Live Surgery Urogynecology Course

4th edition

Robotic Surgery, Prolapse, Neuromodulation & Advances in Onco-Urogynecology

Pestana Palace Hotel, Lisbon
May 17-18, 2024

Design: Ad Médic

Scientific Programme

Live Surgery – Urogynecology Course 4th Edition

Robotic Surgery, Prolapse, Neuromodulation & Advances in Onco-Urogynecology

Head of the Department of Urology

Luís Campos Pinheiro, MD, PhD

Course Coordinator

Frederico Ferronha, MD

International Faculty

Antonio Rodriguez (SPAIN)

Urologo (Figueres, España). Licenciado en Medicina y Cirugia por la Universidad Autonoma de Barcelona en 1994.
Especialista en Urologia, con formación en Hospital Clinic de Barcelona 2001.
Diploma univervesitario en Cirugia Laparoscopia (Université Louis Pasteur-Strasbourg-2006)
Amplia experiencia en cirugia laparoscopica oncologica y reconstructiva desde 2005.
Jefe de Servicio de Urologia del Hospital de Figueres desde 2016 hasta la actualidad.

Cassio Riccetto (BRAZIL)

Cassio Riccetto, M.D., M. Sci, Ph.D. He is currently Head the Female Urology Division at University of Campinas Faculty of Medical Sciences (UNICAMP) in Brazil. In addition, he is full professor of the Surgical Sciences Postgraduate Program at the same institution. He published more than 130 peer-reviewed articles in journals specialized in Urology and Gynecology and owned 26 national plus international awards for his researches on urinary incontinence and voiding dysfunction. In addition, he is the coordinator of Female Urology Section of Brazilian Society of Urology and former general secretary of the Latin American Pelvic Floor Association.

Cristiano Gomes (BRAZIL)

Professor of Urology at the Faculty of Medicine of the University of São Paulo (SUP), working in the areas of urinary incontinence, neurogenic bladder, reconstructive surgeries and benign prostatic hyperplasia. I am a member of the Neurourology Committee of the International Continence Society and Associate Editor of the journals Continence and International Brazilian Journal of Urology.

Hugo Davila (USA)

A board-certified urologist and Clinical Assistant Professor at Florida State University, College of Medicine, Dr. Hugo Davila completed his surgery and urology training at University of South Florida and Moffitt Cancer Center. He currently practices at Florida Healthcare Specialists (an affiliate practice of Florida Cancer Specialists & Research Institute) and Cleveland Clinic Indian River Hospital.

Dr. Davila is a leading physician researcher, having previously completed clinical studies on fibrosis, aging and nitric oxide, which were published in prestigious journals, such as Biology of Reproduction, Cardiovascular Research, Urology and British Journal of Urology. In 2004-5, Dr. Davila was awarded a Pfizer research grant about the "Effects of long-term therapy with Sildenafil on the histological and functional alterations of the aged corporal tissue; implications for reversal of corporal veno-occlusive dysfunction."

His most recent investigations have included the evaluation of robotic surgical techniques and pelvic floor ultrasonography for the correction of pelvic organ prolapses, with several publications in the Urology gold journal, Journal of Robotic Surgery and Journal of Obstetrics and Gynecology. Recently, Dr. Davila described a robotic and laparoscopic single site approach to apical prolapses using native tissue. He also presented a new robotic technique without mesh for pelvic organ prolapses at the European Association of Urology. He has described a new technique integrating intraoperative ultrasound during Robotic sacrocolpopexy improving outcomes and decreasing recurrence of pelvic organ prolapses. These publications in the Journal of Robotic Surgery and Urology Gold Journal describes a new approach using ultrasonography assisted robotic surgery with pubocervical fascia plication and the description of the pubocervical fascia injury with 3D endovaginal ultrasound.

An active member of the American Urology Association (AUA), European Association of Urology (EAU), Society of Robotic Surgery (SRS) and Latin-American Society of Pelvic Floor (ALAPP), he has a special interest in female pelvic medicine and reconstructive surgery. He has presented multiple videos, podium and posters at the AUA, EAU, SRS and many international meetings.

Isabel Ñíguez Sevilla (SPAIN)

Isabel Ñíguez Sevilla, MD PhD – Specialist in gynecology and obstetrics. Work at Virgen de la Arrixaca University Clinical Hospital Murcia; Researcher at the Murcian Institute of Biomedical Research; Practice professor of the Master in Medical Surgical Pathology of the Pelvic Floor; Multiple scientific publications and communications.

Javier Cambronero (SPAIN)

Dr. Javier Cambronero Santos (MD, PhD) – Professor of Medicine in Universidad Complutense of Madrid; Chief of Section in Hospital Infanta Leonor (Madrid); Chief of Incontinence and Pelvic floor disorders Unit; Chief of Urology Service in Hospital Quironsalud San José

Jorge Hidalgo (SPAIN)

After completing the residency program in Urology at the Fundació Puigvert –Universitat Autónoma de Barcelona, he completed a fellowship in Laparoscopic surgery at the Université Livre de Bruixelles- Hopital Erasme.

Since 2005, he has routinely performed laparoscopic surgery for the treatment of kidney and prostate cancer, as well as pelvic organ prolapse.

Since 2017, through Laparoscopic Pectopexy and Hysteropectopexy.

He has organized numerous workshops in Laparoscopic Pectopexy and has been a professor in the pelvic floor master's degree at the Miguel Hernández University of Alicante, teaching the technique of Laparoscopic Pectopexy and Hysteropectopexy.

José Carlos Truzzi (BRAZIL)

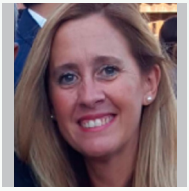
Master and Doctor in Urology from Escola Paulista de Medicina - Federal University of São Paulo; Director of the Department of Female Urology, Pelvic Floor and Urodynamics of the American Confederation of Urology (CAU); Head of the Infections Department of the Brazilian Society of Urology (SBU).

Levin Martinez (URUGUAY)

Prof. holder of the chair of Urology, hospital de clinicas; Facultad de Medicina, Montevideo, Uruguay; Mastery in Uro-Oncology; Diplomature in university teaching

Luis Lopez-Fando (SPAIN)

Functional Urology; Urology deparment. Hospital La Princesa. Madrid; CEO UROLF (urolf.com; IG/FB @clinicaurolf); ICS, SINUG, EAU, AEU member; Functional Urology is my main area of interest. Development of complex laparoscopic pelvic floor surgery such as sacrocolpopexy, neurolisis of pudendal nerve entrapment, female artificial urinary sphincter, enterocystoplasty, repair of vesicovaginal and ureterovaginal fistula, as well as laparoscopic oncological surgery; UROLF is a clinic and also a website platform focus on the diagnostic functional urology and neurourology (urodynamics, videourodynamics, electronic bladder diary).



Maria Luisa Sánchez Ferrer (SPAIN)

Gynecologist and head of the multidisciplinary pelvic floor section in the hospital Universitario "virgen de la Arrixaca in Murcia, Spain. I am a full professor of Obstetrics and Gynecology in the University of Murcia. My expertise areas are pelvic floor diseases and genitourinary malformations in women. I have published 70 articles indexed in JCR (https://pubmed.ncbi.nlm.nih.gov/?term=Sanchez+Ferrer+M&sort=date) and now we are leading a multicenter trial about laparoscopy treatment of apical prolapse.

Rogério de Fraga (BRAZIL)

Associate Professor of Urology at the Federal University of Paraná; Vice Coordinator of the Postgraduate Program in Surgical Clinic at UFPR; Coordinator of the Functional Urology Service at CHC-UFPR; Founder of the Pelvic Floor 360 Virtual Reality Mentoring Program

Vincent Tse (AUSTRALIA)

Associate professor of Urology at Sydney University and Macquarie University. His special interests are in functional and female urology. He is the first urologist in Australia to perform robotic sacrocolpopexy and also more recently the first robotic female AUS. For his many years of services and dedication in surgery, education, and research both in Australia and Asia, he was awarded last year the Urological Society of Australia and New Zealand Medal, and also an honorary membership by the Urological Association of Asia.

Faculty

Alexandra Henriques
Alexandra Montenegro
Alexandre Ambrósio
Alexandre Lourenço
Amália Martins
Ana Bello
Ana Fatela
Ana Luísa Ribeirinho
António Quintela
Avelino Fraga
Belmiro Parada
Bercina Candoso
Cabrita Carneiro
Cardoso de Oliveira
Carlos Ferreira
Carlos Veríssimo
Catarina Gameiro
Cristina Nércio
Fernando Calais
Filipa Silva
Fortunato Barros
Francisco Fernandes
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Hugo Pinheiro
Inês Francisco Pereira
Isaac Braga
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João Colaço
João Gramaça
João Marcelino
João Pina
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Miguel Eliseu
Miguel Ramos
Njila Amaral
Palma dos Reis
Patena Forte
Patrícia Amaral
Paula Ambrósio
Paulo Príncipe
Paulo Temido
Paulo Vale
Pedro Alves
Pedro Baltazar
Pedro Galego
Pedro Martins
Pedro Nunes
Raquel Robalo
Ricardo Leão
Ricardo Pereira e Silva
Rita Torres
Rui Alves
Rui Bernardino
Rui Miguel Viana
Rui Pinto
Rui Sousa
Sara Rocha
Sofia Alegra
Sónia Oliveira
Susana Mineiro
Teresa Mascarenhas
Tiago Antunes Lopes
Tiago Rodrigues
Vanessa Andrade
Vanessa Vilas Boas
Vaz Santos

SCIENTIFIC PROGRAMME

Friday, 17th May 2024

07:30h Opening of registration desk

08:30-08:45h **WELCOME SESSION**
Frederico Ferronha and Luís Campos Pinheiro

08:45-10:00h **1st SESSION CAU SESSION – ANATOMY & PELVIC ORGAN PROLAPSES**
Panel: Palma dos Reis, Frederico Ferronha, Amália Martins and Alexandra Henriques

Functional anatomy of pelvic floor *(15 m)*
José Carlos Truzzi

Physiopathology of pelvic organ prolapses *(15 m)*
Cassio Riccetto

Pelvic anatomy and neuroanatomy in virtual reality (METAVERSE) – Immersive experience in dynamic virtual reality glasses *(20 m)*
Rogério de Fraga

What is the place for mesh surgery in 2024: The rise and fall of meshes for POP *(15 m)*
Cassio Riccetto

10:00-10:30h **2nd SESSION CONSERVATIVE TREATMENT OF PROLAPSES**
Panel: Patena Forte, João Pina, Teresa Mascarenhas and Ana Bello

Election of the patient and the ideal vaginal pessaries – What, when and how? *(10 m)*
Guida Gomes

Laser in pelvic floor disfunctions – Where are we now? *(10 m)*
Mafalda Martinho Simões

10:30-10:45h **OPENING SESSION**
Luís Campos Pinheiro, Frederico Ferronha, Ana Fatela, Miguel Ramos, and Rui Alves

10:45-11:30h Coffee break

11:30-13:20h **3rd SESSION SEMI-LIVE SURGERY: SURGICAL MANAGEMENT OF APICAL POP – HOW I DO IT**
Panel: Paulo Vale, João Marcelino, Bercina Candoso and Alexandre Ambrósio

Apical correction with 4-arm mesh Callistar *(10 m)*
Alexandre Lourenço

Transvaginal repair with mesh Sure-Lift *(10 m)*
Javier Cambronero

Transvaginal repair with mesh BSC *(10 m)*
Njila Amaral

v-NOTES vaginal histerectomy *(10 m)*
Sofia Alegra

Laparoscopic hysteropexy surgery according to the Dubuisson technique (Lateral Suspention) *(10 m)*
Maria Luisa Sánchez Ferrer and Isabel Ñíguez Sevilla

Laparoscopic pectopexy *(10 m)*
Jorge Hidalgo

Laparoscopic sacrocolpopexy *(10 m)*
Frederico Ferronha

Robotic sacrocolpopexy
Luis Lopez-Fando *(10 m)* and Hugo Davila *(10 m)*

13:20-14:30h Lunch

14:30-15:50h **4th SESSION RECORRENT UTI & SEXUALLY TRANSMITTED DISEASES**
Panel: João Varregoso, Francisco Fernandes, Pedro Martins and Sara Rocha

Recurrent urinary tract infection. Specific approach in the stages of the life of the woman: UTI in gestation & UTI in post menopause *(15 m)*
Hugo Pinheiro

Evidence for prophylaxis of recurrent UTI in women: Probiotics, immunotherapy, vaccines, and other options *(15 m)*
Vanessa Vilas Boas

UTI in patients with intermittent catheterization: How to manage it! *(10 m)*
Mariana Medeiros

Human *papillomavirus* (HPV): From prophylaxis to conservative treatment. What to do? *(20 m)*
Patrícia Amaral

Human *papillomavirus* (HPV) vaccination: From theory to clinical practice, how & when *(10 m)*
Rita Torres

15:50-16:40h **5th SESSION CHRONIC PELVIC PAIN**
Panel: Luís Abranches Monteiro, Frederico Carmo Reis, Rui Miguel Viana, Geraldina Castro and Joana Faria

Pharmacology therapy and botulin toxin of the CPP *(10 m)*
Carlos Ferreira

CPP in endometriose: Can surgery resolve it? *(10 m)*
Rogério de Fraga

Sacral neuromodulation in CPP *(10 m)*
Ricardo Pereira e Silva

The role of the radiologist in CPP *(10 m)*
Pedro Alves

16:40-17:00h Coffee break

17:00-19:00h **6th SESSION ONCO-UROGYNECOLOGY**
Panel: Sónia Oliveira, António Quintela, Ricardo Leão, Paula Ambrósio and Fernando Calais

Markers of metastatic disease in PSMA PET/CT imaging for prostate cancer *(10 m)*
Rui Bernardino

Controversies in active surveillance in prostate cancer – 15 years' experience *(10 m)*
Levin Martinez

Metastatic hormone-sensitive prostate cancer – Therapeutic decision *(20 m)*
Isaac Braga

Current challenges in the treatment of mCRPC *(20 m)*
João Gramaça

Breast cancer treatment and implications on sexuality and QoL *(20 m)*
Alexandra Montenegro

Therapeutic landscape of advance/recurrent endometrial cancer *(20 m)*
Filipa Silva

19:00h End of the 1st day

Saturday, 18th May 2024

07:30h Opening of registration desk

08:00-08:30h **7th SESSION SURGICAL MANAGEMENT OF POP – ABDOMINAL APPROACH: SIMULTANEOUS TRANSMISSION**
Panel: Luís Campos Pinheiro, Cardoso de Oliveira, Carlos Veríssimo and Geraldina Castro

Robotic sacrocolpexy
Frederico Ferronha

Laparoscopic pectopexy
Jorge Hidalgo and Antonio Rodriguez

08:30-09:00h **8th SESSION URODYNAMIC AND PELVIC HEALTH IN THE ELDERLY WOMAN**
Panel: Vaz Santos, Tiago Rodrigues, João Colaço and Alexandra Henriques

Is urodynamics helpful in functional female Urology *(10 m)*
Vincent Tse

Urinary incontinence vs. emptying dysfunction in elderly women *(10 m)*
Cristiano Gomes

09:00-09:40h **BACK TO LIVE SURGERY**

Simultaneous transmission: Robotic sacrocolpexy & laparoscopic pectopexy

09:40-10:20h **9th SESSION UNDERACTIVE BLADDER**
Panel: Paulo Temido, Rui Sousa, Raquel Robalo and Liana Negrão

The enigma of the underactive bladder: Current and future therapeutic strategies of detrusor underactivity *(10 m)*
Tiago Antunes Lopes

Stress incontinence and underactive bladder... How can I manage it? *(10 m)*
José Carlos Truzzi

Hyperactive detrusor and hypoactive detrusor – How to treat? *(10 m)*
José Carlos Truzzi

10:20-11:00h **BACK TO LIVE SURGERY**

Simultaneous transmission: Robotic sacrocolpexy & laparoscopic pectopexy

11:00-11:30h Coffee break

11:30-11:50h **10th SESSION OVERACTIVE BLADDER**
Panel: Belmiro Parada, Luís Severo, Susana Mineiro and Inês Francisco Pereira

Betmiga: 10 years of experience *(15 m)*
Tiago Antunes Lopes

11:50-12:10h **BACK TO LIVE SURGERY**

Simultaneous transmission: Robotic sacrocolpexy & laparoscopic pectopexy

12:10-13:00h **11st SESSION SEMI-LIVE SURGERY: IS THERE SURGICAL TREATMENT FOR IDIOPATHIC OVERACTIVE BLADDER?**
Panel: Miguel Ramos, Pedro Baltazar, Sofia Alegra and Vanessa Andrade

CESA/VASA mesh *(10 m)*
Pedro Galego

Botulin toxin injection *(10 m)*
Rui Pinto

Management of OAB: Is the new era of neuromodulation? *(10 m)*
Manuel Oliveira

Enterocystoplasty and urinary diversions *(10 m)*
Rogério de Fraga

13:00-14:30h Lunch

14:30-15:15h **12nd SESSION CURRENT STATE OF TREATMENT OF SUI WITH HIGH GRADE OF INTRINSIC SPHINCTER DEFICIENCY**
Panel: Miguel Eliseu, Ana Luísa Ribeirinho and Vincent Tse

Adjustable slings *(10 m)*
Patrícia Amaral

Are bulking agents a good alternative? *(10 m)*
Catarina Gameiro

Is artificial urinary sphincter a good option in women? Laparoscopic/robotic approach *(15 m)*
Luis López-Fando

15:15-15:40h **13rd SESSION CROSS FIRE SESSION**

Panel: Pedro Nunes, Gil Falcão, Francisco Martins and Njila Amaral

Idiopathic female urethral stricture vs. functional obstruction? Does Idiopathic female urethral stenosis exist? Or it is a functional obstruction? *(20 m)*
Cristiano Gomes vs. Cassio Ricetto

15:40-16:50h **14nd SESSION CONTROVERSIES**

Panel: Paulo Príncipe, João Colaço and Cristina Nércio

Clinical applicability of pelvic floor imaging: What is the evidence? From the diagnose in the office to the treatment in the operating theatre *(15 m)*
Hugo Davilla

Use of virtual reality, augmented reality and artificial intelligence in urogynecology *(15 m)*
Rogério de Fraga

Female urethral strictures – Management options *(15 m)*
Francisco Martins

Urogenital fistulas in women. Abdominal vs. vaginal route *(15 m)*
Vincent Tse

16:50-17:20h Coffee break

17:10-18:20h **15th SESSION ABSTRACT SESSION: PODIUM PRESENTATIONS**

Panel: Avelino Fraga, Fortunato Barros, Cabrita Carneiro and Liana Negrão

Moderated e-Poster

Abstracts accepted as moderated electronic posters will be physically presented at the meeting. Each presenter will give 3 minutes of highlights, using their electronic posters (no slides are permitted). Moderators will address questions at their discretion, either after each presentation or at the end of the session.

Note: Presenting Authors of accepted abstracts must be registered

18:20-18:30h **CLOSING SESSION**

Luís Campos Pinheiro and Frederico Ferronha

Posters

PO 01

COLPOCLEISIS: WHEN OBLITERATIVE SURGERY IS THE OPTION – A RETROSPECTIVE STUDY

Francisca Cruz Vilaça; Lisandra Mendonça; Vera Silva; Damasceno Costa; Marta Fernandes
Centro Hospitalar Tondela-Viseu, EPE / Hospital de São Teotónio, EPE

Introduction: Pelvic organ prolapse affects millions of women and one in five women will undergo surgery for prolapse or incontinence by age 80 years. Obliterative surgery corrects prolapse by closing off all or a portion of the vaginal canal to reduce the viscera back into the pelvis. Obliterative procedures, such as colpocleisis, are an effective option for patients who do not want, or cannot tolerate, more extensive surgery and/or who accept loss of vaginal function (ie, ability to have vaginal intercourse). In addition, obliterative procedures are associated with high rates of satisfaction.

Goals: The main goal of this abstract is to describe and compilate the cases of the women who underwent obliterative surgery (colpocleisis) in our service between 2015 and 2023.

Material and methods: Retrospective study of women who underwent colpocleisis at ULS Viseu-Dão Lafões between January 2015 and December 2023. Data were collected from clinical records.

Results: During the study period, 10 women underwent obliterative surgery. The patients had a mean age of 79,6 years old, a mean BMI of 30,7 kg/m² and all of them were multiparous. From these 10 women, 2 had undergone previous prolapse surgery (cystocele correction) and 3 of them were previously hysterectomized.

All of them had multiple comorbidities, such as high blood pressure and high BMI. In addition, 4 of them had type 2 diabetes and 7 of them were taking blood thinners as primary prevention.

A total of 8 women had tried to manage the prolapse with a pessary and had no response.

The indications for the obliterative surgery were complete prolapse of 3 pelvic organ compartments stage 3 or more and not wishing to preserve sexual function. 7 of them underwent Le Fort colpocleisis and 3 of them underwent a colpectomy (complete colpocleisis). In 1 pacient was performed simultaneously anti-incontinence surgery (transobturador mid urethral sling TVT-O). The mean time of stay at the hospital was two days and all of them had a follow-up appointment 2 months after surgery. There were no complications during or post-surgery.

With mean follow up of three and a half years, the grade of satisfaction was high. There was no prolapse recurrence, no voiding dysfunction and no new urinary incontinence was registered until date.

Conclusions: In conclusion, obliterative procedures such as colpocleisis are less invasive and better tolerated by patients with significant medical comorbidities compared to other prolapse surgery procedures, maintaining a high rate of satisfaction. Also, they have a shorter operative duration, decreased perioperative morbidity and an extreme low risk of prolapse recurrence. Although the procedure is performed less frequently, it is still a very good option for older and frail women who do not have intercourse and have already tried other treatment options.

PO 03

STAGE IV PELVIC ORGAN PROLAPSE: TWO OPPOSING SURGICAL APPROACHES

Beatriz Ferro[1]; Daniela David[1]; Lisandra Mendonça[2]; Dora Antunes[1]; Inês Coutinho[1]; João Paulo Marques[1]; Fernanda Águas[1]

[1]Centro Hospitalar e Universitário de Coimbra / Hospitais da Universidade de Coimbra; [2]Centro Hospitalar Tondela-Viseu

Introduction: Pelvic organ prolapse (POP) is a common benign condition that can impact daily activities. In case of stage IV POP, it can lead to more serious complications such as obstructed defecation or urination, which can ultimately lead to acute kidney injury.

Goals: Description of two cases of stage IV POP, both submitted to surgical treatment using different surgical approaches.

Material and methods: Clinical case presentation and description of surgical management.

Results: In the first case, we introduce a 72-year-old woman, multiparous, not sexually active, who presented to the emergency department due to hemorrhoidal pain, weight loss, anorexia, asthenia, vomiting, constipation, and sensation of a vaginal and rectal bulge. At observation, she had a reducible stage IV POP and complete rectal prolapse. Complementary diagnostic tests showed an exacerbation of her chronic kidney disease, as well as a microcytic/hypochromic anemia with a hemoglobin of 8g/dL and a severe bilateral uretero-hydronephrosis at the ultrasound. An attempt of pessary introduction was performed to correct the vaginal prolapse, but it was always exteriorized, and the patient was submitted to urinary catheterization to prevent urinary retention. A surgical approach was suggested combined with general surgery and the patient was submitted to vaginal hysterectomy with colpocleisis and perineoplasty and correction of rectal prolapse with the Altemeier procedure. One month after surgery, there was a reduction in hydronephrosis and stabilization of baseline renal function; at the three months appointment, she had no complaints and showed good healing progress.

The second case referred to a 62-year-old woman, multiparous, sexually active, who presented at a gynecological appointment with vaginal bulge sensation and increased voiding difficulty, with the need of manual prolapse reduction. At observation, she had a stage IV POP, and was proposed to surgery. A pessary was introduced while she waited for surgery, but it was later exteriorized. She was then submitted to laparoscopic subtotal hysterectomy with sacrocervicopexy and perineoplasty. At the two months postoperative appointment, she was satisfied, asymptomatic, and at observation her cervix was well suspended with no residual prolapse.

Discussion/Conclusions: The surgical approach in cases of complicated stage IV POP must be individualized for each patient. In these two cases, they were corrected using two different surgical approaches, both with successful results.

PO 04

IS SACRAL NERVE STIMULATION ONLY USEFUL IN PATIENTS WITH URINARY INCONTINENCE ?

Joao Bernardo Almeida e Melo[1]; Raquel Marques[2]; Marta Vasconcelos[3]; Carlos Luz[3]; Filipa Santos[3]

[1]Centro Hospitalar de Lisboa Norte, EPE / Hospital de Santa Maria; [2]Hospital Garcia de Orta; [3]Hospital Garcia de Orta, EPE

Introduction: Fecal incontinence (FI) is defined as uncontrolled passage of feces for at least 1 month duration in an individual who previously had control. Those who are suitable for surgical intervention and who have failed conservative management, sacral nerve stimulation (SNS) has emerged as the treatment of choice in many patients. This study aims to evaluate the functional and symptomatic outcomes of this procedure in a cohort of 10 patients from three different hospitals.

Goals: The primary objective is to assess the impact of sacral neuromodulation on fecal incontinence by employing the Vaizey and Wexner scales to measure symptom severity and quality of life. These scales measure incontinence for solid and liquid stools, incontinence for gas, frequency of alteration in lifestyle, frequency of need to wear pads or plugs, use of constipation medication and lack of ability to defer defecation for 15 minutes.

Methods and materials: A retrospective database review was conducted, involving 10 patients who underwent sacral neuromodulation surgery after conservative management was tempted without success. The study cohort comprised 9 females and 1 male, with a mean age of 59. Evaluation was performed using the Vaizey and Wexner scales, administered both before and after the surgical procedure.

Results: The results demonstrated a significant reduction in symptom severity following sacral neuromodulation. The mean reduction in the Vaizey scale was 9 points, and in the Wexner scale, it was 7 points. Notably, improvements were particularly evident in the frequency of incontinence of solid stools with a mean decrease of 1.7 points in both scales (68% reduction) and in the frequency of alteration in lifestyle with a mean decrease of 2.2 points (55% reduction). Despite the overall positive trend, one patient experienced worsened outcomes, another remained unchanged. None of the patients had remission of all symptoms.

Discussion/Conclusion: While the study's limited sample size necessitates caution in drawing definitive conclusions, the observed improvements in symptom severity and quality of life are noteworthy. The outcomes indicate the potential of sacral neuromodulation to offer tangible benefits in the management of fecal incontinence. Further investigations with larger cohorts that evaluate the impact of sacral neuromodulation in fecal incontinence are warranted to validate and expand upon these findings.

PO 05

RARE PRESENTATION OF ABDOMINAL WALL ENDOMETRIOMA: A CASE REPORT

Joao Bernardo Almeida e Melo[1]; Raquel Marques[2]; Marta Vasconcelos[2]; Aline Branco[2]

[1]Centro Hospitalar de Lisboa Norte, EPE / Hospital de Santa Maria; [2]Hospital Garcia de Orta

Introduction: Endometriosis is a common gynecological disorder characterized by the presence of endometrial-like tissue outside the uterus, typically within the pelvis. However, extra-pelvic endometriosis, particularly involving the abdominal wall, is rare. We present a rare case of a 32-year-old female with abdominal wall endometriosis.

Goals: This case report aims to highlight the rarity of endometriosis involving the abdominal wall and discuss its clinical presentation, diagnostic approach, management, and histological findings.

Methods and materials: Retrospective analysis of patient data, diagnostic records, and surgical procedure. The article is supported by PubMed articles.

Results: A 32 year-old female presented a history of abdominal pain and right flank mass that worsened during menstruation. It lasted for 5 months. At physical examination a 5 cm abdominal mass at the right flank was palpated. the mass was fixed and well limited. Abdominal ultrasound was performed, revealing a hypoechoic and heterogeneous 5 cm right flank nodular formation suggestive of endometrioma. The patient underwent excision of the lesion, which was adherent to the anterior abdominal wall, specifically the rectus sheath. Reconstruction was achieved using onlay mesh repair. The excised lesion was histologically confirmed to be an endometrioma. The patient's symptoms improved postoperatively, and there were no complications during the recovery period.

Discussion/Conclusion: Endometriosis involving the abdominal wall is a rare manifestation

of the disease. The pathogenesis of abdominal wall endometriosis remains unclear, but theories suggest retrograde menstruation, metaplasia, or iatrogenic factors. Clinical suspicion, coupled with imaging studies and histological confirmation, is crucial for accurate diagnosis and appropriate management. Surgical excision, often with mesh repair, is the mainstay of treatment, providing symptomatic relief and preventing recurrence. Awareness of this rare presentation is essential for timely diagnosis and management.

PO 06

UNVEILING THE UROGYNECOLOGICAL CHALLENGES OF FEMALE GENITAL MUTILATION: IMPLICATIONS FOR CARE

Luisa M. A. Moreira; Margarida André;
Marta Vasconcelos; Nuno Figueira; Miguel Carvalho
Hospital Garcia de Orta

Introduction: Female genital mutilation/cutting (FGM/C or FGM) refers to all procedures involving the injury, alteration, and partial or total removal of the external genitalia for non-medical reasons. Every year, over 4 million girls worldwide are at risk of FGM. The recognition of FGM cases is hindered both by stigma and by the variability in objective examination. Thus, four types of FGM have been defined to aid in the identification and communication of cases. In Portugal, hundreds of cases are identified annually, with reported complications in psychological, obstetric, sexual, and urogynecological domains.

Objectives: To discuss the genitourinary consequences arising from FGM and their treatment.
Materials and Methods: A literature review on FGM and its urological consequences was conducted. The PubMed platform was used, and relevant articles for the study question were selected.

Results: Approximately 30% of FGM survivors develop urogynecological consequences. These can be classified as early or late, such as bleeding, pain, urinary retention and infection; urethral obstruction, vaginal obstruction, bladder calculi, incontinence, aberrant healing, and adjacent organ injury. There are also secundary complications such as higher rates of poor obstetric outcomes, mentioning perineal tears, obstructed labour and vesicovaginal fistulas. The management of these complications may involve symptomatic therapy (urethral catheterization, pelvic physiotherapy, sexual therapy) or surgical correction (surgical or CO2 laser defibulation, urethroplasty, reconstructive plastic surgery).

Discussion and conclusions: Recognizing FGM cases is the first step in identifying and addressing their consequences. This approach should be impartial and sensitive to the individual's cultural background. Any therapeutic option should be presented considering the risks and benefits, paying special attention to expectation management. There is a scarcity of literature on the topic of FGM, attributed to imprecise referral of cases and their complications, difficulty in identification, and lack of or non-seeking of healthcare. Thus, it is urgent to raise awareness among healthcare professionals regarding the practice, aiming to optimize care provided and improve the quality of life of survivors. Prevention of FGM practice remains a hot topic, included in the global mission of eradicating gender-based violence and inequality.

PO 07

LAPAROSCOPIC MANAGEMENT OF MESH MIGRATION IN PELVIC SURGERY: TWO CASE REPORTS

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Introduction: Complications from synthetic mesh use in pelvic organ prolapse and stress urinary incontinence surgeries are well-docu-

mented, including mesh migration and urinary calculi formation (1-10% incidence). The choice of surgical approach depends on the individual patient's clinical presentation, the extent of mesh migration, associated complications, and the surgeon's expertise. We present two cases of laparoscopic management of mesh migration.

Clinical cases: Case 1: A 67-year-old woman with a history of urinary incontinence underwent anterior colporrhaphy with mesh placement in 2011. Mesh migration to the bladder trigone led to recurrent endoscopic cystolitholapaxies in 2019, 2020, and 2023. In February 2023, she presented with lower urinary tract symptoms (LUTS) and a 2 cm calculus adherent to the bladder mucosa. Given the failure of previous endoscopic approaches, a laparoscopic cystolithotomy with mesh excision via transperitoneal approach was performed. The calcified mesh was excised, and its bed was fulgurated, followed by bladder closure in two planes. The patient was discharged on the second postoperative day. At 6 months of follow--up, she reports no urinary incontinence, LUTS, or urinary tract infection.

Case 2: A 65-year-old woman with a history of urinary incontinence underwent a transobturator sling (out-in technique). Ten years later, she presented with persistent urinary incontinence and pelvic pain when seated. Bladder ultrasound revealed an arciform image in the trigone, confirmed by urethrocystoscopy showing a foreign body extending from the trigone to the left bladder wall. Initial attempt at endoscopic removal was unsuccessful, prompting a laparoscopic cystolithotomy with mesh excision using a transperitoneal approach. The calcified mesh was excised, and its bed was fulgurated, followed by bladder closure in two planes. She was discharged on the second postoperative day, with resolution of urinary incontinence, pelvic pain and LUTS.

Discussion/Conclusion: Both cases highlight the challenges and complexities in managing mesh-related complications in pelvic surgeries. Laparoscopic cystolithotomy with mesh excision proved effective in resolving symptoms and preventing recurrence in these cases. This approach offers a viable treatment option for patients with recurrent complications secondary to mesh migration. Further studies are warranted to evaluate long-term outcomes and refine management strategies for these challenging cases.

PO 08

MINI-SLINGS VS MIDURETHRAL SLINGS: WHICH ONE HAS THE STRONGEST ASSOCIATION WITH DYSPEREUNIA

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Introduction: Pelvic floor pathologies, which include urinary incontinence, are impactful conditions on a social, physical and psychological level. Studies on prevalence in the United Kingdom, certainly underestimated, point to 6 million women with clinically significant symptoms, including women of working age.

Conservative treatment appears as the first line, despite the frequente pursuit to surgical treatment in selected cases.

Until recently, synthetic mesh midurethral slings, as outside-in and inside-out obturator tapes (TOT), were the standard surgical treatment for stress urinary incontinence. More recently, single incision mini-slings were introduced with the aim of reducing peri-operative morbidity.

The study from which this work was developed concluded the non-inferiority of minislings in relation to midurethral slings with regard to subjective success, the study's primary outco-

me, at the end of 36 months. Outcomes related to quality of life and sexual function were similar between the two groups, with the exception of dyspareunia, reported in 11.7% of women undergoing minislings, as opposed to 4.8% of women undergoing midurethral slings.

Objectives: Establish a comparison between the results obtained in patients undergoing the two surgical approaches mentioned above at ULS São José and those found in the literature. Complement existing studies with more cases so that, in the future, guidelines based on robust evidence can be developed in order to decide which surgical technique to apply to each patient.

Material/methods: Existing scientific articles were gathered from online platforms, and a literature review was carried out. A survey of mini-slings and TOT over the last 3 years at ULS São José was also carried out. The clinical platforms of the aforementioned hospital unit were used, and 75 patients were identified.

Results: Of the 75 patients undergoing surgical intervention in the context of stress urinary incontinence, 56 underwent TOT and 19 underwent minisling. From the 75 patients mentioned, 72 revealed subjective cure.

When questioned retrospectively, 5 patients revealed chronic inguinal pain, 3 of which underwent minisling.

With regard to dyspareunia, 22 of the 75 patients had an affirmative answer, 40 a negative answer and, in 13, the question was not applicable.

Discussion/conclusions: Those intervened reported subjective cure in 96% of all cases.

Regarding reports of chronic groin pain, there was a higher percentage in minislings (15.79%) compared to TOT (3.57%). Focusing on dyspareunia, it was also higher in minislings, with a percentage of 52.6% compared to TOT, counting with 21.4%.

Some limitations in the present work stand out, based on obtaining retrospective information, with a limited sample. It is therefore essential to survey a greater number of cases and study them, so that appropriate therapeutic technique can be applied for each patient.

PO 09

THIRD DEGREE PERINEAL TEARS: PREVALENCE AND RISK FACTORS

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Introduction: The prevalence of perineal tears varies significantly across different populations, with conflicting data on the significance of various obstetric risk factors. Obstetric Anal Sphincter Injuries (OASIS) can be associated with multiple factors, including maternal (advanced age, nulliparity), fetal (macrosomia, occipitoposterior position), and delivery-related factors (prolonged second stage, median episiotomy, instrumented delivery, shoulder dystocia). These tears can adversely affect a woman's quality of life, increasing the risk of fecal and urinary incontinence, chronic pelvic pain, and dyspareunia.

Goals: This study aims to assess the current prevalence and risk factors for third-degree perineal tears in a single hospital setting.

Materials and methods: We conducted a retrospective observational study involving postpartum women who had a vaginal birth with a third-degree perineal laceration between January 2019 and December 2022. Data were collected from clinical records.

Results: Over a span of four years, third-degree perineal lacerations were identified in 47 cases, representing an incidence of 1,16% out of 4044 vaginal deliveries.

The median maternal age was 29 years (interquartile range: 26-34 years), and the median maternal pre-pregnancy BMI was 23 kg/m² (interquartile range: 20,4-26,4 kg/m²). A total of 78,72% of the cases were primiparous.

Approximately 48,94% of the labor cases were induced, predominantly using prostaglandins. Most vaginal births (72.34%) were dystocic and often required assistance with vacuum extraction. Mediolateral episiotomy was performed in 70,21% of deliveries. Two cases reported shoulder dystocia.

The median birth weight of the newborns was 3,390 grams (interquartile range: 3,180-3,667 grams), with occipitoposterior positioning observed in 23,53% of dystocic deliveries.

At discharge, four women reported urinary incontinence, and three reported fecal incontinence. A total of 78,72% of the cases were referred to urogynecology and physical medicine and rehabilitation consultations.

Discussion/Conclusions: Our study identified 47 cases of third-degree vaginal lacerations out of 4044 vaginal deliveries, resulting in an incidence rate of 1,16%, which is lower than the 6,3% reported in the literature.

The prevalence of complications was 17,08%, with urinary incontinence being the most common complication.

PO 10

"AN UNEXPECTED POSTOPERATIVE LONG-TERM COMPLICATION: MESH MIGRATION CLOSE TO THE CERVIX?"

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Introduction: Worldwide, mid-urethral slings using mesh are the main surgical approach for the treatment of stress urinary incontinence. Even though it presents high success rates, exposure of the mesh remains a concern, contributing as a postoperative complication for up to 22% of the cases. There has been an enduring argument regarding the question of whether suboptimal sling location is dependent on primary incorrect implantation or rather associated with migration of the sling.

Goals: Description of a possible mid-urethral sling migration with exposition of the mesh.

Material and methods: Clinical case presentation and description of surgical management.

Results: We present a case of a 74-year-old woman, multiparous and not sexually active. She had hypertension, depression, Body Mass Index of 28.9 Kg/m2 and underwent surgery 7 years earlier with a mid-urethral sling to treat stress urinary incontinence in Germany without complications. She was referred to a gynecological appointment due to persistent purulent vaginal discharge and presented no stress urinary incontinence relapse. At observation, a purulent discharge with foul odor was objectified with the presence of an apparent mesh exposure located in the anterior and right lateral fornices of the vagina with about 2 cm of extension. A pelvic magnetic resonance was was performed and revealed slight thickening and hyperenhancement of the anterior and right lateral fornices of the vagina with a imprecisely nodular effect, measuring 14 mm in longitudinal diameter and 8 mm in thickness, with no extension beyond the vagina. No involvement of the cervix, uterus, parametrium or bladder was found. She was submitted to endovenous antibiotherapy and surgical approach was suggested. Therefore, the patient was submitted to an excision of both branches of the sling with reepithelization of the vaginal mucosa.

Conclusions: In this case we describe a rare case of a possible migration of a mid-urethral sling. Although the operative report in Germany indicated proper placement without complications, perforation of the vaginal epithelium or improper initial placement should be considered as a cause for this outcome.

PO 11

LAPAROSCOPIC VERSUS ROBOTIC-ASSISTED COLPOPEXY: ARE THERE SIGNIFICANT DIFFERENCES?

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Introduction: Pelvic organ prolapse is a highly prevalent condition in women with different potential surgical approaches. Colpopexy is advocated as the best procedure for complex prolapses. In the past, the technique was performed open or laparoscopically. However, robotic-assisted colpopexy is gaining popularity as a minimally invasive technique.

Goals: The main aim of this study is to compare the laparoscopic colpopexy versus the robotic-assisted colpopexy approaches in the surgical treatment of pelvic organ prolapses.

Material and methods: This is a retrospective and single-center analysis of women submitted to colpopexy in a tertiary hospital. Patients submitted to laparoscopic colpopexy between February 2022 and February 2024 were included. Furthermore, patients submitted to robotic-assisted colpopexy since the implementation of this robotic procedure in our hospital in October 2023 to February 2024 were also included and compared to the first group. Concomitant hysterectomy, surgical duration, blood losses, intraoperative and postoperative complications and efficacy were reported.

Results: 42 patients were included in this study: 21 were submitted to laparoscopic colpopexy and 21 were submitted to robotic-assisted colpopexy. In the laparoscopic colpopexy group, mean surgical duration was 243 min in the colpopexy with concomitant hysterectomy group and 198 min in the colpopexy only group. In the robotic-assisted colpopexy group, mean surgical duration was 215 min in the colpopexy with concomitant hysterectomy group and 193 min in the colpopexy only group. In the laparoscopic colpopexy group, mean blood losses were 56 mL in the colpopexy with concomitant hysterectomy group and 59 mL in the colpopexy only group. In the robotic-assisted colpopexy group, mean blood losses were 126 mL in the colpopexy with concomitant hysterectomy group and 43 mL in the colpopexy only group. Overall mean length of stay at hospital was 2.3 days in the laparoscopic group versus 1.2 days in the robotic-assisted group. 2 intraoperative complications were reported in each group: 2 bladder perforations in the laparoscopic colpopexy group and 1 vaginal perforation and 1 bladder perforation in the robotic-assisted group, all solved without sequelae. No significant postoperative complications were reported. 3 patients in the laparoscopic colpopexy group had persistence or recurrence of the prolapse while none in the robotic-assisted group had recurrence.

Discussion and conclusions: Both laparoscopic and robotic-assisted surgical approaches are safe with similar low rates of complications. However, the robotic-assisted colpopexy was shown to have shorter surgical time and shorter mean length of stay at the hospital. To conclude, this study confirms that the robotic-assisted colpopexy is superior to the laparoscopic approach for the treatment of pelvic organ prolapses in women.

PO 12

BOTULINUM TOXIN IN TREATMENT OF OVERACTIVE BLADDER – A 3 YEARS EXPERIENCE

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Introduction: Overactive bladder syndrome is a chronic condition that can have debilitating effects on patient's quality of life. This high prevalent condition can be divided as idiopathic or neurogenic. In patients refractory to conservative therapy such as antimuscarinics or in those presenting contraindications for pharmacological management, intravesical botulinum toxin injection can be an safe and effective option.

Goals: Characterize the population of patient submitted to intravesical botulinum toxin injections.

Demonstrate that intravesical botulinum toxin injection is a safe procedure.

Material and methods: Retrospective observational study with 256 patients submitted to botulinum toxin injection between january 2020 and march 2023. Clinical data was collected from patient clinical reports and then submitted to statistical analysis with SPSSv28.

Results: The target population for this therapy has 59.9±16.0 years, predominantly female (79.3%), and with at least one comorbidity (83.6%), with psychiatric disorders being the most frequent (56.3%).

The primary reason for be submitted to this treatment was the lack of efficacy of usual oral medications (85.5%), such as beta-adrenergic agonists or anticholinergics.

Regarding treatment efficacy, 82% of the sample showed a response to treatment, of which 53.1% report significant improvement. Regarding complications, the most frequent was the need for catheterization (7.9%), followed by UTIs within 12 weeks post-procedure (3.9%). Comparing locations of treatment, an higher occurrence of post-procedure UTIs was observed in treatment room compared to the operating room (central or ambulatory).

Discussion/Conclusions: Intravesical botulinum toxin injection is a safe and effective procedure to offer to overactive bladder syndrome's patients and can be easily performed as an outpatient procedure or in hospitalization setting.

PO 14

ANTERIOR COLPORRHAPHY UTILIZING RECTUS FASCIA IN THE NEW ERA OF REDUCING MESH UTILIZATION

Guilherme Amorim de Moraes Cavalcanti; Lorella Miranda Auricchio, Daniel Charret Diegues; Wagner Aparecido França, Luis Augusto Seabra Rios, Renato Panhoca
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PO 15

A CASE SERIES OF LATE PERIRENAL FAT RECURRENCE OF RENAL CELL CARCINOMA

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Introduction: Radical and partial nephrectomy are the primary treatments for renal cell carcinoma, with proven long-term survival rates. Although rare, local recurrence can occur, often in the perirenal tissues, including ipsilateral adrenal gland, regional lymph nodes, psoas muscle, perirenal fat or Gerota's fat. The optimal approach for managing locally recurrent RCC remains uncertain due to limited evidence.

Objectives: To present two cases illustrating late perirenal fat recurrence of RCC.

Methods: Patients' clinical records and pertinent literature on RCC local recurrence were reviewed during case series development.

Results: Case 1: A 61-year-old man underwent

a partial nephrectomy in 2012 for a 22x24mm renal cell carcinoma. The procedure was uneventful. Pathological examination revealed a clear cell carcinoma, T1a, Fuhrmann grade 2, with a focal positive surgical margin. Over the subsequent decade, regular CT scans were conducted during scheduled follow-ups. A recent abdominopelvic CT scan unexpectedly revealed two localized lesions (measuring 15mm and 7mm) within the perirenal fat, with no recurrence in the remaining kidney or any distant metastasis. Subsequent abdominopelvic MRI confirmed the suspicion.

The patient underwent complete excision of the lesions along with perirenal fat. Pathological examination confirmed clear cell carcinoma recurrence. However, a follow-up CT scan six months later showed a recurrence of the lesions. Surgical removal versus radical nephrectomy is under consideration. Case 2: A 62-year-old woman underwent a partial nephrectomy in 2017 for a 36x33mm renal cell carcinoma. The procedure was uneventful, and pathological examination indicated a clear cell carcinoma, categorized as T1a with Fuhrmann grade 1, with no positive surgical margin. Similar to the first case, this patient also underwent periodic CT scans over a span of six years. A recent abdominopelvic CT scan confirmed the presence of an 11x9mm lesion in the perirenal fat, adjacent to the previous lesion site. The patient is waiting for surgical resection of the lesion.

Discussion/Conclusion: This case series endorses the limited literature about tumor seeding within the retroperitoneum subsequent to partial nephrectomy. As in both cases the recurrence location corresponded with the lower pole site of the original tumor, we hypothesize that direct tumor breach during the partial nephrectomy might have led to this.

Further research is warranted to establish optimal preventive measures against such recurrences, identify individuals at heightened risk necessitating extended follow-up, and determine the most effective treatment strategies upon recurrence.

PO 16

ARTIFICIAL INTELLIGENCE IN URODYNAMICS – A SCOPING REVIEW

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Introduction: Voiding disorders cause severe morbidity and lowers quality of life in both children and adults. Urologists rely heavily on urodynamic studies (UDS) to diagnose and assess the presence and severity of lower urinary tract pathology and can be important in determining whether individuals are at risk for complications, but their interpretation has high interobserver variability (that can be higher than 50%) and time/resources consuming.

While Machine learning is used with increasing frequency in healthcare, recent research has applied it to read and interpret UDS.

Objectives: As part of this project, we aim to undertake a scoping review of recent literature in order to determine the current state-of-the-art of artificial intelligence in Urodynamics (including uroflowmetry, urodynamic studies and videourodynamics) and to identify its challenges and constraints.

Methods: MESH search terms derived from the key questions were incorporated into the literature search constructed and English medical literature was accessed. The initial search yielded 97 potential studies and the final review incorporated 10 articles.

Results: A total of 10 investigation articles of interest were found, all written within the last 3 years. The majority investigated machine learning models applied to urodynamic studies (n=5), followed by uroflowmetry (n=4) and videourodynamics (n=1). Moreover, 5 studies investigated AI capacity for a non-specific scenario, being 4 studies specific for detrusor overactivity detection and one for detrusor underactivity detection. All studied models revealed

a diagnostic accuracy that ranged from 78% to 100% and an AUC between 0,73 and 0,919. Models specifically developed to identify DO have shown stronger performances than models evaluating hypoactivity or evaluating the whole urodynamic studies.

Conclusion: AI reading and interpretation of Urodynamic studies findings is a potential option in clinical practice to improve the diagnosis and treatment of voiding disorders.

However, more investigation is needed to mature these technologies and assess how they compare to the expert. Economic evaluation studies should also be performed in the future.

PO 17

REWEING THE LONG TERM RESULTS OF TRANSOBTURATOR TAPE (TOT) SLING PROCEDURE IN A MULTIDISCIPLINARY CENTER IN A 3 YEAR PERIOD

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Introduction: Urinary incontinence is defined as the complaint of any involuntary loss of urine. Stress urinary incontinence is the involuntary leakage of urine during exertion (exercise or movements such as coughing, sneezing, and laughing). Stress urinary incontinence has an observed prevalence of between 4% and 35% and is often seen in women after middle age. In stress incontinence the intrinsic structure sphincter itself is intact and normal but it loses efficiency because of excessive mobility and loss of support, so hypermobility Pelvic Pain, Prolapse & Neuromodulation or lowering of the position of the vesicourethral segment cause stress urinary incontinence. The principal treatment of stress urinary incontinence is proper suspension and support of the vesicourethral segment in a normal position, mainly through the use of the trans-obturator tape sling procedure.

Goals: The objective of this study is to determine the success rate and complications associated with the trans-obturator tape sling procedure.

Material and methods: We retrospectively reviewed the data of patients submitted to trans-obturator tape sling procedure for treatment of stress urinary incontinence between 2018 and 2020 in Central Lisbon University Hospital Centre, all patients were evaluated for presence of urinary stress incontinence and for surgical complications of the procedure. The final data was analyzed as per the standard statistical method.

Results: A total of 157 patients were included in the analysis, of which 16 (10,19%) had some degree of stress urinary incontinence. There were 14 (8,92%) post-surgical complications, one (0,64%) vaginal erosion, two (1,27%) perineal pain, two (1,27%) dyspareunia and eleven (7,01%) de novo urgency incontinence.

Discussion/Conclusions: In our study most of the patients achieved surgical cure of stress urinary incontinence, with a 89,81% success rate and just a 8,92% complication rate, of which de novo urinary urgency incontinence (7,01%) was the most common, only two (1,27%) patients were reoperated due to complications of the procedure. Most patients with complications were successfully managed without reintervention and were satisfied with the results of the procedure. Trans-obturator tape sling procedure remains a safe and effective treatment option for patients with stress urinary incontinence, the observed complication rate was low, de novo urinary urgency incontinence the most common, with most complications being managed in outpatient care.

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