

840

### Prevalence of Silent Voiding Dysfunction in Morbidly Obese Women Before and After Bariatric Surgery

Hessami S,<sup>1</sup> Azar J,<sup>1</sup> Shklyanka O,<sup>1</sup> Trivedi A.<sup>2</sup> <sup>1</sup>Obstetrics and Gynecology, Saint Joseph Regional Medical Center, Paterson, New Jersey; <sup>2</sup>Bariatric Surgery, Saint Joseph Regional Medical Center, Paterson, New Jersey

**Study Objective:** To determine the prevalence of silent voiding dysfunction in morbidly obese patients (BMI>35 kg/m<sup>2</sup>) before and after bariatric surgery.

**Design:** This is a prospective, single-center based study.

**Setting:** Private bariatric surgical group office.

**Patients:** Data were collected from fifteen morbidly obese female patients, candidates for bariatric surgery.

**Intervention:** All patients underwent laparoscopic gastric sleeve surgery.

**Measurements and Main Results:** Age, BMI and point reduction in BMI after surgery were compared using unpaired T test, while Fisher exact test was used for other demographic data like history of hysterectomy, urinary tract infection, kidney stones and smoking.

Prevalence of silent voiding dysfunction before bariatric surgery was 76% and dropped to 54% after, showing that 45% of patients had improvement in their symptoms. There were no significant demographic differences in obese patients with and without voiding dysfunction. There was no significant difference in point reduction in BMI in obese patients who had improvement in voiding dysfunction symptoms and who did not.

**Conclusion:** Weight reduction surgery has significant impact on the improvement of silent voiding dysfunction symptoms but larger prospective and case control studies are required to establish this effect.

841

### Device for Safely Removing a Placed Mesh for Pelvic Organ Prolapse

Sekine M, Ichikawa M, Wada H, Ono S, Mine K, Akira S, Takeshita T. *Obstetrics and Gynecology, Nippon Medical School Hospital, Tokyo, Japan*

**Study Objective:** If a mesh removal is required due to complications after mesh surgery for pelvic organ prolapse, such case not only makes an identification difficult due to contracture of mesh but also would require a careful attention to damage on surrounding tissue and sophisticated skills. We report that we attempted to remove a mesh safely by laparoscopic manipulation with transvaginal manipulation concurrently for such case.

**Design:** Case series.

**Patients:** Patients who had the removal surgery of mesh due to erosion and pain in our hospital.

**Intervention:** Case 1 The patient at the age of 57 who had vaginal total hysterectomy and a mesh placement at anterior and posterior walls 5 years ago. The removal surgery was conducted due to erosion. Firstly, separated adhesion between vaginal stump and mesh laparoscopically. Secondly, vaginally identified the edge of mesh and separated the mesh upwardly while pulling it, cut the arm, then removed the mesh. Case 2 The patient at the age of 75 who had a mesh placement at anterior wall 4 months ago. The removal surgery was conducted due to pain at arms. Firstly, separated a paravesical cavity laparoscopically. Identified the arms of mesh and cut it laterally. Then, vaginally identified and removed the mesh while pulling it. Case 3 The patient at the age of 59 who had laparoscopic sacrocolpopexy 10 months ago. The mesh removal surgery was conducted due to dyspareunia associated with mesh. Firstly, vaginally identified the mesh at posterior wall and separated it approximately 2/3 upwardly. Then removed the mesh laparoscopically.

**Measurements and Main Results:** There was no complication such as damage on surrounding tissue in each case, and the postoperative pain was improved.

**Conclusion:** The method to separate mesh by using transvaginal method and laparoscope concurrently would be one of the safe and sure methods.

842

### Redo Modified Laparoscopic Colposuspension

Kent A, Shakir F. *Minimal Access Training Therapy Unit (MATTU), Royal Surrey County Hospital, Guildford, Surrey, United Kingdom*

**Study Objective:** We have previously described the technique of a Modified Laparoscopic Colposuspension [1] and furthermore demonstrate the versatility of this technique by performing the procedure in a patient with recurrent stress incontinence and prolapse following an open colposuspension carried out 17 years previously.

**Design:** Technical demonstration including video of a redo modified laparoscopic colposuspension following a failed open procedure in the past.

**Setting:** The procedure was performed at the Nuffield Health Guildford Hospital, Guildford, UK, a tertiary referral center for minimally invasive gynecological surgery.

**Patients:** A 55 years old woman had previously undergone an open Burch colposuspension at the age of 38 for treatment of her urinary stress incontinence. This had subsequently failed with recurrence of her stress incontinence and vaginal wall prolapse. Video urodynamics demonstrated a stable bladder of reasonable capacity. There was proven stress incontinence. Vaginal examination revealed second degree, anterior and posterior vaginal wall prolapse.

**Intervention:** Our described technique of modified laparoscopic colposuspension was adopted in this case [1]. Following trans-peritoneal dissection of the retro-pubic space the previously placed Ethibond sutures could be identified. These were still secured to the ilio-pectineal ligaments but had parted company from the paravaginal tissues. Two further Ethibond 0 sutures were then placed through the paravaginal tissues on either side and attached to the ipsilateral ilio-pectineal (Cooper's) ligament. The steps performed at surgery are demonstrated.

**Measurements and Main Results:** Six weeks post surgery the patient had no stress incontinence and no residual vaginal prolapse.

**Conclusion:** This modified laparoscopic colposuspension can be utilized in most instances as it is a trans-peritoneal technique. This case highlights the versatility of the technique and it has the advantage of requiring significantly less dissection than the traditional techniques, resulting in reduced operating time.

References:

1. Kent A, Jan H & Shakir F (2014). *Journal of Minimally Invasive Gynecology* Vol 21(6) Page 980.

843

### Evaluation of Vaginal Vault Position With Dynamic MRI in Women Who Had Laparoscopic Sacrocolpopexy for Uterine Prolapse

Yoldemir AT,<sup>1</sup> Cimsit C,<sup>2</sup> Guclu M,<sup>1</sup> Akpınar IN.<sup>2</sup> <sup>1</sup>Obstetrics and Gynecology, Marmara University, School of Medicine, Research and Training Hospital, Istanbul, Marmara, Turkey; <sup>2</sup>Radiology, Marmara University, School of Medicine, Research and Training Hospital, Istanbul, Marmara, Turkey

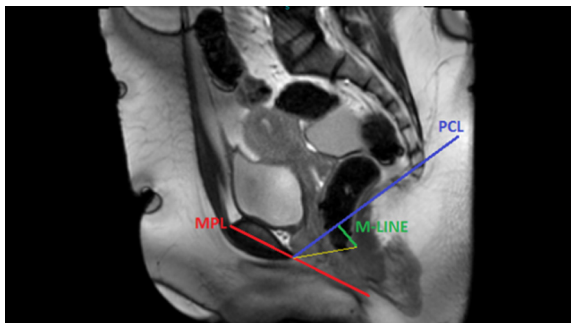
**Study Objective:** The objective is to evaluate the anatomic position of the polypropylene mesh inserted laparoscopically during sacrocolpopexy with dynamic magnetic resonance imaging (d-MRI).

**Design:** Women with uterine descent (stage 2 or more) who had been managed by laparoscopic sacrocolpopexy (LSCP) were invited to have pelvic d-MRI on their postoperative 6th month follow-up. P-QoL and FSFI forms were also filled by each woman.

**Setting:** Tertiary care; university affiliated teaching hospital.

**Patients:** Thirty women who had LSCP with polypropylene mesh were enrolled for the study.

**Intervention:** MR imaging was performed at rest and during straining in the supine position with slightly flexed legs using a 3T MR scanner. Midsagittal images at rest and on maximal strain were used for evaluation. M line, Pubococcygeal line (PCL), and mid-pubic line (MPL) were used to detect and grade prolapse.



**Measurements and Main Results:** The position of the apical compartment after LSCP was subjectively evaluated. The association between the presence of descent after LSCP and P-QoL and FSFI scores were investigated. We have done two cases so far and showed that d-MRI is very reliable in detecting the localization of vaginal vault. We hope to finish analysing d-MRI scans of all 30 women.

**Conclusion:** The follow-up of LSCP patients is done by using POP-Q staging and different inventories and questionnaires. d-MRI of the pelvis determines objectively the situation of the apical (vaginal vault) compartment. We postulate that d-MRI should be a part of the surveillance protocol together with other validated scales.

844

#### Treatment of First Trimester Tubal Ectopic Pregnancy Through Posterior Colpotomy: Residents Can Easily Do It

Zanatta A,<sup>1</sup> Maia T,<sup>1</sup> Zingler E,<sup>1</sup> Reis PR,<sup>1</sup> Alfredo Filho CA,<sup>2</sup> Zaconeta AC.<sup>1</sup> <sup>1</sup>Obstetrics and Gynecology, University of Brasilia, Brasilia, Distrito Federal, Brazil; <sup>2</sup>Mater Dei Hospital, Ouro Preto do Oeste, Rondonia, Brazil

**Study Objective:** To report 2 additional cases of first trimester tubal ectopic pregnancy treated by posterior colpotomy, in the setting of an academic hospital.

**Design:** Case report.

**Setting:** University hospital in Brasilia, Brazil.

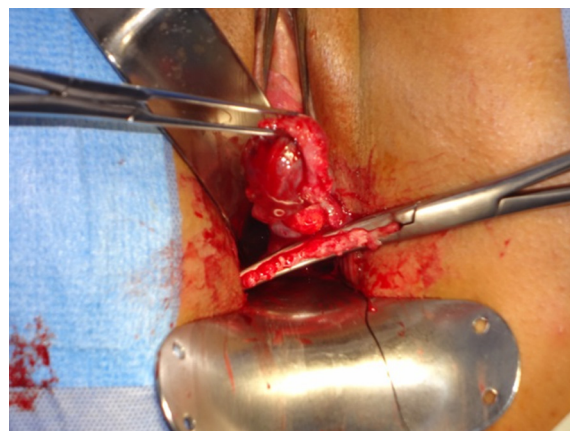
**Patients:** two consecutive patients with ectopic pregnancy operated in December 2014 and January 2015. Patient 1: 27-year old, G1P0, asymptomatic woman having a presumed diagnosis of ectopic pregnancy. Her last menstrual period (LMP) had been 10 weeks before. Regular follow-up evaluation revealed a beta-hCG level of 5736 mIU/ml, and a 3,3 cm embryo with cardiac activity in the right adnexa. Patient 2: 29-year old, G2P1, asymptomatic woman referred with a diagnosis of left adnexal ectopic pregnancy. She referred her LMP 7 weeks before. Beta-hCG levels were 17994 mIU/ml and

sonography revealed a 3,3 cm embryo with cardiac activity in left adnexa. Both patients were found to have surgical indication for ectopic pregnancy.

**Intervention:** patients were placed under dorsal lithotomy position. A posterior colpotomy was performed with cold scissors, and eventual free blood was drained. Tubes containing ectopic pregnancy were readily identified since they “fell” in the posterior cul-de-sac, because of the weight of the ectopic pregnancy.



Unilateral salpingectomies were performed using a Z-clamp (figure 2) and Vicryl-1 was used for suturing the mesosalpinx and for the vaginal colporrhaphies.



Medical residents with limited experience in vaginal surgery performed both surgeries.

**Measurements and Main Results:** Surgeries lasted less than 40 minutes and bleeding was less than 20 ml. Both patients had uneventful recoveries and were discharged between 12 and 36 hours after the procedure. Patients had been followed for 40 and 45 days respectively, with no interurrences. They wish to conceive, and their obstetrical results are awaited.

**Conclusion:** first trimester ectopic tubal pregnancy can be readily managed by posterior colpotomy, even by doctors with limited experience in vaginal surgery. The technique should be routinely taught in medical residence programs.