



FOREMANO
2014

THE ART OF RECONSTRUCTION *program*

**JULY
15&16**

Grand Hyatt Melbourne
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If the meeting is used for critical reflection and practice improvement, PR&CRM points can be claimed by submitting a reflection worksheet to RANZCOG.

Visit the RANZCOG website or AGES Registration Desk at the Symposium for forms.

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Membership application forms are available from the AGES website or from the AGES Secretariat.

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welcome

Dear Colleagues,

We welcome you to Melbourne for the AGES Pelvic Floor Symposium where we will examine The Art of Reconstruction.

Our stellar and diverse international speakers are A/Prof Peter Rosenblatt (USA) and A/Prof Andrew Sokol (USA). We will be challenging our speakers to present their thoughts and evidence which may not conform to everyday thinking. We want to challenge them with the questions from you, the audience. Besides conventional topics and updates with specific tips and tricks, we have a surgical video session and the ever popular 'challenge the experts' session. A galaxy of local speakers will also contribute to the diverse sessions on sexuality, new inventions, obstetrics and urogynaecology.

We hope you will enjoy this truly educational feast and all Melbourne has to offer as Australia's cultural capital.

Prof Ajay Rane OAM
Conference Chair

Dr Haider Najjar
Board Member, AGES
Conference Co-Chair

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JULY 15 | MEETING PROGRAM

0715-0800	CONFERENCE REGISTRATION
0800-1000	SESSION ONE: TO OPERATE Chairs: Anusch Yazdani & Haider Najjar
0800-0820	Pelvic Floor Surgery - The Evolution Peter Rosenblatt
0820-0840	Native Tissue Surgery Ajay Rane
0840-0900	The Role of Laparoscopy in Pelvic Floor Surgery Joseph Lee
0900-0920	Pelvic Floor Surgery - The Place of Robotic Surgery Salwan Al-Salihi
0920-0940	Slings - The Best and the Worst Andrew Sokol
0940-1000	Panel Discussion
1000-1030	MORNING TEA AND TRADE EXHIBITION
1030-1220	SESSION TWO: I DO IT MY WAY Chairs: Ajay Rane & Alan Lam Interactive session where experts demonstrate current trends in surgery.
1220-1320	LUNCH AND TRADE EXHIBITION
1320-1515	SESSION THREE: NOT TO OPERATE Chairs: Peter Rosenblatt & Robert O'Shea
1320-1340	Pelvic Anatomy - The Difference Between Laparoscopy and Vaginal Surgery Andrew Sokol
1340-1400	Vaginal Pessaries, Clinical Applications Geoffrey Edwards
1400-1420	Urodynamics and Neurophysiology - The Evidence Fay Chao
1420-1440	Pelvic Power Janetta Webb
1440-1500	PRP Treatment for Vaginal Atrophy Peter Lewis
1500-1515	Panel Discussion
1515-1545	AFTERNOON TEA AND TRADE EXHIBITION
1545-1730	SESSION FOUR: BLADDER Chairs: Andrew Sokol & Harry Merkur
1545-1605	Bladder Pain Syndrome/Interstitial Cystitis Anna Rosamilia
1605-1625	Neuromodulation, From Research to Practice Marcus Carey
1625-1645	Bladder Over Activity, Management Hot Off the Press Gil Burton
1645-1705	Fecal Incontinence - Reverse the Thinking Peter Rosenblatt
1705-1730	Panel Discussion
1730	CLOSE
1915-2230	GALA DINNER

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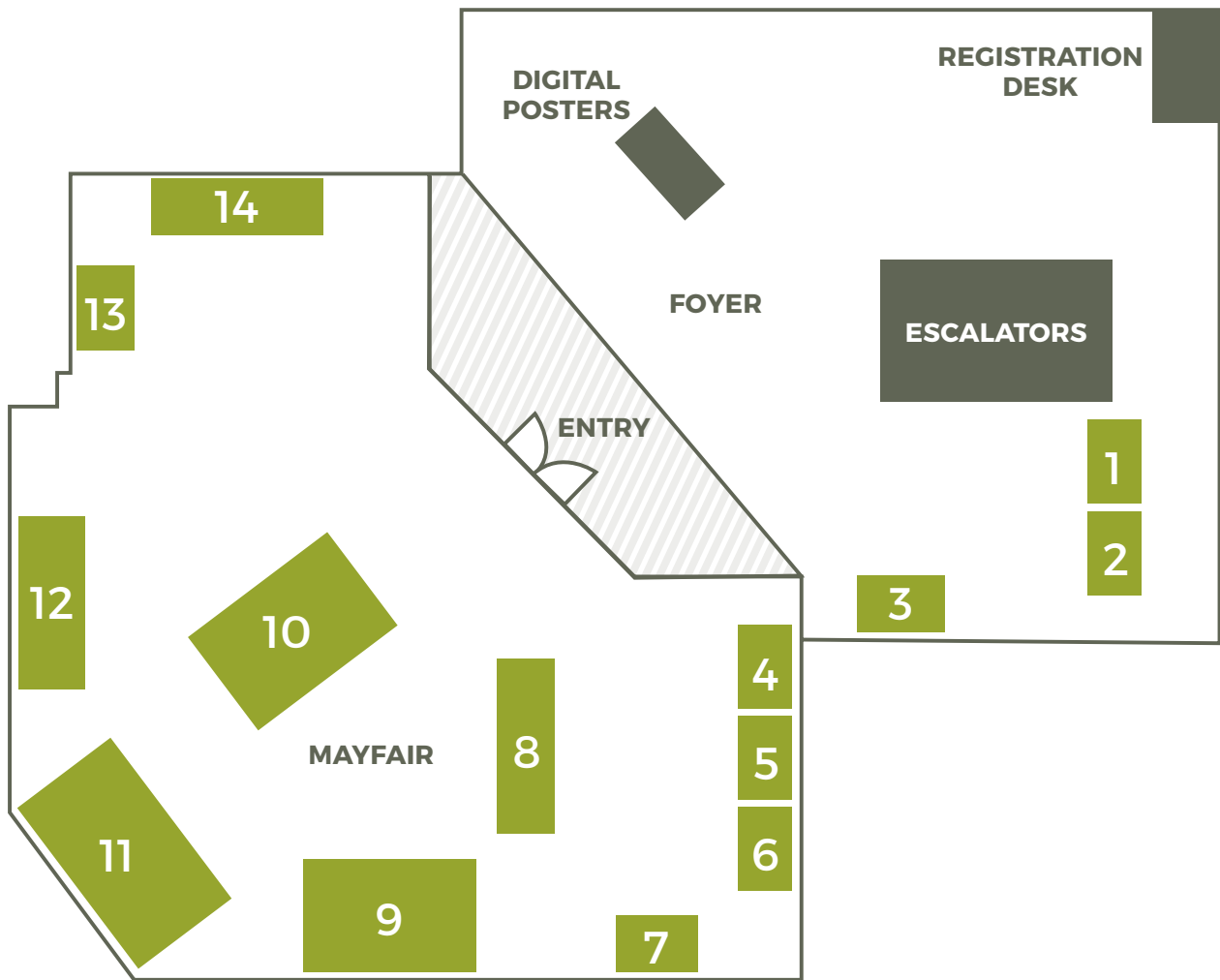


JULY 16 | MEETING PROGRAM

0730-0800	CONFERENCE REGISTRATION
0800-0930	SESSION FIVE: STUMP THE EXPERTS Chairs: Alan Lam & Jason Abbott Conundrums in daily life managements. 
0930-1000	MORNING TEA AND TRADE EXHIBITION
1000-1230	SESSION SIX: THE LATEST, THE GREATEST Chairs: Anna Rosamilia & Rachel Green
1000-1020	The Latest in Uterine Morcellation Peter Rosenblatt
1020-1040	Stem Cell Research - An Update Caroline Gargett
1040-1100	Apical Support for Benign Hysterectomy Andrew Sokol
1100-1120	Back to the Future, Traditional Surgery, Reemerging Fashion Elvis Šeman
1120-1140	Colorectal and Pelvic Floor Surgeons - Working Side by Side Eugene Ong
1140-1200	Sharing the Pelvis with the Urologists Sandra Elmer
1200-1220	Pelvic Floor- A Medico-legal Update. Laparoscopic Bowel Injury- Why do we Take so Long to Diagnose It? Peter Henderson
1220-1230	Panel Discussion
1230-1330	LUNCH AND TRADE EXHIBITION
1330-1430	SESSION SEVEN: FREE COMMUNICATIONS Chairs: Stephen Lyons & Fay Chao
1430-1530	SESSION EIGHT: WHAT'S BEST FOR WOMEN? Chairs: Salwan Al-Salihi & Geoffrey Edwards
1430-1445	Continuing Urogynaecology Education and the Role of IUJ Peter Dwyer
1445-1500	FGM - Gynaecologist Perspective Khai Mohamed-Noor
1500-1515	What Does Society Think About FGM? Ajay Rane
1515-1530	Panel Discussion
1530-1600	AFTERNOON TEA AND TRADE EXHIBITION
1600-1650	SESSION NINE: INNOVATIONS, WHAT DOES THE FUTURE HOLD? Chairs: Simon Edmonds & Emma Readman
1600-1620	Slings - What Does the Future Hold? Peta Higgs
1620-1640	Mesh Surgery - Looking Beyond the Horizon Peter Rosenblatt
1640-1650	Next Generation Robot - What is Next Haider Najjar
1650-1730	PRESIDENT'S DEBATE - TO OPERATE OR NOT TO OPERATE; THAT IS THE QUESTION Chairs: Anusch Yazdani and Ajay Rane For.. Salwan Al-Salihi and Peter Rosenblatt Against.. Fariba Behnia-Willison and Andrew Sokol
1730	CLOSE

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PRE-CONFERENCE WORKSHOP

Chair: Peter Rosenblatt
Faculty: Charlie Khamis, Ajay Rane OAM,
Salwan Al-Salihi, Anna Rosamilia and
Joseph Lee
Date: Thursday 14th July, 1pm - 5pm
Location: Grosvenor 1, Grand Hyatt Melbourne

SOCIAL

PROGRAM

GALA DINNER

The Residence, Grand Hyatt Melbourne
Friday 15th July 2016 | 7.15pm
TICKET COST: \$145.00



*about
us*

PETER ROSENBLATT, MD

Dr. Rosenblatt is the Director of Urogynecology and Reconstructive Pelvic Surgery at Mount Auburn Hospital, a community teaching hospital of Harvard Medical School in Cambridge, Massachusetts. He is an Assistant Professor of Obstetrics and Gynecology at Harvard Medical School. He currently serves on the Board of Directors of the American Urogynecologic Society.



ANDREW SOKOL, MD

Dr. Andrew Sokol is an Associate Professor of OB/GYN and Urology at Georgetown University Medical School, in Washington, DC. He is a board-certified Female Pelvic Medicine and Reconstructive Surgeon and serves as Associate Director of Minimally Invasive Surgery at MedStar Washington Hospital Center.

As an internationally recognized expert in minimally invasive pelvic floor surgery, Dr. Sokol served as a member on the Board of Trustees of AAGL. He holds numerous leadership positions in AAGL, the American Urogynecologic Society, and is an elected member of the prestigious Society of Gynecologic Surgeons.

Dr. Sokol's research interests include surgical management of pelvic organ prolapse and urinary incontinence, biomaterials (e.g., mesh) and pelvic reconstructive surgery. He is actively involved in clinical research trials that focus on surgical therapy for pelvic organ prolapse and stress urinary incontinence, as well as minimally invasive surgical teams.

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SESSION SEVEN - FREE COMMUNICATIONS

SAVOY 1 | 1:30PM - 2:30PM

Effect of Parity on Ovine Vaginal Wall Tissue Properties

Stuart Emmerson

Culture Expansion of Undifferentiated Human Mesenchymal Stem/Stromal Cells for Management of Pelvic Organ prolapse

Shanti Gurung

Maternal Country of Birth as a Risk Factor for Anal Sphincter Injuries in Primiparous Obstetric Patients in a Western Sydney Tertiary Centre.

Supuni Kapurubandara

MiniArc vs TVT Abbrevio Suburethral Sling in Women with Stress Urinary Incontinence - an RCT - 6m Follow Up

Joan Melendez

Evidence to Justify Retention of Transvaginal Mesh: Comparison Between Laparoscopic Sacrocolpopexy and Transvaginal Elevate Mesh Series

Valerie To

Surgical Anatomical Outcomes Using Posterior Repair Quantification (PR-Q) to Identify Defects - Short Report

Audris Wong

DIGITAL FREE COMMUNICATIONS EXHIBITION AREA

Factors Determining Career Choice in Obstetrics & Gynaecology

Harsha Ananthram

Perigee - 10 Year Follow Up

Harsha Ananthram

Stress Incontinence: What Non-surgical Choices do I Have?

Fariba Behnia-Willison

Urethrovaginal Fistula Presenting as Stress Urinary Incontinence in a Young Woman with Previous Genital Self-mutilation

Alexandra Frain

Sarcomas Still Happen!

Bassem Gerges

The Case of the Mismanaged Prolapse : Video Presentation and Review of Literature

Supuni Kapurubandara

Laparoscopic McCall Culdopexy [extended] Using Non-absorbable 'V-Loc' Sutures in the 'EndoStitch': The Operation of Choice for Vaginal Vault Suspension in the Post-mesh Age: A Simpler and Less Complicated Procedure than Sacral Colpopexy with Good Results

Roger McMaster-Fay

Female Perspectives on Female Genital Mutilation

Noor Naqueeb

Xenform - Audit of Short Term Outcomes

Ajay Rane

Diagnostic Dilemma of A Rare Case of Vulval Aggressive Angiomyxoma

Stanley Santiago

Anterior Vaginal Wall Leiomyoma: A Case Report

Priyanka Singh

Is Mesh Erosion Following Laparoscopic Sacrocolpopexy Time-Dependent?

Valerie To

Laparoscopic Uterosacral Fascial Suspension - An Alternative to a Vaginal or Mesh Approach for Prolapse

Audris Wong

Audit of Native Tissue Posterior Repair Incorporating Uterosacral Plication

Yogender Yadav

Hysteroscopy as a Diagnostic Aid for Uterine Arteriovenous Malformation: Video Demonstration

Yogender Yadav

Program Abstracts

Friday 15 July 2016

Session One: To Operate

0800 – 1000

Pelvic Floor Surgery – The Evolution Peter Rosenblatt

Abstract not yet received.

Native Tissue Surgery Ajay Rane

The resurgence of native tissue repair is considerable. This is because of the controversies surrounding transvaginal meshes and slings.

What constitutes a native tissue repair? would the use of biologic mesh fall under this category? Would the use of permanent non absorbable sutures fall into this remit?

Are there any standardized techniques that have with stood the test of time and scientific rigour?

Anterior Compartment: Who would you operate on?

Methods of plication, depth of dissection, sutures of choice. Apical techniques: midline or lateral sacrospinous fixation?

What about para vaginal repairs?

Evidence

Posterior Compartment: Who would you operate on?

Methods of plication, depth of dissection, sutures of choice, defect specific repairs

What about levator myorhapphy?

Evidence

Apical Compartment: Who should you operate on?

Methods- transvaginal native tissue or laparoscopic native tissue

Evidence

Stress Incontinence, Vaginal looseness, Vaginal flatus and the role of native tissue repairs here are also relevant.

Finally – Who should DO the operations? What does the College say? What do societies say? What do the lawyers say?

The Role of Laparoscopy in Pelvic Floor Surgery

Joseph Lee

Abstract not yet received.

Pelvic Floor Surgery – The Place of Robotic Surgery

Salwan Al-Salihi

Abstract not yet received.

Slings – The Best and the Worst

Andrew Sokol

Mid-urethral slings are considered to be the gold-standard treatment for stress urinary incontinence, and over 4 million have been performed worldwide. While they are minimally invasive and reproducible, minor and major complications can occur. This talk will provide an overview of complications prevention and management strategies associated with mid-urethral slings.

Session Two: I Do it My Way

1030 – 1220

Interactive session where experts demonstrate current trends in surgery

Session Three: Not to Operate

1320 – 1515

Pelvic Anatomy – The Difference Between Laparoscopy and Vaginal Surgery

Andrew Sokol

The ability to practically apply knowledge of pelvic anatomy is of paramount importance to the pelvic surgeon. Anatomical relations and common areas of complication differ between laparoscopic and vaginal approaches. This talk will highlight the differences in structures encountered during both laparoscopic and vaginal approaches to hysterectomy. Structural support of the vagina will also be reviewed.

Vaginal Pessaries, Clinical Applications

Geoffrey Edwards

The management of prolapse and urinary incontinence is varied and encompasses a wide range of treatment options. The use of pessaries has been traditionally reserved for the frail and elderly but more recently they have been more extensively used as an alternative for surgery for those women that choose a non-surgical intervention. They are minimally invasive and provide immediate relief of symptoms. Women who choose pessary treatment are as likely to be satisfied and to have improved pelvic floor function as those selecting surgery.

Most women can be successfully fitted with a pessary when they present with prolapse.

Pessaries are primarily made of medical grade silicon which is inert and hypoallergenic. There are two main types of pessaries for prolapse-support and space occupying. The support pessaries include ring (with or without diaphragm), Shaatz, Gehrung, and Smith and Hodge pessaries. Space occupying include gellhorn, donut, cube and inflatoball. Incontinence ring pessaries and incontinence dish pessaries are specifically designed to treat urinary stress incontinence. Clinical applications of each pessary will be discussed.

Pessaries have a low incidence of complications. The common complications include vaginal erosions/ulceration, vaginal odour and vaginal discharge. Vaginal erosions can be treated with removal of pessary and vaginal estrogen supplementation. Serious complications such as recto vaginal fistula and vesico vaginal fistula are generally related to neglected pessaries. Complications are minimised if women are taught to self care. Regular follow up is essential.

Pessaries should be considered in all women presenting with symptomatic prolapse and/or urinary stress incontinence.

Urodynamics and Neurophysiology - The Evidence

Fay Chao

1. Monash Health and Eastern Health, Glen Waverly, VIC, Australia

Urodynamics is a functional study of the lower urinary tract. It is a group of tests that assesses the filling and storage phase and, the voiding phase of the bladder and urethra. Urodynamic studies can range from simple urodynamics to multichannel cystometry to, video/fluoroscopic urodynamics.

Recent studies have found that urodynamic studies do not improve surgical outcomes and have therefore questioned the value of urodynamics in stress urinary incontinence surgery and pelvic organ prolapse surgery. Before applying evidence from these studies to widespread practice, it is important to carefully consider the inclusion and exclusion criteria of these studies especially in the current climate where insertions of mid-urethral slings has been scrutinized following the recent US Food and Drug Administration (FDA) warning.

Urodynamics are merely tests that provide additional information regarding lower urinary tract symptoms. Before undertaking pre-operative urodynamics, all clinicians should consider what the urodynamics question being asked and how it will change patient management. Urodynamics do not improve surgical outcomes but they offer valuable information to the surgeon and patient that could help patients and surgeons accurately assess the risks and benefits of surgery, and facilitate optimal pre-operative counseling which can have significant impact on patient expectations and satisfaction. Pre-operative tests also provide information that can guide and improve patient management overall and not just the outcome of surgery.

Pelvic Power

Janetta Webb

1. *Melbourne Continence Group Physiotherapy, Gardenvale, VICTORIA, Australia*

Pelvic floor muscle training (PFMT), lifestyle modifications and advice about appropriate fitness activities form the basis of a physiotherapy program aimed at preventing or treating POP. Evidence suggests that PFMT compared to no intervention significantly improves prolapse symptoms.

The components of a structured, intensive PFMT program will be discussed including motivation and compliance of women to adhere to such a program.

PRP Treatment for Vaginal Atrophy

Peter Lewis

1. *Surecell Australia, Malvern, VIC, Australia*

Platelet-Rich Plasma (PRP) is rapidly emerging within the field of regenerative medicine as a highly efficacious, well-tolerated and low-risk form of treatment. PRP involves the injection of autologous plasma to accelerate tissue regeneration and collagen production. It is commonly used to treat musculoskeletal injuries and degenerative conditions such as osteoarthritis and tendinopathies. In the past 6 years, PRP has increased 100% per annum from relative obscurity to become a widely practiced and accepted therapy within orthopaedics, cosmetics and plastic surgery. With over 7,000 published studies that validate its effect, PRP has been called the “treatment of choice” for mild-moderate osteoarthritis by level 1 studies and meta-analyses, such as Kanchanatawan et. al (1). PRP is well-established as an effective treatment option for musculoskeletal conditions, PRP has recently emerged as a therapy in gynaecology, for conditions such vaginal atrophy, dyspareunia, urinary incontinence and prolapse.

Dr Peter Lewis will discuss the rationale of gynaecological PRP. Wasterlain et. al demonstrated that PRP contains platelet-derived growth factor (PDGF) and vascular endothelial growth factor (VEGF) in concentrations more than fifty times higher than that of normal serum (2). This occurs through the degranulation of platelets and white blood cells during the centrifugation and light activation processes, resulting in elevated levels of human growth hormone (HGH) in serum after PRP injection. HGH and PDGF have been proven to accelerate the closure of abdominal wounds and reduce pain in muscular injuries and improve post-operative recovery (3).

This theory has been supported by studies demonstrating the efficacy of PRP in the treatment of a number of gynaecological conditions, including cervical erosions, where it has outperformed laser ablation (the current treatment of choice) with a faster healing time and fewer side effects (4). When combined with autologous-derived fibrin glue, PRP has successfully treated rectovaginal fistulae (5). In addition, it has been shown to significantly reduce post-operative pain and analgesia after gynaecological surgery (6,7).

Session Four: Bladder

1545 – 1730

Bladder Pain Syndrome/Interstitial Cystitis

Anna Rosamilia

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

Bladder pain syndrome/interstitial cystitis (BPS/IC) is a chronic pain syndrome characterised by pain/discomfort attributed to the bladder, with associated urgency and urinary frequency. According to the American Urological Association (AUA) guidelines, symptoms should be present for a period of more than 6 weeks.¹ Confusable diseases, such as overactive bladder and recurrent urinary tract infection, need to be excluded prior to a diagnosis of BPS/IC.

The underlying etiology of BPS/IC is not well understood and it is likely that a number of mechanisms play a role in the development of the condition. The urothelium/transitional epithelium is thought to play a fundamental role in the pathogenesis of BPS/IC. The protective layer of glycosaminoglycans (GAG) on the surface of the urothelial cells provides a barrier against solutes in the urine. Components of this layer include hyaluronic acid, chondroitin sulphate, heparin sulphate, dermatan sulphate and keratin sulfate.² This GAG layer has been shown to be defective in some patients with BPS/IC.³⁻⁵ Once the subepithelial cells come into contact with urinary solutes, an inflammatory reaction is triggered, in turn resulting in decreased urothelial production of GAG and exacerbation of urothelial permeability and inflammation. Urothelial damage results in pathologic C-fibre activation, causing smooth muscle contraction, neurogenic inflammation, and hypersensitivity. As with other chronic pain conditions, central pain sensitization results.

Management of BPS/IC requires a multimodal approach. The American Urological Association (AUA) and the European Urological Association have produced management guidelines for BPS/IC, both of which were updated in 2014.

First line therapy is aimed at educating the patient about the chronic nature of the condition and advocating behavioural and lifestyle modifications that may help ameliorate the symptoms, as well as providing a pain management plan. Intravesical therapies are indicated if first line therapy fails and are used in conjunction with physiotherapy techniques (myofascial release/pelvic floor muscle relaxation) and oral agents. The rationale for the use of many of the currently used intravesical therapies is to replenish the deficient GAG layer or to alter the process of neurogenic inflammation and hypersensitivity. Other therapies include intravesical injection of Botulinum toxin and sacral neuromodulation, immunosuppressive therapy and lastly major urologic surgery.

Neuromodulation, From Research to Practice

Marcus Carey

Abstract not yet received.

Bladder Over Activity, Management Hot Off the Press
Gil Burton

Abstract not yet received.

Fecal Incontinence - Reverse the Thinking
Peter Rosenblatt

Abstract not yet received.

Saturday 16 July 2016

Session Five: Stump the Experts **0800 - 0930**

Conundrums in daily life managements

Session Six: The Latest, The Greatest **1000 - 1230**

The Latest in Uterine Morcellation
Peter Rosenblatt

Abstract not yet received.

Stem Cell Research - An Update
Caroline Gargett

1. *Hudson Institute of Medical Research, Clayton, VIC, Australia*

Our goal is to address problems associated with the use of vaginal mesh for treating Pelvic Organ Prolapse (POP) using a tissue engineering approach. We propose to use autologous mesenchymal stem cells derived from the endometrium (eMSC) delivered on novel polyamide/gelatin composite meshes. MSC are easily obtained and purified from endometrial biopsies from pre- and short-term estrogen-treated post-menopausal women using SUSD2 magnetic-bead cell sorting. We first examined the effect of cultured human eMSC seeded on polyamide/gelatin mesh in a rat fascial defect model, but the eMSC only survived 14 days. Nevertheless, the eMSC increased vascularisation and modulated the macrophage response to promote wound healing, resulting in deposition of physiological, crimped collagen in comparison to scar-like collagen in mesh-only controls. At 90 days, the mesh-tissue complex was biomechanically less stiff in eMSC-treated rats compared with mesh alone, indicating a paracrine action in modulating the tissue response to the mesh. We are also developing an autologous preclinical vaginal surgery model by implanting ovine FACS-sorted CD271⁺eMSC purified and cultured from hysterectomy tissue. The eMSC seeded onto polyamide/gelatin mesh (3 x 5 cm) were implanted into parous ewes with weakened vaginal walls as assessed by a modified POP-Q and a novel fibre optic pressure sensor device. Our pilot data from several ewes vaginally implanted with their own eMSC showed they survived longer than in the rat model and possibly engrafted into the vaginal

wall. Our tissue engineering approach using autologous eMSC delivered on polyamide/gelatin scaffolds addresses some problems associated with the use of vaginal mesh and may have the potential to improve surgical outcomes for treating POP.

Apical Support for Benign Hysterectomy

Andrew Sokol

Failure to reestablish apical support at the time of hysterectomy may increase the risk of post-hysterectomy prolapse. This talk will highlight surgical approaches to apical prolapse, specifically focusing on strategies for the prevention of post-hysterectomy prolapse. Current guidelines regarding preventative apical suspension procedures will also be reviewed.

Back to the Future, Traditional Surgery, Re-emerging Fashion

Elvis Šeman

In Robert Zemeckis' 1985 film "Back to the Future", Marty McFly travels 30 years back in time in the DeLorean time machine to make sure that his parents, who are then still in high school, fall in love and marry to ensure his own future. In 2016, pelvic surgeons are being transported back in surgical history and the 'vehicle' is the withdrawal of mesh products for prolapse repair and urinary incontinence.

Drawing on the medical literature and a 2015 survey of practice of Australasian gynaecologists, this presentation will examine why we are going back, how far back we are likely to go (our surgical 'destination'), what procedures may be available (the surgical 'landscape') and how we can ensure a better future for our patients who suffer from pelvic floor dysfunction.

Colorectal and Pelvic Floor Surgeons - Working Side by Side

Eugene Ong

Abstract not yet received.

Sharing the Pelvis with the Urologists

Sandra Elmer

Complex gynaecological conditions, such as deeply infiltrative endometriosis and locally invasive malignancies, can present treatment challenges for both the gynaecologist and urologist, given that an extensive dissection is usually necessary. When operating in a hostile environment, the urinary tract is extremely vulnerable. Injuries to the ureter are the most common; therefore, familiarity with the special anatomy of the ureter is essential for every surgeon operating in this area. When indicated, a multidisciplinary surgical team should be employed for optimal results. In select patients, primary surgical laparoscopic management of ureteral lesions with ureterolysis can be performed with success. If required, ureteric reconstruction options range from primary ureteroureterotomy, uretero-neocystostomy, psoas-hitch, and Boari flap, depending on the length and location of the involved ureter.

Medico Legal Update - On Pelvic Floor Surgery

Peter Henderson

1. AVANT MUTUAL, Brisbane, QLD, Australia

Avant has developed a coding system for claims made. Data has been extracted concerning claims made following bowel injury not recognised during the procedure.

The signs and symptoms have been during the delay in diagnosis have been examined to see if we can diagnose this complication earlier.

Session Seven: Free Communications

1330 - 1430

Effect of Parity on Ovine Vaginal Wall Tissue Properties

Stuart J Emmerson¹, Caroline E Gargett¹, Natharnia Young^{1,2}, Anna Rosamilia^{1,2,3}, Jerome Werkmeister^{3,4}, Aditya Vashi⁴, Sharon Edwards⁴, Jacinta White⁴

1. Hudson Institute of Medical Research, Clayton, VIC, Australia
2. Monash Health, Clayton
3. Department of Obstetrics and Gynaecology, Faculty of Health, Medicine and Nursing, Clayton
4. CSIRO Manufacturing, Clayton

Context: Pelvic Organ Prolapse is a major clinical burden affecting 25% of women. We are developing mesh that incorporates cell-based therapy to regenerate vaginal tissue. Ewes are used as a large animal preclinical model to test our tissue engineering approach.

Objective: To define the relationship between vaginal wall displacement and the histological, biochemical and biomechanical properties of the ovine vaginal wall in nulliparous, primiparous and multiparous ewes. We hypothesised that the vaginal wall of parous ewes would exhibit altered concentrations of extracellular matrix (ECM) proteins, less smooth muscle and lower tensile strength than nulliparous ewes, which will be related to vaginal displacement.

Methods: Border-Leicester-Marino ewes (n=22) were examined vaginally using traction while conscious without sedation using an adapted human POP-Q measurement. Ovine POP was defined as descent to the introitus from Aa 3cm above the introitus on the anterior wall, Ap 3cm above the introitus on the posterior wall or increased Ba anterior wall descent above the urethra (≥ 0). Vaginal tissue was collected from nulliparous (n=6), primiparous (n=8) and multiparous (n=8) ewes. Tissue histology was assessed using Masson's Trichrome, PicroSirius Red birefringence and α smooth muscle actin immunostaining and image analysis. Biochemical analysis of collagen used a hydroxyproline assay and dimethylmethylene blue was used to quantify glycosaminoglycan. Biaxial tensiometry was used to generate load-elongation curves from which linear region stiffness, breaking load and breaking extension of the vaginal tissue were determined. Correlation analysis was used to determine associations between all parameters.

Results: Primiparous and multiparous ewes had greater displacement of vaginal wall tissue compared to nulliparous at points Aa ($p < 0.05$), Ap ($p < 0.05$) but not Ba. The vaginal muscularis of multiparous ewes was thinner than primiparous and nulliparous muscularis (p

Conclusion: Parity had a significant impact on the structure and function of the ovine vaginal wall. Multiparous vaginal tissue was weaker, more distensible, had thinner muscularis and possessed less immature collagen fibrils than nulliparous ewes. This correlated with "POP-Q" scores showing greater tissue laxity in multiparous compared to nulliparous ewes.

Culture Expansion of Undifferentiated Human Mesenchymal Stem/Stromal Cells for Management of Pelvic Organ prolapse

Shanti Gurung¹, James Deane¹, Jerome Werkmeister², Caroline Gargett¹

1. *The Ritchies Centre/Hudson Institute of Medical Research/Monash University, Rowville, ACT, Australia*
2. *CSIRO, Clayton, Victoria, Australia*

Pelvic Organ Prolapse (POP) is a major hidden problem affecting millions of women worldwide. Mesh-augmented surgery for its management has helped women, however, it is associated with high rates of complications such as mesh erosion into surrounding organs. Therefore, we are proposing cell-based therapy as a new approach. Human endometrial mesenchymal stem/stromal cells (eMSCs) are a novel source of MSC purified using the SUSD2 antibody. The rarity of MSCs requires their ex vivo expansion, but cultured MSCs undergo spontaneous differentiation into fibroblasts and replicative senescence, decreasing their purity, survivability and efficacy for clinical applications. We have identified that A83-01, a small molecule TGF- β receptor inhibitor, promoted SUSD2+ human eMSC proliferation, and blocked senescence and apoptosis in vitro. The aims of this study were to determine if A83-01 1) has similar effect on MSCs obtained from menstrual blood, placenta, adipose tissue and bone marrow, and 2) improves eMSCs survival in vivo. MSCs were isolated from dissociated tissues using SUSD2 magnetic beads and cultured in serum free medium (SFM) with bFGF/EGF in 5%O₂/5%CO₂. At passage 6 (P6), MSCs were incubated with or without A83-01 for 7 days, then analysed for MSC properties. A83-01 treatment promoted SUSD2+ MSC proliferation, increasing the %SUSD2+ post-menopausal endometrial, bone marrow, adipose tissue, placental, and menstrual blood MSCs in P6 cultures. There was no change in expression of CD90, a standard MSC marker or CD140b, while CD146 was downregulated. P1 SUSD2+ eMSC transduced with a mCherry vector and treated with/without A83-01 retained high expression of the fluorescent protein until P6, after which 5X10⁵ were transplanted under kidney capsule of NSG mice until harvest at 7, 14, 30 days. The A83-01 treated eMSC survived under the kidney capsule for a longer duration and in greater number than the untreated eMSCs as detected by mCherry immunofluorescence, SUSD2 flowcytometry and Alu sequence PCR. Small molecules such as A83-01 that promotes proliferation of various MSC types in the undifferentiated state may provide an approach for the expansion of undifferentiated MSC for use in tissue engineering and cell-based therapies, including POP.

Maternal Country of Birth as a Risk Factor for Anal Sphincter Injuries in Primiparous Obstetric Patients in a Western Sydney Tertiary Centre.

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

1. *University of Sydney, Sydney*
2. *SWAPS, Sydney West Area Pelvic Surgery Unit, Sydney, Australia*
3. *O&G, Westmead Hospital, Westmead, NSW, Australia*
4. *Department of Urogynaecology, Westmead Hospital, Westmead, NSW, Australia*

Maternal morbidity and mortality has significantly reduced over the years due to advances in peripartum care, however obstetric anal sphincter injuries (OASIS) continues to be an ongoing important complication of vaginal delivery. The incidence of OASIS in Australia is 2.46% (2013) and women born overseas have a higher rate of OASIS (2.8%) than Australian born mothers (1.7%)¹ Following OASIS, women may develop subsequent pain, dyspareunia and faecal incontinence as long term consequences. Hence it is prudent to identify risk factors for OASIS to enable appropriate counselling of obstetric patients and implementation of the appropriate care in order to reduce the incidence of OASIS where possible.

Ethnic background as a risk factor has been described in previous studies.² The obstetric population delivering at Westmead Hospital is quite ethnically diverse compared to state and national statistics. In 2013, Western Sydney local health district (WSLHD) had 43% of the residents born overseas as compared to the New South Wales average of 27%.

Methods: A retrospective cohort review was conducted on all singleton cephalic vaginal deliveries to primiparous women over a 7 year study period (January 1st 2009 - December 31st 2015). Data was obtained from the electronic obstetric recording system at a single tertiary institution, Westmead Hospital.

All potential confounding variables such as maternal factors (age, BMI, country of birth), obstetric factors (previous caesarean section, parity, plurality, mode of delivery, type of tear, length of second stage of labour) and fetal factors (fetal weight, gestational age, head circumference) were collected.

The country of birth was grouped as per the Standard Australian Classification of Countries (SACC) which is utilized consistently by the Australian Bureau of statistics for reporting.

The primary outcome is to determine if country of birth is an independent risk factor for OASIS. Cross-tabulation between OASIS and the different covariates was performed in order to define the characteristics of the study population. The association between country of birth based on SACC classification and OASIS were also cross-tabulated. All cross-tabulations were assessed using a Chi-squared or Fisher exact test, ignoring missing values, with a two-sided 5% significance level concluding statistical significance. Multivariate logistic regression analysis was used to determine the risk factors for OASIS which is represented as odds ratios (OR) and 95% confidence intervals.

Discussion: Results of the multivariate analysis together with a literature review pertaining to risk factors and prevention of OASIS will also be discussed.

1. *Australian Institute of Health and Welfare. (2015b). Perinatal data portal: Labour and birth - Perineal status. Canberra.*
2. *McPherson KC, Beggs AD, Sultan AH, Thakar R. Can the risk of obstetric anal sphincter injuries (OASIs) be predicted using a risk-scoring system?. BMC Research Notes 2014, 7:471*

MiniArc vs TVT Abbrevio Suburethral Sling in Women with Stress Urinary Incontinence – an RCT – 6m Follow Up

Joan Melendez¹, Meirav Braverman¹, Anna Rosamilia¹, Natharnia Young¹, Alison Leitch¹, Joseph Lee^{1,2}

1. *Monash Health, Bentleigh East, VIC, Australia*
2. *Pelvic Floor Unit, Mercy Hospital for Women, Heidelberg, VIC, Australia*

OBJECTIVE: To evaluate objective and subjective outcomes of MiniArc SIS and TVT Abbrevio midurethral sling (MUS) in women with stress urinary incontinence.

METHODS: Female subjects with stress urinary incontinence were eligible to participate in this study. Women with intrinsic sphincter deficiency (maximum urethral closure pressure (MUCP) of 20 cmH₂O or less abdominal leak point 60 cm H₂O or less), previous failed suburethral tapes or untreated detrusor overactivity were excluded.

Patients were randomised with computer-generated blocks of 4-8. Surgeons or patients were not blinded once allocation was revealed. Assuming an objective cure rate of 90% for TVT AbbrevioTM with a power of 80%, a sample size of 79 each arm was required to detect a clinical difference of 15%, using a one sided α of 0.05. The target recruitment number was 220 allowing for an attrition rate of 15%. Institution ethics approval (11261B) was obtained and the trial was registered with the national clinical trial registry.

Routine preoperative assessment was conducted for objective data, whilst patient reported outcome tools (PRO) were utilised for subjective outcomes. TVT AbbrevioTM or MiniarcTM were performed in a standardized fashion, together with any concomitant prolapse surgery, followed by routine post operative care including voiding trial and assessment of post operative pain. Review was conducted at 6 weeks and at 6 months at which time, uroflowmetry, a clinical cough stress test and examination were performed in addition to symptom and quality of life questionnaires.

Objective cure was defined as a negative cough stress test with a comfortably full bladder. Subjective cure was defined as no report of leakage with physical exertion. All Data was collected on a standardized proforma including patient characteristics. Outcomes were compared with exact binomial tests (eg, Fisher exact test for dichotomous data) for categorical data and Student t test or exact versions of Wilcoxon tests for numerical data as appropriate.

RESULTS: Between 2011 and December 2015, 244 women were randomized to receive MiniArc (111) or TVT Abbrevio (113) with 20 withdrawals from the study; Baseline characteristics were clinically balanced except ALPP, a difference which was not clinically significant.

At the current time-point, 138 women were assessed and there were no significant differences in subjective or objective cure at 6 month follow up,

except a lower ICIQ OAB score in the TVT Abbrevio of doubtful clinical significance.

CONCLUSION: Miniarc SIS outcomes are not inferior to TVT abbrevio MUS at 6 month follow-up, in women without intrinsic sphincter deficiency.

Evidence to Justify Retention of Transvaginal Mesh: Comparison Between Laparoscopic Sacrocolpopexy and Transvaginal Elevate Mesh Series

Valerie To¹, Pattaya Hengrasmee¹, Anna Lawless¹, Justin Lam¹, Alan Lam¹

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

Background: Sacrocolpopexy is considered the most durable procedure for pelvic organ prolapse. Transvaginal procedures on the other hand have the advantage of being less invasive, especially in patients with comorbidities. However, with the controversies regarding transvaginal mesh-related complications, less of these procedures are being performed. We are reviewing here our experience with laparoscopic sacrocolpopexy compared with transvaginal mesh with Elevate, in terms of apical support and mesh erosion rates.

Methods: Patients who underwent laparoscopic sacrocolpopexy from 2006 to 2015 were compared with patients who had apical prolapse (POP-Q point C \geq 1) and underwent Elevate mesh placement, without history of sacrocolpopexy. All the procedures were performed by one experienced gynaecological surgeon at our tertiary care referral centre. Chart review was performed and comparisons between the two groups were calculated using t test, Fisher exact or Chi square test.

Results: 290 patients underwent sacrocolpopexy and 146 patients were included in the Elevate mesh group. The sacrocolpopexy group had a mean age of 59 years old and a BMI of 25.8. Patients in the Elevate group were older with a mean age of 63 and a BMI of 26.3. The majority of both groups presented with pelvic organ prolapse stage III (74.5 and 87%) and their mean POP-Q point C were not significantly different (1.4 vs. 1.2cm). Operative time was significantly higher in the sacrocolpopexy group (113 vs. 91 minutes), but estimated blood loss was lower (80cc vs. 137cc). Mesh erosion rate at one year was higher in the sacrocolpopexy group (2.8% vs 1.4%), although this difference was not statistically significant. One year objective cure rate, defined as no descent beyond the hymen, was 97.5% in the sacrocolpopexy group and 97.2% in the Elevate group. The overall recurrence (objective, subjective recurrence or reoperation) was also not different between the groups (3.8% vs. 4.8%). 5 patients (1.7%) in the sacrocolpopexy group had recurrence in the apical compartment compared to 3 patients (2.0%) in the Elevate group.

Conclusion: Although apical support appears to be similar between laparoscopic sacrocolpopexy and transvaginal Elevate mesh, erosion rate may be higher with sacrocolpopexy, although that difference was not significant.

Surgical Anatomical Outcomes Using Posterior Repair Quantification (PR-Q) to Identify Defects – Short Report

Bernard Thomas Haylen¹, Audris Wong², Phoebe Hong², Stephen Kerr³, Warwick Birrell⁴

1. *St Vincent's Clinic, Darlinghurst, NSW, Australia*
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3. *Kirby Institute, University of New South Wales, Kensington, NSW, Australia*
4. *Mater Hospital, North Sydney, NSW, Australia*

Hypothesis / aims of study: Posterior repair quantification (PR-Q)¹⁻³ provides a clear, alternate set of four measurements to the equivalent POP-Q₃ posterior compartment measurements. Using PR-Q (and POP-Q) measurements, posterior compartment defects have been found more at the vaginal vault (Level I) and vaginal introitus (Level III) than at the mid-vagina (Level II)^{1,2}. We hypothesize that the use of PR-Q as surgical indicators might facilitate consistent and favourable postoperative surgical anatomical outcomes.

Study design, materials and methods: In a cross-sectional study of 300 consecutive posterior repairs (PRs), mostly following prior or concomitant hysterectomy, the following were measured pre- and immediately postoperatively: (i) from POP-Q²: points C, Ap and Bp and genital hiatus (GH); from PR-Q¹: perineal gap (PG), posterior vaginal vault descent (PVVD), mid vaginal laxity (MVL) vault undisplaced, rectovaginal fascial laxity (RVFL – n/a postop). The range of other demographic and surgical factors noted included: age; parity; weight; height; BMI. Surgical initiatives such as (i) excision of the perineal defect (PG); (ii) vault suspension (sacrospinous colpopexy – SSC); (iii) vaginal skin excised; (iv) rectovaginal fascial suturing were recorded and compared with surgical outcomes.

Results: Demographic data for the 300 – Number (range) Standard deviation (SD) were; (i) Age: 63.6 (31-91) SD11.8; Weight (kg) 71.7 (44-141) SD 14.6; Height (cm) 162.9 (142-187) SD 7.1; BMI (Kg/m²) 26.7 (18.6-41.3) SD 5.0; Parity 2.6 (0-8) SD 1.2. Mean cumulative surgical outcomes (%) at the different Levels were: (i) Level I: Overall 98% reduction in defect (PVVD – Point C similar reduction), 99% if SSC performed (84% cases) or 83% if SSC not performed (16% cases); (ii) Level II: 85% reduction in defect (MVL – Points Ap, Bp similar reductions); (iii) Level III: Elimination (100% reduction) of defect (PG) with 30% reduction in GH.

Conclusion: PR-Q¹⁻³ posterior prolapse surgical markers facilitate (i) identification of anatomical defects at the different Levels I-III; (ii) exact surgical planning for each Level; (iii) consistent, favourable and statistically interpretable anatomical surgical outcomes for each Level.

1. *Haylen BT, Avery D, Chiu TL, Birrell W (2014) Posterior repair quantification (PR-Q) using key anatomical indicators (KAI) – Preliminary Report. International Urogynecological Journal, 2014(25): 1665-1672.*
2. *Haylen BT, Naidoo S, Kerr S, Yong CH, Birrell W (2016) Posterior vaginal compartment repairs: Where are the main anatomical defects? Int Urogynecol J. 27:741-745. Neurourol Urodyn 2015, 34 (S3):S130-131.*
3. *Haylen BT, Maher CF, Barber MD, Camargo S, Dandolu V, Digesu A, Goldman HB, Huser M, Milani AL, Moran PA, Schaer GN, Withagen MIJ*

(2016) An International Urogynecological Association (IUGA) / International Continence Society (ICS) Joint report on the Terminology for Pelvic Organ Prolapse. Neurourol Urodyn 35(2):137-168.; Int Urogynecol J 27(2):165-194.

Session Eight: What's Best for Women?

1430 - 1530

Continuing Urogynaecology Education and the Role of IUJ

Peter Dwyer

1. Mercy Hospital, Fitzroy, VIC, Australia

It is interesting to consider how we all continue to learn and improve our clinical knowledge and skills so that we can provide better, more effective and safer treatment for our patients- remembering the title of this session is What's Best for Women?

Some of the ways for continuing Urogynecology education are

1. Trial and error - a fool learns from his/her own mistakes, a wise man from others.

Colleagues/mentors/apprenticeships

1. Commercial representatives -handouts
2. Workshop/courses usually run/sponsored by companies
3. Conferences such as AGES Pelvic floor meeting
4. Publications Journals/books
5. Internet

How reliable are these and free from bias and commercial interference?

The controversy of the use of polypropylene mesh in urinary stress incontinence and Pelvic Organ Prolapse (POP) continues and has entered a new phase with large healthcare companies withdrawing from the area of female pelvic floor surgery either partially (Perigee -Johnson and Johnson) or completely (Astora Women's Health formerly -American Medical Systems). This has occurred because of adverse publicity and cost of medical litigation mainly in the USA. However in Australia, Shine lawyers are running a class action in Australia; supposedly again commercial companies but this will no doubt flow onto litigation against doctors.

So what lessons are there for ongoing education and the implementation of new medical technology to be learnt from this mesh saga?

Medical journals accessed either electronically or in print are an important means to keep updated on the latest developments in Urogynecology. The International Urogynecology (IUJ) is a monthly publication with 12 issues a year and more than 2000 pages dedicated to the study solely of female pelvic floor disorders. More than 650 manuscripts are submitted, with approximately 300 (42%) manuscripts being accepted and published. Article types are original research, reviews and clinical opinions, editorials, videos, image case reports, Urogynecology digest and letters to editor. More than 3000 reviewers are invited and 2000 reviews completed. The average reviewer takes 10 days to complete the review and does 3.6 reviews a year. Every review is assessed and graded by the editor before she

or he makes the final decision. Many reviews are performed by members of the editorial board who are experienced clinicians and give their time and good name to the journal so that the publication is of high quality. The authorship of the articles is truly global as is the readership.

FGM – Gynaecologist Perspective

Khai Mohamed-Noor

1. The Women's, Parkville, VIC, Australia

It is estimated that 140 million girls and women worldwide are affected by Female Genital Cutting (FGC). The practice is limited to some African, Middle East and South East Asian countries. With increasing migration particularly from Somalia, Sudan and Ethiopia, Medical Practitioners and Gynaecologist in Australia will have to manage patients that are affected by FGC. This brief is to give an overview of Female Genital Cutting and an understanding of the clinical presentations and its management.

What Does Society Think About FGM?

Ajay Rane

The first conviction for performing FGM happened in Australia in May 2016. So FGM is happening in Australia. On what scale?

Are there any DRGs that tell us of admissions to hospitals for complications of these procedures in Australia?

We present the views of men and women on FGM in Australia.

What about our neighbours Indonesia and Malaysia?

We present a brief glimpse into some changes in philosophies here.

Session Nine: Innovations, What Does the Future Hold?

1600 – 1650

Slings – What Does the Future Hold?

Peta Higgs

1. The Sunshine Coast Private Hospital, Maleny, Q, Australia

The midurethral mesh sling is the most commonly used surgery for urinary stress incontinence. There is short and midterm data from RCTs to support the effectiveness and safety for both the retropubic and transobturator approach. There is a higher risk of bladder perforation and voiding dysfunction with the retropubic approach and a higher risk of groin pain post obturator approach. [1]

The Scottish review on transvaginal mesh and the European review on urogynecological mesh have both supported the use of midurethral slings for stress urinary incontinence. No regulatory body has recommended withdrawal of any mesh sling although the FDA has required 522 studies on single incision slings.

However, the midurethral slings have been included in the Class Actions against the manufacturers of vaginal mesh. This has resulted in withdrawal of some of the midurethral slings from the market.

If gynaecologists wish to continue to use mesh slings, it is important that we ensure that these surgeries are performed for the correct indications, that

complications are managed appropriately and in a timely manner and that training and teaching of the techniques are strictly supervised and documented. Newer slings which do not have appropriate data should only be used in the setting of a clinical trial with approval from an ethics committee.

Mesh Surgery - Looking Beyond the Horizon

Peter Rosenblatt

Abstract not yet received.

Next Generation Robot - What is Next

Haider Najjar

Abstract not yet received.

President's Debate

1650 - 1730

To Operate or Not to Operate; That is the Question

FOR: Salwan Al-Salihi & Peter Rosenblatt

AGAINST: Fariba Behnia-Willison & Andrew Sokol

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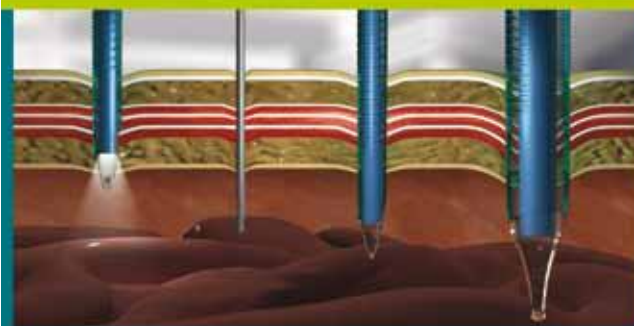
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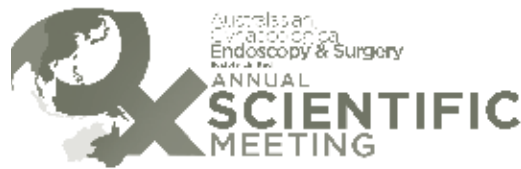
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