

tion was 93.4%. The rate of de novo constipation was 27.8% and the rate of de novo SUI was 11.4% (1.6% of recurrent surgery). One patient suffered from de novo dyspareunia (1.6%). No cases of vaginal erosion were found. The rate of anatomical success was 96.3%. In fact, we regret 3 cases of anterior compartment recurrence (at 1, 8 and 12 months) requiring reoperation by transvaginal route (2) or by laparoscopy (1). 94% of patients stated that they were completely cured and 91% said that they would recommend this intervention to a friend.

Discussion and Conclusions: LSC offers global repair of POP with a low morbidity and a high satisfaction rate. The technique requires perfect knowledge of pelvic anatomy and experienced surgeons. Medium-term anatomical and functional results are excellent. Severe constipation is a minor but frequent post-operative complication. LSC seems to give both less post-operative pain and less dyspareunia than the transvaginal POP repair. Further randomized studies comparing laparoscopic and transvaginal techniques are needed to confirm this matter.

Key-words: laparoscopic sacrocolpopexy, pelvic organ prolapse, functional results.

FC18_7

An anatomic comparison of the traditional TVT-O versus a modified TVT-O procedure

P. Hinoul, P. Bonnet, C. De Roover, F. Gomez, D. Waltregny, J. de Leval

Université de Liège, Ethicon, Genk, Belgium

Aims: A modification to the inside-out TVT-O procedure, decreasing both the amount of dissection required and the amount of mesh tape is described in this study. Our objective was to compare the impact of the modification on the relation of the tape to the obturator anatomy.

Materials and Methods: Five fresh frozen cadavers were operated upon to study the impact on the anatomical trajectory of using a reduced TVT-O tape procedure in comparison to the traditional TVT-O tape procedure. The TVT-O procedure was performed as originally described by the inventor. The modified TVT-O and the traditional TVT-O procedures were performed in pairs with the exception of the first one, alternating the type of procedure between the right and left side on the same cadaver. A device specifically designed for this study was used: one side from the midpoint consisted of a traditional TVT-O device, whilst the other side was modified to include only 6 cm of mesh extended with a loop suture (“positioning sutures”). To assure that this modified study device actually represented a truly modified, shortened TVT-O procedure, the first cadaver was operated upon with a fully modified, shortened TVT-O tape. In contrast with the original

procedure, the obturator membrane was not perforated, neither by the guide nor by the scissors, and the aim of the modified dissection was to obtain a channel with a minimal width of only 5 mm, sufficient to allow insertion of the winged guide. Consequently, as opposed to the original procedure, in the modified technique, the helical passer was the sole instrument to perforate the obturator membrane. The straight tip of the helical passer was inserted in the gutter of the winged guide and advanced until perforation of the obturator membrane. Similarly to the original procedure, the winged guide was subsequently removed and the helical passer was slowly rotated whilst bony contact with the inferior pubic ramus was maintained at all time during insertion, thus ensuring a tight passage around the bony structure, with the tip of the passer finally exiting at the skin level. The adjustment of tensioning prior to removal of the helical passer sheaths remained the same. To allow for this, positioning sutures were located at the end of the shortened tape. To facilitate centering of the shortened TVT-O tape, a “placement loop” in the centre of the tape was foreseen. Relevant distances between the tape and anatomical structures were recorded, as were the individual amounts of mesh in individual muscular structures.

Results: The modified tape traversed less muscular structures than the traditional tape, but consistently traversed the obturator membrane. The distance from the tape to the obturator canal measured on average 2.3 cm vs 1.8 cm, to the anterior obturator nerve 3.1 cm for both, and to the posterior obturator nerve 2.2 cm versus 2.1 cm, in the modified versus the traditional tape, respectively. The amount of mesh left behind in the hemipelvis was 6.3 cm in the modified versus 9.3 cm in the traditional procedure. In the obturator internus (0.9 and 1.1 cm in the modified and original TVT-O, respectively) and obturator externus muscle (1.1 cm and 1.3 cm in the modified and original TVT-O, respectively), no significant difference was seen in the amount of mesh left behind in these muscles. However, the amount of mesh left behind in the adductor magnus muscle differed significantly: 0.2 versus 1.4 cm in the modified and original TVT-O, respectively.

Discussion: One of the most striking observations in this study was the difference in the amount of tape left behind in the body by both procedures. In a bilateral procedure, on average, the tape would measure 12.8 cm in the modified procedure and 18.6 cm in the original technique. This translates into a reduction by one third of the length of the mesh inserted into the body. This anatomical study also showed that the shortened mesh was “anchored” in those critical tissue planes that can accomplish this, namely the internal and external obturator muscles in combination with the obturator membrane. In one cadaver, the tape perforated the obturator externus muscle for only 0.4 cm. This underscores the accuracy required to position the shortened

tape, aided by the placement of a loop to ensure symmetric tape placement. The total length of the modified tape (12 cm) seemed sufficient to overarch the distance between both obturator membranes. The closest distance to the posterior obturator nerve was measured rather medially, approximately at the level where the tape traverses the obturator externus and, sometimes, a small portion of the adductor magnus muscle. This is the location where the modified tape ceases to exist. Consequently, the modified tape can theoretically no longer exert any local influence on the more lateral course of the posterior branches of the obturator nerve.

Conclusions: The modified tape traversed significantly less muscular structures than the traditional TVT-O technique, while still consistently anchoring in the obturator membrane at a similarly safe distance from the obturator canal. The modified tape reached equally close to the obturator nerves as in the traditional technique; however, the distance that the shortened tape's trajectory lied in proximity to the nerve branches is limited.

Key-words: incontinence, TVT-O, anatomy.

FC18_8

Laparoscopic sacral colpo-hysteropexy: two years follow-up

P.S. Litta, G. Guidetti, L. Conte, A. Borghero, S. Borgato, C. Saccardi

Department of Gynaecological Science and Human Reproduction (Padua University), Italy

Object: To evaluate efficacy of laparoscopic sacral colpo-hysteropexy in conservative correction of genital prolapse.

Materials and Methods: 19 women with grade II and III genital prolapse, evaluated in the Department of Gynaecological Science and Human Reproduction (Padua University), desirous of conservative surgery, undergone laparoscopic sacral colpo-hysteropexy. Vaginal exam, urodynamic study as well as surgical variables were recorded. All patients were assessed pre-operative and at 1, 6, 12 and 24 months after surgery by vaginal exam and written questionnaire about pelvic discomfort, urinary incontinence and intestinal disorders.

Results: The median age was 52 years (range 39–66), median blood loss was 10 cc (range 10–200 cc), median operative time was 209 min (range 113–305 min). In 7 (36.8 %) patients trans obturator tape was placed for stress urinary incontinence. In only one case post operative urinary retention was detected, resolved spontaneously after 11 days of hospitalisation. One month after surgery, 10 (52.6 %) women complained of intestinal disorders and in 3 (15.7 %) patients of these also dyschezia. At 24 months 4 (21.0 %) patients presented grade II or III asymptomatic

cystocele. At 24 months there were no cases of meshes erosion. All patients referred good satisfaction of procedure, with no bladder, bowel or sexual disorders.

Conclusions: laparoscopic sacral colpo-hysteropexy resulted a good option for restoring pelvic functionality in women desiring conservative surgery, with totally patients' satisfaction.

Key-words: laparoscopic sacral colpo-hysteropexy, genital prolapse, mesh.

FC18_9

Quality of life and treatment of pelvic organ prolapse

V.I. Krasnopolsky, A.A. Popov, B.A. Slobodyanyuk, T.N. Manannikova, M.R. Ramazanov, M.A. Chechneva, A.A. Fedorov, I.V. Krasnopolskaya, O.V. Machanskite, K.N. Abramyan

Moscow Regional Scientific Research Institute of Ob/Gyn, Moscow, Russia

Background: POP is one the most frequent cause of pelvic floor dysfunctions and this could significantly affect health related QoL.

Materials and Methods: We assessed anatomical and functional outcome of repairs of severe forms of POP using PROLIFT total and laparoscopic sacrocolpopexy (LS SCP). We use standard examination, POP-Q measurements, vaginal and perineal ultrasonography, anorectal manometry, electromyography of EAS to all patients. Attention was paid on place of QoL assessment tools (PISQ-12, PFDI-20, PFIQ-7) and it's applicable in clinical practice. From January 2007 to April 2008, 60 consecutive symptomatic patients with POP II–IV were operated. Follow up was 2 years for all patients. Prolift total (35) LS SCP (25). Mean age was 56.3 (27–84). Simultaneously we performed Burch colposuspension (20%), laparoscopic paravaginal repair (11%), TVT-O (25%), hysterectomy (60%), anal sphincteroplasty (12%) and levator myorrhaphy (28%).

Results: Using questionnaires we've found significant prevalence of different syndromes before surgery: obstructive urination (68%), urgency/nocturia (48%), SUI (55%), obstructive defecation (50%), pain during defecation (27%), flatal incontinence (58%), fecal incontinence (33%), pelvic pain (60%). Also, we've found good correlation between objective success and score of questionnaires. These operations did not improve sexual life according total PISQ-12 score.

Conclusions: LS SCP and Prolift provides good anatomic and functional results. Disease-specific questionnaires can give additional information about symptoms (i.e. anal incontinence), which is important, and objectify postoperative results. PISQ-12, PFDI-20, PFIQ-7 are recommended to use not only in studies, but in daily practice.

Key-words: QOL, prolapse, sacrocolpopexy.