AGES XIX PELVIC FLOOR SYMPOSIUM 2018

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PROGRAM

More than Gynaecology?

The Pelvic Floor MDT(Multi-Disciplinary Team)

Australasian Gynaecological Endoscopy & Surgery Society Limited
PELVIC FLOOR SYMPOSIUM

3RD & 4TH AUGUST 2018

Sofitel Brisbane Central, Brisbane

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Dear Colleague,

Pelvic floor surgery has been a controversial focus of the medical, legal, and political world for the last few years, especially with the problems associated with surgically implantable permanent materials. For women who have been injured and suffer problems, we must continue to provide solutions to improve their health and recognise the issues that led to these problems. Loss of quality of life from pelvic floor damage due to ageing and childbirth will never disappear and we must look to new, collegiate and evidence-based methods of diagnosing, managing and understanding this critical area of gynaecological surgery. On behalf of the Board of the Australasian Gynaecological Endoscopy and Surgery Society and our local organising committee, we are delighted to welcome you to Brisbane for the 19th Annual AGES Pelvic Floor Symposium.

The symposium, "More than Gynaecology", is a multidisciplinary approach to pelvic floor medicine with clinical care at its core. Surgical techniques are scrutinised to reveal their current and potential future roles in addressing pelvic floor symptoms. We need to continue to be forward looking, constantly questioning and more collaborative to improve the health outcomes of the women we care for. By working in multi-disciplinary teams with allied health professionals, scientists, colorectal specialist and urologists we can collectively learn and advance ways to improve the health and quality of life of women with pelvic disorders.

Our program focuses on the importance of the specialist gynaecologist surgeon and their role in the front-line management of pelvic floor problems – a founding pillar of our training and knowledge. The interprofessional collaboration with the subspecialist uro-gynaecologists, advances and recent changes in pelvic floor surgery, options for management of urinary incontinence possibly without suburethral slings, upskilling in pelvic floor surgical techniques and methods of teaching surgery to colleagues and trainees in the operating theatre environment will all be core elements of the symposium. Pelvic pain management in women with and without pelvic mesh will be explained, explored and analysed and an essential update on the current surgical mesh situation in Australia and New Zealand will be presented. Finally, the management and prevention of obstetric perineal trauma will be explored and debated with an assembled faculty of Australian and International colleagues.

Our invited faculty includes Dr. G Willy Davila (USA), Prof. Don Wilson (NZ), Prof. Lorimer Moseley (Aust), Colorectal surgeons, Prof. Mark Coleman (UK), and Dr. Tom Cecil (UK).

Take the opportunity while in Brisbane to partake in many of the outdoor activities the city is known for. Whether it be an early morning cycle around Brisbane, bush walking in national parks, exploring rooftop bars or push the boat out and compete in the Brisbane Marathon Festival on 5th August. We can guarantee that you won't be disappointed.

This year's AGES pelvic floor symposium is one of positivity and necessity. Pelvic floor issues for women remain a huge burden of illness and we must look beyond the current controversies and focus on solving the problems for women. Our role as a specialist gynaecological surgeon has never been more important and this meeting is one that celebrates collaboration, education and collegiality. We are confident that you will enjoy your time in Brisbane with this entertaining and educational meeting with practical approaches to improve the lives of the women we care for through a multidisciplinary approach.

Prof Ajay Rane OAM
AGES Pelvic Floor Chair

Dr Michael Wynn-Williams
AGES Pelvic Floor Co-chair & Scientific Chair

INTERNATIONAL FACULTY

Dr Tom Cecil BM FRCS DM, (UK)

Colorectal Consultant and Clinical Director Peritoneal Malignancy Institute, Basingstoke

Tom Cecil started as a Consultant colorectal Surgeon in Basingstoke in 2002. He specialises in laparoscopic colorectal surgery and peritoneal malignancy surgery. He is the Clinical Director of the Peritoneal Malignancy Institute in Basingstoke.

Dr Cecil ran one of the Lapco training centres for laparoscopic colorectal surgery. He has developed the Lapco TT courses for different specialities and in different countries.

A/Prof Mark Coleman MB ChB FRCS honFRCPSG FFST RCSEd MD, (UK)

Consultant Surgeon, Plymouth Hospitals NHS Trust
Mark Coleman is a colorectal surgeon with interests in laparoscopic surgery. He has an international reputation in surgical training.

A/Prof Coleman has been a Consultant Surgeon, Derriford Hospital, Plymouth, UK since 2001. He was the Lead Clinician for Lapco, the National Training Programme for laparoscopic colorectal surgery (2008-2013). He was Chairman, External Affairs Association of Coloproctologists, Great Britain (2011-2016). He is Chairman, Bowel Cancer West (Charity). Chairman of the Plymouth Postgraduate Medical Centre. Associate Professor, Plymouth University Peninsula Schools of Medicine and Dentistry. Co-Director Lapco International Consultancy

Dr G. Willy Davila, (USA)

Willy Davila, MD, Head of Urogynecology and Reconstructive Pelvic Surgery at Cleveland Clinic Florida in Weston, Florida.

Dr. Davila has given nearly 400 presentations and has published more than 130 book chapters and articles in peer-reviewed journals. He has co-authored 5 textbooks including Pelvic Floor Dysfunction: A Multidisciplinary Approach and Practical Guide to Female Pelvic Medicine.

Dr. Davila is the Past-President of the International Urogynecologic Association (IUGA) and past-Chairman of the Board of the National Association for Continence (NAFC) in the US

Prof Don Wilson, (NZ)

Don Wilson is a urogynaecologist and Emeritus Professor of Obstetrics and Gynaecology and Associate Dean, at the University of Otago, New Zealand.

Prof Wilson has been actively involved in many aspects of female urinary incontinence research and in particular epidemiological studies looking at the effect of pregnancy and delivery on subsequent pelvic floor dysfunction and its prediction and prevention.

Prof Wilson is a past Editor of the Cochrane Urinary and Faecal Incontinence Review Group, past Chair of Conservative Management for three of the International Consultations of Incontinence and the Urogynaecology Subspecialty Committee of RANZCOG. He recently chaired the Group contextualising the NICE Guideline on Urinary Incontinence in Women for New Zealand.

FRIDAY 3RD AUGUST 2018

0700 - 0800	Conference Registration	
0800 - 1000	**SESSION 1: BOWEL ISSUES - WORKING TOGETHER SMOOTHLY**	
	Session Chairs: Ajay Rane & Stephen Lyons	Ballroom 2&3
	Welcome	
	Bowel function - What is normal? - **Allison Bryant**	
	Assessment of Colorectal function - How does it direct management? - **Chris Gillespie**	
	Constipation - How to push it out! - **Natalie Kiel**	
	Colorectal/Urogynaecolgy Pelvic floor clinic – What is the formula for success? - **Carina Chow**	
	Obstructed defecation "How to get it moving again" - **Andrea Warwick**	
	KEYNOTE: An anatomic approach to rectocele repair - **Willy Davila**	
	Case/Panel Discussion	
1000 - 1030	MORNING TEA, TRADE EXHIBITION & DIGITAL COMMUNICATIONS	EXHIBITION FOYER
1030 - 1230	**SESSION 2: BLADDER MATTERS**	
	Session Chairs: Emma Readman & Salwan Al-Salihi	Ballroom 2&3
	We are getting older - How are we going to manage incontinence without midurethral slings? - **Anna Rosamilia**	
	The 'knack' and all that: When to start and when to stop - **Lori Forner**	
	The top tier - Re-evaluating laparoscopic colposuspension - **Peta Higgs**	
	The Urologists approach to incontinence - Friend or Foe? - **Kate Gray**	
	Bugs in the bladder - The biome and recurrent UTI - **David Paterson**	
	Management of Iatrogenic Vesico-vaginal Fistula in Australia - **Judith Goh**	
	Managing bladder abnormalities in kids who then grow up and get pregnant - **David Winkle**	
	Panel Discussion	
1230 - 1330	LUNCH, TRADE EXHIBITION & DIGITAL COMMUNICATIONS	EXHIBITION FOYER
1330 - 1500	**SESSION 3: FREE COMMUNICATIONS**	
	Session Chairs: Haider Najjar & Hannah Krause	Ballroom 2&3
1500 - 1530	AFTERNOON TEA & TRADE EXHIBITION	EXHIBITION FOYER
1530 - 1730	**SESSION 4: PELVIC FLOOR SURGERY**	
	Session Chairs: Simon Edmonds & Robert O'Shea	Ballroom 2&3
	Training & Pelvic Floor Surgery - Who should we be training? - **Anna Rosamilia**	
	Consent for Pelvic Floor Surgery - Do we need a lawyer sitting with us in the consultation? - **Justin le Goullon**	
	Communicating with our patients about pelvic floor mesh - **Alan Lam**	
	The distressed specialist - How and when do I get help? - **Margaret Kay**	
	Removal of Mesh - Can mesh only be removed by a "chosen" few? - **Willy Davila**	
	KEYNOTE: Surgical Treatment of Pelvic Organ Prolapse - Now and the Future - **Chris Maher**	
	Panel Discussion	
1730	Close of Day One	
1915	Gala Dinner	Ballroom 1

GALA DINNER
Venue: Ballroom 1, Sofitel Brisbane Central
Ticket cost: $145.00 per person

SATURDAY 4TH AUGUST 2018

0730 - 0800	Conference Registration	
0800 - 1000	**SESSION 5: PAIN IN THE PELVIC FLOOR**	
	Session Chairs: Jason Abbott & Peta Higgs	Ballroom 2&3
	KEYNOTE: Pain Explained - **Lorimer Moseley**	
	Pelvic Floor Hyperactivity - Is it such a problem? - **Jason Chow**	
	Dear Physio. Please see Pelvic Pain. - **Alex Diggles**	
	Pharmacology: The Good, The Bad...and the Ugly - **Jayne Berryman**	
	What's up with Pudendal Nerve Pain? - **Ken Law**	
	Management of Mesh Pain - Is the pain really related to the Mesh? - **Thierry Vancaillie**	
	Practical management of pelvic floor pain for the Generalist - **Philip Hall**	
	Panel Discussion	
1000 - 1030	MORNING TEA & TRADE EXHIBITION	EXHIBITION FOYER
1030 - 1230	**SESSION 6: UPSKILLING YOUR PELVIC FLOOR PRACTICE**	
	Session Chairs: Michael Wynn-Williams & Anna Rosamilia	Ballroom 2&3
	How to teach Surgery - Theories of teaching in the operating room - **Tom Cecil**	
	The impact of structured teaching in the operating theatre - **Stuart Salfinger**	
	The LapCo Experience - How the NHS upskilled its Colorectal Surgeons - **Mark Coleman**	
	Teaching Vaginal Hysterectomy - The ACOG experience - **Willy Davila**	
	Should we all be able to perform laparoscopic sacrocolpopexy? - **Alexandra Mowat**	
	Back to the Future - Laparoscopic Colposuspension - **Salwan Al-Salihi**	
	The new world of simulation in Gynaecology Surgery - How can it help me upskill? - **Emma Readman**	
	Panel Discussion	
1230 - 1330	LUNCH & TRADE EXHIBITION	EXHIBITION FOYER
1330 – 1430	**SESSION 7: THE PELVIC FLOOR MDT**	
	MDT SESSION – HOW WE CAN ALL LOOK AFTER OUR PATIENTS TOGETHER AS A TEAM	
	Chairs: Peta Higgs and Ajay Rane	Ballroom 2&3
	PANEL: **Jason Abbott, Salwan Al-Salihi, Jason Chow, Willy Davila, Lori Forner, Chris Gillespie, Adrian Guest, Philip Hall & David Winkle**	
1430 - 1500	AFTERNOON TEA & TRADE EXHIBITION	EXHIBITION FOYER
1500 - 1645	**SESSION 8: OBSTETRICS AND THE PELVIC FLOOR - WORKING TOGETHER**	
	Session Chairs: Rachel Green & Alexandra Mowat	Ballroom 2&3
	KEYNOTE: Prevention and Prediction of Pelvic Floor Dysfunction—UR-CHOICE! - **Don Wilson**	
	The patients perspective of birth trauma - **Amy Dawes**	
	Consent for SVD without paternalism? - **Harsha Ananthram**	
	OASIS in Paradise? The Pacific Island OASIS Program - **Hannah Krause**	
	Episiotomy - Reduce pelvic floor trauma in the first place - **Ajay Rane**	
	Panel Discussion	
1645 - 1715	DEBATE: "Do you solemnly swear to look after my pelvis in this pregnancy and delivery?" - **Jenny King & Don Wilson**	
	Session Chairs: Jason Abbott & Willy Davila	
1715	Close of Conference	

Program is correct as of 07/27/18 & is subject to change without notice

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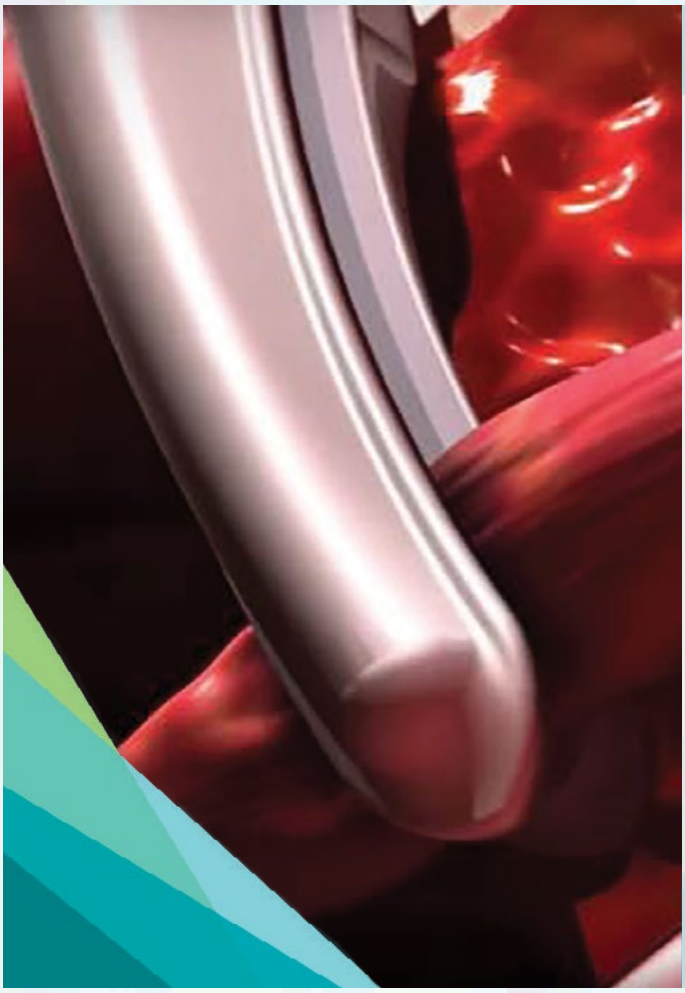

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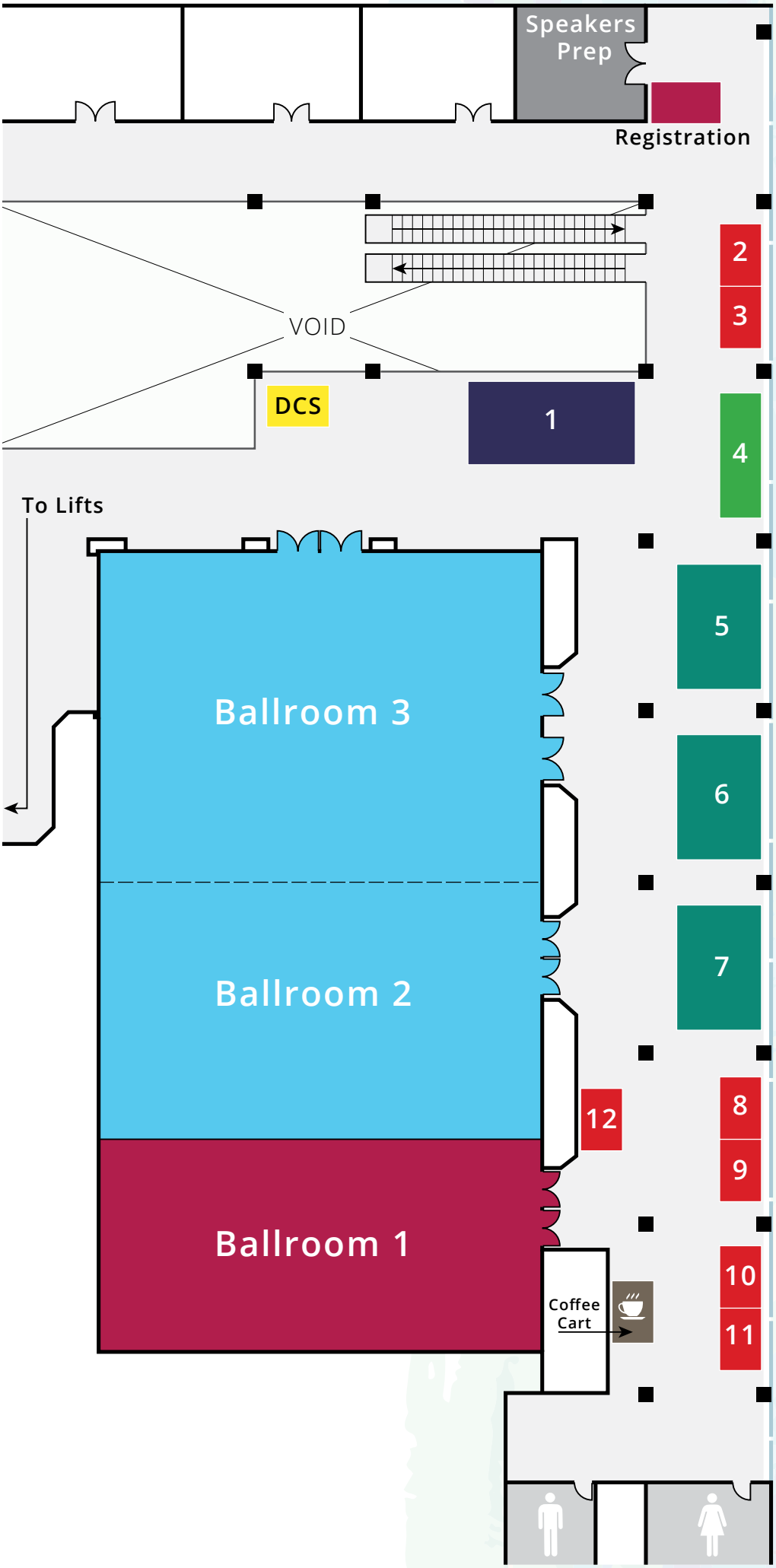

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ART PRIZE

SHANNON HAMILTON **2018/19**

Shannon Hamilton was the winner of the 2018/19 AGES Art Prize. Shannon's work will be featured on the cover of the **AGES Pelvic Floor Symposium XIX, Focus Meeting 2018 & AGES XXIX Annual Scientific Meeting 2019.**

ART PRIZE **2019/20**

The 2019/20 AGES Society Art Prize is now open, *for more information on how to enter please visit the ages website,* **www.ages.com.au/ages-events/ages-society-art-prize/**

SESSION 3: FREE COMMUNICATIONS
FRIDAY 3RD AUGUST
1330 – 1500
BALLROOM 2&3

Fariba Behnia-Willison
Treatment of Vaginal Mesh Exposure with Platelet Rich Plasma (RegenPRP®) and Regen Extracell-membrane

Sapna Dilgir
Adenexectomy Via Vaginal Natural Orifice Transluminal Endoscopic Surgery

Lauren Kite
Evaluating the effect of adding hyaluronic acid to local anaesthetic in pudendal nerve blocks for the treatment of pudendal neuralgia – An observational study

Mugdha Kulkarni
Video presentation: VITOM a viable alternative for teaching vaginal surgery

Mugdha Kulkarni
Fosfomycin : The New 'Easy' Therapy for UTIs?

Jessica Lowe
Is there an optimal location for mesh fixation in sacrocolpopexy?

Claire McGannon
Long-term voiding function following retropubic midurethral sling

Tran Nguyen
Pelvic Floor Medicine with CO2 laser and Platelet-rich Plasma: Chance, Change, Challenge

Basia Slusarczyk
The Outcome of TVT-O Procedure with Cough Test in Theatre under Local Anaesthesia and Sedation: Retrospective Case Series of 111 Women

DIGITAL COMMUNICATIONS EXHIBITION AREA

FRIDAY MORNING TEA, 1000-1030

Myriam Girgis
Anti-NMDA-receptor encephalitis and ovarian teratoma

Myriam Girgis
A rare case of massive hemoperitoneum with a finding of an Allen-Masters window in a patient on therapeutic Clexane for hepatic vein thrombosis

Deborah Hawkins
Contained Power Morcellation

FRIDAY LUNCH, 1230-1330

Pattaya Hengrasmee
Does Bilateral or Unilateral Fixation Matter for the Surgical Outcomes of High Uterosacral Vaginal Vault Suspension Procedure?

Alexandra Limmer
Laparoscopic excision of a large para-rectal mature cystic teratoma

Jessica Lowe
When complications arise with mesh

Elliot Mackenzie
Vaginal hysterectomy and unilateral uterosacral ligament suspension in a unicornuate uterus with solitary kidney mullerian anomaly.

Andrew McIntyre
Multidisciplinary dual console robotic hysterectomy with stage IV endometriosis

Andrew McIntyre
Vaginal evisceration following colpocleisis and sacrocolpopexy

Tran Nguyen
Surgical management of interstitial ectopic pregnancy

Nina Reza Pour
Parasitic Leiomyoma after Open Myomectomy

Awards will be presented at the Gala Dinner

AGES Events 2018/19

Australasian Gynaecological Endoscopy & Surgery Society Limited
FOCUS MEETING

AGES Focus Meeting 2018
QT, Canberra
2nd & 3rd November 2018

NOVEMBER 2 NOVEMBER 3

Australasian Gynaecological Endoscopy & Surgery Society Limited
CADAVERIC WORKSHOP

AGES Cadaveric Workshop
MERF QUT, Brisbane

Dissection Workshop:
1st December 2018

DECEMBER 1

Australasian Gynaecological Endoscopy & Surgery Society Limited
ANNUAL SCIENTIFIC MEETING

AGES XXIX Annual Scientific Meeting 2019
Crown, Perth
7th - 9th March 2019

MARCH 7 MARCH 8 MARCH 9

Australasian Gynaecological Endoscopy & Surgery Society Limited
FOCUS MEETING

AGES Focus Meeting 2019
in conjunction with The World Endometriosis Society
Grand Hyatt, Melbourne
2nd & 3rd August 2019

AUGUST 2 AUGUST 3

Australasian Gynaecological Endoscopy & Surgery Society Limited
PELVIC FLOOR SYMPOSIUM

AGES Pelvic Floor Symposium 2019
Sheraton on the Park, Sydney
1st & 2nd November 2019

NOVEMBER 1 NOVEMBER 2

PROGRAM ABSTRACTS

FRIDAY 3RD AUGUST 2018

0800 – 1000 SESSION 1: BOWEL ISSUES - WORKING TOGETHER SMOOTHLY

Bowel function - What is normal?

Allison Bryant

When you consider overall general health, gastrointestinal function needs to be on the short list.

But there are many myths about lower GI function. How often should we empty? What is normal stool consistency? How can the pelvic floor team work together for the best outcome for the patient?

This talk will discuss what is required for normal bowel function and how we can work together to achieve the best result for patients.

Assessment of Colorectal function - How does it direct management?

Chris Gillespie

Abstract not yet received.

Constipation - How to push it out!

Natalie Kiel[1]

1. *Queen Elizabeth II Jubilee Hospital, Brisbane*

Chronic constipation remains a major healthcare burden, with major financial and healthcare quality of life related implications. The ROME criteria define constipation as the passage of less than three bowel motions per week, with >/=25% of stools lumpy/hard, straining >/=25% of bowel motions, a sensation of incomplete evacuation in >/=25% of bowel motions, a sense of blockage in >/=25% of bowel motions and loose stools rarely presenting without laxative use. For diagnosis, symptoms must be present for three months, with onset of symptoms more than six months prior to diagnosis. There must also be insufficient symptoms to meet criteria for Irritable Bowel Syndrome.

The pathophysiological mechanism underpinning chronic constipation is dysfunction of the colonic sensorimotor system, with investigation into patient's symptoms reflecting this. Assessment of constipation in the clinical setting is primarily with the use of transit studies – either involving the use of radiopaque markers and plain x-ray, or nuclear medicine scintigraphy studies. Use of high resolution colonic manometry is currently mostly limited to the research setting, however continues to provide further information on the myoelectric activity of the colon and hence potential future therapeutic targets.

Although treatment of constipation is often viewed as relatively straight forward, management of constipation is often associated with high rates of patient dissatisfaction. In addition, inadequate management of constipation can lead to the development of megacolon, fecal impaction and perforation. Whilst research into the gut microbiome heralds exciting developments into further understanding our gut physiology and potential future therapies, current management of constipation is based on increasing dietary fibre intake, selected use of prokinetic agents and physiotherapy when there is a component of pelvic floor or defecatory dysfunction to the patient's symptom presentation.

Colorectal/Urogynaecolgy Pelvic floor clinic – What is the formula for success?

Carina Chow

Abstract not yet received.

Obstructed defecation "How to get it moving again"

Andrea Warwick

Abstract not yet received.

KEYNOTE: An anatomic approach to rectocele repair

Willy Davila

Abstract not yet received.

1030 - 1230 SESSION 2: BLADDER MATTERS

We are getting older - How are we going to manage incontinence without midurethral slings?

Anna Rosamilia

Abstract not yet received.

The 'knack' and all that: When to start and when to stop

Lori Forner

Physiotherapy intervention is proposed as first-line management of urinary incontinence (UI) in women, as suggested by the European Association of Urology and the National Institute for Health and Care Excellence [1, 2].

Aside from research supporting pelvic floor muscle training programs in the treatment of UI, including a Cochrane review [3], physiotherapists also play a role in screening patients who are most *unlikely* to be successful with physiotherapy intervention and hence referral to, and ongoing communication with, medical professionals.

This session will discuss the significant role physiotherapists play, in addition to their limitations, in treating women with urinary incontinence (with focus on stress incontinence) as well as the concepts of conservative treatment success and failure.

1. Thuroff, J.W., et al., EAU guidelines on urinary incontinence. European Urology, 2011. 59: p. 387-400.
2. Smith, A., et al., Management of urinary incontinence in women: summary of updated NICE guidance. BMJ, 2013. 347: p. f5170.
3. Dumoulin, C., E. Hay-Smith, and G. Mac Habee-Seguin, Pelvic floor muscle training versus no treatment, or inactive control treatments, for urinary incontinence in women (Review). The Cochrane Collaboration, 2014(5).

The top tier - Re-evaluating laparoscopic colposuspensio

Peta Higgs

Most data relates to open Burch Colposuspension, which has been shown to be an effective treatment for SUI. In theory, the laparoscopic approach should offer speedier recovery however the long term effectiveness is unknown.

Initial studies showed a lower success rate, likely due to a change in technique from open to laparoscopic. As the technique was refined and the use of the same number and placement of sutures occurred, it is likely that both procedures hold similar cure rates.

Comparison to other surgeries for SUI confirm similar cure rates with MUS and Fascial sling procedures but with different complication rates. In particular, the rate of vault and posterior vaginal wall POP is more common after colposuspension when compared to MUS. [1]
Recently there has been a renewed interest in SUI procedures using native tissue and it is recommended that mesh and non-mesh procedures be discussed for women with bothersome SUI not responding to conservative treatment. [2]

The technique of laparoscopic colposuspension will also be discussed.

1. Ward KL, Hilton P. Tension-free vaginal tape versus colposuspension for primary urodynamic stress incontinence: 5- year follow up. BJOG 2008;115:226-233.
2. www.safetyandquality.gov.au

The Urologists approach to incontinence - Friend or Foe?

Kate Gray

Abstract not yet received.

Bugs in the bladder - The biome and recurrent UTI

David Paterson

Abstract not yet received.

Management of Iatrogenic Vesico-vaginal Fistula in Australia

Judith Goh[1]

1. *Greenslopes Private Hospital, Greenslopes, QLD, Australia*

Referrals of women with iatrogenic lower urinary tract fistulas were reviewed from 2008-2018. Women referred to Prof Judith Goh (JG) and Dr Hannah Krause (HK) at the QEII Hospital, Brisbane and Greenslopes Private Hospital were reviewed. Ethics approval from Greenslopes Hospital and Brisbane Metro South were obtained. Women with ureteric fistulas and operated elsewhere by JG and HK were excluded.

A total of 53 women were included for analysis. The average age of the women was 48 years. The majority of women were from Queensland but referrals included all states in Australia except Tasmania. For the majority of women, hysterectomy was the antecedent event (including abdominal hysterectomy, laparoscopic assisted and total laparoscopic hysterectomies). Other procedures resulting in fistulas included caesarean section (without hysterectomy), urethral slings, vaginal repair, urethral diverticulum surgery, excision of vaginal mesh complications, cervical cerclage and construction of neo-vagina.

The average size of the fistula was 10mm.

All women returned to the original surgeon with urinary incontinence. Almost 30% of injuries were recognised at time of initial surgery. Nearly one third of women were referred by a secondary referral (GP

or urologist). Women had on average 2 investigations prior to referral for urinary incontinence or diagnosis of fistula. 17 women underwent urodynamic assessment for post-operative urinary incontinence (fistula not previously diagnosed). Other investigations for post-operative urinary incontinence included ultrasound scan of pelvis, MRI pelvis, CT cystourethrogram, CT pelvis and cystoscopy. 63% of these investigations gave a false negative or inconclusive result for fistula. Dye test was 100% accurate. Only 1 patient had 1 investigation prior to referral – the dye test; the other women had more than 1 investigation.

Excluding 8 patients with chronic fistula who had surgeries prior to 2005, the average time from initial surgery to referral was 138 days. Lower urinary tract injury at time of initial surgery did not expedite diagnosis of fistula or referral for treatment.

For the management of the post-operative urinary incontinence prior to referral, some women underwent pelvic floor rehabilitation, anticholinergic and vaginal laser therapy.

Thus, in this series, there is significant delay from initial surgery to referral for definitive management of fistula even in cases of intraoperative injuries. The dye test is a simple, low cost test that was 100% successful in diagnosing a fistula in our hands.

Managing bladder abnormalities in kids who then grow up and get pregnant

David Winkle[1]

1. *Mater Adult Hospital, Brisbane*

The life expectancy and quality of life of someone born with a major structural or functional abnormality of the lower urinary tract has dramatically improved over the last five decades.

Many women born with conditions such as bladder exstrophy and myelomeningocele are now able to achieve successful pregnancies.

These women are, however, at increased risk of more complicated pregnancies and more complicated deliveries. Morbidity relating to the underlying abnormality such as abnormal pelvic anatomy, neural and spinal pathology, and associated issues such as urinary infections, renal and bladder calculi, pelvic organ prolapse (up to 50% in bladder exstrophy female patients) and chronic kidney disease, will have an impact on a pregnancy.

A significant proportion of these patients will have undergone surgery to the urinary tract including, initial bladder re-construction, augmentation cystoplasty, urinary diversion and various urinary continence procedures such as fascial sling bladder neck suspension, artificial urinary sphincter placement and bladder neck ligation.

Because pregnancies in this group of women are more complicated, a multidisciplinary ante-natal approach is necessary. Similarly deliveries are more complex from a surgical and anaesthetic perspective. Up to 55% of neuropathic patients and up to 100% of bladder exstrophy patients will require a caesarean section. Given the high rates of previous urinary tract and pelvic surgery, urologic involvement in any obstetric intervention is appropriate.

This presentation aims to review the current management of pregnancy in patients with an underlying structural or functional urinary tract abnormality and offer advice as to concurrent urological management.

1330 - 1500 SESSION 3: FREE COMMUNICATIONS

Treatment of Vaginal Mesh Exposure with Platelet Rich Plasma (RegenPRP®) and Regen Extracell-membrane

Fariba Behnia-Willison[1, 2,] Tran T Nguyen[2]

1. *FBW Gynaecology Plus, Ashford, SA, Australia*
2. *Flinders Medical Centre, Bedford Park, SA, Australia*

Objective:

To present our experience of treating vaginal mesh exposure with various modalities including Platelet Rich Plasma(RegenPRP®), Surgisis and Regen extracell-membrane.

Study Design:

There were 34patients who were referred to FBW gynaecology practice for treatment of symptomatic mesh exposure from 2009 to 2018.

Background:

Mesh exposure can occur in up to 10% of women who underwent vaginal mesh surgery. The current conservative management is topical oestrogen treatment (E2); however due to severity of atrophic changes and inflammatory reaction between the vaginal mucosa and synthetic mesh, E2 treatment is not adequate and often excision of mesh is required. Platelet rich plasma is used in the treatment of tissue damage as well as tissue remodeling in multiple disciplines such as orthopedics (joint preservation), plastic/reconstructive surgery (wound healing and burns), sports medicine (tendon and ligament treatment), dermatology (acne and alopecia) and recently in gynaecology (atrophic vaginitis, lichen sclerosus). The growth factors released by the activated platelets aid tissue remodeling by stimulation, migration, proliferation of local and peripheral stem cells to regenerate new and healthy tissue.

Surgisis (Cook Surgical, Bloomington IN) is a biological graft which no longer has TGA approval. The most recent innovative technology to create an autologous biological membrane by Regenlab has given the gynaecologist a new chance to overcome the challenges associated with large mesh exposure/defects and tissue augmentation for pelvic floor native tissue repair. A video will be demonstrated on how to create an autologous membrane prior to surgery.

Results:

Six women responded to long-term (3-6 months) E2 treatment and needed no further treatment.

Four patients did not respond to E2 treatment and did not wish to have surgery; they received PRP and had complete re-epithelization of the vaginal mucosa.

Fourteen women underwent surgical excision and primary closure with PRP injection at the time, nine of the 14 women needed no further surgery after six months. Three women had repeat surgery for further mesh exposure.

Conclusion: The treatment of symptomatic vaginal mesh exposure is challenging. In recurrent cases, multi-modal treatment may be required. RegenPRP® and Regen extracell-membrane may benefit women whose mesh exposure is associated with severe atrophy or where large areas of vaginal epithelium need removal.

1. Gorlero F, Glorio M, Lorenzi P, Bruno-Franco M, Mazzei C (2012). New approach in vaginal prolapse repair: mini-invasive surgery associated with application of platelet-rich fibrin. Int Urogynecol J 23:715-722.
2. Hersant, B et al (2018). Efficacy of injecting platelet concentrate combined with hyaluronic acid for the treatment of vulvovaginal atrophy in postmenopausal women with history of breast cancer: a phase 2 pilot study. Menopause 25:000-000.

3. Behnia-Willison, F et al (2016). Use of Platelet-rich Plasma for Vulvovaginal Autoimmune Conditions Like Lichen Sclerosus. Plast Reconstr Surg Glob Open 4: e1124.

Adenexectomy Via Vaginal Natural Orifice Transluminal Endoscopic Surgery

Sapna Dilgir[1, 2], Jay Iyer[1, 2]

1. *Mater Hospital Townsville, Waterloo, QLD, Australia*
2. *Gynaecology , Townsville HOspital, Townsville , QLD, Australia*

Vaginal natural orifice transluminal endoscopic surgery (VNOTES) is an upcoming variation to minimally invasive gynaecological surgery. This approach to surgery requires use of a natural orifice (mouth, stomach etc.) to gain access to the abdominal cavity. It has readily been adopted by several gynaecologists given the vagina and cul de sac serve as a routine approach to surgery in this field. It is being used to perform adenexectomies and hysterectomies for benign pathologies. The limited but existing literature has demonstrated no increase in complications and a potential reduction in operating time and cosmetic satisfaction as there are no abdominal wounds. Potential difficulties with this approach include limited triangulation, poor traction, over reliant on diathermy and the need to convert to laparoscopy if difficult anatomy is discovered. However, the importance of careful patient selection via use of a through history and examination is of utmost importance. VNOTES should be avoided in those with those with an intact hymen, narrow vagina, obliterated cul de sac, suspicion of pelvic adhesions, history of pelvic inflammatory disease, malignancy, active lower genital tract infection and pregnancy. Furthermore, it is best done by a surgeon with significant experience in both laparoscopic and vaginal surgery given the anatomy is reversed from a laparoscopic approach. We would like to present a video presentation of a VNOTES adnexectomy. In the presentation, we will demonstrate patient preparation for the procedure. We will demonstrate entry into the posterior cul de sac and use of a gellpoint device to maintain a pneumoperitoneum and port access via the vaginal cavity. We well use routine laparoscopic instruments to perform the adenexectomy. We will briefly highlight the existing literature conclusion on this novel approach.

1. Baekelandt J. Robotic Vaginal NOTES Hysterectomy: Two New Surgical Techniques. Journal of Gynecologic Surgery. 2016;32(5):270-277. doi:10.1089/gyn.2016.0020.
2. Baekelandt J, De Mulder PA, Le Roy I, et al. Postoperative outcomes and quality of life following hysterectomy by natural orifice transluminal endoscopic surgery (NOTES) compared to laparoscopy in women with a non-prolapsed uterus and benign gynaecological disease: a systematic review and meta-analysis. European Journal of Obstetrics and Gynecology. 2017;208:6-15. doi:10.1016/j.ejogrb.2016.10.044.
3. Kale A, Sarıibrahim B, Başol G. Hysterectomy and salphingoopherectomy by Transvaginal Natural Orifice Transluminal Endoscopic Surgery(NOTES): Turkish surgeons' initial experience. International Journal of Surgery. 2017;47:62-68. doi:10.1016/j.ijsu.2017.09.062.

Evaluating the effect of adding hyaluronic acid to local anaesthetic in pudendal nerve blocks for the treatment of pudendal neuralgia – An observational study

Lauren Kite, Thierry Vancaillie, Elizabeth Howard, Jason Chow

Background

Pudendal neuralgia (PN) is a condition in which pain occurs in the dermatomal distribution of the pudendal nerve without evidence of other ongoing pathology. It may be attributed to previous obstetric or other trauma, pelvic floor dysfunction or previous pathology such as infection. It is a clinical diagnosis that is not often considered but can be debilitating and very difficult to treat. Pudendal nerve blocks (PNB) with local anaesthetic have been shown to reduce symptoms, but generally for only a short time.

Small studies of nerve blocks performed with the addition of hyaluronic acid (HA) in other body areas have shown some benefit in the degree and longevity of pain relief and so this study aimed to explore its benefit in PNBs1.

Method

A retrospective survey of patients who had undergone a pudendal nerve block with the addition of 1% HA was conducted. Participants were asked to rate their pain on a scale of 0-10 as they recalled it prior to the block, at one week and 3 months after having the block. They were also asked to estimate how long they felt they experienced noticeable relief.

Results

Thirty-seven responses were received. A paired-samples t-test revealed a significant improvement in average pain ratings following the procedure at both one week (mean 4.03, $p<0.001$) and three months (mean 3.74, $p<0.001$) compared to the average pain score prior to the procedure (mean 5.84). Fourteen respondents reported that their pain relief lasted less than 1 week, 6 reported up to 1 month, 4 between 1 and 3 months, 3 between 3 and 6 months and 7 reported relief for greater than 6 months with the longest time specified being 18 months and still reporting improvement. No adverse events were recorded.

Conclusion

The addition of HA appears to potentiate the effect of the pudendal nerve block. A randomised controlled trial is currently underway to further define this effect.

1. Campa J. Cross-linked hyaluronic acid in the treatment of lower extremity neuropathic pain The Journal of Pain 2016 17; S80

Video presentation: VITOM a viable alternative for teaching vaginal surgery.

Mugdha Kulkarni[1], Ajay Rane[1]

1. *Mater Pelvic Health, Townsville, QLD, Australia*

The American College of Obstetricians & Gynaecologists (ACOG) states vaginal hysterectomy is the preferred route whenever feasible. Evidence suggests it is associated with better outcomes when compared to other approaches of hysterectomy. Training in vaginal surgery is difficult for many reasons. There is significant drop in the number of vaginal hysterectomies being performed the world over with a corresponding increase in hysterectomies via laparoscopic approach despite good patient outcomes and less associated costs with the former.

In view of the recent reduction in hours worked by trainees, fewer vaginal surgical procedures are possible during this period. The trainee assistant or second surgeon has to contend with the often-poor visibility of the operating field and is subject to discomfort arising out of an awkward assisting angle. This increases the challenges for training in vaginal surgery. Consequently it was necessary to find an appropriate model for teaching vaginal surgery. Currently no high-fidelity simulator exists for vaginal surgery.

Townsville hospital has been running a vaginal skills workshop for 15 years, as a one-of-a- kind hands-on workshop. In a national first we used Video Telescope Operating Monitor (VITOM®), for the vaginal surgical skills workshop in Townsville hospital. VITOM® (Karl-StorzTM) is not inserted into the body but placed at working distance above the surgical field and attaches readily to the laparoscopic stack. Due to its slim and compact design, the VITOM® system provides a good overview of the surgical field and reduces space requirement in the operating theatre. The monitors enable the surgeon, the assistants and the entire operating theatre team, to obtain an unrestricted view of the surgical site under magnification. This allows the entire team to appreciate the nuances of each surgical step in real-time; the VITOM® is particularly beneficial when the surgeon is dealing with a complication.

Surgery was remotely streamed in the education room where discussion regarding each step was carried out by another facilitator offering his own inputs without disturbing the theatre team. This also enabled multiple trainees to attend, watch comfortably and maintain patient privacy.

We would like to present the video of how easy it is to set up theVITOM®and its benefits.

1. 1. Karl Storz endoscope. VITOM HD. STORZ Karl-Storz Endoscope. https://www.karlstorz.com/au/en/vitom-hd.htm . Update: 18/02/2011. Cited: 28/095/2018
2. 2. Taylor B, Myers EM. Initial Gynecologic Experience Using the VITOM® HD Exoscope for Vaginal Surgery. Journal of minimally invasive gynecology. 2015 Nov 1;22(6):S103.

Fosfomycin : The New 'Easy' Therapy for UTIs?

Mugdha Kulkarni[1], Ajay Rane[1]

1. *Mater Pelvic Health, Townsville, QLD, Australia*

Urinary tract infections (UTI) among women are extremely common. It is estimated that one in every three women experience at least one episode of UTI requiring antimicrobial treatment by the age of 24. Short distance between anus and urethra likely explains why women are at higher risk of urinary tract infections compared to men.

Escherichia Coli is the commonest microbial cause of cystitis, occasional species of Enterobacteriaceae (such as Klebsiella pneumoniae and Proteus mirabilis) also noted. Increasing rates of resistance in urinary pathogens to commonly used agents like trimethoprim-sulphamethoxazole and ciprofloxacin have been noted worldwide. Antimicrobial Use and Resistance in Australia (AURA) report in 2016 showed that antibiotic use in hospitals and community are high compared to other countries. This as a consequence may be leading to increasing antibiotic resistance.

Fosfomycin is a broad-spectrum bactericidal which has shown activity against a range of gram-positive, gram-negative organisms including drug resistant varieties. In 2011, Infectious Diseases Society of America (IDSA) and the European Society for Clinical Microbiology and Infectious Diseases (ESCMID) updated their guidelines for the treatment of acute uncomplicated UTI and pyelonephritis in women by recommending fosfomycin as one of the first-line agents for treatment.

Fosfomycin was approved as a New Chemical Entity by TGA in 2017 for acute cystitis. Although not a new antibiotic, it was only available in Australia through Special Access Scheme (SAS) previously. Currently a single dose regime of 3gm oral fosfomycin has found comparable results to 3-7 day courses of other antimicrobials for uncomplicated UTIs. In a review of 17 studies, 11 studies reported atleast 90% of multi-drug resistant (MDR) organisms like Enterobacteriaceae, including ESBL- producing organisms to be susceptible to fosfomycin.

Currently multiple studies are being conducted worldwide to assess the use of fosfomycin alone or combination therapy for MDR systemic infections. At the same time reports of emergence and spread of resistance in some corners of the world, are concerning and require close monitoring.

There is no data regarding fosfomycin use in Australia. The aim of this presentation is to present the existing literature about fosfomycin, the ease of its use and lack of knowledge regarding its availability.

1. Foxman B. Epidemiology of urinary tract infections: incidence, morbidity, and economic costs. Am J Med 2002;113:5Se13S.
2. Falagas ME, Kastoris AC, Kapaskelis AM, Karageorgopoulos DE. Fosfomycin for the treatment of multidrug-resistant, including extended-spectrum b- lactamase producing, Enterobacteriaceae infections: a systematic review. Lancet Infect Dis 2010;10:43e50.
3. Sastry S, Doi Y. Fosfomycin: Resurgence of an old companion. J Infect Chemother [Internet]. 2016;22(5):273–80. Available from: http://dx.doi.org/10.1016/j.jiac.2016.01.010

Is there an optimal location for mesh fixation in sacrocolpopexy?

Alan Lam[1], Jessica Lowe[1]

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

Background:

Following the removal of transvaginal mesh products used in the treatment of pelvic organ prolapse via transvaginal implantation by the Therapeutic Goods Administration (TGA) in November 2017, it is anticipated that there will be increasing interest in and uptake of sacrocolpopexy (SCP) for treatment of apical prolapse.

Based on the current Consensus statement of the Royal Australian and New Zealand College of Obstetricians & Gynaecologists (RANZCOG) and the Australasian Gynaecological Endoscopy & Surgery Society (AGES), SCP is a Level 6 Scope of Clinical Practice procedure encompassing the highest level of complexity. Unambiguously, the American Urogynecologic Society, in its Guidelines for Privileging and Credentialing Physicians for SCP in 2013, stated that SCP is a complex surgical procedure which should only be performed by surgeons with board certification, requisite knowledge, surgical skills and experience in reconstructive pelvic surgery, appropriate ongoing surgical volume, adequately trained and equipped surgical team, and the ability to monitor outcomes and adverse events.

Crucial for safe and effective performance of SCP is detailed knowledge of the presacral space, skilful dissection and astute identification of the 'optimal' location for mesh fixation within the relatively small presacral space occupied by highly variable blood vessels and nerves in close proximity to ureter and bowels.

Objectives of presentation:

* To highlight vascular, ureteral and sacral nerve anatomical landmarks in relation to the mid-sacral promontory

* To determine the 'optimal' location for mesh fixation within the presacral space

* To propose strategies to mitigate potential complications during mesh fixation to the sacral promontory

Methodology:

* Examination of anatomical relationships between sacral promontory and vascular, ureteral and sacral nerve structures in cadavers

* Comparison and contrast with a selection of laparoscopic and robotic sacrocolpopexy procedures to highlight the marked variation in anatomical landmarks

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Long-term voiding function following retropubic midurethral sling

Paivi K Karjalainen, Claire McGannon, Joan Melendez-Munoz, Geoff Edwards, Germana Ryan, Alison Leitch, Joe Lee, Anna Rosamilia

Objectives:

To assess long-term voiding dysfunction in women with retropubic mid-urethral sling.

Methods:

This is a retrospective, observational cohort study. Patients with retropubic sling inserted more than 5 years before were eligible to participate in the study. We identified eligible patients from the hospital database and invited them to participate. The patients were invited to attend uroflowmetry and complete International Prostate Symptom Score (IPSS) questionnaire. Patients who declined uroflowmetry were asked to complete IPSS only. Planned sample size was 120 patients.

Primary outcome was change in maximal flow rate (Qmax) and post-void residual (PVR) between preoperative and follow-up assessment. We compared preoperative and postoperative values using Wilcoxon rank-sum test. Secondary outcome was total International Prostate Symptom Score (IPSS-T) and IPSS voiding to storage sub-score ratio (IPSS-V/S) which were only collected at the follow-up.

Results:

We identified 240 eligible patients. 105 (44%) volunteered to participate by completing IPSS. 41 (39%) of them volunteered for follow-up uroflowmetry. 33 (31%) had both preoperative and follow-up uroflowmetry data available.

Mean age at the surgery was 63 (SD 11) years . Median follow-up time was 7 years (IQR 2). 53%, 33% and 24% had had previous hysterectomy, prolapse surgery and incontinence surgery, respectively. Concomitant POP surgery was done for 39 patients (37%). 6 % of the slings required loosening during first 3 weeks. None of the inserted slings required division.

Median voided volume was 260 ml (IQR 261) preoperatively and 180 ml (IQR 225) at follow-up (n=33; NS). Median Qmaxdecreased from 25 ml/s (IQR 17) preoperatively to 13 ml/s (IQR 17) at follow-up (p<0.001). Median PVR increased from 20 ml (IQR 54) preoperatively to 50 ml (IQR 45) at follow-up (p=0.012).

The median IPSS-T was 10 (IQR 11) and median IPSS-V/S 0.8 (IQR 0.9) (n=105). 16 (16%) patients had IPSS-T more than 20 (severely symptomatic). 82 (80%) of patients had IPSS-V/S less than 1.33 suggesting relation to urinary storage symptoms rather than voiding dysfunction. In participants without uroflowmetry data (n=71), the median IPSS-T score was 7 (IQR 12) and median IPSS-V/S 0.7 (IQR 0.95). 11 (16%) patients had IPSS-T more than 20. 56 (79%) of patients had IPSS-V/S less than 1.33 suggesting very low probability of objective voiding dysfunction.

Conclusion:

We observed deteriorated Qmaxand PVR five years after sling insertion. However, based on IPSS this was not clinically meaningful in most of the participants.

Pelvic Floor Medicine with CO2 laser and Platelet-rich Plasma: Chance, Change, Challenge

Tran T Nguyen[1], Fariba Behnia Willison[2, 1]

1. *Flinders Medical Centre, Bedford Park, SA, Australia*
2. *FBW Gynaecology Plus, Ashford, SA, Australia*

Pelvic floor surgery affects women physically, economically, and socially due to possible complications, treatment failures, and prolonged post-op recovery. Pelvic floor surgery has become more complex in recent times due to multiple factors. Women a better informed, more educated, time-poor, and desire minimally-invasive surgery with little down-time. In addition, recent transvaginal mesh controversies have instigated the need for gynaecologists to seek a more holistic and comprehensive approach to conservative management.

Other specialities, including dermatology and reconstructive surgery, have demonstrated that fractional micro-ablative CO2 laser and platelet rich plasma (PRP) can enhance tissue revitalisation and remodelling. These cell therapies can be applied to pelvic floor medicine.

In this presentation, the role of pelvic floor medicine as an alternative to surgery will be discussed, including our retrospective study of CO2 laser and PRP with 12-month follow-up results for stress urinary incontinence and urinary urge incontinence.

There were 62 women with stress urinary incontinence (SUI) who received 3 sessions of CO2 laser and PRP. At 12 months follow-up, there was 62% improvement of symptoms.

There were 66 women with urinary urge incontinence (UUI) who received 3 sessions of CO2 laser and PRP. At 12 months follow-up, there was 55% improvement of symptoms.

In conclusion, pelvic floor medicine with CO2 laser and PRP could be an effective alternative treatment for SUI and UUI.

The Outcome of TVT-O Procedure with Cough Test in Theatre under Local Anaesthesia and Sedation: Retrospective Case Series of 111 Women

Nader Gad, Basia Slusarczyk, Brooke O'Brien, Andrew Mitchell

Aim:

To assess the intra-operative and postoperative outcomes of the TVT-O procedure performed under local anaesthesia and sedation, with an intra-operative cough test, on patients with stress urinary incontinence with or without intrinsic sphincter deficiency.

Methods:

This is a retrospective review of 111 consecutive patients who underwent the procedure of TVT-O (Gyanecare, Ethicon) at Darwin Private Hospital, between December 2004 and April 2013.

All 111 procedures were performed by one surgeon. There was one main specialist anaesthetist who administered the sedation in the majority of these patients.

The primary outcome was the resolution of stress urinary incontinence. The secondary outcomes were resolution of urge symptoms, detrusor over activity and occurrence of post-operative complications.

All patients underwent a preoperative evaluation including medical history, physical examination, Urinalysis and Urodynamic Assessment (UDA). The patient's notes were analysed retrospectively and recorded on a purpose made master sheet. The data collected included age, parity, mode of previous deliveries, presenting symptoms, previous hysterectomy or surgery for SUI or Pelvic Organ Prolapse (POP), presence or absence of POP or hypermobile bladder neck (HMBN) during pelvic examination. Preoperative UDA was performed in all patients by the author and included uroflowmetry and filling cystometry. In this study, ISD was identified by the following conditions: SUI on valsava or cough at less than 60cm H2O or MUCP less than 20cm H2O.

Results:

The success rate was 99.1% in 106 out of 111, who were followed-up (Range: 6-208 weeks, Average: 23 weeks), including the 30 women (27%) with intrinsic sphincter deficiency. The resolution of urge symptoms and detrusor over activity occurred in 93% and 85% of women respectively. Urinary retention occurred in 2 women (1.8%). Upper thigh pain occurred in 1.8%, and resolved by 6 weeks. Three women (2.7%) complained of dyspareunia at 6 weeks post-operatively and two of them required tape division. One of these two cases was the only case of mesh exposure in the study (0.9%). There were no other significant complications.

Conclusions:

Our study demonstrated a subjective cure rate of stress urinary incontinence in 99.1% in patients undergoing the TVT-O procedure under sedation and local anaesthesia, performed with cough test in theatre. It shows low rates of urinary retention and high cure rates for symptoms of detrusor overactivity.

1530 - 1730 SESSION 4: PELVIC FLOOR SURGERY

Training & Pelvic Floor Surgery - Who should we be training?

Anna Rosamilia

Abstract not yet received.

Consent for Pelvic Floor Surgery - Do we need a lawyer sitting with us in the consultation?

Justin le Goullon[1]

1. *Avant, Brisbane, QLD, Australia*

Recent notable legal cases combined with the increasingly litigious society we live in can make it seem that having a lawyer present during the consultation is the only way to stay out of trouble. It is important to recognise the distinction between obtaining consent to perform an intervention and a medical practitioner's legal duty to disclose information to the patient. What Avant data shows is that 95% of the complaints to regulators regarding surgical consent are about the provision of information, but how much is enough? In terms of patient satisfaction, the patient who understands that complications can occur will be less likely to leave your care dissatisfied. In the event of a complication or adverse outcome, of which the patient has been warned, the patient is much more likely to be accepting of the consequences and less likely to litigate. This is effectively a 'closing of the consent loop'. This presentation will examine these issues and outline best practice.

Communicating with our patients about pelvic floor mesh

Alan Lam

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

Listening to continual negative media reports about mesh complications, catching sensational headlines regarding class actions, hearing colourful speeches laden with emotive language from the senate enquiry, dismayed by the hasty removal of all transvaginal mesh products from the ARTG (Australian Register of Therapeutic Goods), it is clear that communicating with our patients about pelvic floor surgery in general, and mesh implant in particular, represents one of the most challenging and time-consuming tasks facing gynaecologists in the current highly emotionally charged medico-legal situation.

Furthermore, against a background of increased patient expectations, unrealistic demand for high-quality, long-term evidence on safety and efficacy, rapidly evolving technologies and changing regulations, striving to deliver appropriate care above the expected standards requires a systematic approach to ensure that complex communication issues between patient and the provider are covered.

In this presentation, using case studies, we offer practical tips on how to prepare and disclose:

- Information for patients seeking advice for pelvic organ prolapse (POP)
- Information for patients considering mesh implant for POP
- Information for patients with mesh implant for POP
- Information for general practitioners regarding mesh implant for POP

1. AVANT CONNECT Issue no.5 – Communicating for better outcomes.
2. Information for Patients Considering a Mesh Implant for Pelvic Organ Prolapse (also called Vaginal Prolapse). www.health.nsw.gov.au/sabs/Publications/patients-considering-mesh-implant.pdf.
3. Information for Patients with Mesh Implant for Pelvic Organ Prolapse (also called Vaginal Prolapse) www.health.nsw.gov.au/sabs/Publications/patients-with-mesh-implant.pdf
4. Information for General Practitioners regarding Mesh Implant for Pelvic Organ Prolapse. . www.health.nsw.gov.au/sabs/Publications/gp-mesh-implants.pdf

5. Transvaginal mesh implants for pelvic organ prolapse. www.health.nsw.gov.au/sabs/Documents/2017-sn-015.pdf

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The distressed specialist - How and when do I get help?

Margaret Kay[1]

1. *The University of Queensland, Herston, Qld, Australia*

This presentation by the Medical Director of the Queensland Doctors' Health Programme provides insights into the medicolegal process from the perspective of the doctor who has had a complaint made against them. Recognising that this is an increasingly common experience for doctors, a series of 'next steps' are presented to assist the doctor who is managing this situation. The impact of the medicolegal process on the doctor involved is described and strategies to protect against these are outlined.

Removal of Mesh - Can mesh only be removed by a "chosen" few?

Willy Davila

Abstract not yet received.

KEYNOTE: Surgical Treatment of Pelvic Organ Prolapse - Now and the Future

Chris Maher

Abstract not yet received.

SATURDAY 4TH AUGUST 2018

0800 - 1000 SESSION 5: PAIN IN THE PELVIC FLOOR

KEYNOTE: Pain Explained

Lorimer Moseley

Abstract not yet received.

Pelvic Floor Hyperactivity - Is it such a problem?

Jason Chow[1]

1. *Operative Gynaecologist and Pain Physician , Sydney*

An assessment of pelvic floor hyperactivity is a recognised component in the evaluation of the woman with pelvic pain. Postulated management includes physical therapy, botulinum toxin, pharmacotherapy and neuromodulation. Reducing pelvic floor hyperactivity to a clinical diagnosis is problematic however and may lead the clinician to pursue a narrow biomedical course of treatment. Pelvic floor hyperactivity may be representative of neurobiological mechanisms including viscerosomatic convergence and central sensitisation. Pelvic floor symptoms are also associated with a history of sexual trauma. Understanding the context of pelvic floor hyperactivity in a patient helps direct management.

Objectives:
Identify pelvic floor activity in the woman with pain

Evaluate pelvic floor hyperactivity as part of the sociopsychobiomedical asseessment
Recognise the benefits and harms of biomedical therapies

Dear Physio. Please see Pelvic Pain

Alex Diggles

Abstract not yet received.

Pharmacology: The Good, The Bad…and the Ugly

Jayne Berryman

Abstract not yet received.

What's up with Pudendal Nerve Pain?

Ken Law

Pudendal neuralgia is a chronic condition due to neuropathic pain arising from the pudendal nerve. The pudendal nerve carries motor, sensory and autonomic fibres, and both afferent and efferent pathways may be affected. The pudendal nerves are derived from the S2-S4 nerve roots, and divides into 3 branches:

- inferior rectal nerve (supplying the anal canal, peri-anal skin, rectum, and external anal sphincter),
- perineal nerve (supplying the perineum, vagina, urethra, labia majora/minora, transverse perineal muscle, and urethral sphincter), and
- dorsal nerve of the clitoris (supplying the clitoris, bulbocavernosus, and ischiocavernosus muscles).

The classical presentation manifests as a burning perineal pain that is worse on sitting, increasing as the day progresses, and resolves during the night or when lying down. Other women may present with vulval pain or pain during/after sexual intercourse. Afferent signals to the bladder and bowels may also be affected, leading to urinary frequency, overactive bladder symptoms, and faecal urgency.

The diagnosis of pudendal neuralgia is based on clinical history and physical findings, and Nantes Criteria may serve as a useful framework for diagnosis. Patients may have hyperalgesia, allodynia and paraesthesia in the distribution of the pudendal nerves, and this may be unilateral or bilateral. The diagnosis is further supported by temporary relief of symptoms with a diagnostic pudendal nerve block.

Treatment using a multi-modal multi-disciplinary approach can be effective. Physiotherapy is the mainstay of treatment, whilst oral neuromodulators and pudendal nerve injection with local anaesthetics and corticosteroids may be useful as therapeutic adjuncts.

Management of Mesh Pain - Is the pain really related to the Mesh?

Thierry Vancaillie

Pain after prolapse repair surgery with mesh is a post-surgical neuropathy like any other, and needs to be treated.

The presentation will focus on prevention and treatment of mesh neuropathy. The proposed algorithm will look at 1] severe pain in the immediate postoperative period; 2] mild delayed pain in the months or years after surgery; and 3] severe delayed pain.

Practical management of pelvic floor pain for the Generalist
Philip Hall

Abstract not yet received.

1030 - 1230 SESSION 6: UPSKILLING YOUR PELVIC FLOOR PRACTICE

How to teach Surgery - Theories of teaching in the operating room
Tom Cecil

Abstract not yet received.

The impact of structured teaching in the operating theatre
Stuart Salfinger

Abstract not yet received.

The LapCo Experience - How the NHS upskilled its Colorectal Surgeons
Mark Coleman

The Lapco programme was a NHS funded national laparoscopic colorectal training network for specialist surgeons in England from 2008-2014. In that time laparoscopic resections of the colon and rectum increased from 10-50%. This presentation describes how the programme was developed and run and describes opportunities in other specialties such as gynaecology.

Teaching Vaginal Hysterectomy -The ACOG experience
Willy Davila

Abstract not yet received.

Should we all be able to perform laparoscopic sacrocolpopexy?
Alexandra Mowat

Abstract not yet received.

Back to the Future - Laparoscopic Colposuspension
Salwan Al-Salihi

Abstract not yet received.

The new world of simulation in Gynaecology Surgery - How can it help me upskill?
Emma Readman

Abstract not yet received.

1330 – 1430 SESSION 7: THE PELVIC FLOOR MDT

MDT SESSION – HOW WE CAN ALL LOOK AFTER OUR PATIENTS TOGETHER AS A TEAM

PANEL: Jason Abbott, Salwan Al-Salihi, Jason Chow, Willy Davila, Lori Forner, Chris Gillespie, Philip Hall & David Winkle

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1500 - 1645 SESSION 8: OBSTETRICS AND THE PELVIC FLOOR - WORKING TOGETHER

KEYNOTE: Prevention and Prediction of Pelvic Floor Dysfunction—UR-CHOICE!

Don Wilson[1]

1. *University of Otago, New Zealand*

Pelvic floor dysfunction [PFD] in women results in the combination of some or all of the following conditions: urinary incontinence, faecal incontinence and pelvic organ prolapse. It has a significant effect on quality of life and affects millions of women worldwide. With the changing obstetric demographics, PFD is thought to increase and prevention of this condition is a major priority in women's health.

Identification of women "at risk" is a key element in current prevention strategies.

In this talk, the evidence for the main prevention strategies [Caesarean section and other delivery factors, pelvic floor muscle training and modifiable risk factors/lifestyle interventions] will be reviewed.

We have constructed and validated prediction models using variables known before and after childbirth [UR-CHOICE]. These models provide individualised estimates of the risk of developing pelvic floor disorders 12 and 20 years after childbirth and significantly advance our ability to counsel women before and after delivery with the aim of preventing/reducing the impact of PFD. Examples of the use of our UR-CHOICE on line calculator will be presented

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The patients perspective of birth trauma

Amy Dawes

Why was the Australasian Birth Trauma Association founded? - In Australia 1 in 3 women identify their birth as traumatic, while 1 in 4 end up with significant birth injuries. Amy will talk about the wants and needs within our community.

There is limited discussion about how clinicians can effectively communicate and discuss risk in pregnancy with women, to achieve the best balance between the risks and benefits of care options. So what is it women really want to know and how can we better inform, diagnose and treat them?

ABTA aims to provide healthcare providers with the most up-to-date research about the evidence concerning birth-related trauma and how to effectively communicate this information to women such that they are best able to make decisions about their care. We aim to provide a constructive approach to considering the concerns of women and clinicians when providing such information, with the ultimate aim of reducing birth-trauma and its impact.

Consent for SVD without paternalism?

Harsha Ananthram

Abstract not yet received.

OASIS in Paradise? The Pacific Island OASIS Program

Hannah Krause[1]

1. *Greenslopes Private Hospital, Brisbane*

OASIS occurs in around 3% of all deliveries. Here in Australia where comprehensive training programs and educational opportunities are available, OASIS management is generally swift and standardised. In regions where there is poor access to effective surgical repair of OASIS injuries or where health care providers are unfamiliar with the surgical techniques and guidelines for repair of OASIS, women who develop OASIS are at risk of lifelong pelvic floor and ano-rectal dysfunction.

Our near neighbours, PNG and the Pacific Islands which consist of numerous countries and territories, have limitations in health care provision in many areas. Obstetric care throughout this vast geographical area is largely provided by nurses/ midwives with varying degrees of expertise and experience, with O&G specialists located in only the larger population centres.

OASIS/perineal workshop training is required to provide effective training to doctors and nurses/ midwives in the repair of perineal trauma. The Pacific Society for Reproductive Health (PSRH) was established in 1993. PSRH runs conferences every 2 years and include relevant workshops focusing on O&G ultrasound, colposcopy, emergency maternal and neonatal training, basic laparoscopy, safe theatre techniques, and research. OASIS workshops have been held in conjunction with the PSRH conference since 2009, and have also been run separately on a few other occasions.

OASIS workshops are very practical with anatomy and management of OASIS lectures given followed by a hands-on suturing session. Each participant is trained in effective perineal tear repairs including OASIS. Local abattoirs are contacted and depending on availability, ox tongues or pigs' bottoms are utilised for the training.

Currently in addition to the 2nd yearly conference workshops, further workshops are being planned throughout the Pacific to disseminate these skills. An illustrated booklet of repair techniques has been prepared and will be distributed at each location. Identifying key people in each country or region who are keen to train as trainers, is also planned. Thus very regular up-skilling of local staff could continue at a more local level, in conjunction with the ongoing regular formal workshops throughout PNG and the Pacific,

This OASIS in the Pacific workshop program (and other PSRH educational workshops), relies on volunteers who are willing to travel and want to provide training and mentorship to fellow health care providers to promote safe and effective management options for all women suffering with reproductive and gynaecological health concerns, often in regions where health care provision is limited.

Episiotomy - Reduce pelvic floor trauma in the first place

Ajay Rane

Abstract not yet received.

DEBATE: "Do you solemnly swear to look after my pelvis in this pregnancy and delivery?" - Jenny King & Don Wilson

Anti-NMDA-receptor encephalitis and ovarian teratoma

Myriam Girgis[1], Unine Herbst[2]

1. *Obstetrics & Gynaecology, Liverpool Hospital, Sydney, NSW, Australia*
2. *Gynaecology Oncology, Liverpool Hospital, Sydney, NSW, Australia*

Background:

Anti-N-methyl-D-aspartate receptor (NMDA-R) encephalitis is a paraneoplastic syndrome caused by ovarian teratomas. Neural tissue in a teratoma can trigger production of anti-NMDA-R antibodies (1) which alter NMDA receptors in the limbic system (2). It presents with psychiatric, neurological, and autonomic features. We will review the three cases that presented to our institution.

Case description:

A 23-year-old woman presented with confusion, psychosis and involuntary movements. She was admitted for presumed meningitis. A CT revealed a 12 cm pelvic mass. She experienced recurrent syncope secondary to bradycardia due to autonomic dysfunction. Anti-NMDA-R antibodies were detected in serum and CSF, and she underwent a laparoscopic right salpingo-oophrectomy. Histopathology confirmed a mature cystic teratoma. She was discharged on day 27 of admission on immunotherapy.

The second case is a 25-year-old who presented with confusion, aggression and tonic-clonic seizures. Anti-NMDA-R antibodies were found in the CSF and serum. She had autonomic dysfunction causing hypertension, tachycardia and pyrexia, and was intubated for a fluctuating GCS. She had a right salpingo-oophrectomy for an ovarian teratoma. This patient was intubated for 8 months and remains hospitalised on immunotherapy.

The third case is a 37-year-old who presented with syncope, seizure activity and confusion. she was diagnosed with anti-NMDA-R encephalitis secondary to an 18mm left ovarian dermoid and underwent a left salpingo-oophrectomy. She received immunotherapy and was extubated on day 25 postoperatively.

Discussion:

Anti-NMDA-R encephalitis was initially described in 1997 in two young women with psychiatric symptoms, an ovarian teratoma and altered levels of consciousness with improvement upon removal of the tumour (3).

The mean age is 24 (1). As anti-NMDA-R encephalitis is uncommon, diagnosis is often delayed whilst more common conditions such as seizure disorders and infective encephalitis are being considered (3).

Diagnosis is made by confirmation of anti-NMDA-R antibodies in the blood or CSF and ovarian teratoma on imaging. Timely diagnosis and surgery are essential to reduce risk of permanent neurological injury (2,3). There's neurological improvement in 80% of patients who undergo tumour excision and immunotherapy (3). The mean time to recovery is 3.6 months but permanent sequelae is seen in 10% of patients, and 7% die from encephalitis-related complications (1).

Conclusion:

Early tumour detection and removal result in improved prognosis (3). Whilst the majority of ovarian teratomas won't trigger anti-NMDA-R encephalitis, the patient and their family should be alerted to report neuropsychiatric or behavioural changes if a teratoma is for expectant management (2).

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A rare case of massive hemoperitoneum with a finding of an Allen-Masters window in a patient on therapeutic Clexane for hepatic vein thrombosis

Myriam Girgis[1], Kalai Shek[2]

1. *Obstetrics & Gynaecology, Liverpool Hospital, Sydney, NSW, Australia*
2. *Obstetrics & Gynaecology, Western Sydney University, Liverpool Hospital, Sydney, NSW, Australia*

Background:

This is a case of massive haemoperitoneum in the setting of therapeutic anticoagulation, requiring an urgent explorative laparoscopy.

Case description:

A 36-year-old lady presented with sudden onset severe lower abdominal pain. This is on a background of Budd-Chiari syndrome and heterozygous Factor V Leiden, on therapeutic Clexane for hepatic vein thrombus. She suffered from primary unexplained infertility. A CT reported a large haemoperitoneum, with a sentinel clot in the pelvis suggesting that the bleeding is from the right fallopian tube or ovary. Clexane was reversed and she was transfused. On day 2, her haemoglobin dropped from 126 to 75. Decision was made to undergo an explorative laparoscopy. A 1.5 litre haemoperitoneum was evacuated. The uterus and bilateral ovaries and fallopian tubes were normal with no active bleeding. A small adherent clot was found overlying a peritoneal recess in the right pouch of Douglas. The defect was explored and found to be an Allen-Masters window lined by endometriosis which was cauterised. There were no other visible pelvic or abdominal endometriotic deposits. Anticoagulation was recommenced postoperatively and she was discharged home.

Discussion:

Endometriosis is a common gynaecologic condition that affects 10% of women of reproductive age (1). Allen-Masters windows may be seen in deep infiltrating endometriosis. These are peritoneal defects found in the pouch of Douglas, the broad and uterosacral ligaments (1). Women with endometriosis usually present with chronic pelvic pain, dysmenorrheoa, deep dyspareunia and infertility (1). Our patient, aside from a history of infertility, did not disclose other symptoms or signs of endometriosis.

Whilst endometriosis is a known cause of acute abdomen due to small leakage from an endometrioma, massive haemoperitoneum as a cause of acute abdomen secondary to endometriosis is rare (2). A rare and catastrophic complication reported in the literature is a spontaneous haemoperitoneum in pregnancy due to bleeding endometriotic deposits or endometriosis-linked rupture of utero-ovarian vessels diagnosed on laparotomy (2). These women present with sudden severe abdominal pain and signs of hypovolaemic shock and a marked drop of haemoglobin (2). There is fewer case reports of non-pregnant women presenting with massive haemoperitoneum in the setting of endometriosis (3).

Conclusion:

It is queried whether this patient's massive bleed originated from endometriosis given the clot found overlying the Allen-Masters window, and no other identifiable source of bleeding. The surgeon should be vigilant to localize rare sites of bleeding due to endometriosis (3).

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Contained Power Morcellation

Deborah Hawkins, Alex Ades

Morcellation has been used in gynaecological surgery for nearly a century. The advent of power morcellation allowed gynaecologists to efficiently perform this task through small incisions. In 2014, the US Food and Drug Administration (FDA) issued a safety communication against the use of power morcellators due to the risk of disseminating occult malignancy. [1] Thereafter, rates of minimally invasive (MIS) hysterectomies decreased. A recent retrospective cohort study demonstrated increased rates of both minor and major complications in women undergoing hysterectomy for uterine fibroids after the FDA communication compared with those who had undergone surgery prior to the warning; in these women the rate of MIS hysterectomy fell from 56.1% before 2014 to 49.7% after 2014. [2]

Containment bags have been proposed as a way to mitigate the risks of morcellation. Some of the bags in the market have attracted criticism such as poor visibility, cumbersome handling, inadequate size, possible leakage or rupture, and surgical inefficiency. The Espiner ECO-T Containment Bag addresses these issues better than any other currently available containment systems. It has coloured markers to aid in orientation, facilitating the insertion of the bag and placement of the specimen inside the bag; it has an accessory camera port to allow for direct visualization during morcellation; it is made of ripstop nylon that is leak proof and puncture resistant; and it saves surgical time during morcellation by keeping bowel protected and eliminating the need for chip retrieval.

In this video, we present the 4000 ml bag and accompanying 15mm trocar. The patient underwent subtotal hysterectomy to treat uterine fibroids and abnormal bleeding. The size of the bag and orientation markers have allowed a fast learning curve for bag placement and specimen retrieval. Morcellation is performed efficiently despite the patient's large uterus and calcified fibroids. The specimen is maintained inside the bag and there is no dissemination into the abdomen.

The use of the Espiner ECO-T Containment bag has the potential to reduce the risk of intra-operative dissemination of malignancy, endometriosis, and peritoneal leiomyomatosis. We agree with the AAGL that further long-term follow-up and prospective studies would be beneficial to evaluate the possible advantages of the use of containment bags. [1] We hope that by sharing our experience with the Espiner bag, more surgeons will utilize it so we can collectively gain experience that can be used to improve patient care.

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Friday 3rd August
1230 – 1330 Lunch

Laparoscopic excision of a large para-rectal mature cystic teratoma

Alexandra Limmer[1], Yen-ni Yu[1], Kim-Chi Phan-Thien[2]

1. *Liverpool Clinical School, UNSW, Sydney, NSW, Australia*
2. *St George Clinical School, UNSW, Sydney, NSW, Australia*

Introduction:

Extra-gonadal germ cell tumours are rare, accounting for less than 5% of all germ cell tumours.[1] They most frequently arise in the sacrococcygeal region (67%) followed by the head and neck region (9%), retroperitoneum (8%) and mediastinum (7%).[1] We demonstrate laparoscopic excision of a large para-rectal benign mature cystic teratoma.

Case:

A 35-year-old female had an incidental finding of a right paravaginal cystic lesion during delivery. Her past medical history included two previous lower segment Caesarean sections. At laparoscopy, the lesion was in close proximity to the rectum. Biopsies demonstrated a benign mature cystic teratoma containing a few hair follicles and hair shafts. She was referred for consideration of pelvic resection.

On review, she was asymptomatic with no rectal bleeding. On bimanual examination, a 3 cm soft cystic lesion was palpable in the right para-rectal space. At colonoscopy, there was minimal indentation of the upper rectum and no mucosal lesions were identified. The patient underwent laparoscopic adhesiolysis and excision of the para-rectal teratoma. The teratoma was found to be adherent to the rectum, pelvic side wall and vagina and required careful dissection from the mesorectum. Variceal pelvic vessels were noted and bleeding controlled with focal pressure. An air-leak test confirmed rectal integrity.

Histopathology demonstrated a mature cystic teratoma comprised of ectodermal, mesodermal and endodermal derivatives. There were no immature elements or evidence of malignancy.

Discussion:

The majority of sacrococcygeal teratomas (SCTs) are congenital in aetiology and diagnosed on prenatal ultrasound.[2] In adults, SCTs are rare, predominantly intrapelvic and usually an incidental finding.[2] Hypotheses for the origination of extragonadal germ cell tumours include abnormal pluripotent germ cell migration from the yolk sac during embryonic development, ectopic ovarian tissue and auto-amputation of primary ovarian teratomas with reimplantation elsewhere within the abdominopelvic cavity.[1]

Complete surgical resection, which may include rectal and coccygeal attachments, is recommended.[1] The risk of malignant transformation of adult mature cystic SCTs is up to 12.5%.[1] Mature cystic SCTs have a good prognosis with complete excision.[1] The overall risk of recurrence is reported to be 10% for mature teratomas and 20% for immature teratomas.[3]

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Is there an optimal location for mesh fixation in sacrocolpopexy?

Alan Lam[1], Jessica Lowe[1]

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

Background:

Following the removal of transvaginal mesh products used in the treatment of pelvic organ prolapse via transvaginal implantation by the Therapeutic Goods Administration (TGA) in November 2017, it is anticipated that there will be increasing interest in and uptake of sacrocolpopexy (SCP) for treatment of apical prolapse.

Based on the current Consensus statement of the Royal Australian and New Zealand College of Obstetricians & Gynaecologists (RANZCOG) and the Australasian Gynaecological Endoscopy & Surgery Society (AGES), SCP is a Level 6 Scope of Clinical Practice procedure encompassing the highest level of complexity. Unambiguously, the American Urogynecologic Society, in its Guidelines for Privileging and Credentialing Physicians for SCP in 2013, stated that SCP is a complex surgical procedure which should only be performed by surgeons with board certification, requisite knowledge, surgical skills and experience in reconstructive pelvic surgery, appropriate ongoing surgical volume, adequately trained and equipped surgical team, and the ability to monitor outcomes and adverse events.

Crucial for safe and effective performance of SCP is detailed knowledge of the presacral space, skilful dissection and astute identification of the 'optimal' location for mesh fixation within the relatively small presacral space occupied by highly variable blood vessels and nerves in close proximity to ureter and bowels.

Objectives of presentation:

* To highlight vascular, ureteral and sacral nerve anatomical landmarks in relation to the mid-sacral promontory

* To determine the 'optimal' location for mesh fixation within the presacral space

* To propose strategies to mitigate potential complications during mesh fixation to the sacral promontory

Methodology:

* Examination of anatomical relationships between sacral promontory and vascular, ureteral and sacral nerve structures in cadavers

* Comparison and contrast with a selection of laparoscopic and robotic sacrocolpopexy procedures to highlight the marked variation in anatomical landmarks

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Vaginal hysterectomy and unilateral uterosacral ligament suspension in a unicornuate uterus with solitary kidney mullerian anomaly.

Elliot Mackenzie[1], Sarah Te Whaiti[1]

1. *Dunedin Hospital, Southern DHB, Dunedin, DUNEDIN, New Zealand*

Vaginal hysterectomy and uterosacral ligament of the vault of a unicornuate uterus has not been described. Decision to proceed with surgery in case of unusual findings may be challenging. Paying attention to anatomy is always key .

We describe findings and the procedure in a mullerian anomaly initially identified at the time of surgery. Images of findings are provided.

In theatre examination showed a normal appearing cervix, however, the uterus was deviated to the left adnexa. The right uterosacral ligament was not palpable. The left uterosacral ligament was palpable. After the hysterectomy had been completed, there was evidence of no right adnexa, only a left adnexa identified. At cystoscopy, single ureteric jet identified on left side, but no ureter on the right side. Cystoscopy performed at three intervals during this procedure. Images of the bladder cavity obtained, as well as images of the uterus.

PROCEDURE:

The patient was prepped and draped in routine fashion for vaginal surgery. Timeout was taken to ensure the correct patient and correct procedure and that the patient had received her antibiotics and TED stockings were in place. The cervix was visualized. A heavy-weighted speculum was placed in the vagina. The cervix was circumferentially injected with 0.25% lignocaine with epinephrine. Bulging prominence noted only on the right side of Pouch of Douglas which looked unusual. A circumferential incision was made of the vaginal mucosa along the cervix. The posterior peritoneum was identified with some difficulty and cut with the Mayo scissors. Retractors were placed in the posterior cul-de-sac. The uterosacral ligaments only palpable on the left side, grasped with a hysterectomy clamp, suture ligated with 0 Vicryl and cleaved distal to the clamp bilaterally. The cardinal ligaments were grasped with a hysterectomy clamp, suture ligated with 0 Vicryl and cleaved distal to the clamp, bilaterally. The uterine arteries were grasped with a hysterectomy clamp, suture ligated with 0 Vicryl and cleaved distal to the clamp, bilaterally.The anterior peritoneum was identified and cut with Metzenbaum scissors and entered. Sympathectomy placed for bladder retraction. The utero-ovarian ligaments and fallopian tubes were only identifiable on the right side and grasped with a hysterectomy clamp, suture ligated with 0 Vicryl and cleaved distal to the clamp, thus, amputating the uterus. Uterus examined and has adnexae only on the left side, Unicornuate uterus suspected at this stage. Cystoscopy performed with Fluorescein dye. Only left ureter identified. The trigone nor prominent and the right aspect of bladder wall looked empty. Strong suspicion of solitary left kidney and a unicornuate uterus consistent with mullerian anomaly. I made a decision to proceed with unilateral vault suspension to the uterosacral ligament and request renal scan postoperatively.

The left uterosacral ligaments were identified as they had been tagged during earlier dissection. The sutures was augmented with a vicryl 0 incorporating the vaginal mucosa. The left uterosacral ligament was traced proximally by palpation and their insertion into the sacrum identified. The capio suture device was used to place 2 PDS sutures in the ligament 3 cm cephalad and medial to the ischial spine. These sutures were tagged and retained untied at this point in the operation. Fluorescein 0.25 mls was administered intravenously. Cystoscopy was performed. The solitary left ureteric orifice was examined while tension was placed on each suture individually. Ureteric spill was seen with both sutures under tension.The cystoscope was removed from the bladder and the repair of the vaginal cuff was started. The uterosacral suspension sutures were anchored to the anterior and posterior vaginal epithelium. The cuff was closed with continuous suturing using a vicryl 0 suture.The retained stitches in the left uterosacral ligament were tied down, thus, suspending the vault.

Midurethral sling with Advantage Fit TVT- local anesthetic was administered utilizing a mixture of 30 mL of 0.5% lignocaine with 1:200,000 adrenaline and 30 mL of normal saline for injection. A total of 40 mL of this mixture was used. It was injected at the abdominal puncture sites, the planned vaginal incision sites and the planned trocar path in the retropubic space. Two Allis clamps were used to grasp the vaginal epithelium underlying the mid-urethra. A scalpel was used to incise the planned skin puncture sites and then a vertical suburethral incision was made through the vaginal epithelium. The Allis clamps were placed on either side of the vaginal incision and the vaginal epithelium was dissected free of the underlying periurethral tissues with Metzenbaum scissors. The Metzenbaum scissors were used to create a path to the retropubic space behind the inferior pubic ramus to the endopelvic fascia. The endopelvic fascia was punctured with the Metzenbaum scissors bilateral.

The Advantage Fit Midurethral sling and plastic covering sheath were lubricated with sterile lubricating gel. The Foley catheter guide was placed into the bladder catheter and the Foley catheter guide was used to deflect the bladder off to the patient's left. The sling trocar was then placed in the vaginal incision and angled towards the patient's right side. This sling device was advanced to the endopelvic fascia defect and the handle was dropped and the trocar path coursed along the backside of the pubic ramus. The rectus fascia was punctured and the trocar was guided through the previously made skin incision on the patient's right. A clamp was used to grasp the trocar at the exit site of the skin. The bladder was deviated to the right side and the Advantage Fit device used to insert the sling on the left side using the same fashion as above. The catheter was then removed and cystoscopy performed. There was no bladder trauma or sling exposure.

There was noted to be no twist in the tape. The centring device was cut and removed. Metzenbaum scissors with the tips slightly spread were then placed between the graft and the urethra and the graft was then

adjusted to be tension-free, lying beneath the mid-urethra.The sling trocars were then pulled out to remove the sling plastic covers. Again, the Metzenbaum scissors with the tips slightly spread were between the graft and the urethra at this point of the procedure. Once the scissors were removed from beneath the graft, it was noted that there was a tension-free positioning of the tape. The excess graft was cut from the abdominal aspect and forceps were used to separate the skin from the cut graft. The vaginal epithelial incision was closed in a running locking fashion using size 2-0 Vicryl with excellent hemostasis. Suprapubic puncture sites were closed with Dermabond.

The vagina was packed with Ovestin soaked gauze and procedure completed.

POST OP:

Renal scan identified empty right renal fossa. Renal function remained normal. Histology confirmed unicornuate uterus.

References pending

Imaging to be supplied.

Multidisciplinary dual console robotic hysterectomy with stage IV endometriosis

Andrew McIntyre[1], Yogesh Nikam[1]

1. *SWAPS, Western Sydney, NSW*

The robotic approach to minimally invasive surgery is gaining popularity. Its advantages to the patient include reduced blood loss, conversion to laparotomy and length of hospital stay. The surgeon benefits from three dimensional viewing, wristed movements, tremor filtration and enhanced ergonomics. The dual console platform became available in 2009, allowing two surgeons to operate and assist each other simultaneously using the same robot. Instruments may be transferred between surgeons with ease, and the interactive virtual pointer facilitates instruction and supervision. Published reports from gynae-oncology, urology and colorectal surgery have shown that the dual console reduces operating time without compromising patient outcomes. There is very little evidence however relating to its use in a multidisciplinary setting. This video presentation demonstrates the collaboration between a gynaecologist and colorectal surgeon in performing robotic hysterectomy for a 47 year old woman with stage IV endometriosis, and represents the first multidisciplinary dual console robotic surgery performed in the SWAPS unit.

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Vaginal evisceration following colpocleisis and sacrocolpopexy

Andrew McIntyre[1], Norman Blumenthal[1], Harry Merkur[1]

1. *SWAPS, Western Sydney, NSW*

Vaginal vault dehiscence with evisceration is a rare complication after hysterectomy. It constitutes a surgical emergency, where early recognition is important to prevent ischaemic intestinal perforation and sepsis. Postmenopausal women are at risk, particularly in the presence of vaginal atrophy and previous surgeries for prolapse. Following reduction of the eviscerated contents and evaluation of bowel viability, surgical repair of the vaginal defect can be performed via abdominal, vaginal or laparoscopic approach. There is no consensus as to the optimal surgical approach for treatment and prevention. Both colpocleisis and sacrocolpopexy have been proposed, however case reports exist as to evisceration occurring after either of these procedures. This case presentation, relating to an 89 year old woman who presented acutely with evisceration, represents the first occurrence following both.

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Surgical management of interstitial ectopic pregnancy

Tran T Nguyen[1], Robert T O'Shea[1]

1. *Flinders Medical Centre, Bedford Park, SA, Australia*

Video objective

Minimally invasive surgical management is an effective conservative treatment for interstitial ectopic pregnancy.

Setting

A single case report of a large unruptured interstitial ectopic pregnancy was referred to a tertiary hospital in Adelaide, Australia for further management. She was a 36-year-old gravida 2, nulliparous woman at 8 weeks and 3 days gestation after in vitro fertilisation, and was diagnosed with an interstitial ectopic pregnancy at her dating pelvic ultrasound. She was further investigated with an MRI pelvis for diagnostic confirmation prior to an operative laparoscopy.

Intervention

Laparoscopic cornuostomy was performed over interstitial ectopic pregnancy using monopolar scissors. After gestational sac was removed by endocatch, the myometrial defect was closed with 2.0 absorbable v-lock in 3 layers. Cell-saver and cross-matched blood were prepared but not required.

Conclusion

Laparoscopic cornuostomy is an effective minimally invasive technique for treatment of a large interstitial ectopic pregnancy.

Parasitic Leiomyoma after Open Myomectomy

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Introduction:

Parasitic leiomyomas were first described as early as 1909 but are a rare condition. In recent years, due to the rise of laparoscopic surgery and power morcellation, several cases of parasitic leiomyomas associated with this surgical procedure have been reported. In contrast, parasitic leimyoma after laparotomy is very uncommon. We report a case of parasitic leiomyoma 17 years after open myomectomy.

Case Report:

A 47-year-old nulliparous woman, presented with an episode of mid-cycle bleeding. She was previously healthy with only history of open myomectomy 17 years before. Transvaginal ultrasound revealed a bulky multi-fibroid uterus and a 7cm solid mass was reported in the right adenexa. The tumour markers were within normal limit. Plan for diagnostic laparoscopy was made.

At laparoscopy, a very large myoma-looking structure attached to the omentum and completely separate from the uterus was noted with prominent cluster of vessels at the postrolateral edge. Although there was no obvious evidence of malignancy, operation was abandoned in order to further investigate with imaging.

CT abdo-pelvis did not show any lymphadenopathy however a 7 x 8 x 12 cm heterogeneous vascular mass was again seen in the right hemipelvis. After consultation with gynaecology-oncologist the diagnosis of parasitic liomyoma was made and the patient underwent laparotomy and removal of parasitic fibroid. Intra-operative frozen section confirmed the diagnosis of leiomyoma without any malignant features.

Discussion:

Classically, parasitic leiomyomas have been defined as unusual variants of pedunculated leiomyomas that, for some reason, lie free from the uterus in the abdominal cavity, surviving by obtaining a blood supply from neighboring structures.

In recent years, with the rise of laparoscopic surgery, a new type of parasitic leiomyoma has emerged, that with an iatrogenic origin, in particular, as a complication of laparoscopic myomectomy or hysterectomy that require morcellation of the surgical piece to be extracted through a small incision. After morcellation, small fragments of the leiomyoma may remain unnoticed in the abdominal cavity and become implanted and take a blood supply from neighboring structures.

On the other hand, the condition is not only associated with laparoscopic myomectomy and hysterectomy using power morcellation, since some cases of parasitic leiomyomas have also been observed after abdominal myomectomy by laparotomy, vaginal or abdominal hysterectomy, and in some cases there is no history of any uterine surgery at all.

Parasitic leiomyoma is associated with non-specific clinical signs and symptoms. The most common sign is pain, which can manifest in various ways, including as dyspareunia. But, most cases are incidentally diagnosed after investigations for another reason.

Given that growth in the number of cases of parasitic leiomyomas is attributable to wider use of endoscopic techniques for uterine surgery, it is very important to be careful using this technique during the first surgery. Moreover, use of a containment bag has been proposed to reduce the risk of developing parasitic leiomyoma after power morcellation or some scientific societies have recommended to completely avoiding intraabdominal morcellation if in doubt or there is suspicion of uterine malignancy.

Even in open surgeries, it is essential to always properly check the cavity after myomectomy, and irrigate the abdominal cavity with normal saline to avoid leaving myoma fragments behind.

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Does Bilateral or Unilateral Fixation Matter for the Surgical Outcomes of High Uterosacral Vaginal Vault Suspension Procedure?

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Introduction: The concept of POP repair in accordance with DeLancey's theory is to correct all existing anatomical defects. For apical prolapse repair, the aim is to reconstruct the level I pelvic support by re-suspending the apical compartment to the uterosacral-cardinal ligament complex. With intra- or retro-peritoneal passage of sutures bilaterally through the uterosacral ligaments near the level of ischial spine, the vaginal cuff can be securely fixed without vaginal axis distortion, making this procedure applicable to all types of vaginal prolapse repair. However, the drawback of this procedure is the possibility of ureteral kinking leading to subsequent removal of the suspensory sutures which may affect effectiveness and successful outcome of the repair.

Objectives: To evaluate outcomes of transvaginal high uterosacral vault suspension for apical prolapse repair by comparing between unilateral and bilateral fixation in terms of success rate, recurrence rate, functional outcomes, and perioperative complications.

Materials and Methods: This is a retrospective cohort study of patients undergoing transvaginal high uterosacral vault suspension for advanced stage POP between July 2009 and December 2016. Following clinical assessment, the prolapse severity and location were identified according to the POP-Q system. Preoperative urodynamic study was performed when indicated. Traditional vaginal hysterectomy was carried out in all patients with uterovaginal prolapse. High uterosacral vault suspension was performed by passing the suspensory sutures between the vaginal cuff and the ipsilateral uterosacral ligament at the level of the ischial spine intraperitoneally. For those with vaginal vault prolapse, the procedure was carried out retroperitoneally. Anterior and/or posterior colporrhaphy was also performed as required. The suspensory suture on the affected side was removed if ureteric patency could not be confirmed during cystoscopy. Demographic data, operative time, blood loss, and peri-operative outcomes were recorded. At each follow-up visit, reassessment of symptom and POP-Q measurements were carried out. Differences in POP-Q measurements were demonstrated using independent and paired Student's t test. The P-value of less than 0.05 indicated statistical significance. The objective cure was defined as prolapse at or above hymen, and the subjective cure determined as resolution of prolapse sensation at the last follow-up visit**.**

Results:

Of 117 women undergoing uterosacral vaginal vault suspension, 94% were post-menopausal and 15.4% were post-hysterectomy patients. Mean age was 66.55±9.41 years and mean BMI was 24.96±3.62 kg/m2. Unilateral uterosacral suspension was carried out in one-fifth of the patients. Regarding baseline characteristics, there were no significant differences when compared between unilateral and bilateral suspension groups. No

significant differences were found between the two groups regarding pre- and post-operative POP location and severity. 90% were diagnosed with advanced stage prolapse. The mean operative time for all carried out procedures was 141.79±34.08 minutes and the mean blood loss was 150.51±111.65 ml. There were no significant differences between the two groups in terms of adds-on procedures, operative time, blood loss, and perioperative complications. Ureteric obstruction occurred in only 1 patient requiring double-J stent insertion and removal of one suspensory suture. Mean follow-up time was 27.3 months. Significant improvement in clinical symptoms and POP-Q measurements were demonstrated from early postoperative period up to 7 years. Overall objective cure was 88.9%, whereas overall subjective cure was 94.9%. When evaluating only the outcome of apical prolapse repair, very high success rates were demonstrated (objective cure 96.6% and subjective cure 97.4% respectively). No significant differences were found when comparing between unilateral and bilateral vaginal vault suspension.

Conclusions: High uterosacral vaginal vault suspension is a very effective and feasible prolapse repair procedure with low morbidity. Although there is the disadvantage of ureteral kinking leading to subsequent removal of one of the suspensory sutures, the surgical outcomes of unilateral uterosacral suspension is still comparable to the standard bilateral fixation.

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