

P-IS-121 Conservative management of pelvic organ prolapse with soft or hard type pessaries

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[Objective] Two types of ring pessaries, soft and hard ones, for pelvic organ prolapse (POP) are available in Japan. The purpose of this study is to compare clinical outcomes of these two type pessaries. [Methods] Seventy-four patients aged 47-88 years with POP using ring pessaries were enrolled in this study with the informed consent. The demographic variables evaluated were: age, management period, initial and current size and type of pessary, change the type of pessary, and complications. [Results] The mean age of initial treatment was 67.0 years, and the average of management period was 41 months. The modes of initial hard and soft ring size of diameter were 70mm and 68mm. Main complications of hard ring were pain and troubles in removal and insertion. Incidence of vaginal discharge in soft ring was relatively higher (38.2%vs. 25%) than in hard ring. In 44 patients using hard type pessary, 36 changed to soft one, but 10 cases of 36 needed to return hard one due to increasing vaginal discharge and unsuccessful fitting. [Conclusion] Pessary management of POP is generally convenient and good efficacy as non-surgical treatment. However, the complications associated with device usage should be carefully examined and managed for the women's health.

P-IS-122 Transvaginal surgical technique for female urinary incontinence using the in-fast ultra sling system with intesh

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Introduction: Surgical treatment of female stress urinary incontinence (SUI), often referred to as genuine stress incontinence (GSI), has undergone revolutionary change over the past 12 years, the most important of which is the increasing use of pubo-urethral transvaginal slings. There has been an increasing awareness that GSI has a component of intrinsic sphincter deficiency (ISD) and a much better understanding of bladder anatomy, physiology and pathophysiology. A problem has been with so many alternative operations for the management of SUI (GSI) that it can be a difficult decision as to which procedure is best.

Technique and Method: The InFast Transvaginal Sling Procedure with InteMesh, creates a hammock of support beneath the urethra and bladder neck with a twofold effect: 1) preventing rotational descent during stress maneuvers, 2) supports the proximal half of the urethra in the region of the urethral rhabdosphincter to that of the bladder base (urethro-vesical angle) preventing bladder neck descent during stress maneuvers. Patient evaluation of medical, surgical, obstetric and gynaecological history is documented. Urinary symptoms are often a complex mix of incontinence and detrusor instability (DI), and not necessarily excluded from this series. Multi-channel urodynamics studies were employed. The patient is anaesthetized and placed in lithotomy position. A midline incision, from 1cm below the urethral orifice, extending to 1cm below bladder neck, is made in the anterior vaginal wall, vaginal mucosa is reflected laterally, leaving paraurethral/bladder fascia intact. The retropubic space is accessed with minimal sharp and blunt dissection; a Foley's 18F/30cc balloon is in-situ for anatomical identification of urethra and bladder base. The In-Fast inserter is introduced, having clean contact between bone and screw, enabling screw with pre-attached prolene suture to be placed into the right and left pubic rami. This enables the attachment of the prosthesis. The InteMesh silicone coated mesh is tied over a urethral 8mm splint to prevent over-compression of the urethra. Cystoscopy is performed to exclude bladder, ureteric, urethral injury. The anterior vaginal wall mucosa is then closed.

Results and Discussion: Sling procedures have become a gold standard for treatment of all types of SUI requiring surgery. Support of the proximal 1/2-2/3 of urethra and bladder neck is achieved, correcting ISD and bladder neck hypermobility, and restoring bladder neck anatomy. In the series of 312 cases, 104 had combined vaginal hysterectomy. In 75/312 had anterior and posterior pelvic compartment pelvic floor reconstruction. Of the 312, 75 had previously undergone urinary incontinence procedures. Mean age of patients was 54 years, and the mean follow-up interval was 5 years. At follow-up, 93% had no further urinary leakage, while 7% had >75% improvement of incontinence. Six patients had the prosthesis removed or modified. Average operating time was 31mins for sling procedure and repair of cystocele. In 90% of patients the catheter was removed after a mean time of 14 hours, while 10% of patients had transient prolonged catheterisation. Four patients had chronic retention, lasting for 2 weeks. No instances of bladder trauma or sexual dysfunction were encountered and no incidence of osteomyelitis was encountered.

Conclusions: Transvaginal sling surgery is safe, can be performed concomitantly with vaginal hysterectomy and/or pelvic floor reconstruction with minimal morbidity and hospital stay and minimal postoperative pain. Patients return to physical activities and normal bladder function rapidly. The technique of the Transvaginal In-Fast Ultra with InteMesh silicone coated mesh is simple and expertise is rapidly acquired.