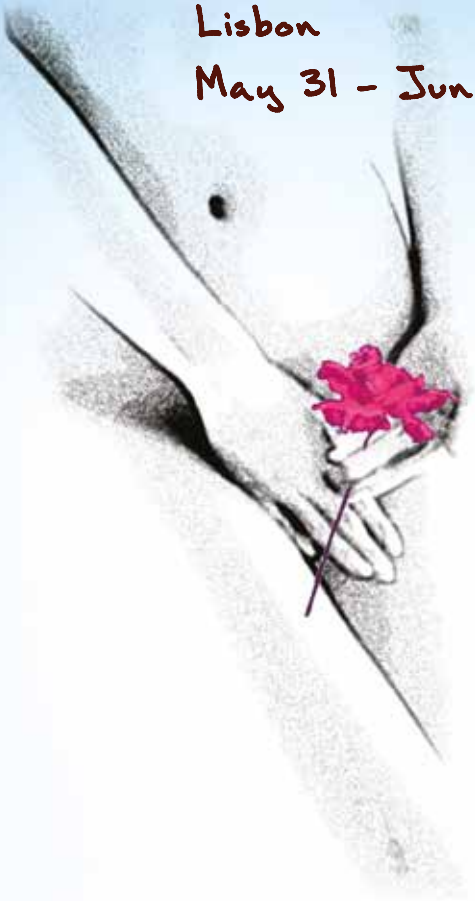
Live surgery Urogynecology Course 2nd Edition

Pelvic Pain, Prolapse & Neuromodulation

Pestana Palace Hotel

Lisbon

May 31 - June 1, 2019



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Urologist, Lisbon

SCIENTIFIC PROGRAMME

Friday, 31st May 2019

07:30h Opening of registration desk

08:30-08:45h **Welcome session and introduction**
Frederico Ferronha & Luís Campos Pinheiro

08:45-10:00h **1ST SESSION: SURGICAL MANAGEMENT OF POP**
Chairman: Ricardo Mira
Co-Chairmen: Palma dos Reis & Amália Martins

The Integral System: Function, dysfunction, diagnosis and treatment of prolapse *(30m)*
Paulo Palma

No-mesh in POP surgery: Controversy – Evidence vs. emotion *(15m)*
Elisabetta Costantini

What is the place for vaginal mesh surgery in 2019 *(15m)*
Frederico Ferronha

Q & A *(15m)*

10:00-10:45h **LIVE SURGERY SESSION I**
Surgical management of POP – Vaginal approach (Simultaneous transmission)
Chairman: Bercina Candoso
Co-Chairmen: João Pina & Ana Luísa Ribeirinho

› **Vaginal native tissue repair** — Coloplast
Surgeon: Philippe Ferry

› **Vaginal native tissue repair** — Boston Scientific (Advancing science for life™)
Surgeon: Alexandre Lourenço

10:45-11:15h Coffee break

11:15-11:30h **Opening session**

11:30-12:45h **LIVE SURGERY SESSION II**

Surgical management of POP – Vaginal approach (Simultaneous transmission)

Chairman: Pedro Nunes

Co-Chairmen: Alexandra Henriques & Pedro Faustino

› **Transvaginal repair with mesh**

Surgeon: Javier Cambronero

› **Transvaginal repair with mesh**

Surgeon: Achim Niesel

12:45-13:30h **2ND SESSION: CONSERVATIVE MANAGEMENT OF PROLAPSE**

Chairman: Alexandre Lourenço

Co-Chairmen: Rui Miguel Viana & João Pina

Physiotherapy: For whom? *(15m)*

Renata Buere

Election of the patient and the ideal vaginal pessaries – What, when and how? *(15m)*

Guida Gomes

Q & A *(15m)*

13:30-14:30h Lunch

14:30-16:30h **LIVE SURGERY SESSION III**

Surgical management of POP – Abdominal approach

(Simultaneous transmission)

Chairman: Luís Campos Pinheiro

Co-Chairmen: Sofia Alegra & Elisabetta Costantini

› **Laparoscopic sacrocolpexy**

Frederico Ferronha

› **Laparoscopic integral sacrocolpexy**

Luís López-Fando

16:30-17:00h Coffee break

17:00-18:30h **3RD SESSION: CHRONIC PELVIC PAIN**

Chairman: Luís Abranches Monteiro

Co-Chairmen: José Anacleto Resende Junior & João Varregoso

LECTURE:

Intrapelvic Nerve Entrapments: Concept, diagnoses and management *(20m)*
Nucelio Lemos

ROUNDTABLE:

Chronic pelvic pain: How the physiotherapy can help? *(10m)*
Renata Buere

Instillation for BPS patients: Myth or reality? *(10m)*
Catarina Gameiro

Pharmacology therapy and Botulin toxin of the CPP *(10m)*
Rui Pinto

Sacral Neuromodulation – The uroneurologist vision *(10m)*
Manuel Oliveira

Percutaneous approach – The radiologist vision *(10m)*
Pedro Alves

Pudendal entrapment: Diagnostic and treatment technique in 2019 *(10m)*
Rui Lúcio

Q & A *(10m)*

18:30-19:40 **ABSTRACT SESSION: PODIUM PRESENTATIONS**

Chairmen: Cabrita Carneiro, Avelino Fraga & Paulo Dinis

Podium presentations

Moderated Poster

19:40h End of the 1st day

Saturday, 1st June 2019

08:00h Opening of registration desk

08:30-09:45h **4TH SESSION: UNDERACTIVE BLADDER**
Chairman: Paulo Vale
Co-Chairmen: David Martinho & Frederico Carmo Reis

The enigma of the underactive bladder *(15m)*
Tiago Lopes

Is urodynamics helpful for underactive bladder diagnosis? *(15m)*
José Ailton Fernandes

Current and future therapeutic strategies of detrusor underactivity *(15m)*
Miguel Ramos

Stress incontinence and underactive bladder… How can I manage it? *(15m)*
Carlos Ferreira

Q & A *(15m)*

09:45-10:45h **5TH SESSION: CONTROVERSIES IN SUI**
Chairman: Carlos Silva
Co-Chairmen: João Colaço & Rita Torres

The future of surgery for SUI: Will the MUS survive? *(15m)*
Paulo Temido

Autologous fascial sling – Alive & kicking in 2019 *(15m)*
Paulo Palma

Are injections a real alternative to suburethral slings? *(15m)*
Biagio Adile

Q & A *(15m)*

10:45-11:10h **6TH SESSION: CROSS FIRE**
Chairman: Teresa Mascarenhas
Co-Chairmen: Fortunato Barros, Pedro Martins & Patrícia Amaral

Does rehabilitation solve stress incontinence? Face to face physiotherapist vs. surgeon *(25m)*

José Anacleto Resende Junior & Renata Buere

11:10-11:30h Coffee break

11:30-12:15h **SYMPOSIUM: STAYING ON TREATMENT WITH OAB** *(45m)*
Chairman: Paulo Dinis
Co-Chairmen: Rui Sousa & João Marcelino
Speaker: Christopher Chapple

12:15-13:45h **7TH SESSION: CONTEMPORARY SURGICAL TREATMENT OF OVERACTIVE BLADDER**
Chairman: Vaz Santos
Co-Chairmen: Cardoso de Oliveira & José Ailton Fernandes

Urge according to integral theory *(15m)*
Paulo Palma

Neurogenic detrusor overactivity – The role of laparoscopic implanted neuromodulation *(15m)*
Nucelio Lemos

Management of OAB: Is the new era of neuromodulation? *(15m)*
Manuel Oliveira

Botulin toxin injection *(15m)*
Rui Pinto

CESA/VASA mesh *(15m)*
Pedro Galego

Q & A *(15m)*

13:45-14:00h **Closing Session**
Luís Campos Pinheiro & Frederico Ferronha

14:00-15:00h Lunch

15:00-19:00h **URODYNAMICS COURSE**

INTRODUCTION AND TECHNIQUE PRINCIPLES

Urodynamic evaluation: when, why and how? *(20m)*
Hugo Pinheiro

How to structure a urodynamic lab: equipment, room and team *(20m)*
José Ailton Fernandes

How to prepare the patient for a urodynamic examination? *(20m)*
José Ailton Fernandes

Practical principles of uroflowmetry and cystometry *(20m)*
Hugo Pinheiro

Setting up urodynamic equipment *(20m)*
José Ailton Fernandes

16:40-17:00h Coffee break

CLINICAL CASES / PRACTICAL SESSION

Stress urinary incontinence *(20m)*
José Ailton Fernandes

Overactive bladder *(20m)*
Hugo Pinheiro

Bladder outlet obstruction in man *(20m)*
Hugo Pinheiro

Bladder outlet obstruction in woman *(20m)*
José Ailton Fernandes

Neurogenic bladder *(20m)*
José Ailton Fernandes

Artifacts and pitfalls of urodynamics *(20m)*
Hugo Pinheiro

IN THIS COURSE YOU WILL LEARN:

- **Comprehend need for urodynamic testing**
- **Prepare the patient and software**
- **Run tests and recognize artifact**
- **Basic troubleshooting techniques**

Designed for professionals who have little or no experience with actual urodynamic testing procedures and for those with some experience but wish to become more comfortable performing urodynamic testing.

POSTERS

P01

COMBINATION OF SLINGS AND SITE-SPECIFIC FASCIAL POP REPAIR. MULTICENTER STUDY

Boris Slobodyanyuk;YUlia Dobrokhotova; Svetlana Kamoeva;Alexander Slobodyanyuk; Valentina Dimitrova
Pirogov Russian National Research Medical University RNIMU, gynecology, Moscow, Russia; Medsi Clinic Moscow, Russia; Zhukowsky clinical hospital, gynecology, Zhukowsky, Russia; Inozemtsev municipal hospital, gynecology, Moscow, Russia

Background: Due to FDA warnings regarding using mesh in vaginal surgery and medicolegal issues worldwide there are big intention to diminish use of synthetic material with good outcome and improvement of QoL. With development of Integral Theory by P.Petros we understand importance of precise anatomical restoration and augmentation all pelvic "ligaments" using polypropylene tapes with preserving vaginal tissues and it's elasticity. We developed "low cost" variant of trocar guided variation of POP restoration "Total paracervical reconstruction".

Methods: Procedure begins with the incisions of anterior and posterior vaginal wall, mobilization of the rectovaginal and pubocervical fascia, identification SSL, CL and internal obturator muscle. We use two 7mm wide low elastic polypropylene tapes. Posterior sling pass through SSL "inside-out" manner and fixing middle part in front of cervix. Anterior sling is passing through obturator foramen near attachment of ATLA to pubis symphysis (anterior transobturator approach). Both slings are fixed to the cervix anteriorly. After that, we restore fasciae in site-specific manner and plicate both cardinals in front of the cervix with prolene of PDS sutures thus covering the tapes anteriorly. If indicated, lax perineal body, anal spinster repair or MUS also performed when indicated.

Results: Since 2016 we have done 34 procedures in 4 clinics in Moscow region performed by senior surgeons. Indication was: different types of symptomatic POP 2-4 stages (POPQ). Simultaneous operations were: trachelectomy in 8,8%, LS supracervical hysterectomy in 8,8%, TVT-O in 23% cases, PB repair (29%) include EAS repair (3%). To estimate outcome we used: QOL questionnaires (PFDI-20, PFIQ-7, FSFI) and factor analysis of the symptoms according diagnostic algorithm, ultrasound examination of pelvic floor, Rö defecography if indicated. Operation time was 90±25 min. Blood loss never exceed 150 ml. We have 1 complication during perineoplasty breakdown of the needle which required wide dissection of right ishiorectal space results in hematoma of subcutaneous fat – without consequences. In all cases pain was mild (1-4 VAS) localized in perineal body or buttocks treated with NSAID not more 2-4 days. Mean follow up were 15±3 mounts. Erosion rate was zero. There were statistical improvements of functional results of symptoms before and after the operation: PFDI-20 115,5/48,7 ($p<0,01$), PFIQ-7 68,7/14,4 ($p<0,01$). Sexually active patients (58%) report improvements according FSFI ($p<0,01$). There was significant improvement of symptoms: bulge 96 to 0%,

pelvic pain - 14 to 3%, dyspareunia 29 to 3%, obstructive urination 29 to 0%, frequency 47 to 6%, urgency - 11,7 to 0%, stress incontinence - 23 to 7% (in 7% cases of de novo SUI midurethral sling was performed during first 12 month), obstructive and dyssynergic defecation 17 to 3%, AI 7 to 0%, nocturia 29% to 0%. We noted 2 (5,8%) asymptomatic cases of cystocele and apical prolapse 2-nd degree without reoperation.

Conclusions: Short-term results make possible to consider this approach as effective minimally-invasive method of "functional surgery". However, long-term multicenter studies are needed.

P02

VAGINAL RECONSTRUCTION AND LAPAROSCOPIC LATERAL SUSPENSION IS A GOOD OPTION FOR ADVANCED APICAL POP IN YOUNG PATIENTS

Alexander Slobodyanyuk; Boris Slobodyanyuk; Yulia Dobrokhotova

Zhukowsky clinical hospital, Gynecology, Zhukowsky, Russia; Pirogov Russian National Research Medical University RNIMU, gynecology, Moscow, Russia

Background: POP still remains unresolved problem. In spite of plenty of methods described rate of recurrences are still high. We know that many "classical" operations didn't provide normal anatomic position of pelvic organs which can lead to failure. That's why in complex cases it's reasonable to use some sort of prosthesis. Frankly speaking all these procedures per se are not ideal. For SSF vaginal vector of proximal vagina goes backward facilitate cystocele formation and SCP particularly promontofixation suspend vagina very high and frontally.

Methods: From January 2015 for young and sexually active patients with advanced prolapse (C<+7 cm) we use combination of site-specific pericervical fascial reconstruction of pubocervical and rectovaginal fascia with bilateral SSF of vagina or cervix either with prolene sutures or transsacrospinal sling and our developed 25 year ago laparoscopic version of Kapanji operation with fixation of vault or cervix in front of rectus sheath with long polypropylene tape. The sling passing form lateral trocar ports retroperitoneally via parametria and fix it with nonabsorbable sutures to cardinal-uterosacral complex or vaginal vault. Lateral portions of the slings pass in subcutaneous fat and suturing together with mild tension in front of rectus sheath. In rehabilitation program we always include PFMT.

Results: Total 11 patients enrolled in the study. Three with vault prolapse, 2 with cervical stump prolapse and other – uterine prolapse. Mean preoperative "C point" was 12 cm. Age was 41 ± 6 year. Total procedure time was 109 ± 20 min. Blood loss was minimal. In all cases we've got excellent results. Pain was minimal. Mean follow up was 20 months. No mesh related compilations. The position cervix or vaginal vault was very high as well as anterior or posterior compartments. All patients didn't experience any sexual discomfort. Due to SUI in 2 cases transobturator urethropexy were performed. According PFDI-20 and PFIQ-7, function of bladder and rectum was satisfactory without worsening of symptoms in any cases.

Conclusions: This laparovaginal method is highly effective for the young sexually active patients with 4-th degree advanced apical POP. On the one hand it provides correction of all defects at perineal level and 2-nd level, on the other hand strong long-term fixation of apical compartment with minimal complications in experienced hands.

P03

ADJUSTABLE SLING – WHICH COMPLICATIONS MAY ARISE FROM POST-SURGERY ADJUSTMENTS?

Alexandra Coelho; Rita Torres; Ana Bello; Guida Gomes; Marta Brito; Patrícia Isidro Amaral
Maternidade Dr. Alfredo da Costa - Centro Hospitalar Universitário Lisboa Central

Introduction: Urinary incontinence affects approximately 25% of postmenopausal women with progressive increase with age. Surgical treatment of stress urinary incontinence, with suburethral slings, allows for the strengthening of pubourethral ligament and thus improved continence. Despite the good results, this procedure may be associated with voiding dysfunction or persistence of complaints due to poor fit of the tape. Therefore, a new system with possibility of adjustment in the postoperative period was required, in order to minimize the risk of those complications - the adjustable sling.

Clinical case: A 48-year-old female smoker, multiparous (two previous eutocic deliveries) patient with progressive urinary incontinence complaints. She denied urgency symptoms or sexual dysfunction. On pelvic examination the stress test was positive, without urethral hypermobility. The Urodynamic Study revealed Low Abdominal Leak Point Pressure (ALPP): 42cmH2O, without detrusor instability and with increased bladder capacity: 741ml. It was decided for an adjustable sub-urethral sling which occurred without incidents. In immediate post-operative period, there was a urinary retention of 1200 ml, requiring several sling adjustments, with a progressive reduction of the post-void residue. The patient was discharged on the 2nd day, with no complaints. Six weeks after surgery, she was asymptomatic, with good cicatricial evolution. However, after 3 months the patient returned, referring male discomfort in sexual relations. A medial extrusion of the sling was confirmed, and a new surgical procedure was proposed.

Conclusion: We describe a case of adjustable sling extrusion after several adjustments on the first postoperative day. As a recent technique, the authors wonder if postoperative adjustment through the vaginal tape may increase the risk of medial extrusion of the sub-urethral sling. More cases will be needed for further conclusions.

P04

URINARY INCONTINENCE IN WOMEN WITH MULTIPLE SCLEROSIS – EVALUATION OF FEMALE SEXUAL MATTERS ASSOCIATED WITH THEIR LUTS

Thiago Guimarães; João Guerra; Mariana Medeiros; Rui Bernadino; Francisco Fernandes; Ciprian Muresan; Jorge Morales; Luís Campos Pinheiro
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Introduction: Lower urinary tract symptoms (LUTS) negatively impact Quality of Life (QoL).

Goals: This study aims to describe the prevalence of Urinary Incontinence in women with Multiple Sclerosis (MS) and to assess the extent wich women are sexually affected by their UI.

Materials and methods: In all, 67 clinically stable MS women followed by their LUTS in Uroneurology of our center since 2013 to 2019 answered the International Consultation on Incontinence Questionnaire - Female Sexual Matters associated with their LUTS (ICIQ-FLUTSsex). Demographic and clinical parameters including the Expanded Disability Status Scale (EDSS) and urodynamics results were collected. Statistical analyses were performed to determine the prevalence of UI and to what degree these women are sexually bothered by their UI.

Results: The mean age was 47,85 (±11,6) years.The mean MS disease duration and EDSS were 13,179 (±9,09) and 3,71 respectively. The mean BMI were 25,43kg/m². A total

of 20 (29,85%) of women only had Urgency Urinary Incontinence on Urodynamics (UUI), 11 (16,41%) had Stress Urinary Incontinence (SIU) and 6 (8,95%) had Mixed Urinary Incontinence (MUI). 24 women (35,82%) with UI were sexually actives. When applied the ICQ-FLUTSsex, women with SM and SIU had a higher ICQFLUTS-sex scores when compared with women with MS without SIU determined by higher level of urinary symptoms and urinary leakage during sexual intercourse.

Discussion and conclusion: The prevalence of UI in women with MS is high and affects negatively their QoL, including sexual matters. A comprehensive urological evaluation of a woman with MS should include assessment of UI and how it affects their QoL.

P05

URINARY INCONTINENCE AMBULATORY SURGERY – A 24H FOLLOW-UP

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Introduction: Advances have allowed adequate ambulatory surgical (AS) programs to promote a rational and cost-effective use of resources. Simultaneously, health care humanization and patient satisfaction is enhanced, in part by improving compatibility between recovery and family and social activity.

One of the tools used to evaluate the healthcare quality and safety is the 24-hour after-surgery phone call, to obtain information about the patient (clinical evolution, possible complications, degree of functional activity and immediate care satisfaction).

Goals: This study aims to identify postoperative complications in the first 24 hours after a urinary incontinence procedure, to assess the degree of functional activity and to understand if given information and prescribed analgesia were adequate.

Materials & methods: A retrospective analysis of the information collected from the 24-hour phone call after a urinary incontinence surgery in our AS Unit from 01/07/2014 to 28/02/2019 was conducted.

Results: 1871 gynaecological ambulatory surgeries were performed, of which 183 (9.8%) were urinary incontinence procedures (the majority transobturator inside-out tension-free urethral suspension - TVT-O®). 18.6% did not answer the phone call.

The most frequent complications were: pain (n=110, 73,8%), namely mild pain (83,6%) and moderate pain (16,4%), requiring analgesic therapy in 81,8%; mild haemorrhage (n=3, 2%); nausea, vomiting, dizziness, headache and paresthesia were rare (2 cases each, 1,3%).

Most patients reported that the information provided (n=148, 99,3%) and prescribed analgesia (n=144, 96,6%) were satisfactory.

Regarding the degree of functional activity in the first 24 hours, most patients (n=120, 80,5%) reported some limitation while moving; total disability was reported in only 1 case.

In the first 24 hours, 98% of the patients had no clinical concerns (n=146) although 3 patients were instructed to visit a healthcare unit (2 to emergency department).

Discussion/Conclusion: Global patient satisfaction was high. This study shows that in the first 24 hours most patients had no clinical concerns, had only some movement limitations and the most frequent complications were minor (mild and moderate pain), which supports the safety of the ambulatory approach. Information provided and analgesia prescribed were considered adequate by the patients.

This suggests that efforts must be maintained to optimize and continue the urinary incontinence ambulatory surgery programs.

P06

TREATMENT SUCCESS OF TRANSOBTURATOR MID URETHRAL SLINGS: OUR EXPERIENCE

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Introduction and objective: The mid-urethral slings are the gold standard surgical treatment of urinary stress incontinence (SUI). However, despite the success of this type of surgery, the studies are almost all conducted in well experienced centers1. The aim of this study is to access the efficacy of transobturator midurethral slings (TOT) procedure in our Urology Department. We evaluate this surgical procedure in terms of efficacy, safety and improved quality of life.

Material and methods: Two-hundred patiens who underwent TOT for urinary incontinence (mixed and stress) from January 2010 and August 2017 were followed up. The general characteristics of the patients, incontinence risk factors, obstetric history and urodynamic examination results were recorded.

Scales were used in the follow-up, such as Urogenital Distress Inventory short form (UDI-6), and the outcomes were evaluated.

Results: The mean age was 53 years, with a range of 40-80 years. The mean follow-up time was 50 months, with a range of 4-90 months. Sixty four percent of the patients had stress urinary incontinence, while 36% had mixed urinary incontinence. Five percent of the patiens (n=10) had experienced prosthesis extrusion. None of the patients had other complications including injury of bladder, urethra, obturator vessel or nerve during the surgery. After pulling out the catheter, no one suffered moderate or severe pain or difficulty of urination. At the first follow-up visit, 1 month after surgery, 73% of all patients were free of complaints. The overall cure rate for stress urinary incontinence was 80% with 100 patients cured, and for mixed urinary incontinence was 65% with 45 patients cured. The patients' life quality also improved significantly

Conclusion: Our work demonstrates that TOT surgery provides good success rates and has a positive impact on life quality. The ease of application and lower complication rate makes TOT still a valuable alternative for other treatment approaches in the surgical treatment of SUI. The efficacy of surgery remained stable in medium term, and the patients' quality of life improved significantly.

P07

MALE-TO-FEMALE GENDER-AFFIRMING SURGERY – 7 YEARS-RETROSPECTIVE ANALYSIS.

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Introduction: In recent years, greater social acceptance of transgender individuals and the inclusion of medical coverage for gender-affirming surgeries (GAS) has led to an increasing number of patients seeking surgical treatment. Penile inversion vaginoplasty is still considered to be the gold standard for gender reassignment surgery in transgender women. This work aims to describe the results and technique on genital male-to-female GAS of a reference Center on gender dysphoria in a Portuguese tertiary Hospital.

Materials and methods: Retrospective study based on clinical records of all patients with male-to-female gender dysphoria treated at our Hospital over the last seven years. Demographic data, surgical techniques and follow up were analysed. The main goals being to analyse postoperative functional and anatomical complications, as well as secondary procedures required.

Results: Since November 2011 until December 2018, 17 male-to-female patients underwent genital GAS. The mean age at the first surgery was 35 years old (min 22 y; max 42 y). The inverted peno-scrotal flap was the surgical technique of choice for vaginoplasty. We used skin grafts to elongate the constructed vaginal canal in 35,3% of cases (6 patients). The rate of major complications was 17,6%, with two cases of partial necrosis of the penile-scrotal flap and one case of partial clitoris necrosis. The reported minor complications were labia minora asymmetry, hematoma or dehiscence. Ten patients (58,8%) required additional surgeries. After at least one year of follow-up, we had four cases of vaginal stenosis. In all of these patients, except for one, we used skin grafts to elongate the neo-vaginal canal. We reported two cases of non-compliance to the dilation schedule-protocols.

Conclusions: Since 2011 to 2018 we had a significant increase in the number of patients attended in our Hospital. Postoperative care protocols, including strict adherence to a dilation Schedule protocols, are critical to a successful reconstruction and maintenance of adequate neovaginal depth. The key to success for performing GAS is to develop a multidisciplinary team that consists of a combination of reconstructive surgeons (plastic surgeons, urologic surgeons, urogynecologists), endocrinologists, physical therapists and mental health specialists so that all aspects of a patient can be adequately addressed accordingly.

P08

VULVO-VAGINAL RECONSTRUCTION: A 3 YEARS RETROSPECTIVE ANALYSIS

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Introduction: Vulvar carcinoma is a rare cancer, accounting for 3-5% of all gynecological cancers worldwide. Surgery is the standard treatment alone or, in selected cases, in combination with chemo-radiotherapy. Postoperative reconstruction improves aesthetic and functional results, guarantees an adequate coverage of large tumors resection and assures safe surgical margins. This study presents a retrospective review of our past 3 years of experience in vulvo-vaginal reconstruction and it aims to analyze the different flaps used and the total complication rate.

Material and methods: A retrospective chart review of consecutive patients who underwent vulvo-vaginal reconstruction at our institution, between March 2016 and March 2019, was performed. Data regarding demographics, preoperative diagnosis, surgical approach, preoperative radiotherapy, length of hospital stay (LOS), postoperative complications and reoperation rate were collected.

Results: A total of 19 flaps were performed in 13 patients for vulvoperineal reconstruction. Patients' age ranged from 52 to 83 years, with mean age of 73.7 years old. Only 4 were primary cases, while 9 were cancer relapses. Six patients had undergone previous radiotherapy. In 8 patients, ablative surgery consisted of total vulvectomy and the remaining 5 patients underwent partial vulvectomy or hemivulvectomy. In 4 cases, there was some vaginal resection and in 2 cases some urethral resection. Four types of flaps were transferred for vulvoperineal reconstruction: 8 lotus flaps, 5 profunda artery perforator (PAP) flaps, 4 vertical rectus abdominis myocutaneous flaps

and 2 pudendal thigh fasciocutaneous flaps (also known as Singapore flaps). There were no cases of flap loss. There were 6 cases of wound dehiscence in the recipient site and one case in the donor site. Our reoperation rate was null.

Discussion/Conclusion: An ideal flap does not exist, however a tailored procedure, based on patients' characteristics, size and location of the defect is still the goal of reconstructive surgery. Proper planning, knowledge of the different surgical options and technical skills are very important in order to obtain good results.

P09

THE USE OF BULKING AGENTS FOR URINARY INCONTINENCE

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Injectable urethral bulking agents are a minimally invasive treatment option for stress urinary incontinence (SUI). Bulking agents aim to restore continence by increasing urethral resistance at rest, while still allowing the urethra to open during micturition. For patients with isolated intrinsic sphincteric deficiency (abdominal leak point pressure [ALPP] <100 cmH20) with minimal hypermobility of the proximal urethra and bladder neck (15 degrees descensus or less) who cannot undergo or do not wish to undergo an invasive surgical treatment for SUI, bulking agents are a reasonable treatment option.

We present the results of twenty of our patients who went through this kind of therapy and analyze the data.

Keywords: Bulking Agent; Stress Urinary Incontinence.

P10

URGENCY-PREDOMINANT MIXED URINARY INCONTINENCE TREATMENT: RETROSPECTIVE STUDY OF CENTRO HOSPITALAR E UNIVERSITÁRIO LISBOA CENTRAL

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About one-third of women with UI have Mixed Urinary Incontinence (MUI) with symptoms of both Stress Urinary Incontinence (SUI) and UUI (Urgency Urinary Incontinence), and this becomes more common with increasing age. In terms of evidence base, many studies include patients with MUI, but is rare for these studies to provide a separate analysis of patients with MUI. The European guidelines suggest the treatment of most bothersome symptoms first in patients with MUI, however, without significant levels of evidence. (1) The objective of this work consists in verifying the surgery efficiency of the bladder injections of abobotulinum toxin A combined with mid-urethral sling or injection of a urethral bulking agent at the same surgical time for the mixed urinary incontinence, performed between 2012 and 2018.

135 clinical records of patients that were submitted to a urinary incontinence surgery were analysed between January 2012 and January 2018, and from these, only female patients that undergone urgency-predominant mixed urinary incontinence surgery were selected. The procedure consisted in administering abobotulinum toxin A (500 U) on 20 points of bladder wall above the trigone. This method was applied in 40 patients alone. Another 11 patients were submitted to the aforementioned treatment combined with mid-urethral sling and finally a third group of 10 patients

that were submitted to abotoxtulinum toxin A injection combined with urethral bulking agent. All patients had urgency urinary incontinence refractory to conservative therapy (such as pelvic floor muscle training and/or drug treatment). To evaluate the satisfaction grade, patients completed a 10-point satisfaction questionnaire (scale 0–10) answering the question "How satisfied are you with the outcome of your treatment?" and "For how long, in months, did you feel better symptoms after being submitted to this treatment?"

Mean follow-up was 49 months (±34); 4 patients within the group undertaking treatment with abobotulinum toxin A only, have shown surgical premature complications, UTI, being medicated with directed antibiotherapy, without other occurrences. In the group of patients submitted to abotoxtulinum toxin A injection combined with mid-urethral sling, there was a case of episodic pelvic pain as a postoperative complication. Of all the three groups, none of the patients required clean intermittent catheterisation. All the treatments were proven to be efficient by the reduction of daily pads ($p < 0.05$), however the satisfaction rate, on a scale from 0 up to 10, was bigger in the abobotulinium toxin A with mid-urethral sling group 7,27 ± 1,07. This group also shown more efficiency longevity according to the patient's questionnaire, 22,182±5,480 months.

The satisfaction rate of the group abobotulinum toxin A with mid-urethreal sling might be linked to the less amount of pads after procedure, hence the improvement of patient's symptoms being experienced for longer periods of time. We also have to be mindful that this group was the youngest. The fact the mid-urethral sling is able to treat the SUI component, might benefit the surgical outcome in the treatment of mixed urinary incontinence. Regarding SUI, studies report collagen injections showed less efficiency but equivalent levels of satisfaction and fewer serious complications compared to procedures with mid-urethral sling. In our study, the bulking agent group had no further surgical complications, however, the satisfaction rate was lower. The main limitation of this study is associated with the relatively small universe of participants represented here, but also because of the retrospective and ambiguous nature of the study, as its efficiency was assessed by the patients. Besides that, the urodynamic prior and after the procedure was not taken into account, which means less objectivity.

P11

PELVIC ORGAN PROLAPSE REPAIR WITH SIX-POINT FIXATION TRANSVAGINAL MESH

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Introduction: Pelvic organ prolapse (POP) is a major health issue affecting 1 in 9 women. Repair using mesh products was initially associated with great satisfaction and few complications, but nowadays, with the generalized use, raise the concerns about mesh related complications.

Goals: Review and describe the main aspects of POP treatment with Surelift® mesh. Report our experience on this procedure. Assess clinical and functional outcomes, patient satisfaction and complication rates.

Material and methods: We retrospectively assessed patients who had undergone a repair of POP using a Surelift® transvaginal mesh Satisfaction with surgery was assessed on a 0–10 scale. Data were obtained from the patients clinical database and telephonic interview.

Results: A total of 26 patient were included with a mean age of 72.65±7.61 years. Satis-

faction rate was 8.45. Seven patient had POP recurrence. One case of chronic pelvic pain and one of dyspareunia were reported. Mesh erosion was not reported.

Discussion/Conclusion: The use of Surelift® mesh is effective and has a high satisfaction rate while complications are really rare.

P12

LEFORT PARTIAL COLPOCLEISIS – A REVISITED PROCEDURE

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Introduction: The pelvic organ prolapse (POP) is a frequent pathology in multiparous postmenopausal women, associated with changes in quality of life, bladder, bowel, and sexual dysfunctions. Patients with POP may undergo extensive pelvic reconstructive surgery or simple obliterative procedures. Contrarily to reconstructive surgery who aims to restore the normal anatomy, obliterative surgery is used to correct prolapse by closing off a portion of the vaginal canal, thereby reducing the viscera back into the pelvis. Partial colpocleisis is a viable alternative for women with POP grade III-IV. Patients who are ideal candidates for colpocleisis usually have poor functional status with medical comorbidities rendering them unsuitable for extensive reconstructive procedures. Because this procedure interferes or even precludes sexual intercourse, it should be reserved only for those who are not, and do not plan future coital activity. The LeFort partial colpocleisis is based on the premise that apposition of the vaginal walls could prevent uterine prolapse and that a widened genital hiatus may lead to unsuccessful outcomes.

Objectives: Review and describe the most important aspects of the LeFort procedure (partial colpocleisis); Briefly review the existing bibliography on this procedure; Review the surgical indications and possible outcomes of this technic; Report our initial experience on this procedure; Assess the clinical and functional outcomes for sexual, bladder and bowel domains, determine the anatomical results and patient's satisfaction.

Material and methods: Data were obtained from the patients clinical database including demographics, comorbidities, medications, and urinary and bowel symptoms; Prolapse was quantified using the "Pelvic Organ Prolapse Quantification Scale" (POP-Q); All patients were submitted to a Papanicolaou test and a endovaginal ultrasound; Operative characteristics were recorded; Patients also were asked about urinary and bowel symptoms as well as overall satisfaction; Surgical results were assessed in function of intraoperative and postoperative surgical complications, hospital stays, necessity of further interventions and satisfaction rates; Bibliographic review was based on Medline® database.

Results: Two patients were submitted to the procedure in our institution. Both patients were 83 years old and with multiple co-morbidities. Mean operative time was 105 minutes and Mean hospital stay was 3.5 days. No intraoperative or postoperative complications occurred. Both patients were satisfied with the procedure. No recurrence occurred after 4 years follow up.

Conclusion: LeFort partial colpocleisis is an effective and low-risk procedure; Our results confirm the efficacy, the low morbidity rate, high satisfaction level, good clinical and functional outcomes and high satisfaction rate of this procedure; LeFort partial colpocleisis remains an excellent surgical option for the elderly patient with advanced pelvic organ prolapse that do not desire to maintain coital activity or have a high surgical risk.

P13

WHAT IS THE BEST APPROACH FOR TREATMENT OF VAGINAL VAULT PROLAPSE?

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Introduction and aim of the study: An increasing life expectancy has resulted in a growing number of older women seeking gynecological care.

In an epidemiological study, Olsen et al estimated that 11% of all women will undergo surgery for POP during their lifetime and that 30% of these women will require reoperation for prolapse recurrence.

Currently, the use of implanted materials for treating pelvic organ prolapse (POP) raises controversy and should be restricted to complex cases.

This study aims to compare the efficiency associated to POP cure in transvaginal and laparoscopic approach using a mesh, in regards to complication rate, recurrence, surgical reintervention and patient satisfaction.

Materials and methods: 102 patients were studied retrospectively, undertaking POP repair, of which 51 by transvaginal approach using a mesh and 51 submitted to laparoscopic sacral colpopexy.

All the patients showed dominant mid-compartment prolapse equal or superior to 2, in association or not with other compartment prolapses.

Results: The average age of the patients group submitted to POP treatment via the vaginal route was higher 71,85 ± 1,074 years of age, when compared with the laparoscopic sacral colpopexy group.

The demographic outline of the population characteristics can be found on table 1.

Regarding our recurrence results, the rate was higher on the group of patients submitted to POP treatment by the vaginal route in comparison with the group of patients submitted to laparoscopic sacral colpopexy (18,4% vs 7,8%).

The rate of mesh-related complications was also higher on this group, with two patients experiencing mesh erosion (3,9%) and for this reason having to undertake new surgery. There were no complications associated to the group of patients undergoing laparoscopic sacral colpopexy surgery.

On the other hand, the intra-operative complication rate was higher by laparoscopic route, with 4 (7.8%) cases of cystostomy, with intraoperative bladder repair. Additionally there was a patient displaying vesicovaginal fistula that underwent surgery.

Discussion/conclusion: The small number of patients was a limitation for this study.

The recurrence definition that was established might be the cause to the higher rate found in our department, possibly by overvaluation. Besides, the POP-Q classification was not used, which restricts this study's objectivity.

This study has shown that patients submitted to POP repair by vaginal route had more complications association with a mesh, as well as, a higher recurrence rate. However, the group of patients undergoing laparoscopic sacral colpopexy had a higher rate of intra-operative complications.

In conclusion, the approach chosen should always depend on each specific case.

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