Lukban J, Roovers J, Moore RD, et al. A prospective multi-center study evaluating elevate apical and posterior for treatment of posterior and/or apical vaginal wall prolapse: twelve-month follow-up. International Urogynecology Journal. 2010;21(supplement 1):S405-S406.

Impressive Clinical Outcomes to Advocate the Use of Elevate Posterior and Apical Mesh System for the Treatment of Pelvic Organ Prolapse

Pattaya Hengrasmee¹, Alan Lam¹

1. Centre for Advanced Reproductive Endosurgery, St Leonards, NSW, Australia

Introduction: Pelvic organ prolapse (POP), defined as protrusion of pelvic organs into or beyond vaginal introitus, can lead to various symptoms affecting women's QoL. A woman's lifetime risk for undergoing surgery for prolapse is approximately 11-19%. Nearly one-third will require additional surgery for recurrent prolapse. Synthetic mesh was then introduced to overcome surgical failures associated with native tissue repair. However, with increased use of mesh, there is higher risk for perioperative adverse events.

Methods: This was a retrospective, single-centre study aiming to evaluate surgical outcomes of Elevate Posterior and Apical mesh among 145 women presenting with POP during March 2010 and May 2015.

Results: Mean age was 58.9±11.7 years and mean BMI was 27.2±7.4 kg/m². Among 145 women, one-third were post-hysterectomy, 19% previously underwent traditional repair procedures and 9% had undergone anti-incontinence surgery. 98.6% presented with prolapse symptoms, 57% had voiding difficulty, 60% had stress leakage, 76% had overactive bladder symptoms and 63% had bowel evacuation difficulty. Defecation urgency/faecal incontinence occurred in 20% while 37% complained of difficulty having sex. Vaginal oestrogen was prescribed for preoperative use in 45% of postmenopausal women while 56% were given postoperatively. Preoperative urodynamic test was performed in 88 women among which half were diagnosed with urodynamic stress incontinence. Elevate Posterior mesh was inserted in women with at least stage II posterior vaginal prolapse. Mean blood loss was 123±99 ml and mean operative time was 82±21 minutes. Concomitant procedures included 6.2% hysterectomy, 76% anterior fascial repair, 2% laparoscopic sacrocolpopexy and 35% mid-urethral sling. Massive haemorrhage occurred in only 2%, whereas postoperative voiding difficulty was found in 9 women of which 7 had undergone concurrent sling procedures. Two cases of mesh extrusion were reported for which one required surgical excision. Significant improvement was achieved in terms of prolapse symptoms, urinary, bowel and sexual function. Mean follow-up time was 7.9 months. For proportion of women returning for follow-up, there were 98.6% at 6 weeks, 53.1% at 6 months and 16.6% at 1 year. All POP-Q scores except TVL were remarkably improved. According to POP recurrence definition of prolapse bulging at or beyond hymen, the objective cure rates were 99.3% at 6-week, 95.2% at 6-month, 94.5% at 1-year and 93.1% at 5-year follow-ups. Among 10 women with recurrent prolapse, 8 underwent repeat repair procedures including 2 sacrocolpopexy, 4 Elevate Anterior, 1 posterior fascial repair and 1 combined sacrocolpopexy and anterior fascial repair.

Conclusion: Elevate Posterior and Apical mesh system is a very effective tool in treating POP and preventing POP recurrence.

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Session 5 / 3.30pm – 5.30pm

Choices, Chances, Changes of Sexuality

What's normal?

Ajay Rane OAM

Female genital cosmetic surgery has increased tremendously in the last decade. The need to conform to the 'Barbie doll' look of the vulva has seen quite a lot of unnecessary mutilating genital surgeries.

Where do these perceptions come from? Who do they come from? Males or females?

We present the combined data of two studies – FEMALE perception of female genitalia in Australia and YOUNG MALE perception of female genitalia in Australia.

The results present interesting findings about what is normal and what is not

Assessment of female sexual dysfunction

Lesley Yee¹

1. St Leonards, NSW, Australia

There are often changes to a woman's ability to have sexual activity and sexual intercourse following pelvic floor dysfunction and its surgical treatment. This may result from physical and physiological changes, changes to body image, changes to the relationship dynamic and changes in the way women can now express themselves sexually following surgery and medical treatment. This session will outline the different categories of female sexual dysfunction. A case study will be used to look at the medical, psychological and relationship aspects when working with sexual dysfunction in women following pelvic floor problems. A positive and holistic view around continued sexual expression for women is the aim of any intervention.

Physiologic measurements of the vagina to study effects of surgery on pelvic floor function

Jan-Paul Roovers

The relationship between abnormal anatomy and abnormal function of the pelvic floor is not well understood. If we would understand the physiology of pelvic floor function, we could study the effects of surgery on the physiology and this could generate insight into functional changes. In order to improve treatment selection and optimize counselling of the patient about the effects of surgery, our group aims to quantify innervation and vascularisation of the vagina and surrounding visceral organs.

The autonomic innervation of the vagina originates from the inferior hypogastric plexus. This plexus generates the nervus hypogastricus (which originates from the lower part of the superior hypogastric plexus) and the nervi erigenti (also called nervi spinchi). It is feasible to test vibration by providing an electric stimulus with increasing current wave to the epithelial layer. This electric pulse stimulates the afferent nerves in this layer, and the threshold of sensation is a measurement of innervation status.

The vascularisation can be measured in 2 ways. We can measure vaginal congestion using plethysmography. This technique measures the increase in vaginal blood-flow at the moment the patient is exposed to an erotic stimulus. We can also measure the microcirculation, which is a calculated sum of the diameter of vessels in a pre-defined surface. It is a measurement for oxygenation of the tissue, and effects of surgery, oestrogen therapy, radiation damage, and so on, can be measured.

In the AMC Amsterdam a vaginal probe has been developed to measure both innervation and vascularisation at the same moment. At the meeting the validation and first prospective studies with this device will be presented. There is a huge demand for physiologic testing, as we are looking for individualised, tailored, surgery, where each patient receives treatment advice based on unique parameters representing the physiologic status.

Male and female sexual dysfunction after repair surgery

Catherine Matthews

1. Carolinas Institute for Pelvic Health, Winston Salem, North Carolina, USA
2. University of Cape Town, Cape Town, South Africa

Women with symptomatic prolapse report a high rate of sexual dysfunction including pain and sexual aversion due to embarrassment regarding their condition. The majority of women undergoing native tissue vaginal repair report a high rate of improvement in sexual function. This effect is not, however, consistently observed with mesh repairs that are associated with rates of de novo dyspareunia of approximately 10%.

Surgical principles that must be followed to avoid post-surgical contraction and scarring of the vagina include preservation of vaginal length, avoidance of aggressive epithelial trimming, avoidance of levatorplasty, creation of a perpendicular plane between the posterior vaginal wall and perineal body, and anatomic restoration of the perineal body and genital hiatus.

The primary objectives of this lecture are:

1. To present examples of poor techniques of repair that can result in insertional dyspareunia
2. Review outcomes of native tissue versus mesh-augmented repairs with regards to post-surgical dyspareunia
3. Discuss the evaluation and management of post-surgical contraction bands, painful scar tissue, shortening of the vagina, and dyspareunia
4. Review the necessary surgical steps to avoid post-surgical dyspareunia.

Following this talk, surgeons will have a better understanding of anatomic considerations that should be made at the time of repair to prevent post-surgical dyspareunia. They will have a working knowledge of the medical and surgical treatment options for women with this condition.

Gender – Choices, Chances, Changes

Stephen Jeffery

1. *University of Cape Town, Cape Town, South Africa*

Society today embraces choice in sexuality like never before in history. While the development of reliable contraception spawned a revolution in heterosexual relationships, we are now seeing a transformation in perceptions on lesbian, gay, bisexual and transgender (LGBT) sex. This was made evident by the recent legalizing of same-sex marriage by the United States congress and steps like this will make a profound impact on our generation and how LGBT sex is perceived.

The increased acceptance of a LGBT lifestyle has meant that choice in sexuality in many societies is open and liberal. Another profound change in modern sexuality is the array of pharmacological interventions to enhance sexual performance for both men and women. This includes simple options such as Estrogen cream for vaginal dryness. The introduction of Viagra in 1998 expanded the range of sexual options, not only for older men but also for their partners.

One of the most difficult problems to manage is decreased libido in women. A recent change in this area has been the recent FDA approval of flibanserin. As physicians we will soon be faced with the choice of prescribing this medication.

This presentation will look at a number of practical aspects in the management of modern sexuality in day to day gynaecological practice.

Saturday 9 August 2015

Session 6 / 8.00am – 10.00am

Real live surgical experience – Pearls & Pitfalls

Faculty	Title
Greg Cario	Laparoscopic site specific pelvic floor repair and Burch Colposuspension
Marcus Carey	Robotic sacral hysteropexy sling: video demonstration of technique Sponsored by Device Technologies
Anna Rosamilia	Removal of TVT-O with groin dissection by plastic surgeon
Catherine Matthews	Almost live robotic sacrocolpopexy for large enterocele and vault prolapse
Jan-Paul Roovers	Vaginal mesh procedure for enterocele
Stephen Jeffery	Vaginal Hysterectomy and Sacrospinous Fixation for Uterine Prolapse using a Minimally Invasive Suture Capture Device

Session 7 / 10.30am – 12.30pm

Taking chances with new choices

Non-surgical choices for management of pelvic organ prolapse

Gil Burton

1. North Shore Private Hospital, St Leonards, NSW, Australia

Pelvic Organ prolapse (POP) affects about 30% of women. However only 8% are symptomatic. Aetiologies with high grades of evidence are forceps, age at time of delivery, baby size and ongoing issues such as BMI, constipation and coughing. There is not a tight association between size and symptoms of bulge and pressure and even less association with reproducible bladder, bowel or sexual dysfunction. These variable causes, signs and symptoms make outcome assessment difficult. This is especially so for conservative measures and has often meant that they have been less rationally assessed.

Conservative choices include observation, lifestyle changes, pelvic floor muscle training and pessary use. Observation of pelvic floor prolapse is based on careful assessment of the actual symptoms and the known facts that some prolapse actually regress and that there is only a weak association between age and deteriorating prolapse.

Lifestyle changes are based on the evidence that high BMI's are associated with 30-50% increase in prolapse and 10% weight reductions change cystocele and rectocele by up to 5% but possibly worsen uterine prolapse. Smoking has a strong association and ceasing clearly has other health benefits. Constipation, coughing and lifting with the pelvis open raises intrapelvic pressure considerably so bowel and chest management and alternative lifting strategies can reduce symptoms considerably.

There are four rigorous trials supporting the use of pelvic floor muscle training in the treatment of POP. These trials show improvements regardless of age and grade of the prolapse. Long term data is lacking but compliance with long term pelvic floor exercises is known to be poor.

Pessary use has a 90% satisfaction rate with 40-70% reductions of bulge and pressure symptoms. Vaginal length and introital width, vaginal scarring and the type of prolapse can influence fitting. There are variable schedules on how often they need to be changed and data on long term use is lacking but clinically they tend to be an all or nothing intervention. Softer grooved pessaries have made patient removal and insertion possible.

Discussion of alternatives is an important part of consent and the clinician needs to carefully explain the very real choices the patient has in the management of pelvic organ prolapse.

A radical change in management of fecal incontinence: Introduction of an innovative vaginal bowel control device

Catherine Matthews ^{1,2}

1. Carolinas Institute for Pelvic Health, Winston Salem, North Carolina, USA
2. University of Cape Town, Cape Town, South Africa

Accidental bowel leakage, or fecal incontinence (FI), is a common but largely silent problem in women's health. Embarrassment surrounding the condition and a lack of successful treatment options has limited public awareness and prevented patients and doctors from discussing the condition. Recent general population surveys indicate the prevalence of FI at 9% to 12% and, in older women, as high as 24%. This translates into as many as 17 million women in the U.S. suffering from FI. While traditionally thought of as a condition that only afflicts the elderly, perhaps the most surprising finding in recent studies is the high prevalence in younger women. The onset of symptoms often occurs in the 40s, 50s and 60s, and sometimes younger, with the average age of onset being 51. At any age, the condition is both physically limiting and emotionally devastating. Those afflicted are often forced to withdraw from social and professional activities and often face problems in their private personal relationships.

The causes of FI are likely multifactorial but are not completely understood. Many women with FI have a history of damage to the pelvic region caused by pregnancy and childbirth and additionally may have changes to the muscles in this area associated with aging. Forceps-assisted vaginal delivery is consistently identified as a major risk factor for anal sphincter injury, the muscle involved in voluntary bowel control. Many women who sustain a severe perineal laceration during vaginal childbirth may suffer from fecal urgency and accidental bowel leakage at a young age. Women with irritable bowel syndrome (IBS) may also experience FI as one of the symptoms of their condition. The damage that may lead to FI and other bowel control issues can involve the internal and external anal sphincters, pelvic floor muscles, and associated nerves. Symptoms from damage sustained during childbirth may not manifest until later in life, when their emergence is possibly due to age-related changes in rectal sensation, compliance, and volume, as well as general weakening of the sphincters and pelvic floor muscles. As the cause to FI is often complex and poorly understood, it has been difficult to develop effective treatments. Existing treatment options have had limited success, and include dietary modification with increased fiber, physical therapy, surgery, and surgical device implants. Without good treatment options, many women with bowel control problems are resigned to coping with the condition in silence using products such as pads and adult diapers.

Recently, the FDA approved a novel treatment device for the treatment of FI. The technology, an intra-vaginal bowel control device called Eclipse, originated at Stanford University as part of a joint development effort between Stanford engineers and physicians. The device is non-surgical and therefore avoids many of the risks and complications of more invasive treatments. Placed intra-vaginally, it resides in a similar position as a diaphragm. It consists of a flexible ring with an inflatable balloon that compresses the rectum through the vaginal wall. The device can easily be removed at any point, so patients can try the treatment as a first-option with little long-term risk. Initial results from clinical evaluations have been promising. The LIFE study demonstrated that 80% of women achieved a >50% reduction in FI episodes with the device.

A simple device with profound results

Ajay Rane OAM

There is an explosion of bowel and bladder disease in the developed world. Conditions like Irritable bowel syndrome, constipation, haemorrhoids, bowel cancer have a causal relationship with diet. Recurrent UTIs, voiding dysfunction although less common may have also have an overlapping causal relationship with bowel disorders – position on the toilet!

Squatting was our default position until the 19th century. Has the design of the WC been partly responsible for all this angst? Our research presented here shows the science behind the invention of DUNEZE – better position, better health!

I want surgery, but can I do crossfit?

Taryn Hallam

No abstract available.

Sacral modulation – role, benefits, limitations

Marcus Carey

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Sacral nerve stimulation (SNS) has become established therapy for the management of severe and refractory over active bladder syndromes (urge incontinence) and idiopathic urinary retention. SNS is also used for neuropathic faecal incontinence. The precise mechanism of action of SNS remains unknown. The implanted sacral nerve stimulator device comprises a pulse generator and lead with quadripolar electrodes. Recent lead modifications have seen a trend towards a two staged implant procedure using small skin incisions. These recent modifications allow for surgery to be completed under local anaesthesia. This new minimal access surgical approach to SNS implantation is likely to result in more accurate patient screening and reduced wound morbidity.

A video demonstration of SNS surgical technique is presented. The patients in this video provided informed consent for clinical photography and surgical video photography. Generally surgery is performed under a combination of sedation and local anaesthesia. SNS surgery is not technically difficult, however, precision is required in order to obtain optimal placement of the sacral electrode and surgeons should undergo appropriate training in order to carry out this procedure effectively. The third sacral nerve root is the target for SNS. This sacral nerve root has a width of 3 to 4 mm and exits from the third sacral foramen. Occasionally, needle insertion into S3 can result in vascular and nerve damage. This damage can be minimized by employing a lateral entry into foramen and by ensuring the needle enters the foramen at an acute angle rather than vertically. The sacral nerves provide many branches to the pelvis and lower limbs. The pudendal nerve, which is the main sensory and motor nerve to the pelvic floor, receives contributions from S2, S3 and S4. Stimulation of S3 results in both a motor and sensory responses. The motor response includes contraction of the levator ani muscle complex ("bellows response) and flexion of the toes via stimulation of the tibial branch of the sciatic nerve. In clinical practice, accurate placement of electrodes into the third sacral foramen is confirmed by the appropriate motor responses and by fluoroscopy.

The most easily identified surface anatomy landmark of the S3 foramen is the greater sciatic notch. The S3 foramen is located medial to the upper edge of the greater sciatic notch and a middle finger's breadth from the spine of the sacrum (midline).

The precise mechanism of action of SNS is unclear and a number of theories have been advanced. Sacral nerve neuromodulation stimulates the afferent somatic nerve fibres responsible for the modulation of sensory processing and the micturition reflex in the spinal cord. It has been postulated that SNS depends on the electrical stimulation of afferent nerve fibres in the spinal roots that, in turn, modulate voiding and continence reflex pathways in the central nervous system.

SNS may cause suppression of bladder over activity by the neuromodulation of several reflex mechanisms. Firstly, direct inhibition of bladder preganglionic neurons suppresses unstable bladder contractions. Secondly, inhibition of unstable bladder contractions by suppression of interneuronal transmission in the afferent limb of the micturition reflex. SNS does not interfere with voluntary voiding mediated by descending excitatory efferent pathways from the brain to the sacral parasympathetic preganglionic neurons.

Efficient bladder emptying relies on the ability of brain pathways to turn off urethral sphincter guarding reflexes. SNS may act by switching off excitatory outflow to the urethral sphincter, thereby promoting bladder emptying in patients with urinary retention.

In Australia, SNS has Medicare funding approval for refractory urge incontinence and idiopathic urinary retention.

Thorough clinical assessment, including neurological evaluation, is mandatory prior to considering SNS. Appropriate investigations are also required prior to SNS to establish a precise diagnosis and exclude neurological disorders (e.g. multiple sclerosis). Often urodynamic studies, cystoscopy and various imaging techniques (MRI; MRI scanning is contraindicated once SNS has been implanted) are performed prior to SNS.

Session 8 / 1.30pm – 2.00pm

Keynote Lecture

Development of a new material to treat pelvic organ prolapse

Jan-Paul Roovers

Polypropylene (PP) has been used as an implant for prolapse surgery since the introduction of these techniques. The selection of PP was not based on science. It was a material that was known for its biocompatibility. The characteristics of the material (pore size, fibre diameter, tensile strength, interstitium diameter, and so on) are even less based on science. They are based on assumptions based on other indications. The high risk on adverse events like exposure and pain are partially related to the material. We need to look for a completely different type of material, to oppose our patients to the benefits of mesh, but decrease the risk on adverse events significantly.

To reach that goal a few things need to be established:

- We need an animal model for pelvic organ prolapse. Of available research the sheep seems to be the best option and in collaboration with other European universities we have started to explore the sheep as an animal model for prolapse.
- We need to develop a new material as implant. We are looking into 3 different directions:
 - Prolonged absorbable materials. Absorbable materials have the benefit that they induce a foreign body response that results in collagen formation. However, the long term outcome is inferior to PP, as the mesh absorbs before the host reaction has been finalized. If resorption would take longer, the outcome could be similar to PP, but with less morbidity.
 - Absorbable meshes that functionalize the environment. In situ tissue engineering is an engineering technique in which the local healing conditions are optimized in order to realize a favorable response. If absorbable implants are coated with materials that can improve wound healing, collagen formation, vascularization and other conditions for optimal healing, which would be beneficial. It would mean that in the time these materials are present, they achieve more (strength, elasticity, vascularization) which results in a material with low complication risk.
 - Electrospinning of synthetic materials. Electrospinning is a technology that uses an electric potential to create ultrathin fibers from a polymer solution. With their nanofibrous structure, electrospun matrices mimic the

geometrical structure of the natural extracellular matrix (ECM), which favors cell attachment and growth. Our research group investigated the mechanical and biological potential of electrospun matrices made of three different biomaterials: [1] Nylon (polyamide 6), a well-known non-degradable material, [2] degradable poly(glycolide-co-lactide acid) blended with poly-caprolactone (PLGA/PCL), and [3] a mixture of polycaprolactone and gelatin as a degradable semi-synthetic material. Gelatin is a natural polymer that increases cell attachment, while PCL provides the mechanical strength. Results of this research will be presented at the meeting.

- Physiologic measurements need to be validated in the animal model to predict the effects of surgery with the new implants in humans.

Session 9 / 2.00pm – 2.40pm

Interactive session – “Help!!! I’m in deep trouble”

No abstracts available for this session.

Session 10 / 3.10pm – 4.50pm

Obstetrics and Urogynaecology

Does mode of delivery affect sexual function?

Alison DeSouza

Alison De Souza¹, PL Dwyer^{1,2}, M Charity^{3,4}, CHJ Ferreira^{1,5}, E Thomas¹, L Schierlitz¹

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This talk is based on the abstract for the study: The effects of mode delivery on postpartum sexual function: a prospective study.

Objective To determine the effect of mode of delivery and perineal injury on sexual function at 6 and 12 months postpartum.

Design Prospective cohort study.

Setting Tertiary women’s hospital in Melbourne, Australia.

Population A cohort of 440 primigravid women.

Methods The Female Sexual Function Index (FSFI) was completed at first visit (7–19 weeks of gestation), and at 6 and 12 months postpartum.

Main outcome measures A statistically significant difference in total FSFI or domain scores over time according to mode of delivery or perineal injury.

Results In this cohort 54% of women had a normal vaginal delivery, 21% had an instrumental delivery, and 25% gave birth by caesarean section. No difference was found in total FSFI or domain scores according to mode of delivery over time between antenatal assessment and 12 months postpartum. Pain was decreased in the caesarean group only at 6 months postpartum. All groups showed pain scores at 12 months that were comparable with antenatal levels. For those who gave birth vaginally, 27% had an intact perineum, 50% had an episiotomy, and 6%, 14%, and 3% had first, second, and third-degree tears, respectively. The only differences between groups were found over time according to perineal injury at 6 months in the arousal domain. At 12 months, total FSFI and domain scores were no different to initial scores.

Conclusions At 12 months postpartum sexual function has returned to early pregnancy levels, irrespective of mode of delivery or perineal injury.

Keywords Delivery mode, episiotomy, perineal trauma, postpartum, sexual function.

Changes in obstetric practice, choices of mode of delivery, chances of placenta accreta

Stephen Lyons

The caesarean section rate in Australia is the subject of some controversy. There is no question that the caesarean section rate in first world countries is increasing. Indeed, the caesarean section in NSW, for example, rose from 17% in 1994 to 31% in 2012. What is not so clear is why the caesarean section rate is increasing.

A trend of the media cycle seems to be the frequent reporting of the dangers of the increasing caesarean section rate in Australia. Part of this reporting often includes what is tantamount to a "demonisation" of women who give birth to their child by caesarean section (irrespective of the indication). Usually implicit in such pieces is that many women are selfishly endangering their baby's life by being "too push to push". Furthermore, obstetricians are often said to be abandoning safe obstetric practice for the own convenience.

What is the truth regarding the factors behind the increasing caesarean section rate? Are there significant changes in obstetric practice? Are pregnant women driving the change by electing to have a caesarean section? Should they be free to choose the mode of their delivery irrespective? And, perhaps most importantly, what are the downsides to an increased caesarean section rate? In particular, how is the increasing caesarean section rate affecting the incidence of placenta accreta? The "changes, choices and chances" related to the increased caesarean section rate will be addressed in this talk.

Placenta etcetera - don't worry, I'm here

Greg Gard

Disorders of placentation such as placenta accreta and percreta are important conditions that can result in massive obstetric haemorrhage. Significant problems at delivery are known to occur due to incomplete placental separation and include haemorrhage, neonatal death, infection, fistula formation, urethral damage and bladder injury. A maternal mortality rate of 7% has been quoted for this condition. At Royal North Hospital, a multidisciplinary group has formulated an approach to placenta percreta which has been proven to be safe and effective. The strategy involves a staged procedure involving femoral artery catheterisation, classical caesarean section and uterine and placental embolization prior to hysterectomy.

I'm incontinent and I've got prolapse, but I want another baby

Stephen Jeffery

1. *University of Cape Town, Cape Town, South Africa*

Pelvic floor surgeons are seeing in an increasing prevalence of younger women with pelvic floor dysfunction. The reasons for this increase are not immediately apparent. One possibility is that there may be an increased awareness of these problems and access to intervention may be more widespread.

The obvious challenge in managing a young women with incontinence and prolapse is that consideration should be given to impact of the intervention on a future pregnancy. Conversely, the impact of the pregnancy and delivery on the repaired pelvic floor should also be considered. The other challenge is that younger women with pelvic floor dysfunction may have significant deficiencies in pelvic floor support and may have a higher risk of failure of the intervention.

Before embarking on surgery in these women, it is essential that a thorough and comprehensive program of pelvic floor rehabilitation be followed. Intensive counselling regarding the benefits and risks of surgery is also an important part of the management strategy, with strong consideration being given to performing surgery after childbearing is complete.

The principles of surgical intervention include:

1. Selection of a uterine-sparing procedure
2. Minimal use of synthetic and mesh devices with consideration of alternatives
3. Avoid procedures that have a potential of impacting on sexual function
4. Prefer a minimally invasive abdominal approach especially in cases of apical prolapse.

For stress incontinence, many surgeons will consider the use of a mid-urethral synthetic sling. The retropubic approach has been shown to have marginally better efficacy and this should be offered to these younger women instead of the Transobturator Tape. Vaginally placed synthetic devices have a broad range of potential adverse outcomes and it may be prudent to consider alternatives. This includes a Rectus Sheath Fascial Sling, which has been shown to be as efficacious as the synthetic TVT. Fascia Lata may also be a good option. A minimally invasive Burch colposuspension is another excellent option.

In women with prolapse, native tissue surgery should be done for lower stage anterior and posterior compartment defects. Vaginal mesh should be avoided at all costs. For large uterine prolapse, the laparoscopic sacrohysteropexy has been shown to be associated with good outcomes. At least three pregnancies have been reported following this operation and the results appear to be favourable.

Managing the young women with prolapse and incontinence remains a challenge. Strict adherence to a number of important principles will ensure satisfactory outcomes.

Session 11 / 5.00pm – 5.30pm

Debate

Go 'Brazilian' if you want to protect your pelvis

Yes: Catherine Matthews & Stephen Jeffery

No: Jan-Paul Roovers & Anna Rosamilia

No abstracts available for this session.

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