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Saturday, August 10, 2019

(Room 1)

14:45 - 15:15 Questions and Discussion (Nurses 3)

Update in Urogynaecology

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10 August 2019

Disclosures

- No relevant conflict of interest to report

Objectives

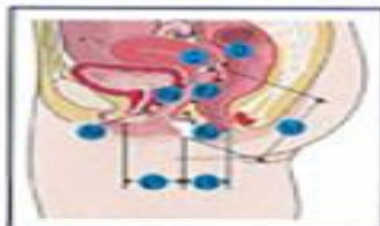
- Review new developments in pelvic organ prolapse and urinary incontinence treatment
- Review indications, strategies and durations of urinary drainage for urogynaecologic surgery patients.
- Talk about anything else you would like to discuss!

Prolapse evaluation: Examine with a Sims or a split speculum



J Tessier. Canadian Journal of CME

IUGA POP-Q Reference Guide



The pelvic organ prolapse quantification (POP-Q) exam is used to quantify, describe, and stage pelvic support.

- There are 6 points measured at the vagina with respect to the hymen.
- Points above the hymen are negative numbers; points below the hymen are positive numbers.
- All measurements except vl are measured at maximum voluntary.

Point	Description	Range of values
Aa	Anterior vaginal wall 3 cm proximal to the hymen	-3 cm to +3 cm
Ba	Most distal position of the remaining upper anterior vaginal wall	-3 cm to +6 cm
C	Most distal edge of cervix or vaginal cuff scar	
D	Posterior fornix (N/A if post hysterectomy)	
Ap	Posterior vaginal wall 3 cm proximal to the hymen	-3 cm to +3 cm
Bp	Most distal position of the remaining upper posterior vaginal wall	-3 cm to +6 cm
Genital hiatus (gh) = Measured from middle of external urethral meatus to posterior midline hymen		
Perineal body (pb) = Measured from posterior margin of gh to middle of anal opening		
Total vaginal length (tvl) = Depth of vagina when point D or C is reduced to normal position		

POP-Q Staging Criteria	
Stage 0	Aa, Ap, Ba, Bp = -3 cm and C or D = (b4 - 2) cm
Stage I	Stage 0 criteria not met and leading edge < -1 cm
Stage II	Leading edge > -1 cm but < +1 cm
Stage III	Leading edge > +1 cm but < + (b4 - 2) cm
Stage IV	Leading edge > + (b4 - 2) cm

REFERENCE: Bump RC, Mellason A, Bu K, et al. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. *Am J Obstet Gynecol* 1996;175:123.

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Pelvic Organ Prolapse: An Interactive Guide

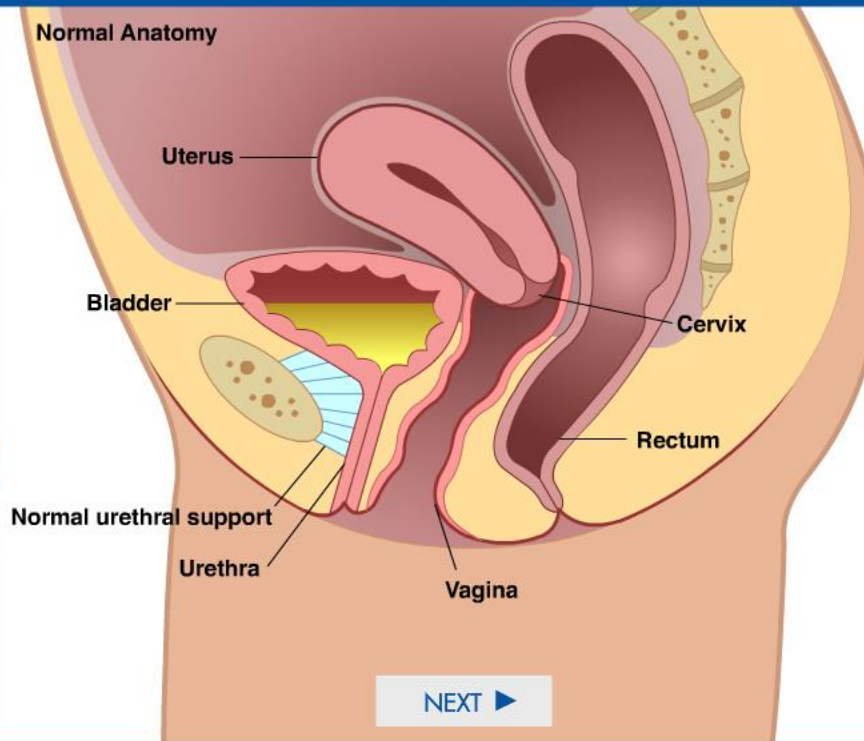
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- Normal Anatomy
- Stress Urinary Incontinence (SUI)
- SUI Treatment with Sling
- SUI Treatment with Bulking Agent

[Interactive Prolapse Evaluation](#)

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Developed in consultation with
Dr. Patrick Culligan, M.D.
Weill Cornell Dept. of Urology, New York, NY


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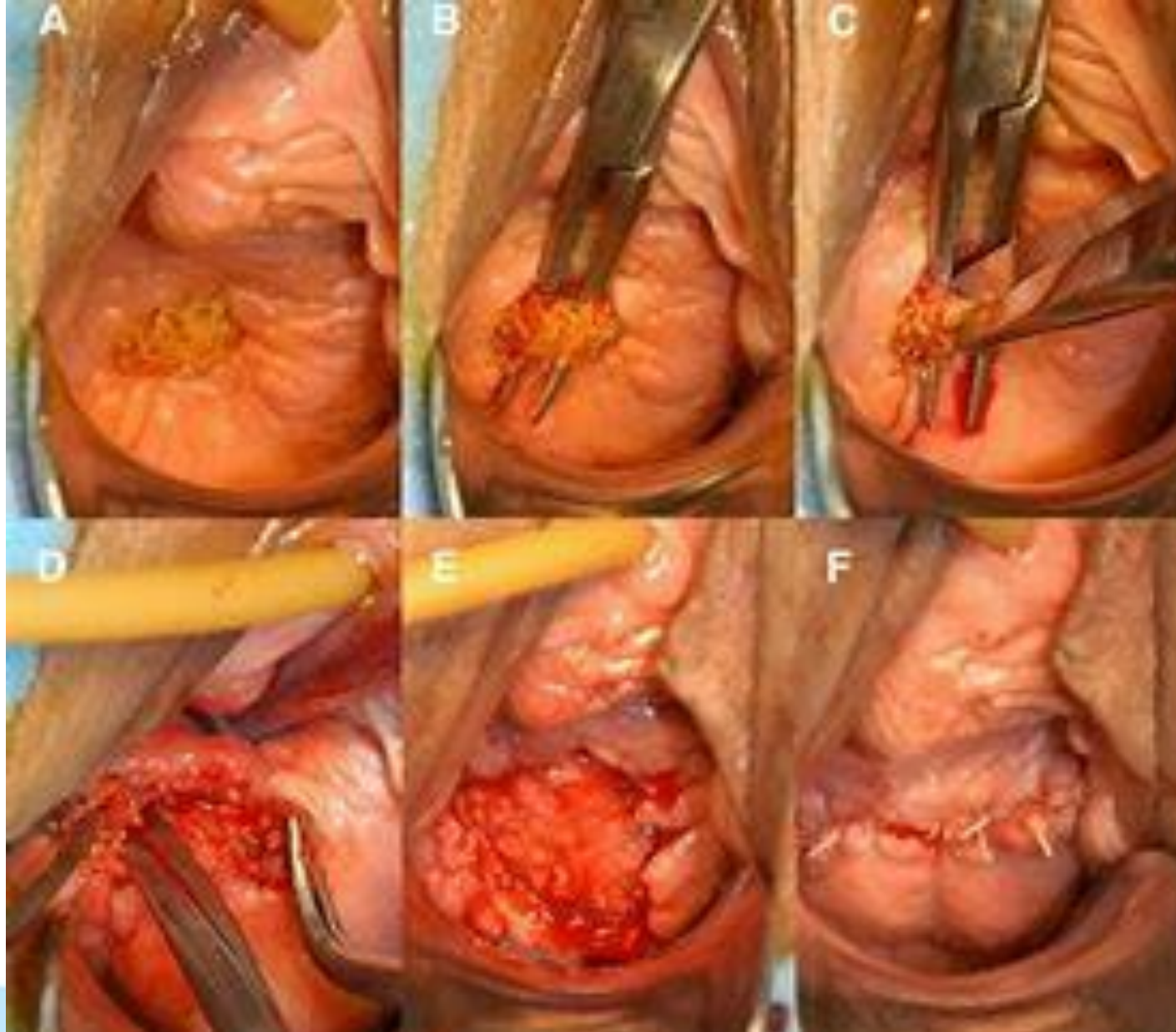
Mesh is a four letter word

- All prolapse mesh products and biologic absorbable graft materials for transvaginal use have been removed from the New Zealand market.
- This limits surgical options for women with recurrent prolapse
- Surgical mesh remains approved for the treatment of stress urinary incontinence and for abdominal placement for prolapse



Transvaginal ~~Mesh~~ Mess

From the website of
Waters, Paul and Kraus



Margulies et al.
AJOG 2008

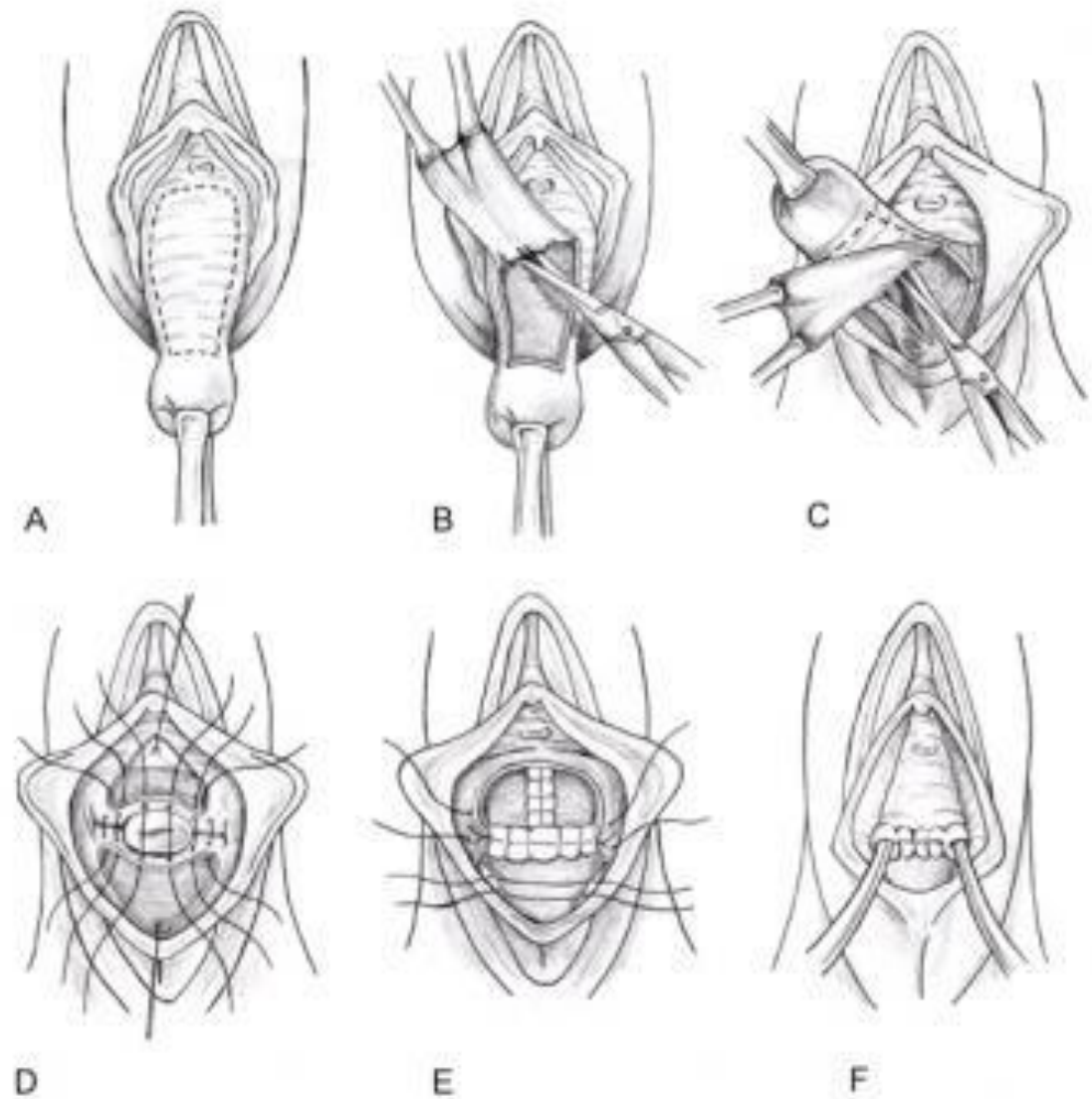
Types of Pessaries



Pessary fitting kit



Colpocleisis



Stress Urinary Incontinence (SUI)

- Mechanism
- Evaluation
- Current treatment options



Pelvic Organ Prolapse: An Interactive Guide

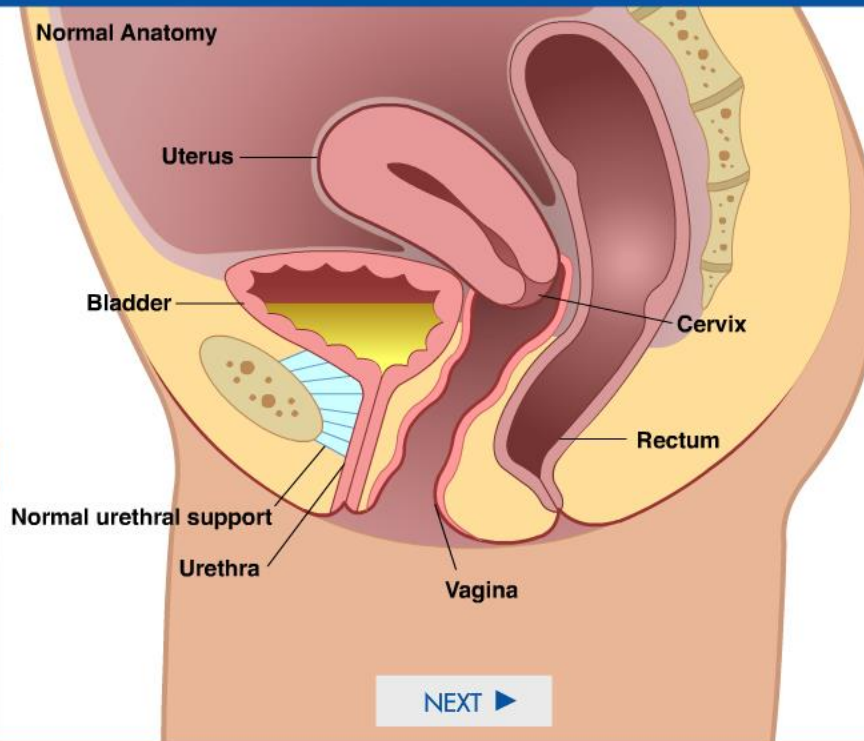
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Pubovaginal sling

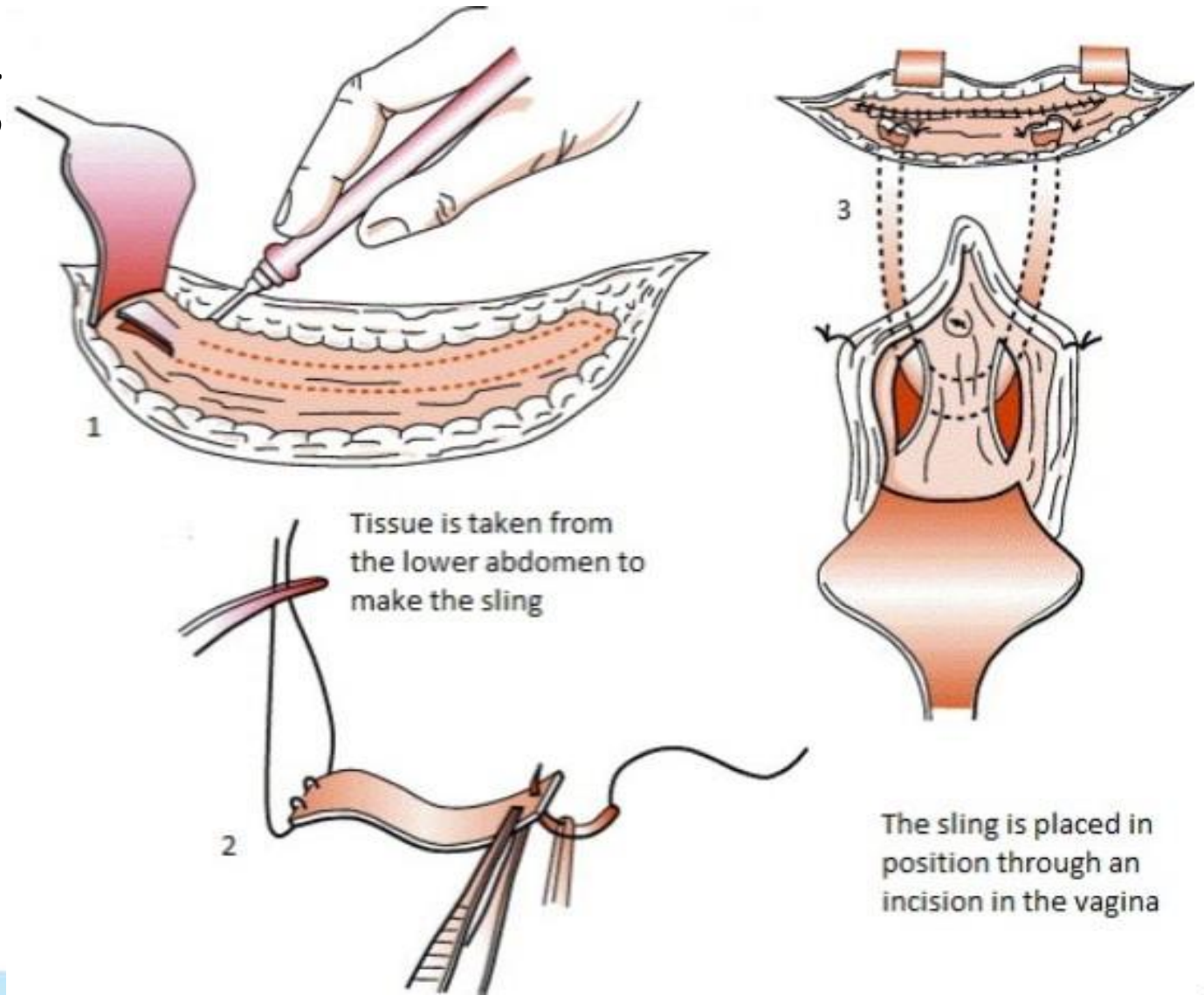


Image from Urology Associates

Mid urethral Sling

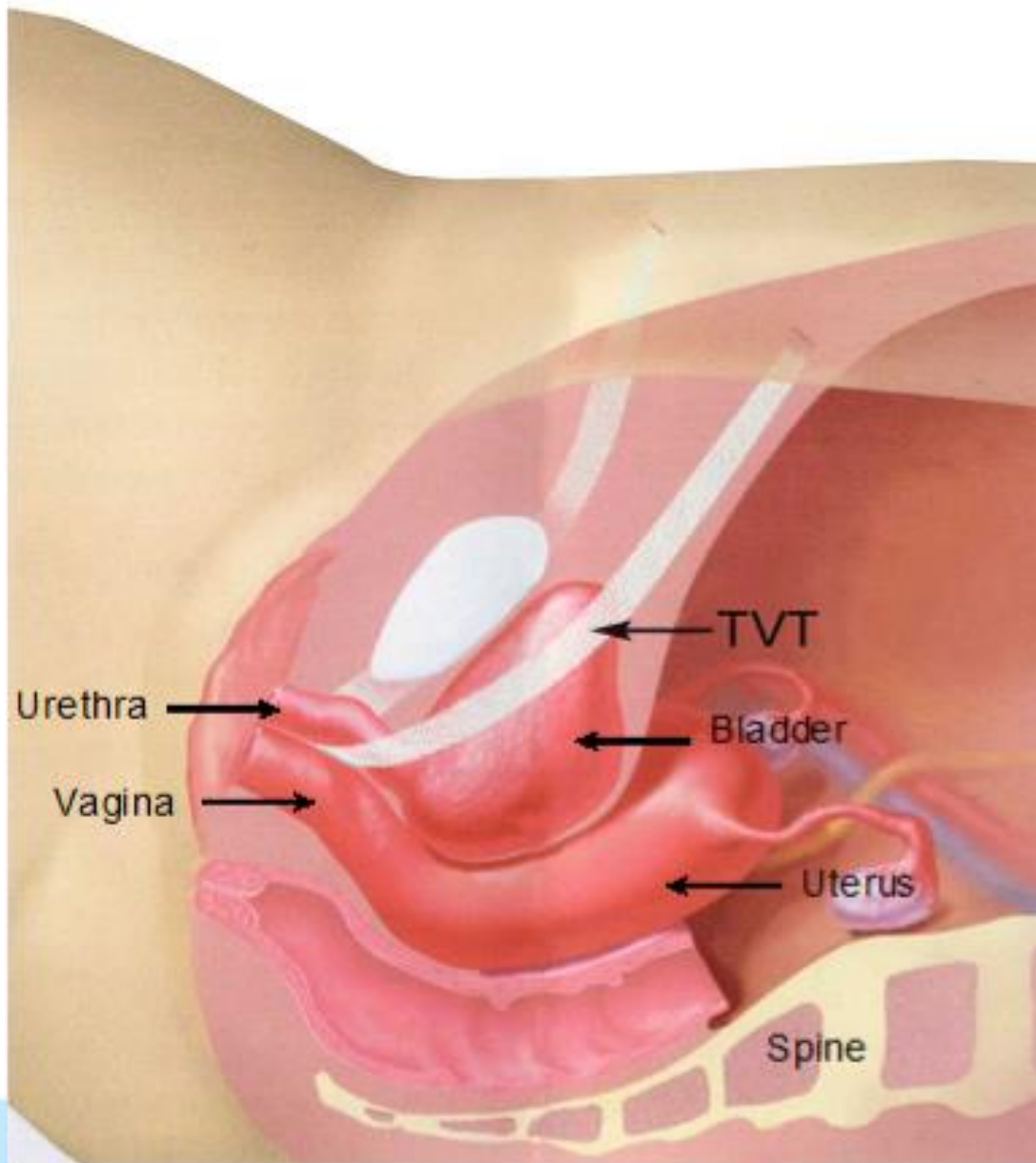


Image from Urology Associates

Stress Urinary Incontinence (SUI)

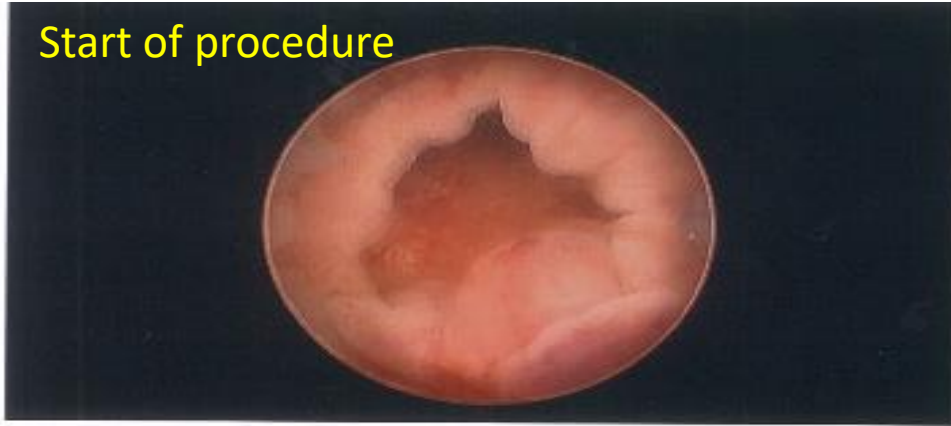
- Surgical therapy-periurethral injections
 - Macroplastique-polymethylsiloxane
 - Bulkamid-polyacrilimide
 - Coaptite-Calcium hydroxylapatite

Stress Urinary Incontinence

- Bulkamide: 80% success at 7 years
- Coaptite: 66.7% success at 2 years
- Macroplastique 64% success at 18 months

Stress Urinary Incontinence (SUI)

Start of procedure



After injections at 4 and 8 o'clock positions



Final result after three injections.



Urinary Urge Incontinence

- Treated with bladder retraining and/or pharmacotherapy
- Usual prescription medications not well tolerated
- Botox injections are very effective!

Botox technique



Urinary Drainage

- Often necessary in the early post-op period due to edema and trauma from the procedure
- Urinary retention is a risk from any prolapse or incontinence procedure
- Risk of retention after sling 2-4% after Botox 5% after periurethral injections 10%

Disposable Foley Catheter



Urinary drainage strategies

- Transurethral catheter
- Suprapubic catheter
- Clean intermittent self-catheterisation

Transurethral indwelling catheter

- Most commonly used
- Best for short-term drainage
- Must be removed for bladder trials

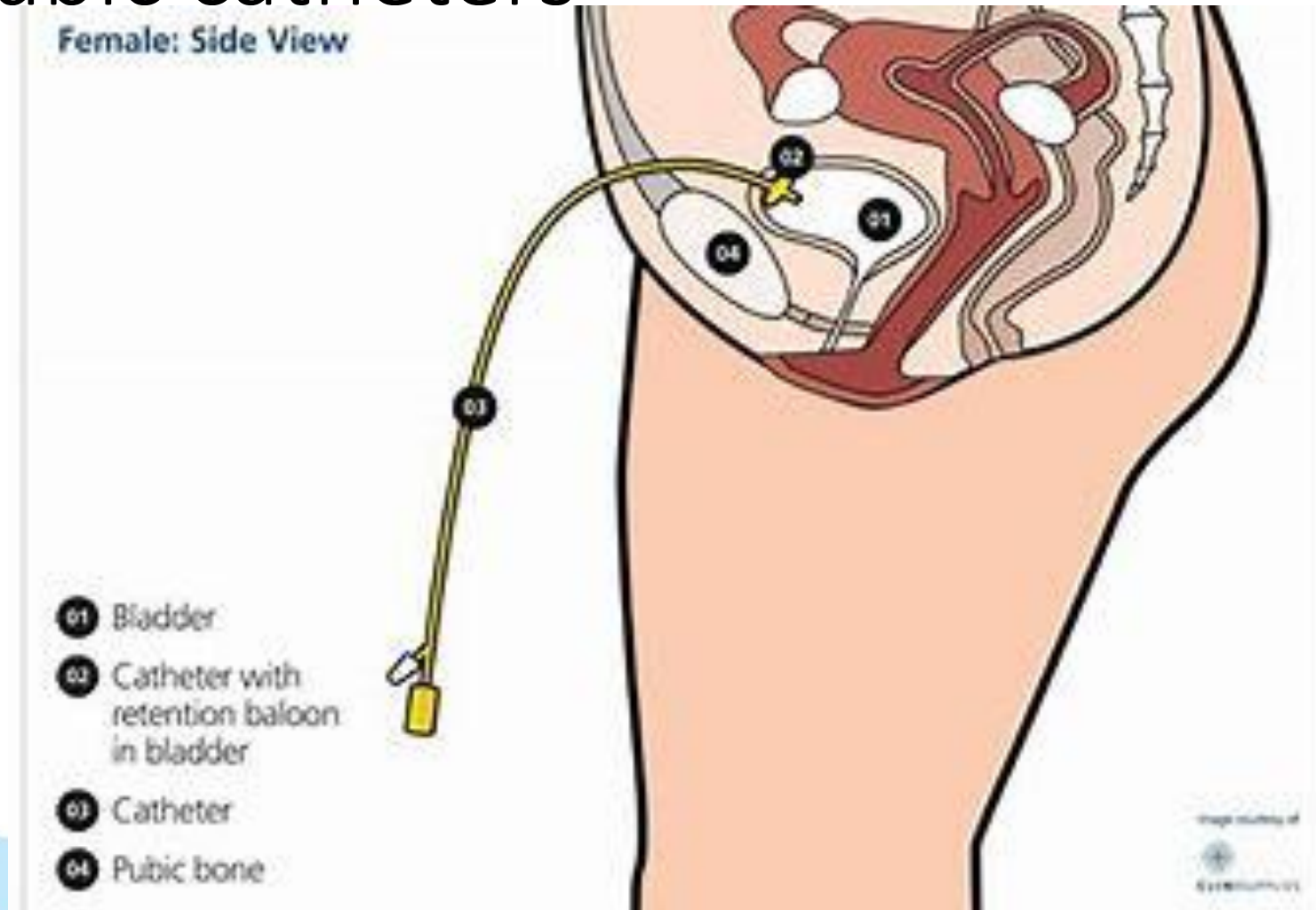
TROC protocols

- Can retrograde fill the bladder through the catheter with 300 mL sterile saline
- Remove IDUC and measure voided volume
- If passes more than 150 mL, GTG
- If high residual, can wait and measure PVR after next void or reinsert the IDUC

Transurethral catheter

- Disadvantages:
- Risk of infection or colonisation if left in place for long periods of time
- Not a great long-term option for this reason
- Bladder trials require removal of the catheter

Suprapubic catheters



Suprapubic Catheter

- Advantages: Inflated balloon often away from incision/repair/injury (if bladder integrity breached)
- Allows for voiding trial without removal of catheter
- Post-void residual volume is easily measured
- Less infection risk
- A better long-term drainage option than transurethral catheter

CISC

- Lower infection risk
- Woman is taught to insert catheter. Can insert post-void for voiding dysfunction, or 4-8 times per day for retention.
- Many unable or unwilling to utilise this method despite the advantages over transurethral catheter

Post-op urinary drainage

- Usual goal is early catheter removal. Post-op day one for most.
- Indication for longer use is usually urinary retention
- Extended drainage is required if urinary tract is breached (bladder or urethral injury)
- In the event of urinary tract injury, surgical team will determine the timing of catheter removal

Botox and voiding dysfunction

- Botox has delayed onset of action
- Urinary retention risk 5%
- If retention occurs related to Botox, onset usually 7-14 days after the procedure
- Suprapubic catheters can be helpful for patients who would be unable to perform clean intermittent self catheterisation

Questions?

