



Australasian Gynaecological
Endoscopy & Surgery
Society Limited

AGES PELVIC FLOOR SYMPOSIUM & WORKSHOP XV

PELVIC FLOOR SURGERY – GOING NATIVE

INTERNATIONAL GUEST SPEAKERS

Assoc. Prof. Roseanne Kho *USA*

Mr Ash Monga *UK*

Assist. Prof. Peter Rosenblatt *USA*

15–16 AUGUST 2014

HILTON ADELAIDE

AUSTRALIA

PROGRAM & ABSTRACTS

14 AUGUST 2014

Pre-Conference Workshop

Boston Scientific

Achieving Ideal Outcomes in the
Treatment of Pelvic Organ Prolapse

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ADELAIDE
15-16 AUGUST 2014
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WELCOME

Dear Colleague

On behalf of the Board of the Australasian Gynaecological Endoscopy and Surgery Society and our local organising committee, we are delighted to welcome you back to Adelaide for this the fifteenth annual AGES Pelvic Floor Symposium and Workshop.

Adelaide is a city of diversity, from the excitement and noise of the Fringe Festive and Clipsal 500 to the relaxed pace of the wine country, beaches and the bikes of the Tour Down Under.

In this backdrop of diversity we wish to review the array of options available to the pelvic floor surgeon.

With the help of our international faculty, Rosanne Kho USA, Ash Monga UK, and Peter Rosenblatt USA, we will explore the lessons learnt in the journey from native tissue repair to mesh augmentation and back again.

The program includes the role of Robotic Surgery and Mesh

Augmentation, focusing on how we can use these procedures to improve our native tissue repairs. The program also includes: interactive sessions, which will discuss obstacles encountered during surgery and how the generalist pelvic surgeon can overcome these hurdles, presentations from other disciplines designed to facilitate patient selection and recovery, as well as the ever popular morning of live surgery to generate debate.

When the day is done, join us in celebrating the reopening of Adelaide's most loved icon – the recently redeveloped Adelaide Oval. Enjoy spectacular views from the Members' Dining Room, reminisce stories of its famous test matches and dreams of the AFL history to come.

We look forward to seeing you in Adelaide. We are confident you will enjoy an entertaining and educational meeting which will provide each of us with something to take home, ultimately improving our patient care.

Dr Jim Tsaltas
AGES President

Prof. Ajay Rane OAM
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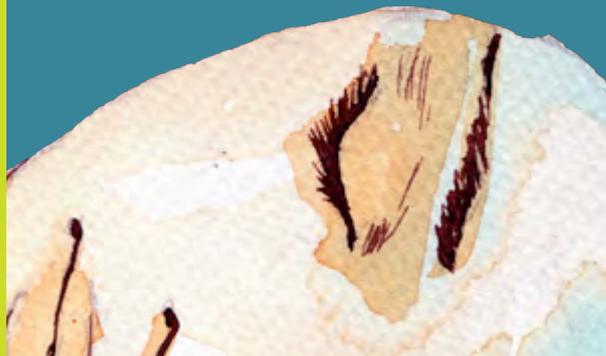
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COMPLICATIONS

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**DAY 1
FRIDAY 15 AUGUST 2014
HILTON ADELAIDE
LEVEL 1 BALLROOM**

0730-0800 **Conference Registration**

0800-1000 **SESSION 1 - Fundamentals of Pelvic Floor Surgery**
Chairs: *J Tsaltas, M Ritossa*
Conference Opening and Welcome *J Tsaltas, M Ritossa*

0800-0820 **Incorporating vaginal surgery back into the surgical armamentarium of the minimally invasive surgeon**
R Kho

0820-0840 **How well do you know your pelvic floor anatomy?**
P Rosenblatt

0840-0900 **Prospective study - mesh vs. native tissue** *A Monga*

0900-0920 **Apical Support - Prophylactic and Therapeutic** *R Kho*

0920-0940 **Pelvic Floor Repair: Critical Analysis of Literature for best Practice**
A Lam

0940-1000 **Prolapse assessment, pre- & intra-operatively: influences on the choice of surgery**
E Šeman

1000-1030 Morning Tea and Trade Exhibition

1030-1230 **SESSION 2 - Live Surgery**
Transmitted from Flinders Private Hospital, Adelaide
Moderators: *J Tsaltas, R Kho, A Lam, A Monga, P Rosenblatt, M Ritossa*
Surgeons: *M Carey, G Cario*

1230-1330 Lunch and Trade Exhibition

1330-1515 **SESSION 3 - Issues with Continence Slings**
Chairs: *C Barry, E Šeman*

1330-1350 **Choosing the right sling for your patient** *P Rosenblatt*

1350-1515 **Panel discussion - Troubleshooting slings**
Panel: *M Carey, P Henderson, A Monga, A Rane, A Rosamilia, P Rosenblatt, I Tucker*

What to do when:

1. The needle won't pass
2. There is copious haemorrhage during passage of the needle
3. The tape is twisted under the urethra (tape ends intact vs. cut)
4. The Transobturator Tape is exposed in the vaginal fornix
5. Check cystoscopy suggests a perivesical haematoma
6. Your assistant has cut the tape ends before removing the plastic sleeves
7. Your assistant has pulled down on the sling after cutting the tape ends, leaving too large a gap i.e. sling loose
8. Patient wakes up with severe groin pain after TOT
9. Patient is unable to void
10. Patient develops severe de novo urgency after a straightforward sling procedure
11. Patient's SUI persists
12. Patient develops recurrent UTI
13. Patient returns after a year with superficial dyspareunia

1515-1545 Afternoon Tea and Trade Exhibition

1545-1730 **SESSION 4 - Scope of Practice, National and International**
Chairs: *R O'Shea, D Munday*

1545-1605 **Credentialing for scope of practice after FDA**
P Rosenblatt

1605-1625 **Scope of practice - use of mesh in the UK** *A Monga*

1625-1645 **Is the Mayo way the only way?** *R Kho*

1645-1705 **Pelvic floor surgery - what is expected of a graduating FRANZCOG?**
M Ritossa

1705-1730 **Panel discussion**

1930 for 2000 **Gala Dinner**
Adelaide Oval
Ian McLachlan Room





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**DAY 2
SATURDAY 16 AUGUST 2014
HILTON ADELAIDE
LEVEL 1 BALLROOM**

0800-0930 **SESSION 5 – Member Presentation: ‘Share your worries with us’**
Chairs: *A Lam, R O’Shea*

0800-0930 **Panel discussion**
Panel: *G Burton, G Cario, R Kho, A Monga, D Munday, P Rosenblatt*

What to do when:

1. Torrential haemorrhage when Capio passed through right Sacrospinous ligament
2. Haemorrhage from Sacral Promontory during mesh attachment
3. Heavy venous bleeding from varices during posterior vaginal repair
4. Bilateral Sacrospinous Colpopexy – at rectal examination suture palpable on left
5. Rectal examination following posterior vaginal repair – rectal perforation 2cm above anal verge
6. Difficult vaginal hysterectomy with Anterior Elevate – cystoscopy shows 1cm tear behind trigone
7. Screening cystoscopy after Total Laparoscopic Hysterectomy, Uterosacral Colpopexy and Paravaginal Repair fails to show flow from right ureter
8. Recurrent cystocoele 3 months after Anterior Elevate complicated by large perivesical hematoma

0930-1000 Morning Tea and Trade Exhibition

1000-1230 **SESSION 6 – Potpourri**
Chairs: *K Harrison, J Abbott, S Salfinger*

1000-1020 **Critical analysis of databases in prolapse surgery**
A Monga

1020-1040 **Current medicolegal trends in Urogynaecology**
P Henderson

1040-1100 **A rational, cost-effective approach to long-term management of OAB**
A Rosamilia

1100-1120 **What do pelvic floor physiotherapists actually teach our patients?**
P Neumann

1120-1140 **Advances in the treatment of primary & secondary dyspareunia**
F Behnia-Willison

1140-1200 **What’s the optimum support/continence pessary for your patient?**
G Burton

1200-1230 **Panel discussion**

1230-1330 Lunch and Trade Exhibition

1330-1430 **SESSION 7 – Free Communications**

Free Communications A: Chairman’s Choice
BALLROOM
Chairs: *D Munday, J Abbott*

1330-1340 **Integrating Master of Advance Gynaecological Surgery to the AGES Laparoscopic Fellowship** *V Qin*

1340-1350 **Transvaginal mesh experience with 700 consecutive cases at CARE**
T Almotrafi

1350-1400 **Vaginal Mesh Repairs Using Prolift and Pinnacle Kits over 8 Years: High Success Rate but There is a Price to Pay**
T Kanade

1400-1410 **The Use of the Power Morcellator in Benign Gynaecology. A Ten Year Audit**
E Inglis

1410-1420 **Effectiveness of the UGSA Pelvic Floor Database for Conducting a Retrospective Audit of Perigee Mesh in a Private Practice**
B Miller

1420-1430 **TVT - 5year Follow Up in the Obese and Non-obese Patient**
J McKenna

Free Communications B: Free Communications
BALCONY 1&2
Chairs: *A Rosamilia, R Ford*

1330-1340 **Does the Increased Space Requirement Explain the High Risk of Levator Avulsion in Forceps Delivery?**
J Weishaupt





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DAY 2

SATURDAY 16 AUGUST 2014

**HILTON ADELAIDE
LEVEL 1 BALLROOM**

1340-1350 **Concordance of FIGO Grade Endometrial Adenocarcinomas in Biopsy and Hysterectomy Specimens and Accuracy of Outpatient Endometrial Biopsy in the Diagnosis of Endometrial Cancer**
R Mohan

1350-1400 **14 years of laparoscopic native tissue pelvic floor repair: at last the outcome**
R McMaster-Fay

1400-1410 **Our Experience at Goulburn Valley Health, Using Surgisis Biograft for Pelvic Organ Prolapse Repair**
I Munu

1410-1420 **Evaluation of Repair of Prolapse with Elevate Mesh -experience of a General Gynaecologist**
R Gulati

1420-1430 **Female Perception of Female Genitalia**
A Rane

Free Communications C: Video Fest

SUITE 3

Chairs: *S Salfinger, I Tucker*

1330-1340 **Antepartum Uterine Rupture at 29 Weeks Gestation: Case Report Following Unilateral Salpingectomy and Review of Literature**
Y Huang

1340-1350 **Sydney Contained In Bag Morcellation**
J McKenna

1350-1400 **Removal of Tissue Fixation System**
N Young

1400-1410 **Robotic Subtotal Hysterectomy and Sacral-Cervico-Colpopexy, Video Abstract Describing the Surgical Steps.**
S Al-Salihi

1410-1420 **What's unusual about this sacrocolpopexy?**
T Almotrafi

1420-1430 **When repeated transvaginal mesh repairs fail, what's next? A video presentation**
T Almotrafi

1430-1530 **SESSION 8 - Practical Surgical Pearls**
Chairs: *M Carey, S Lyons*

1430-1445 **Native tissue repair for recurrent cystocele and rectocele, vaginal approach**
A Monga

1445-1500 **Laparoscopic approach to the anterior compartment following previous vaginal surgery**
R O'Shea

1500-1515 **Which suture/delivery system for which operation - absorbable, delayed barbed or permanent?**
A Rane

1515-1530 **Discussion**

1530-1600 **Afternoon Tea and Trade Exhibition**

1600-1730 **SESSION 9 - Colorectal**
Chairs: *H Najjar, H Merkur*

1600-1620 **Gut motility and constipation - relevance to prolapse management**
P Dinning

1620-1640 **Faecal incontinence - What the gynaecologist should know**
D Wattchow

1640-1650 **Discussion**

1650-1730 **President's debate
'Pelvic floor surgery is for everyone to do'**
Moderators: *M Ritossa, A Rane*
Affirmative: *A Monga, P Rosenblatt*
Negative: *R Kho, A Lam*

1730 Close

CPD POINTS

Full attendance 17 CPD points
(Friday 15th & Saturday 16th August)

Workshop attendance 3 CPD points
(Thursday 14th August)

Attendance by eligible RANZCOG Members will only be acknowledged following a signature of the attendance roll each day of the Symposium, and Boston Scientific workshop.



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**PROGRAM ABSTRACTS
FRIDAY 15 AUGUST 2014**

SESSION 1 / 0800 – 0820

Incorporating vaginal surgery back into the surgical armamentarium of the minimally invasive surgeon

Kho R

The vaginal approach to hysterectomy has traditionally been regarded as indicated for the small and/or prolapsing uterus only. Current rates show that the majority of surgeons prefer to approach the procedure with laparoscopy or the robot which both incur greater operative time, patient morbidity and institutional costs. This presentation focuses on the use of new technologies and techniques to facilitate the performance of the vaginal hysterectomy for the teacher and the learner. Series of surgical videos will be presented on how to maximize exposure, achieve hemostasis, and perform manual morcellation for the large uteri applying the innovative technologies we have learned from laparoscopy and robotics.

SESSION 1 / 0820 – 0840

How well do you know your pelvic floor anatomy?

Rosenblatt P

Surgeons who perform reconstructive pelvic surgery must have a complete understanding of the normal anatomic relationships in the pelvic floor, as well as an understanding of the site-specific defects that contribute to pelvic floor disorders, such as pelvic organ prolapse, as well as urinary and fecal incontinence. The anatomy of the pelvic bones, muscles, endopelvic fascia, and ligaments provide dynamic stability, maintaining pelvic organ support and continence, while at the same time allowing for urination, defecation, coital function and parturition. The endopelvic fascia provides support for the uterus, bladder, urethra, and rectum and is attached laterally at the arcus tendineus fascia pelvis, proximally at the uterosacral / cardinal ligament complex, and distally at the perineal body. Understanding those natural attachments provides the surgeon with knowledge for restoration of injury or laxity of the fascial tissues. The pelvic surgeon must also consider compensatory procedures that utilize alternative attachment sites for effective treatment of pelvic organ prolapse. Use of the sacrospinous ligament and the sacral promontory are the two most obvious examples of strong supporting

structures that have been used for many years to support prolapsed organs. In addition, the use of synthetic mesh and biologic grafts have been shown to play an important role in reconstructive surgery when indicated. Regardless of whether natural or compensatory points of attachment are used by the gynecologic surgeon, an appreciation of the anatomic relationships with regards to blood vessels and nerve supply must be part of the surgeon's training, so that complications may be avoided. These topics will be covered in this talk on understanding pelvic floor anatomy.

SESSION 1 / 0840 – 0900

Prospective study – mesh vs. native tissue

Monga A

SESSION 1 / 0900 – 0920

Apical Support – Prophylactic and Therapeutic

Kho R

Data regarding the use of the high uterosacral ligament suspension at the time of the vaginal hysterectomy for prophylaxis and for repair of apical prolapse will be reviewed. Step by step technique using surgical videos will also be presented to optimize success and avoid complications.

SESSION 1 / 0920 – 0940

Pelvic Floor Repair: Critical Analysis of Literature for best Practice

Lam A

Following the release of the white paper and communication on the safety and effectiveness of transvaginal placement of vaginal mesh for pelvic organ prolapse repair by the U.S. Food and Drug Administration (FDA) in July 2011, many medical organisations, public citizen forums, healthcare and insurance companies have called for major restrictions, permanent discontinuation or total ban on the use of transvaginal mesh for pelvic organ prolapse. However, with the exception of mesh erosion, all the complications mentioned by the FDA also apply to non-mesh surgery as well.





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In the context of the challenging medico-legal climate, it is important to critically evaluate the current literature to see how we can provide adequate counselling and to obtain informed consent about non-mesh and mesh treatment options.

As high-quality evidence to guide decisions is still limited, we need to keep abreast of the latest scientific and non-scientific literature to choose the best surgical management option as no code or guidelines can ever encompass every situation for various types of pelvic organ prolapse, thus ensuring that we practise in a way that would meet the standards expected of you by your peers and the community.

REFERENCES

1. Murphy M et al. Int Urogynecol J 2012: Time to rethink: an evidence-based response from pelvic surgeons to the FDA Safety Communication: "UPDATE on Serious Complications Associated with Transvaginal Placement of Surgical Mesh for Pelvic Organ Prolapse.
2. Maher C, Feiner B et al. (2013) Surgical management of pelvic organ prolapse in women. Cochrane Database of Systematic Reviews.
3. Sara J. Mucofski et al. Use of vaginal mesh in the face of recent FDA warnings and litigation. Am J Obstet Gynecol 2010;203:103.

SESSION 1 / 0940 – 1000

**Prolapse assessment, pre- & intra-operatively:
influences on the choice of surgery**

Šeman E

"Good surgery is all about attention to detail."

1. Assess degree of bother: recommend repair if moderate-severe bother & conservative measures have failed.
2. Measurement of prolapse(POPQ) & other key features:
Higher POPQ stage & wider Genital Hiatus are associated with a higher recurrence rate.
Anterior compartment-preoperatively assess levator integrity (avulsion is associated with a higher risk of cystocele recurrence after colporrhaphy), rugation & sacculation. (smooth-walled, sacular cystoceles are more likely to fail paravaginal repair)
Apex- guidelines for uterine removal & apical suspension vs hysteropexy.

Posterior compartment – level 3 defect assessment.

3. Consent – what are reasonable intraoperative variables? Mesh can only be consented for preoperatively. ie mesh usage is a preoperative decision.
4. Level 3 posterior defect: observe downward migration of hymen to perineum, which acquires an oval shape. This finding indicates the need to dissect out the perineal body fascia & incorporate it into the repair, be it colporrhaphy (purse-string), site-specific (reattach to apex), or using a graft or mesh (attach inferior edge of graft/mesh to fascia). Finding this defect postop may predict persistence of evacuation difficulty, even with a straight ("well-supported") wall.

Tips on dissecting the perineal body fascia.

1. Hysteropexy vs hysterectomy: explanation of concepts of prophylactic vs therapeutic apical suspension, anteverting vs retroverting suspensions & their potential effect on cervical hypertrophy.
2. Hysterectomy during anterior & apical mesh kit- to reduce risk of mesh exposure in inferior vagina, consider mesh placement via colpotomy incision rather than making an extra midline vaginal incision.
3. Posthysteropexy 'prolapse' after posterior reattachment of uterosacral ligs may be due to:
 - a. True uterine prolapse from failure of level 1 support. Least common.
 - b. Cervical hypertrophy – beware the well-supported corpus because posterior cervical scarring making POD entry difficult or impossible transvaginally. Thus consent for laparoscopic or open approach as well. Consider trachelectomy eg with LLETZ loop.
 - c. Apparent uterovaginal prolapse: Hypertrophied cervix has 'dragged down' anterior & posterior walls. Cervix is a 'long stick'. Entry into U-V fold & POD is difficult due to well-supported corpus. Vaginal surgeons beware!

Findings which may influence the course of surgery:

- a. For continence slings- check range of movement of hips & avoid vulval varices
- b. During spinal anaesthesia – ensure normal BP for final check of haemostasis





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- c. Intraoperative haemostasis – always important but critical with graft & mesh surgery including slings – if in doubt use Floseal (including the last 0.5mls) & a firm pack. Insertion technique for pack– use single ended or bivalve speculum, unroll & fold pack into a concertina, soaking in Betadine makes it easier to insert.
- d. During mesh kit repair of cystocele recurring after paravaginal repair- avoid ‘stripping’ vagina off white line as this provokes bleeding. To insert inferior Elevate anchor- create a tunnel of economy which allows safe needle passage avoiding the bladder (above) & lateral vaginal sulcus (below).

REFERENCES

1. Bump RC, Mattiasson A, De Brubaker LP, et al. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. *Am J Obstet Gynecol* 1996; 175:10–17.
2. Whiteside JL, Weber AM, Meyn LA, Walters MD. Risk factors for prolapse recurrence after vaginal repair. *Am J Obstet Gynecol* 2004;191:1533-1538.
3. Dietz HP, Bernado MJ, Kirby A, Shek KL. Minimal criteria for the diagnosis of avulsion of the puborectalis muscle by tomographic ultrasound. *Int Urogynecol J* 2011; 22: 699-704.
4. Rodrigo N, Wong V, Shek KL, Martin A, Dietz HP. The use of 3-dimensional ultrasound of the pelvic floor to predict recurrence risk after pelvic reconstructive surgery. *Aust N Z J Obstet Gynaecol* 2014; 54:206-211.
5. Armitage S, Seman EI, Keirse MJNC. Use of Surgisis for treatment of anterior and posterior vaginal prolapse. *Obstet Gynecol Int* 2012; 2012: 376251. [doi:10.1155/2012/376251].
6. Bedford N, Seman EI, O’Shea RT, Keirse MJNC. Long-term outcomes of laparoscopic paravaginal repair. *J Minim Invasive Gynecol* 2014; submitted for publication.
7. Bedford N, Seman EI, O’Shea RT, Keirse MJNC. Effect of uterine preservation on the outcome of laparoscopic uterosacral suspension. *J Minim Invasive Gynecol* 2013; 20: 172-177.
8. DeLancey JOL. Anatomic aspects of vaginal eversion after hysterectomy. *Am J Obstet Gynecol* 1992; 166:1717–1724.

SESSION 3 / 1330 – 1350

Choosing the right sling for your patient

Rosenblatt P

Minimally-invasive mid-urethral slings (MIMUS) have become the recognized worldwide standard of care for the surgical treatment of stress urinary incontinence in women. Since their introduction in the mid-1990’s, millions of women have been effectively treated with MIMUS, and the procedure has been shown to be safe and reproducible. We now have a variety of options when choosing which MIMUS to perform on our patients. The most commonly performed are full-length retropubic tension-free vaginal tape (TVT) and transobturator tape (TOT). Even these slings can be further divided by direction of insertion. TVT can be performed “top-down” or “bottom-up” and TOT can be inserted “inside-out” or “outside-in”. Furthermore, single-incision slings (SIS) have gained in popularity, although the results of recent studies demonstrate inconsistent rates of success. We will discuss why the surgeon might choose one type of sling over another in different clinical situations. We will look at the evidence comparing TVT and TOT, as well as the studies comparing SIS to full length MIMUS. We will also look at choosing the right sling for your patients with recurrent USI, ISD, USI with or without urethral hypermobility, mixed incontinence, and other special circumstances.

SESSION 4 / 1545 – 1605

Credentialing for scope of practice after FDA

Rosenblatt P

With the new subspecialty certification in Female Pelvic Medicine and Reconstructive Surgery (FPMRS), the primary question that faces our specialty is what this certification means to gynecologists who become board certified, and what the implications are for those who are not. In 2011, concerns about the safety of transvaginal synthetic mesh (TVM) led the FDA to issue a safety update that was similar to the public health notification (PHN) from 2008. The more recent safety update stated that serious complications associated with transvaginal placement of mesh for pelvic organ prolapse are not rare. The most commonly reported adverse event noted in this report was mesh erosion and although many of these erosions can be managed conservatively, the FDA noted that some





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of the erosions required multiple operations to resolve and could be debilitating for women. The FDA made several recommendations for surgeons performing these procedures, including undergoing training for each specific device, to inform patients that surgical mesh is permanent, and that some complications may require additional surgery that may or may not correct the problem. Following this FDA statement, the American Urogynecologic Society (AUGS) issued its own guidelines for providing privileges and credentials to physicians for TVM. AUGS stated that TVM should only be performed by board certified or eligible in Ob/Gyn or Urology and who had the requisite knowledge, surgical skills and experience in pelvic reconstructive surgery. They also recommended that annual audits be performed for monitoring success rates and complications. AUGS subsequently issued guidelines for privileging and credentialing physicians for sacrocolpopexy, with similar recommendations based on knowledge, surgical skills and experience. These two groups of procedures, TVM and sacrocolpopexy, are among the more technically challenging surgeries that pelvic surgeons perform, and making recommendations for privileging and credentialing seem justified and appropriate. There is considerable debate whether other procedures performed for pelvic floor disorders should be restricted to subspecialists, or whether generalists may continue to offer these to their patients. Examples include mid-urethral slings, periurethral injections, sacral neuromodulation and bladder Botox injections. Restricting these procedures to subspecialists may potentially reduce complications, although an unintended consequence of such a policy may limit the availability of these procedures to women living in areas where no subspecialists practice and where generalists may be very experienced in pelvic floor repair.

SESSION 4 / 1605 – 1625

Scope of practice - use of mesh in the UK
Monga A

SESSION 4 / 1625 – 1645

Is the Mayo way the only way?
Kho R

Risk-reducing salpingectomy and complete removal of the high adnexae can both be performed at the time of the vaginal hysterectomy. Following the tradition and principles taught by

vaginal surgeons at Mayo, the techniques will be demonstrated to avoid ovarian remnant syndrome and/or incomplete removal of the adnexae.

SESSION 4 / 1645 – 1705

Pelvic floor surgery - what is expected of graduating FRANZCOG
Ritossa M

Surgery for genital prolapse has existed since the time of Christ. Soranus of Ephesus (98-138AD), commonly considered the foremost gynaecologic authority of antiquity, performed hysterectomy for uterine prolapse and his writings provided the foundation for gynaecologic texts up to the seventeenth century. Over time, many operations for genital prolapse have been described by a variety of surgeons around the world. When there are two approaches to a surgical procedure it is clear there is some debate as to the best method. When there are hundreds of operations to choose from, as there are with pelvic floor surgery, it is obvious that we are a long way from knowing what is ideal for our patients. The recent advent of Mesh implants in an attempt to improve the results of pelvic floor surgery, has only complicated matters further. Unlike the times of Soranus when there was one expert, we now have the situation where there is an ever increasing number of RANZCOG trainees and fellows competing for training. These trainees train in an environment that is very different to that of the last generation. Surgical procedures in the public system are decreasing in number and patient expectations of surgical outcomes are increasing. The trifecta of decreased workload, increased trainee numbers and an increase in the variety and complexity of surgical procedures is making it very difficult for current trainees to be competent and confident in all areas of gynaecological surgery. This presentation will explore the guidelines around pelvic floor training which have been laid down by the leading urogynaecological societies around the world. It will explain the current changes in the RANZCOG training program and how they will influence the scope of practice of our fellows in the future.





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SESSION 6 / 1000 – 1020

Critical analysis of databases in prolapse surgery

Monga A

SESSION 6 / 1020 – 1040

Current Medicolegal Trends in Urogynaecology

Henderson P

The presentation will outline the current position at Avant of claims relating to urogynaecology with particular emphasis to mesh kit related claims. The place of expert witness reports in these claims will be explored. Reflections on personally being sued will be made.

SESSION 6 / 1040 – 1100

A rational, cost-effective approach to long-term management of OAB

Rosamilia A

Around 16% to 45% of adults have overactive bladder symptoms (urgency with frequency and/or urge incontinence - 'overactive bladder syndrome').

It is important to treat other possible causes of this symptom complex such as urinary tract infection, pelvic organ prolapse, mixed urinary incontinence and to identify red flags such as haematuria, pelvic pain or voiding difficulty which point to a different diagnosis.

Initial treatment options have included pelvic floor physiotherapy, bladder retraining, electrical stimulation, acupuncture, drug therapy and neuromodulation.

Anticholinergic drugs are common treatments and these include oxybutynin oral and transdermal, tolterodine, solifenacin and darifenacin. Beta 3 adrenoreceptor agonist, mirabegron has recently been introduced in Australia. Trosipium is not available currently.

In cases of mixed urinary incontinence, a midurethral sling can have a 50 to 60 % chance of improving urgency and 80% chance of improving the stress urinary incontinence.

Improvement with mirabegron 50 and 100 mg has been seen with $\geq 50\%$ reduction in daily incontinence episodes, and decreased urinary frequency. The most common adverse event of dry mouth was found to be similar to placebo. Hypertension needs to be monitored.

In refractory cases, intravesical botulinum toxin and sacral neuromodulation can be offered.

SESSION 6 / 1100 – 1120

What do pelvic floor physiotherapists actually teach our patients?

Neumann P

Women are referred to pelvic floor physiotherapists by endoscopic gynaecologists predominantly for SUI and POP. Management of these conditions is based on Level 1 evidence for their efficacy¹ so patients will be trained in correct pelvic floor muscle technique, provided with biofeedback training, motivated to adhere to their training program and have other contributing factors such as overweight and straining at stool addressed. Other patients may be referred for pelvic pain associated with endometriosis. For these women, increased PFM tension and CNS up-regulation may be underlying their pain², so they will be educated about the nature of chronic pain, taught how to down-regulate their CNS with relaxation, suitable exercise and pacing and trained to relax their PFM (3). Three case studies will be presented to illustrate these scenarios.

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2. Loving S et al. Pelvic floor muscle dysfunctions are prevalent in female chronic pelvic pain: A cross-sectional population-based study. European Journal of Pain 2014





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SESSION 6 / 1120 – 1140

Advances in the treatment of primary & secondary dyspareunia

Behnia-Willison F

Dyspareunia affects up to 22% of women at some point in their lives and is the most common pain problem in a gynaecological setting. The causes are multifactorial, such as anatomical (mucosa, muscles, ligaments, bone and viscera), endocrine and psychological. Many women do not complain about dyspareunia to their family physician or gynaecologist and the current practice in gynaecology in western countries involves limited consultation time, opportunity and skills to address this dysfunction. This creates challenges for physicians in terms of history, investigation and examination, diagnosis and therapy, as well as patient support.

A new understanding of sexual function for women and understanding of pain in general requires practitioners to learn new skill sets, new interpretations concerning origins of dyspareunia and also new innovative therapies in a multidisciplinary setting. This involves the interaction of physiotherapists, sexual counsellors, psychologists and physicians such as gynaecologist/ laparoscopist, interventional radiologist and chronic pain physicians. The outcomes for patients should not only include coital possibility but also coital comfort and pleasure and facilitation of couple intimacy.

This presentation will consider aspects of dyspareunia, including anatomy and neurophysiology, sexual physiology, functional changes, pain in response to disease states and pain after gynaecologic surgical procedures. In particular, consideration will be given to vaginal atrophy which results in dryness, irritability, burning sensation, laxity, itching and painful sexual intercourse. In most cases urethral and vaginal atrophy worsens over time and reduces the patient's general quality of life. For many of these patients traditional treatment options are either ineffective or contraindicated.

Vaginal atrophy is associated with a loss of oestrogen production in the ovaries, especially after menopause. This results in a reduction of collagen in the vaginal mucosa and a thinning of the epithelium, which makes the vagina more susceptible to trauma during sexual intercourse. Moreover a reduction in blood flow causes a decrease in vaginal secretions leading to a dry vagina. This decreases the normal bacteria of the vagina (lactobacilli) which results in an increased PH level that facilitates the growth of pathogens such as yeasts and

bacteria. Although symptoms of vaginal atrophy are commonly seen in menopausal women and post-menopausal woman, many younger women also suffer from the symptoms of vaginal atrophy and dyspareunia.

If atrophic vaginitis that causes superficial dyspareunia was able to be treated by a procedure that rejuvenated the vaginal mucosa and restored its pre-menopausal structure, it is reasonable to think that vaginal atrophy-related problems such as dyspareunia could also be improved. A good treatment should ideally start before the occurrence of vaginal changes, so it is best to begin treatment prior to or as soon as possible after the onset of vaginal atrophy.

Due to the prevalence, discomforts and disturbances of dyspareunia, and because traditional treatments have frequently been ineffective, women are seeking new treatments to restore their quality of life. This presentation will therefore consider new innovative managements for atrophic vaginitis that causes superficial dyspareunia. These treatments include Platelet Rich Plasma (PRP) injections in the vaginal wall and a CO2 LASER procedure called MonaLisa Touch.

Platelet-rich plasma (PRP) is an autologous concentration of human platelets in a small volume of plasma. Because it is a concentration of platelets, it is rich in protein growth factors secreted by platelets implicated in all wound healing. It also contains the 3 proteins in blood known to act as cell adhesion molecules for osteoconduction and as a matrix for bone, connective tissue, and epithelial migration. The vast majority of publications on PRP use report a significant enhancement of healing. PRP development via centrifugation has been greatly simplified so that it can be used in the office setting as well as the operating room. The more platelet concentration, the greater the healing power.

MonaLisa Touch is a non-invasive alternative to HRT for the treatment of symptoms related to Vaginal Atrophy. It is a five minute, painless procedure that has no downtime and is suitable for almost all patients suffering from the effects of Vaginal Atrophy. Most patients experience a noticeable improvement after just one MonaLisa Touch treatment, however a course of three treatments is recommended.

MonaLisa Touch works by stimulating the body's own regenerative processes to create more hydrated and healthy cells and to improve the vascularity of the vaginal mucosa. This has a direct effect on the integrity and elasticity of the vaginal wall and increases the acidity of the vaginal environment to more normal levels. MonaLisa Touch





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is a low-risk procedure that provides longer-lasting improvements than HRT. However, it can be used in conjunction with HRT, as an alternative treatment for patients who are not suitable for HRT or for those patients who have found HRT to be ineffective. Patients can return to their normal daily activities immediately following a MonaLisa Touch procedure with the only post-treatment instruction being no sexual activity for five days.

MonaLisa Touch was introduced into Australia in January 2013 and more than 1000 treatments have been performed. The feedback from the Australian doctors performing the treatments is that MonaLisa Touch is consistently exceeding their expectations. And for many of the patients who have experienced the MonaLisa Touch procedure it has been life-changing. MonaLisa Touch is proving to be an exciting and effective solution for many women experiencing the symptoms of Vaginal Atrophy.

SESSION 6 / 1140 – 1200

What's the optimum support/continence pessary for your patient?

Burton G

The treatment of prolapse and incontinence depends on many factors including the severity, how much it bothers the patient, the treatment preference and patients general health. (Cochrane 2013) There is a high rate (87-98%) of usage of pessaries by gynaecologists (Cundiff 2000) and many use pessaries first treatment of prolapse. Pessaries are generally used to decrease the symptoms of prolapse but they can be used to test for occult incontinence, treat voiding disorders, reduce urge incontinence symptoms, treat vaginal air trapping, reduce pelvic discomfort in pregnancy and have been used in neonatal prolapse in spina bifida cases. There have been less successful attempts at pessaries for stress urinary incontinence. Success rates are 55-90% at three months and 56% at 12 months. (Clemons 2004, Wu 1997, Ferrnado 2006, Komesu 2007). There are different follow up protocols but estrogen cream may be beneficial (Hanson 2006). There is no agreement on how often the pessaries need to be changed (Burton 2003). Most evidence for pessaries are from level II and III trials (Clemons 2004; Clemons 2 2004; Clemons 3 2004; Hanson 2006; Kapoor 2009; Lone 2011; Manchana 2012) but more rigorous trials are needed.

SESSION 8 / 1430 – 1445

Native tissue repair for recurrent cystocele and rectocele, vaginal approach

Monga A

SESSION 8 / 1445 – 1500

Laparoscopic approach to the anterior compartment following previous vaginal surgery

O'Shea R T

Anterior colporrhaphy has been the traditional surgery for anterior compartment prolapse over many years. Randomised trials with this approach have resulted in high objective failure rates. In such instances, the subsequent treatment options have involved either a repeat vaginal procedure with or without mesh, or changing to the laparoscopic route. In view of the recent controversies with the use of vaginal mesh, this latter approach may offer a viable native tissue option. After initial description vaginally, Richardson repopularised this technique in the 1970's using the open abdominal approach. However, with the rise of expertise in laparoscopic surgery, the endoscopic approach has now become viable. In 2007, our Unit reported previous success rate of 79% using objective POPQ criteria. More recently, we have analysed 223 women treated with laparoscopic paravaginal repair from 1999 to 2005 using strict objective POPQ assessment. Median follow-up was 5.2 years (1-12 years), with 46% followed up for greater than 5 years. Using NIH criteria, anterior compartment failure was 36%. However, only 24% had an anterior recurrence beyond the hymen with 30% undergoing a repeat anterior compartment repair. Laparoscopic paravaginal repair offers a viable native tissue option. However, as advanced laparoscopic skills are required for this approach, this would appear to have had a negative effect upon the techniques popularity.





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SESSION 8 / 1500 – 1515

Which suture/delivery system for which operation-absorbable, delayed barbed or permanent?

Rane A

As the use of trans vaginal mesh reduces, the focus on improving native tissue repairs increases. Besides proper diagnosis the basic principles of surgery like hydrodissection, full thickness dissection, proper identification of fascial planes remain paramount. Use of suture materials however has remained predominantly on surgeon choice.

There is a paucity of good quality trials looking at suture materials especially for different levels of prolapse including colposacropexy.

This lecture explores the available data and tries to put together some 'pearls' to take home especially during native tissue repair.

SESSION 9 / 1600 – 1620

Gut motility and constipation - relevance to prolapse management

Dinning P

Prolonged straining in an attempt to have a bowel motion is a common symptom of constipation. A long history of such straining can result in damage to pelvic nerves potentially weakening pelvic floor musculature, which in turn can result in rectal prolapse. Patients with rectal prolapse can also suffer from faecal incontinence, which is thought to result from the denervation of the pelvic floor muscles and also from the dilatation of the internal anal sphincter caused by the rectal descent. While the maintenance of bowel continence and the act of defaecation involves complex mechanisms incorporating pelvic floor musculature, the motility of the ano-rectum and colon also play critical roles and motor abnormalities in these organs are thought to underpin functional defaecatory disorders. However, our understanding of these motor abnormalities remains relatively poor. Indeed despite over 100 years of clinical research studies on gut motility we do not have sound appreciation of normal colonic motility. Colonic motility derives from interactions between spontaneous myogenic activity driven by pacemaker cells and enteric neural circuits, which are modulated by the chemical and physical composition of colonic contents. Enteric neuronal activity is also

influenced by extrinsic parasympathetic and sympathetic pathways driven from the central nervous system.

Investigation of the motor patterns that arise from these mechanisms is achieved through measures of transit (radiology, scintigraphy and, more recently, "smart pills") and by intraluminal manometry, with the latter being the only technique that can record human gut contractility from multiple sites simultaneously in real time, over prolonged periods (hours to days). A search of the published literature on human colonic motility will distinguish (i) antegrade high amplitude propagating contractions (ii) low amplitude propagating sequences (iii) lots of non-propagating contractions and (iv) and rarely episodes of retrograde (oral) propagating pressure waves. However, these descriptions are all based on manometric recordings using catheters with recording sites spaced at least 7cm apart (the majority >12cm). Recent developments in high-resolution fibre-optic manometry catheters has allowed sensors to be spaced at 1cm intervals. This has allowed us to re-examine the published classification of colon motility patterns and it turns out to be very inaccurate. The high-resolution data strongly suggests that conventional sensor spacing (>7cm) has led to a significant over-estimation of the number of non-propagating contractions in the human colon, with most of these events consisting of contractions that propagate over short distances pre-dominantly in a retrograde direction. These retrograde motor patterns which originate mostly in the sigmoid and descending colon, are likely to play a role in maintaining bowel continence. By using these advanced recording techniques we are building a profile of normal and abnormal human colonic motility and importantly we are beginning to determine the likely mechanisms that control this motility. In this presentation these motility patterns in health, constipation and faecal incontinence will be discussed, particular reference as to how abnormal motor patterns may lead to the symptoms and signs that bring patients to the clinic.

SESSION 9 / 1620 – 1640

Faecal incontinence - What the gynaecologist should know

Wattchow D

Faecal incontinence is largely a problem in women. Injury to the anal sphincter mechanism by vaginal delivery is common. This can be damage to the internal anal sphincter (resting tone), external





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anal sphincter (squeeze) and/or the innervation from the pudendal nerves. Recent studies reveal that these nerves also supply the smooth muscle of the IAS, as well as the striated muscle of the EAS. Most patients present later in life. This symptom is socially disabling and a useful clinical measure is the impact on a patient's activities. Faecal incontinence can be graded from minor (flatus), to severe (solid/liquid faeces). An assessment of frequency of incontinence, and allied urinary incontinence is useful.

Much information is gained by history, and rectal examination. There may be a history of obvious childbirth trauma, epistiotomy or forceps usage. One must ask the patient to squeeze to assess the squeeze pressure. Colonoscopy is indicated if there is some change in stool consistency. The sphincter mechanism can be assessed in more detail by manometric recordings of resting and squeeze pressures. Intranal ultrasound gives good images of the IAS, less so of the EAS. Newer ultrasound devices that render 3D images of the sphincter mechanism are now available. The pudendal nerves can be (crudely) assessed by pudendal nerve motor latencies.

Dietary modification and pelvic floor physiotherapy form the mainstay of treatment and about ¾ of patients respond with a satisfactory improvement in symptoms. Sphincter repair for large sphincter defects is reasonable, the role of a covering stoma is debated (but I favour its use). Again the results are modest. Sacral nerve stimulation can be employed if the above fails. This treatment is very expensive, but effective, largely by enhancing retrograde colonic propgations. Stimulation of the posterior tibial nerve (s) is proving equally effective – the strength and duration is yet to be defined, or the mechanism of action. This may be achieved with an inexpensive TENS device.

Very gratifying results, and grateful patients, can be achieved over time for the symptoms of faecal leakage.





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SESSION 7A – Chairman’s Choice Free Communications / 1330 – 1340

Integrating Master of Advance Gynaecological Surgery to the AGES Laparoscopic

Qin V, Merkur H

AGES has introduced a two-year national training program in advanced gynaecological endoscopy in 2013. The laparoscopic fellowship provides a template for the standardization of training in advanced endoscopic surgery in Australia, with consistency in trainee education and access to resources. The Master of Surgery in Advance Gynaecological Surgery (MS) is the only such course available in Australia. This course is developed jointly by the School of Medicine at University of Western Sydney (UWS) and Sydney West Advance Pelvic Surgery Unit (SWAPS).

The curriculum of the MS has been designed for anyone interested in gynaecological minimally invasive surgery. The student will undertake eight units of study over two years. Two units are practicum; the other six units cover topics relevant to gynaecological surgery, such as pelvic anatomy, power modality, port entry, ergonomics, endometriosis and laparoscopic hysterectomy. Similar to the AGES laparoscopic fellowship, a clinical logbook is required. Furthermore, the student is required to reflect and critique different aspects of the operative experience. The incorporation of MS to the AGES laparoscopic fellowship has enriched the learning process of minimal invasive gynaecological surgery.

SESSION 7A – Chairman’s Choice Free Communications / 1340 – 1350

Transvaginal mesh experience with 700 consecutive cases at CARE

Almotrafi T, Lam A, Patel P

Introduction: Since March 2002, mesh has been used both in laparoscopic and transvaginal surgery at CARE for treatment of women with symptomatic pelvic organ prolapse. It is important that surgeons who use mesh in clinical practice keep track of patients who have mesh repairs in order to determine their efficacy and risk profile as products come and go in the rapidly changing surgical environment.

Aim: to report on the anatomical, functional and morbidity outcomes from 700 cases of mesh systems used in repair of pelvic organ prolapse at CARE.

Methods: All patients who have undergone transvaginal mesh repairs with Gynaemesh, Prolift and ELEVATE® at CARE since March 2002 are followed-up. Details include patient demographics, presenting symptoms, POP-Q staging, operative details, post-operative outcomes, post-operative febrile morbidity, mesh infection, erosion, re-operation are recorded using a prospective database. Outcome are compared between the 3 groups to evaluate anatomical, functional and morbidity outcomes including mesh complications.

Results: 700 consecutive cases of transvaginal mesh procedures were performed in women with symptomatic \geq stage 2 POP-Q prolapse. 87.4% of cases were considered successful based on anatomical definition as \leq POP-Q stage 1. Results indicate that there was febrile morbidity, intra-operative haemorrhage, mesh exposure, de-novo dyspareunia and reoperation were more common in Gynemesh and Prolift compared to ELEVATE mesh cases.

Conclusions: While clinical experience is a potential confounding variable, our results indicate there are significant differences in anatomical success, surgical morbidity and mesh complications between the 3 meshes which may be due to differences in mesh properties and delivery systems.

SESSION 7A – Chairman’s Choice Free Communications / 1350 – 1400

Vaginal Mesh Repairs Using Prolift and Pinnacle Kits over 8 Years: High Success Rate but There is a Price to Pay

Kanade T, Cario G, Rosen D, Chou D

Study Objective: To assess the clinical outcomes of vaginal repair using the Prolift mesh and Pinnacle mesh over a 1 year follow up.

Design: Comparative retrospective Observational study.

Patients Population: 191 women with advanced pelvic organ prolapse, Pelvic Organ Prolapse quantification stage IV (n=56), stage III (n=105) and stage II symptomatic (n=18) underwent repair using the Prolift and Pinnacle mesh. These patients followed up at 4 weeks, 6 months and 1 year post surgery.





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Interventions: Transvaginal mesh repairs were done using Prolift mesh during the years 2004 – 2008 and Pinnacle mesh was used during the years of 2010 to 2012, each spanning a period of 4 years. Concurrent pelvic surgery included mid-urethral TVT-O, vaginal hysterectomy and total laparoscopic hysterectomy.

Measurements and Main results: Objective and subjective data was available on 191 patients with mean age of 66 years. The anatomic success rate for both the mesh' was 93.7%. Significant intraoperative complications included one bladder perforation while performing anterior Prolift and haemorrhage resulting in blood transfusion in 1 patient undergoing anterior pinnacle. Post operatively, de novo urge was seen in 14.3% of patients and bleeding from operative site in 5.9% of patients at 4 weeks. The overall erosion rate for our unit was 16.5 % with 16.8 % for Prolift mesh and 16.3% for pinnacle mesh. Erosion rates occurring at 4 weeks, 6 months, and 1 year for anterior Prolift were 8.3%, 9.3% and 5.1%. For posterior Prolift, the erosion rates were 6.6% and 7.6% at 6 months and 1 year. With regards to anterior pinnacle mesh, the erosion rates were 6.6 % and 19.2 % at 4 weeks and 6 months respectively. Subsequent to use of posterior pinnacle, the erosion rates were 6.2 %, 19.2 % and 5.8 % at 4 weeks, 6 months and 1 year. 60% of all erosions needed mesh excisional surgery with or without biological mesh graft.

Conclusion: Despite high anatomic success rate, increased erosion rates are major concern for vaginal mesh surgery when compared to minimal invasive option of laparoscopic sacrocolpopexy (erosion rate in our unit is less than 2%). However, in patients with refractory prolapse or with contraindications of abdominal approach, vaginal mesh may be offered as an option for prolapse repair with appropriate counselling and careful selection.

SESSION 7A – Chairman’s Choice Free Communications / 1400 – 1410

The Use of the Power Morcellator in Benign Gynaecology. A Ten Year Audit.

Inglis E, Anpalagan A, Nawaz Z

The use of the power morcellator had recently come under attention after the FDA released a statement discouraging its use in hysterectomy and myomectomy (1). This statement was based on an estimation by the FDA that the incidence of unsuspected uterine sarcoma in women undergoing hysterectomy or myomectomy

for the treatment of fibroids was 1 in 350, and the concern that if power morcellation is performed in these women there is a risk that the procedure will spread the disease within the abdomen and pelvis, significantly worsening the patient’s prognosis. On the 29th of April the TGA acknowledged the FDA warning and is actively investigating what actions should be undertaken in Australia. After these statements our institution has suspended the use of the power morcellator while awaiting further direction. This lead us to perform a retrospective review of all patients undergoing laparoscopic myomectomy or hysterectomy from 2004 until April 2014, when the TGA statement was released. Cases where the morcellator was used were identified. Hospital medical records and histopathological results were reviewed. During the ten year period 2861 hysterectomies and myomectomies were performed. There were 223(7.8%) myomectomies and 2638 (92.3%) hysterectomies. Of these there were 78 (2.7%) laparoscopic myomectomies and 271 (9.4%) laparoscopic hysterectomies performed. There were no complications as a direct result of the use of the power morcellator. Only one case of uterine sarcoma was identified in a 78 year old woman undergoing laparoscopic hysterectomy for post menopausal bleeding. Morcellation was not used in this case due to a known pre operative history of complex hyperplasia. At our institution there were no cases of sarcoma identified in patients where the power morcellator was used or potentially could have been used. From the results of this study and available world literature we are developing a proforma to identify patients that have a low risk of sarcoma in which the morcellator can be used.

SESSION 7A – Chairman’s Choice Free Communications / 1410 – 1420

Effectiveness of the UGSA Pelvic Floor Database for Conducting a Retrospective Audit of Perigee Mesh in a Private Practice

Miller B, Seman E, O’Shea R, Behnia-Willison F, Nguyen T

The UGSA Pelvic Floor Surgery Database was established by the Urogynaecology Society of Australasia. The purpose of this database is to provide “a cheap and easy way to audit surgical outcomes”. It is modelled on the database established by the British Society of Urogynaecologists (BSUGS). It has been modified to comply with Australian law and slight differences in the health systems.





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The Flinders Endogynaecology group has maintained an Excel spreadsheet based database of pelvic floor cases since 1999. A large number of audits and publications have been produced from information contained in this database. Currently the UGSA database is being trialled to see if it can function as an effective replacement to a spreadsheet based database. The Perigee vaginal mesh system is a transobturator anterior vaginal mesh repair system produced by American Systems Incorporated (AMS). It uses a low density type 1 polypropylene mesh. Although it has mostly been superseded by the Anterior Elevate mesh system the experience and long term outcomes of the Perigee system are still important for our understanding of Vaginal mesh. A Cochrane review has found that the use of mesh reduces the risk of prolapse symptoms and recurrent anterior vaginal prolapse when compared to native tissue repairs. The complications of vaginal mesh including erosion, dyspareunia and litigation make the question of mesh for treatment of cystocele a cause of ongoing contention. The aim of this exercise was to use the UGSA Pelvic Floor Database to record data from a retrospective audit of 39 private practice records where perigee mesh was used for treating cystocele. On average it took 23 minutes per record to enter a full set of data including up to 3 follow-up visits. The UGSA database was shown to have a number of deficiencies. No extra data fields than those supplied can be added. Data can be output in a number of formats, including a limited number of graphs and an excel spreadsheet for further analysis. An important advantage of this database is that it is internet based and can be accessed from any computer with internet access.

after their TVT insertion, in both obese and non-obese patients. The validated ICIQ and 24hrPad tests were used as objective assessments of cure. The results were analysed for all patients irrespective of their pre-operative diagnosis and then in groups based on their urodynamic diagnosis of stress incontinence and treated mixed incontinence. The results were then analysed to look at the effect of BMI on the cure rate. The results support the clinical suspicions of the surgeons undertaking this surgery. They demonstrate that long term the results are inferior for the morbidly obese patient compared to the normal BMI patient.

SESSION 7A – Chairman's Choice Free Communications / 1420 – 1430

TVT - 5year Follow Up in the Obese and Non-obese Patient

McKenna J, Brims F, Sarma S, Parkin K, Allen W, Moore K

The worldwide epidemic of obesity has far reaching implications in almost all facets of medicine. Specifically in gynaecology there is evidence that stress urinary incontinence is more prevalent in the obese patient. There has been conflicting literature about the implications of this on the outcomes of tension free tapes as a treatment for stress incontinence. This prospective study objectively assesses outcomes in a cohort of 170 patients at least five years





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SESSION 7B – Free Communications / 1330 – 1340

Does the Increased Space Requirement Explain the High Risk of Levator Avulsion in Forceps Delivery?

Weishaupt J, Caudwell-Hall J, Dietz H P

AIM: Forceps is associated with an increased risk of pelvic floor trauma, especially to the levator ani muscle ('avulsion'). This study examines the additional space requirement associated with Forceps delivery to determine whether this is a major factor in the risk of levator trauma.

METHOD: This is a combination of a prospective in vitro study of spatial requirements for delivery of a fetal head by Forceps and mathematical modelling on the basis of an observational study of risk factors for levator avulsion at term. Data on antepartum prediction of levator avulsion was obtained from a cohort of primiparous women. A head circumference model was obtained using an inflatable balloon device. Forceps were applied at the widest diameter in 1cm increments for circumference (30- 40cm). Measurements were taken in triplicate. Three types of forceps were utilized to represent a rotational, midcavity, and outlet forceps delivery respectively.

RESULTS: The average increase in circumference of our fetal head model was 1.01cm for Wrigley's, 1.04cm for Kjelland's and 1.64cm for Neville-Barnes Forceps, and this increase was linear throughout the tested range. In 534 singleton pregnancies at term we had obtained an OR of 1.11 per cm of head circumference for avulsion. Hence, the additional space requirement due to Forceps would explain an OR of 1.12, 1.15 and 1.82 respectively for levator avulsion, depending on Forceps type. Comparing the OR associated with Forceps (4.96, CI 2.73- 9.02) in the mentioned observational series with the predicted OR due to the additional space requirement of Forceps, it is evident that the effect of Forceps on avulsion risk is not fully explained by the increase in space requirement alone.

DISCUSSION: Levator avulsion occurs in 10-13.5% of women after a first vaginal delivery, with Forceps as the main risk factor. Three potential mechanisms have been proposed to account for avulsion rates in Forceps. The first is that Forceps requires additional space, adding to head circumference. The second could be termed the 'time factor' as Forceps may allow faster delivery. The third may be termed the 'force factor': Forceps allows the application of greater force.

SESSION 7B – Free Communications / 1340 – 1350

Concordance of FIGO Grade Endometrial Adenocarcinomas in Biopsy and Hysterectomy Specimens and Accuracy of Outpatient Endometrial Biopsy in the Diagnosis of Endometrial Cancer

Mohan R

Objective-

1. To determine the percentage of cases in whom the final histology grade in endometrial cancer differs from initial biopsy and whether this has an impact on patient management.
2. Does the initial method of diagnosis office biopsy vs hysteroscopy and curettage influence the rate of discrepancy.
3. Does review of the initial specimen by Expert pathologists decrease the rate of discrepancy rates.

Background- Women have a 2.5% life time risk of developing endometrial cancer. Women with uterine cancer often present with post-menopausal, peri-menopausal or irregular vaginal bleeding. The majority of patients are diagnosed with some form of endometrial biopsy using various methods prior to hysterectomy. Pipelle endometrial biopsy is a useful office procedure for the assessment of patients with abnormal uterine bleeding. It is minimally invasive outpatient procedure that is less expensive and less time consuming compared with curettage with or without hysteroscopy. However, the impact of histologic type and grade on the accuracy of pipelle is unknown.

Pre operative tumour grading becomes one of the most important predictors for lymphadenectomy at primary surgery for clinical stage-I endometrioid adenocarcinoma. High-grade endometrioid adenocarcinomas are more frequently associated with nodal metastases, and a preoperative diagnosis of this type would likely prompt a complete surgical staging procedure, including pelvic and para-aortic lymphadenectomy. On the other hand, patients with low-grade endometrioid adenocarcinoma are at a lower risk for nodal metastases, and they may undergo simple hysterectomy and bilateral salpingo-oophorectomy alone without lymphadenectomy. However there is an inconsistency of tumour grade between preoperative curettage and final hysterectomy specimens and it's associated factors are poorly understood.





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Research methods-

1. Selection criteria- All patients undergoing hysterectomy from January 2000 to December 2011 at Westmead Hospital, for confirmed cases of endometrial carcinoma or suspicious for endometrial carcinomas, diagnosed by either Pipelle biopsy or D&C. The cases were identified from the Gynae-oncology data base maintained by Gynae-oncology Department at Westmead Hospital.
2. The following data will be abstracted from patient's medical records, operative reports and pathology reports.
 1. Grade on INITIAL curette/BIOPSY and histological type.
 2. Grade on Review by tumour board.
 3. Final histopathology and final grade and FIGO staging.
 4. Whether surgery was performed and if so what SURGERY AND whether pelvic or para-aortic lymph node dissection was done.
 5. Whether postoperative radiotherapy and chemotherapy was given.

Statistical analysis will be performed on the above data using SPSS Statistical Package with the assistance of a statistician.

Results- A total of 368 patients underwent surgical management for endometrial cancer. Preoperatively 160 patients were identified as Grade 1 disease, 93 with grade 2 disease and 35 with Grade 3 disease. Concordance was 72% for Grade 1, 73 % for grade2 and 88.5% for Grade 3. The concordance for grade 3 tumours was higher than for grade 1. Further results are awaited and in process.

SESSION 7B – Free Communications / 1350 – 1400

14 Years Of Laparoscopic Native Tissue Pelvic Floor Repair: At Last The Outcome

McMaster-Fay R A, Dietz H P, Della Zazzera V

RAM-F has been performing laparoscopic pelvic floor repairs in western Sydney since 2000 using the technique is that described by C.Y.Liu (2005) except I use the EndoStitch (Covidien) with Polyester sutures (non-mesh). I have performed approximately 230 operations (AGES presentations 2006, 2013). HPD has for the last 10 years been publishing internationally on the technique perineal ultrasound to assess the pelvic floor (2004,2012). We are at present

recruiting patients from 2012-13 but intend to invite all suitable patients from the series.

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SESSION 7B – Free Communications / 1400 – 1410

Our Experience at Goulburn Valley Health, Using Surgisis Biograft for Pelvic Organ Prolapse Repair

Munu I, Iyengar V

Introduction: Pelvic organ prolapse (POP) repair can be done using native tissue, a variety of synthetic meshes or biological grafts. The use of the latter two options reduces the recurrence of pelvic organ prolapse. We outline our experience using Surgisis biograft for over a 48 month period at Goulburn Valley hospital, Shepparton, Victoria.

Methods: We review a retrospective cohort of women who underwent vaginal hysterectomy, anterior & posterior colporrhaphy, bilateral anterior and posterior sacrospinous fixation, mid-urethral sling procedure (TVT-Abbrevio / TVT-O) plus check cystoscopy. Indications for surgery included GSI and POP stages 2-4, (median-2.5), as per ICS (POPQ). We looked at post-op stay duration, pain score (numerical rating scale), ability to pass urine and defecate on discharge. We also reviewed the same factors during the 6 & 8 weeks post-op visit. All the procedures were done between January 2012 & April 2014.

Results: Ten patients met the criteria. Age range 48yrs-74yrs. (Mean age 56.4 yrs.) Average hospital stay was 2.2 days. The median pain score (with movement) 3. One woman complained of pain during her review appointment. 30% went home with an indwelling catheter, 2 due to failed trial of void (TOV) and one had an iatrogenic bladder injury. All had their catheter removed 7 to 10 days later. Two had





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urge incontinence with proven urinary tract infection (*E. coli*). Their symptom improved after receiving antibiotic for a week. Four were constipated after surgery but none reported pain or difficulty opening their bowel during the post-op consultations. Two were re-admitted for suspected vaginal infection and graft extrusion. High vaginal swabs from both patients failed to culture any bacteria. None required a return to theatre. POPQ scores were significantly better in all patients.

Conclusion: Biologic grafts have a place in primary POP surgery. As these grafts work by helping native tissue re-establish, associated complications are less compared with synthetic meshes and they reduce recurrence encountered with native tissue repair. There have been many other cases of use of this biograft in similar POP repairs at our hospital and by the same surgeon and surgical team. However, these women and the operations they underwent do not exactly fit the whole case selection criteria, so were excluded from this first paper. This minimizes our overall biograft usage numbers. However, overall, we have good numbers and an excellent, single surgeon series developing. One which will provide significant information in due course to databases like UGSA's.

REFERENCES:

1. ICS Fact Sheets, A background to urinary and faecal incontinence. (July 2013)

SESSION 7B – Free Communications / 1410 – 1420

Evaluation of Repair of Prolapse with Elevate Mesh -experience of a General

Gulati R, Chang T

Introduction- The Elevate mesh system offers anterior and apical support by anchoring to obturator fascia and sacrospinous ligaments. The advantage of the Elevate mesh is the provision of level 1 as well as level 2 supports whilst avoiding the morbidity associated with laparotomy or laparoscopic surgery. In this study we plan to evaluate our experience with the Elevate mesh over the last five years.

Aim- The primary aim of this study is to determine surgical morbidity and complication rate in patients who have undergone prolapse repair with elevate mesh. The secondary aim is to assess the outcome in terms of subjective and objective improvement in symptoms with a minimum follow up period of three months.

Summary- This is a retrospective review of outcome of selected patients who underwent Elevate mesh insertion by a general gynaecologist over the last five years. This surgical audit will present data on presenting symptoms and relevant past history and examination findings including initial POPQ assessment. The Intraoperative details including concomitant surgery as well as postoperative assessment will be recorded and the data will be analysed to determine the surgical morbidity and complication rate in relation to the Elevate mesh with a minimum three months follow up.

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1. Botrobin V, Lucot J.P. Use of vaginal mesh for pelvic organ prolapse repair-a literature review. *Gynecol Surg* 2012; 9:3-15
2. Rapp D.E, King A.B. Comprehensive evaluation of anterior elevate system for the treatment of anterior and apical pelvic floor descent-2 year follow up. *Journal of Urol* Feb 2014; vol 191:389-94
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SESSION 7B – Free Communications / 1420 – 1430

Female Perception of Female Genitalia

Rane Ajay OAM, Askern A, Tuffin A, Horrocks E

The incidence of female genital cosmetic surgeries in Australia has increased dramatically over the past ten years. There is little known about the aetiology of this increase or its impact. The aim of this study was to determine how many women were satisfied or dissatisfied with their genitals and if their perception affected their mood or behaviours. We also aimed to identify factors that contribute to women's perceptions of their genitals. A modified version of the "pelvic organ prolapse/urinary incontinence sexual function questionnaire" (PISQ-12) was developed and distributed. This study provides a small insight into how a small sample of women presenting to urogynaecology clinics perceive their genitalia. No factors were identified that significantly affected women's perceptions of their genitalia. In this study we found that 17.2% of women were dissatisfied with the appearance of their genitals and 5.8% perceived their genitals as abnormal.





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SESSION 7C – Free Communications / 1330 – 1340

Antepartum Uterine Rupture at 29 Weeks Gestation: Case Report Following Unilateral Salpingectomy and Review of Literature

*Huang Y, Yim S, Kapurubandara S, Mahmoud I,
Anpalagan A*

Antepartum uterine rupture following unilateral salpingectomy for tubal ectopic pregnancy is a very rare condition with few reported in the literature. 1 There are limited case reports of rupture in the current literature, occurring secondary to interstitial pregnancy following previous salpingectomy. 2 Clinical diagnosis can be challenging and diagnosis is often made intra-operatively and associated with high fetal and maternal mortality and morbidity.

We illustrate a 33 year-old woman, G3P0, who presented with abdominal pain at 29 weeks of gestation. Her previous obstetric history included a first trimester miscarriage and a ruptured right ectopic pregnancy for which she underwent laparoscopic salpingectomy with no breach of uterine cavity. Her antenatal care had otherwise been unremarkable with normal nuchal translucency and morphology ultrasounds confirming intrauterine gestation. Following admission for undetectable fetal hearts, a formal ultrasound revealed an extrauterine stillborn fetus at the right adnexal region with free fluid consistent with intra-abdominal haemorrhage.

These findings were confirmed on CT abdomen/pelvis. Given the patient was haemodynamically stable, she was transferred to a tertiary unit for optimal surgical management by a multidisciplinary team including a gynaecological oncologist. An exploratory laparotomy was performed which revealed a uterine rupture at the right cornua where the fetus had extruded en caur through the uterus into the abdominal cavity. The fetus was delivered and the uterus repaired in 3 layers. The patient made an uneventful postoperative recovery and discharged 5 days following surgery with follow up at week one and again week six.

A review of the current literature including the evaluation of the available diagnostic work up and surgical options for the management of this rare obstetrics and gynaecological condition will be performed.

SESSION 7C – Free Communications / 1340 – 1350

Sydney Contained In Bag Morcellation

*McKenna J, Kanade T, Tsai B, Rosen D, Cario G,
Chou D*

This presentation outlines a modified approach to morcellation of myoma, supracervical hysterectomy and large fibroid uteri. The use of a bag introduced into the abdominal cavity and the creation of a pseudopneumoperitoneum within that bag creates an enclosed space within which morcellation may be more safely carried out with an electrical morcellator. For large fibroid uteri at hysterectomy we propose the introduction of a modified drawstring bag, via a vaginal tube. Once the specimen is retrieved the mouth of the bag is exteriorised onto the abdominal wall and the trocar replaced to allow creation of a pseudopneumoperitoneum. An optical trocar is introduced with a balloon tip trocar and morcellation is performed in the usual fashion. For myomectomy and supracervical hysterectomy we propose the use of Endocatch bag, with extraction of the mouth, re-introduction of the trocar and creation of a pneumoperitoneum and optical trocar as in the hysterectomy case. It is hoped that these two techniques will provide options for a range of surgical procedures to permit the continued use of an existing device which is likely to very soon have sanctions placed on its use.

The risk of disseminating occult leiomyosarcomatous fragments during morcellation of fibroids at myomectomy or hysterectomy has been raised as an issue amongst the Endoscopic Community internationally and we are hopeful that this prototype solution may be a first step in a solution to allow the continued minimally invasive approach to hysterectomy of large fibroid uteri and myomectomy.

SESSION 7C – Free Communications / 1350 – 1400

Removal of Tissue Fixation System

Young N, Braverman M, Chao F, Rosamilia A

A Video of removal of tissue fixation system as a combined laparoscopic and vaginal approach in a 56 year old with chronic pain since insertion.





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SESSION 7C – Free Communications / 1400 – 1410

Robotic Subtotal Hysterectomy and Sacral-Cervico-Colpopexy, Video Abstract Describing the Surgical Steps.

Al-Salihi S

This is a video presentation describing the surgical steps used in performing a subtotal hysterectomy at the supracevical level followed by sacral colpopexy to suspend the apex while repairing the anterior and posterior vaginal compartments. This Robotic surgery demonstrates the surgical steps taken to remove the uterus with the ovaries and fallopian tubes followed by a gold standard procedure providing surgical repair for the apical as well as the anterior and posterior pelvic floor compartments, using a Y-shaped synthetic prosthesis (surgical mesh).

SESSION 7C – Free Communications / 1410 – 1420

What's unusual about this sacrocolpopexy?

Almotrafi T, Lam A, Ford R

Introduction: Sacrocolpopexy has been demonstrated to be a highly effective surgical procedure for treatment of vaginal vault prolapse. The most common mesh used is prolene for this surgery. However, there are exceptional circumstances when prolene may not be the most suitable material choice.

Aim: To demonstrate the use of SURGISIS for laparoscopic sacrocolpopexy in the management of a prolapsed neovagina in a gender-reassigned patient.

Methods: Careful preoperative counselling is presented in the evaluation and choice of materials used for surgical correction of a prolapsed neo-vagina. The video demonstrates the careful dissection to preserve the blood supply to the neo-vagina, the display the prolapse and the secure attachment of SURGISIS mesh. Pre and post-surgical images are also presented as well as follow-up outcomes of this unique case.

Results: The case was completed without complication. The patient was pleased with the anatomical outcome and is hoping to become sexually active.

Conclusions: In circumstances where mesh erosion is a major risk, the use of SURGISIS may be a suitable alternative to prolene for laparoscopic sacrocolpopexy in the management of vaginal vault prolapse.

SESSION 7C – Free Communications / 1420 – 1430

When repeated transvaginal mesh repairs fail, what's next? A video presentation

Almotrafi T, Lam A, Ford R

Introduction: No surgery for pelvic organ prolapse is 100% successful. When repeated transvaginal repairs including the use of mesh have failed, the alternative approach by laparoscopic, robotic or abdominal approach should be considered for several reasons. Firstly, dissection through scarred and fibrotic tissues is difficult, with increased risks of bladder and bowel injuries. Secondly, attempts to reach suitable and strong anatomical landmarks per vagina may be associated with troublesome bleeding. Thirdly, vaginal stenosis or shortening may not allow adequate mobility to suspend the vaginal vault without tension. Finally, the laparoscopic approach allows avascular dissection with clear identification of bladder and rectum and tension-free vault mesh attachment to the presacral ligament.

Aim: To demonstrate the use of laparoscopic surgery for successful sacrocolpopexy in the management of recurrent vaginal vault prolapse in a woman who had undergone multiple transvaginal repairs with mesh

Methods: After careful counselling, the patient proceeded to laparoscopic surgery. The video demonstrates the careful dissection to identify the bladder, the rectum, the anterior and posterior vaginal mesh, the attachment of Restorelle mesh to the vaginal vault and the attachment to the presacral ligament.

Results: The case was completed without complication. The patient was pleased with the anatomical outcome and has been able to resume physical and sexual activity.

Conclusions: In circumstances where repeated transvaginal repairs have failed despite the use of mesh, the laparoscopic, robotic or abdominal approach offers an excellent alternative route in the management of vaginal vault prolapse.





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