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TECHNOLOGICAL ADVANCES AND PERSPECTIVES

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ABSTRACTS

SUPPLEMENT
A - ANATOMY AND PHYSIOLOGY

A1 FASCIAL CONTINUITY OF THE ABDOMINAL AND LUMBAR REGION
CARLA STECCO1
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The connection between the pelvic floor, abdomen and lower back is clinically recognized but the anatomical basis of this link requires further clarification. The purpose of this work was to review the literature on pelvic fasciae, in order to provide a description of their continuity with the fasciae of abdominal muscles and lower back. Basing of the Literature review and the dissertation, we propose a precise organization of the fasciae of the pelvic floor. Particularly, 3 different myo-fascial layers could be recognized:
1) superficial fascia;
2) superficial layer of the deep fascia;
3) deep layer of the deep perineal fascia; this layer can be divided into two separate layers by the levator ani muscle.
Anatomically, the continuity in the fasciae of the abdominal wall, pelvic floor and lumbar region is plausible. A “new” theory of fascial anatomical continuity could have implications in the understanding of the clinical presentation of pelvic pain, the comprehension of the anatomical link between abdominal-lumbar disorders and pelvic floor, and in the treatment of chronic pain conditions, leading to an enhancement in current anatomical knowledge and therapies.
Keywords: Fascia, thoracolumbar fascia, anatomy, pelvic floor

A2 EFFECTS OF CESAREAN AND VAGINAL DELIVERY ON ABDOMINAL MUSCLES AND FASCIA
CARLA STECCO1, CHENGLEI FAN1, DE CARO RAFFAELE1
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Introduction: The possible disorders after cesarean section (CS) can interfere with the quality of life, most commonly pain. Aim: The aim of this study was to evaluate the changes of the fasciae and the abdominal muscles with CS and vaginal delivery and investigate the possible associations between different delivery mode and pain.
Materials and Methods: 13 primiparous women had CS (age: 41±5.8), 10 natural delivery women (age: 47.0±15.2), 13 nulliparous and healthy women (age : 29.3±4.8) were evaluated the thickness of the abdominal muscles and fasciae on both sides at rest and contraction position by ultrasound. Global spinal mobility tests and Pain Questionnaire were used to collect data related range of movement, pain intensity, frequency and location. Associations between the changes of muscle and fascia and pain were examined.
Results: The CS and vaginal delivery could influence the morphology of abdominal muscle and fasciae although the effect is not homogeneous. Compared with the nulliparous group, the abdominal muscles were significantly thinner at least on one side at relaxation and contraction position both in CS and vaginal delivery group, while, there is no significant difference between the CS and vaginal delivery group. The fascia of RA was significantly thicker on both side at relaxation and contraction position both in CS and vaginal delivery group except the left side in CS group during contraction. The loose connective tissue was significantly thicker on both side at relaxation and contraction position both in CS and vaginal delivery group, however, there is no significant difference in the thickness of the fasciae of abdominal and lower back in CS group with these alterations in fascia and abdominopelvic wall. Particularly, 3 different myofascial layers could be recognized:
1) superficial fascia;
2) superficial layer of the deep fascia;
3) deep layer of the deep perineal fascia; this layer can be divided into two separate layers by the levator ani muscle.
Anatomically, the continuity in the fasciae of the abdominal wall, pelvic floor and lumbar region is plausible. A “new” theory of fascial anatomical continuity could have implications in the understanding of the clinical presentation of pelvic pain, the comprehension of the anatomical link between abdominal-lumbar disorders and pelvic floor, and in the treatment of chronic pain conditions, leading to an enhancement in current anatomical knowledge and therapies.
Keywords: Fascia, thoracolumbar fascia, anatomy, pelvic floor

A3 MODULATION OF THE EXTRACELLULAR MATRIX PRODUCTION IN CELLS OF HUMAN FASCIA ACCORDING TO THE SEX HORMONE LEVELS
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It is now recognized that women suffer from myofascial pains more than men, and that the muscular fasciae can respond to hormonal stimuli, thanks to the expression of sex hormones receptors, but how the fasciae can modify their structure under hormonal stimulation is not clear.
In this work an immunocytochemical analysis of collagen-I, collagen-III and fibrinlin were carried out on fibroblasts isolated from human fascia lata after an in vitro treatment with different levels of sex hormones β-estradiol and/or relaxin-1, according to the different phases of a woman period (follicular, periovulatory, luteal, post-menopausal phases and pregnancy).
We have demonstrated for the first time that cells of fascia can modulate the production of the extracellular matrix according to the hormone levels, when treated with β-estradiol: collagen-I goes down from 5% of positivity of the follicular phase to 1.9 in the periovulatory phase. But, when in the cell culture Relaxin-1 was added, the production of extracellular matrix decreased and it was maintained at the same level (1.7% of collagen-I, both with follicular and periovulatory levels of hormones). These results confirmed the antibiotic function of Relaxin-1 by the ability to reduce matrix synthesis, and help to explain why women with hormonal dysfunctions may have myofascial pains by the dysregulation of extracellular matrix production.
Keywords: fascia, estradiol, sex hormones, myofascial pain

A4 MYOFASCIAL RELATED ISSUE: ASSESSMENT AND THERAPY
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Structurally and functionally the pelvis is a complex anatomical region. Within its bony confines converge multiple biological systems and within its cavity lay organs that are at the center of various pelvic pain syndromes. In clinical practice, research and pain modelling very little consideration has been given to the role of the fascial system which invests every organ, nerve, blood vessel and muscle. Given that fascia forms a fibrous communication system which conveys mechanical information to every cell and organ, changes in its malleability and plasticity will impact the optimal performance of organs in the pelvis. The rich innervation of fascia and the ganglia embedded in its network directly links it to chronic pain and pelvic muscle and tensional changes within the fascial system are linked to symptoms of organ distress, loss of function and general perception of ill health.
Keywords: Myofascial Related Issue: Assessment and Therapy

B - PROLAPSES

B1 EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT, BUT WERE AFRAID TO ASK: AN OWN LAWSUIT EXPERIENCE AFTER MESH SURGERY
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Use of surgical mesh through the vagina to treat POP has been associated with higher rates of mesh-related complications, including mesh poking through the vaginal skin, pelvic pain and pain with intercourse. In 2019, the FDA ordered manufacturers of surgical mesh for the transvaginal repair of pelvic organ prolapse to stop selling and marketing their products for further use.
POP to stop selling and distributing their products in the U.S.A. In Europe Great Britain is following this trend.

Transvaginal mesh lawsuits list a variety of claims, depending mostly on the complications experienced by the women filing the suits. In many cases, women who experience any of these severe side effects have limited treatment options, which may include additional surgeries to remove the pelvic mesh and repair damaged tissue. Ethicon, a division of Johnson & Johnson, is the subject of more than 40,727 vaginal mesh lawsuits as of May 2019. Many side effects happen lately and confuse patients as well as doctors. But what about laparoscopic meshes? We don’t really have long-term studies.

We experience in Europe and particularly in Germany a trend to manage POP with laparoscopic mesh techniques in very many variants, free-hand or robotic.

Laparoscopic mesh or tape techniques seem to be applied frequently in order to bypass possible complications of the vaginal meshes and believing they are safe. Is it really so?

In Germany lawsuits particularly claim against surgeon and his employing hospital and not (yet) against manufacturer. The compensations are not as big as in the U.S.A., but endanger the professional future and also the private financial situation of the surgeon.

In an actual lawsuit against managing POP through inserting laparoscopic tapes we experienced a late perforation of the mesh in the bowel. We want to analyse the possible points of attack in the court and find ways to defend ourselves:

- indication for surgery: anatomic- and/or functional disorders?
- the most important: counseling the patient about need of surgery, alternative methods and possible short- or long-term complications
- choosing the best approach: vaginal, transperitoneal or both
- qualification of the pelvic surgeon and his pelvic floor unit
- counseling the patient in choosing her most appropriate INDIVIDUAL therapy; choosing FOR HER the „best“ procedure: TO mesh or NOT TO mesh
- post-operative care, detecting complications early and searching the best way to manage them; guidance of the patient to avoid lawsuits
We shell together think more about this aspect of our practice as pelvic surgeons!

**Keywords:** Vaginal mesh, lawsuit, claim, pelvic surgeon, laparoscopic.

**Acknowledgments:** No conflict of interests

**B2**

**BIOMECHANICAL MAPPING MAY PREDICT CHANGES AFTER PELVIC ORGAN PROLAPSE SURGERY**

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**Objective:** To explore whether pre-surgical biomechanical conditions of the female pelvic floor influence the biomechanical parameter changes after pelvic organ prolapse (POP) surgeries.

**Methods:** This clinical study was designed to explore changes in tissue elasticity, pelvic support, and functions (contractile strength, muscle relaxation speed, muscle motility) after POP surgeries. A Vaginal Tactile Imager (VTI) was used for biomechanical mapping of the pelvic floor before and 4-6 months after surgery. The VTI data were acquired for manually applied pressure. The parameter changes after POP surgery were compared with their pre-surgical values. The correlation coefficient was calculated using Pearson correlation coefficient.

**Results:** Seventy-eight clinical cases involving 255 surgical procedures at five clinical sites were analyzed. Each of the 78 cases had undergone planned surgical procedures as the best fit proposed for the specific pelvic conditions by a urogynecologist. All 521 tests for Group 1 versus Group 2 have p-value ranging from 4.0 *10^-10 to 4.3 *10^-2. This indicates that all of the 52 parameter changes after surgery depend on pre-surgical conditions.

**Conclusions:** POP surgery, in general, improves the biomechanical conditions and integrity of a weak pelvic floor. The pre-surgical VTI parameters can predict biomechanical changes resulting from POP surgery.

**Keywords:** Pelvic organ prolapse, pelvic surgery outcome, biomechanical mapping

**Acknowledgments:** This research was supported by the National Institute On Aging of the National Institutes of Health under Awards Number S1BAG034714.
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B3 COMPLICATION OF RECONSTRUCTIVE PLASTIC SURGERIES CONCERNING PELVIC ORGAN PROLAPSED AT WOMEN

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Purpose: Assess the incidence of complications after surgical treatment of pelvic organ prolapse using mesh

Material and methods. From 2013 to 2016 in clinic Research Institute of Clinical and Experimental Gynecology 179 patients with a pelvic organ prolapse with use of synthetic materials have been operated. All patients underwent vaginal and rectal inspection on a gynecologic chair with assessment of the stage of a prolapsed condition of the leading point of a prolapse on the POP-Q system (ICS 1996). Average age of patients was 60.7 years. Most of patients were in the postmenopausal period more than 5 years. All patients were subject to expedientious treatment of a prolapse with use of synthetic materials. The average time of operation was 64.31 minute. Average blood loss has made about 200 ml. Spinal anesthesia has been chosen as the most preferable. The general anesthesia was used when carrying out simultaneous operations and flat refusal of the patient of spinal anesthesia.

Results: The average time of stay of the patient in a hospital was 18 days. To all patients antibacterial therapy was carried out by an antibiotic of a wide range. The antibiotic was entered into time of operation and within 5 days of the postoperative period. In parallel correction of a pelvic organ prolapse, carried out the combined operations, such as perineoplastic, amputation of a neck of the uterus, stress urinary surgery. All complications have been classified as follows: short-term complications, long-term complications, exposure of synthetic implants, functional complications. Total of complications on 179 performed operations I have made 20 cases (11.5%).

Conclusion: Thus, the accumulated experience forces us to estimate critically approach to universal use of mesh-materials and more accurately to make selection of patients. Despite high efficiency, use of synthetic materials can be followed by heavy complications. Some of them can pose serious hazard to life and health of patients. In a ligature with what, according to us, the best prevention of complications is strict selection of patients for treatment, good knowledge of topographical anatomy of a small pelvis and crotch, exact respect for technology of installation of an implant, and also training of doctors in the certified training centers. According to us, the future of reconstructive surgery of pelvic organs prolapse at women, consists in decrease of cases of use of synthetic implants and transition to use native tissue with various options of use the autologous fibroblasts.

Keywords: pelvic organ prolapse, synthetic implants

B4 FUNCTIONAL RECONSTRUCTION OF VAGINAL PROLAPSE WITHOUT MESH INTERPONATES

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Purpose: To renounce on the use of mesh interponates in the tranvaginal treatment of the prolapse and functional disorders of the pelvic organs.

Material and methods: We describe a minimal- invasive and intuitive operation technique. The method implements all components of the posterior and middle compartment.

Results: Five patients with I to III prolapse have been treated successfully with this innovative method. Clinically identifiable cystocele is co-treated with kolporrahaphia anterior. All patients were satisfied with the results. On the third postoperative day, all patients were discharged. Two of the patients complained postoperatively about buttack pain on both sides. One with one-sided pain. The remaining two patients were symptom free. Postoperative checks after three weeks showed eased buttack pain. In one patient a preoperative minimal fecal incontinence was reduced from 2nd degree to first degree. There was no postoperative dyspaneuria reported.

Conclusion: The described surgical procedures are safe and show promise results. A good architectural reposition of the pelvic organs alone is not sufficient to restore a normal function of the pelvic organs and the pelvic floor. An in-depth knowledge of the entire anatomy and function of the pelvic organs is indispensable.

Keywords: Incontinence, mesh, tranvaginal operation, autologous tissue, dyspaneuria.

B5 LATERAL SUSPENSION AS AN EFFECTIVE TREATMENT FOR PELVIC ORGAN PROLAPSE

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Objective: To evaluate the surgical effectiveness of the procedure, the long-term results postop.

Materials and methods: treatment analysis was carried out for 74 patients with anterior and apical prolapse. The age of patients ranged from 44 to 68 years. Assessment of the severity of the pelvic floor defect was carried out according to the POP-Q classification. All patients underwent intervention using a T-shaped polypropylene mesh implant (Soft) with fixation of the prosthesis in the cervical stump region, uterus and vaginal dome prolapse. The mesh sleeves were passed through formed tunnels under the parietal peritoneum of the anterior abdominal wall to the skin, at a point 4 cm high- er and 2 cm lateral to the anterior superior iliac spine. The duration of the surgery ranged from 60 to 120 minutes. Average blood loss 100 ml. A comprehensive assessment of the effectiveness was carried out using the PFDI-20 (Pelvic Floor Distress Inventory) as well as PFQ-7 (Pelvic Floor Impact Questionnaire) questionnaires. 33 patients stage 0, 13 patients - stage 1. According to the questionnaires, 66 of 74 patients postop showed a significant improvement in the following indicators: foreign body sensation in the vagina, obstructive or urgent urination.

Conclusions: Analysis of the surgical treatment of genital prolapse using the method of lateral suspension showed decrease in the severity of pelvic organ prolapse, a decrease in the duration of surgical intervention as well as the frequency of complications associated with the surgical procedure.

Keywords: lateral suspension, pelvic organ prolapse, apical prolapse

B6 SITE-SPECIFIC AND TAPES POP RECONSTRUCTION BY VAGINAL ROUTE

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Background: Due to FDA restrictions regarding using mesh in vaginal surgery and medicolegal issues worldwide there is 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 and fascia using polypropylene tapes. We developed “low cost” trocar guided variation of POP restoration.

Methods: Procedure begins with the incisions of anterior and posterior vaginal wall, mobilization of the rectovaginal and pubocervical fascia, identification SSL, USL, CL. We use 2.7mm low elastic PP tapes. Posterior sling pass through SSL “inside-out” manner and place middle part in front of cervix. Anterior sling is passing through oburator foramen near attachment of ATLA to PS. Both slings are fixed to the cervix anteriorly. At that, we restore fasciae in specific manner and plicate both cardinals in front of the cervix and USL posteriorly with non-resorbable sutures. If indicated, lax perineal body, anal sphincter or PUL also repaired. Thus we repair all the ligaments (USL, CL, ATPF, PB and PUL) with the tapes and/or with native tissues.

Results: Since 2016 we have done 134 procedures in 4 clinics. Indication: different types of symptomatic POP 2-4 stages (POPQ). Simultaneous operations were: trachelectomy in 7%, LS supracervical hysterectomy in 4%, TVT-O in 23% cases, PB repair (29%) as well EAS repair (3%). To estimate outcome we used: QOL questionnaires (PFDI-20, PPQ-7, SF36) and factor analysis of the symptoms according diagnostic algorithm. Operation time was 90±25 min. Blood loss never exceed 150 ml. We have 1 complication during perineumplasty breakdown of the needle which required wide dissection of right ischiorectal space – 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 23±6 months. Erosion rate was zero. There were statistical long-term improvements of function-
al results of symptoms: PFDI-20 115.5/48.7 (p<0.01), PFHQ-7 68.7/14.4 (p<0.01). Sexually active patients (52%) report improvements according FSFI (p<0.01). There was significant improvement of symptoms: bulge 96 to 4%, pelvic pain - 14 to 3%, dyspareunia 29 to 3%, obstructive urination 29 to 0%, frequency 47 to 10%, urgency - 11.7 to 1.5%, stress incontinence - 23 to 7% (in 15 cases of de novo SUI MUS was placed in 24 months), obstructive defecation 17 to 3%, AI 7 to 0%, nocturia 29 to 0%. We noted 5.8% asymptomatic cases of cystocele mostly paravaginal and 5% of apical prolapse 2nd degree without reoperation.

**Conclusions:** Mid-term results make possible to consider this approach as effective minimally-invasive method of “functional surgery”. However, long-term multicenter study needed.

**Keywords:** POP tape, ITS

Fig 1 - Position of slings. Red arrows show plication of cardinal ligaments

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**B7**

A MODIFIED ROBOTIC-VR WITH A FOLDED SINGLE MESH SUSPENSION TO TREAT COMPLEX PELVIC ORGAN PROLAPSE

**Purpose:** To propose a modified robotic ventral rectopexy for complex pelvic organ prolapse treatment.

**Material and Methods:** From January to December 2018, all the patients with internal rectal prolapse and rectocele associated with middle-anterior-compartment organ prolapse were enrolled. The procedure is robot-assisted (Da Vinci Xi) and based on the conventional ventral rectopexy using a 3.5 cm in-length titanized polypropylene mesh. The recto-vaginal dissec tion reaches the elevator plane and the mesh is sutured to the anterior rectal wall and then fixed to the sacrum. The mesh remnant is then folded and fixed to the posterior or anterior vaginal wall depending on the concomitant prolapse type. The combined suspension is preoperatively decided after accurate clinical and radiological evaluation.

**Results:** Sixteen patients underwent ventral rectopexy. Ten had a concomitant enterocele whereby a posterior vaginal wall suspension was associated. Six underwent to anterior vaginal wall suspension for a concomitant cystocele with vaginal vault prolapse. Mean operative time was 148min. No intraoperative complications were recorded. One hematoma of the rectal stump was recorded in 2 (3.63%) cases.

**Conclusions:** Colpocleisis is a safe procedure used in management of pelvic organ prolapse in elderly women with no desire of sexual function.

**Keywords:** surgical procedures, pelvic organ prolapse, colpocleisis

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**B8**

SURGICAL TREATMENT OF PELVIC ORGAN PROLAPSE IN ELDERLY WOMEN

**Purpose:** To study the role of obliterative procedures performed for severe pelvic organ prolapse (POP) in elderly patients.

**Materials and Methods:** The retrospective study was performed during 2014 and 2019 on 237 patients with different stages of pelvic organ prolapse. In the analyzed group of patients, 88 patients (37.13%) had advanced POP (III-IV stages) and were in 7th and 8th decades.

**Results:** From 88 patients with advanced POP, 17 (19.31%) was recurrent pelvic organ prolapse. The average age of diagnosis was 74.77 years (70 and 96 years). We performed obliterative procedures in 55 (62.5% cases) and reconstructive procedures in 33 (37.5%) cases. The decision to perform obliterative procedures was according to the informed consent of the patient and no desire of sexual function. Procedures for urinary stress incontinence were performed in 25 (28.40%) cases. The average time of the surgery was 34 minutes (30-42 minutes). The average hospital stay was 1.83 days. The recurrence of pelvic organ prolapse after colpocleisis were recorded in 2 (3.63%) cases.

**Conclusions:** Colpocleisis is a safe procedure used in management of pelvic organ prolapse in elderly women with no desire of sexual function.

**Keywords:** surgical procedures, pelvic organ prolapse, colpocleisis

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**B9**

ORGANIC POP REPAIR BUTTERFLY3D® REINFORCEMENT IN RECTOCELE SURGERY

**Purpose:** To evaluate efficacy in terms of vaginal capacity, coital function, and recurrence’s prevention of a new biological graft of bovine periuridium (patented by us as “Butterfly 3D®” produced by ASSUTEUROPE), in the repair and reinforcement of fascial reconstructive surgery in case of severe rectocele and POP central and posterior compartment.

**Materials and Methods:** Thirty cases of patients suffering from stage III-IV uterine or apical prolapse, with severe and symptomatic rectocele, underwent surgical repair by means of a modified wet ileococcigeal muscle suspension combined with a biological graft “Butterfly 3D®, attachment anteriorly to both the cardinal ligaments or uterosacral ligaments, caudally to ileococcigeal weight muscle, and frontally to perineal body fixation. The biological device was replaced inside the pelvis with the goal of reconstructing the transmensional fascial disposition of the structures sustaining the correct axis of vagina: so called “Butterfly 3D®”. Even to stabilize anorectal functionality. Follow-up was done at 12 months with POPQ analysis. Teslacare rehabilitation was proposed.

**Results:** One total graft failure occurred early after surgery due to marked deficiency of anatomy. Two cystoceles were observed at 12 months in two patients treated for apical prolapse where anterior repair was not performed. Two other patients developed a de novo SUI at 12 months. No reported abnormalities of coital function or dyspareunia were ever found after surgery. In case of defecation syndrome or fecal dysfunction & incontinence, patients are all improved.

**Conclusions:** It is possible that the utilization of a tension-free and transmensional placement of Butterfly 3D® Biological Graft might favor a more physiological and safe reconstruction of the vaginal axis as compared with traditional sacropinous suspension, improving defecation and fecal continence.

**Keywords:** Biologic Graft, POP Vaginal Surgery, Prolapse, Biological Mesh, Bovine Pericardium.


B10 CERVICAL ELONGATION IN POP MANAGEMENT. FALSE APICAL PROLAPSE PHENOMENON
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Cervical elongation is described as the protrusion of an enlarged cervix in antero-posterior dimension into the wall of the pelvis due to the weakness of the Cardinal-US ligament system. Sometimes described in the literature as cervical elongation attention focused on vaginal portion of the cervix. This type of longitudinal cervix enlargement must be distinguished from the elongation of the extraperitoneal cervical portion, which can be diagnosed during vaginal hysterectomy. Apical (uterovaginal) prolapse has traditionally been classified anatomically depending on the level of descend of the uterus, cervix and upper vagina (posterior fornix). The true surgical apex of vagina, means the full thickness wall of proximal vagina from the vaginal fornix to the pouch of Douglas (PD). No any POP classification systems focused to the level of the other side of the reproductive tract bulge. In case of elongation of extraperitoneal portion, anatomy, from vaginal view, can be recognized as apical prolapse, but the level of the pouch of Douglas can be on the interspinal line. This mean “False apical prolapse”. Preoperative cervical assessment can be helpful in POP surgical management. Avoidance of unnecessary hysterectomy or apical support procedures in case of cervical elongation can increase postoperative results among young patients.

Keywords: Cervix Uteri, Prolapse, Hysterectomy, Uterine cervical elongation


Fig 1 - Flowchart of study selection process

B11 SACROCOLOPEXY: ADVANTAGES AND DISADVANTAGES BETWEEN ABDOMINAL AND LAPAROSCOPIC APPROACH - META-ANALYSIS
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Pelvic organ prolapse is a medical condition in which one or more pelvic organs descend from their anatomical position. This disorder has become a common problem among women and because of the increasing incidence, several surgical techniques have been developed. Prolapse surgery must take into consideration the cost-benefit, complication rate, morbidity and success of the procedure both short and long-term. The current ‘gold standard’ surgical repair for pelvic organ prolapse is abdominal sacrocolpopexy because of its high success rate and excellent anatomical outcome. Laparoscopic sacrocolpopexy has become an alternative for the abdominal approach. The aim of this systematic review is to compare the advantages and disadvantages between the laparoscopic sacrocolpopexy with the abdominal approach.

Keywords: sacrocolpopexy, pelvic organ prolapse, laparoscopy, abdominal, systematic review, meta-analysis

Tab.1 - LSC and ASC surgical outcomes comparison

B12 THREE LEVEL HYBRID REPAIR OF ADVANCED POP VIA VAGINAL APPROACH
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Purpose: The purpose of the study was to evaluate the efficiency and safety of three level hybrid repair of advanced pelvic organ prolapse (POP).

Materials and methods: The study included 114 patients who received simultaneous transvaginal reconstruction of all levels of the pelvic floor support (according to Delancey), consisting of: unilateral sacrospinous fixation with the use of apical sling (level 1), anterior subfascial colporrhaphy (level 2), and posterior colpoperineorrhaphy (level 3). The 12-month follow-up period included the evaluation of pelvic organ prolapse by standardized POP-Q system and the filling in the validated questionnaires (PFDI-20, ISIQ-SF, PISQ-12).

Results: The mean operative time was 52,1±4,8 minutes. The intraoperative bladder injuries or clinically important bleedings were not revealed. Postoperatively the significant clinical improvement of POP-Q measurements with the total vaginal length (TVL) was noted approximately in all patients. During the 12-month follow-up period the anatomical recurrence was detected at the apical level (C>1) in 1 (0,8%) patient and in the anterior compartment (Ba>1) in 5 (4,3%) patients. No case of vaginal mucosa
erosion was detected as well as the pain syndrome. 6 (5.2%) women de-
veloped de novo dyspareunia after surgery. The majority of patients after the treat-
ment given noted a significant improvement in the quality of life. Only one patient complained of de novo dyspareunia. Satisfaction with the treatment results according to the questionnaires was 94.7%.

**Conclusions:** The reconstruction of all three levels of pelvic floor support allows to spread evenly the bear load between the compartments and thus, to reduce the amount of used synthetic material maintaining high efficiency and safety of the transvaginal surgical reconstruction of POP.

**Keywords:** pelvic organ prolapse, apical sling, sacro-spinous fixation, three level repair

**B13**

**COMPUTER MODELING AND SIMULATION AS A SOURCE OF PRIOR INFORMATION IN CLINICAL TRIALS OF MESHES FOR PELVIC DYSFUNCTION**

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**Introduction** Until recently surgeons relied on the use of meshes in recon-
structive surgeries, but on April 16, 2019, the FDA has forbidden its use. FDA requires that safety and efficacy meshes have to be demonstrated in the context of patient population in a clinical trial. Computer models and simulation can potentially be used in clinical trials as an alternative source of prior information to simulate clinical outcomes in a virtual patient popu-
ulation. A virtual patient model that can be used within mesh premarket approval has been developed. It is expected that the research being reported can contribute to accelerate the adoption of meshes on prolapse correction.

**Methods** In this work was used a pelvic cavity computational model, in-
cluding the pubic bone, the pelvic organs, the PFM, and other support-
ing structures was used. The in vivo biomechanical properties applied to
the pubic bone, the pelvic organs, the PFM, and other support-
ings were expected to be used within mesh premarket approval has been developed. It is expected that the research being reported can contribute to accelerate the adoption of computer simulations.

**Results** The maximum displacement of the bladder and urethra and blad-
ner neck was simulated and the computational analysis shows that the introduction of the FEA has been developed. It is expected that the research being reported can contribute to accelerate the adoption of computer simulations.

**Clinical implications** The computational models coupled with inverse
FEA may help to estimate non-invasively the in vivo biomechanical properties of the structures of the PFM, including the pelvic ligaments. The knowledge of the in vivo biomechanical properties of the pelvic tissues, will help the development patient-specific meshes.

**Keywords:** Pelvic Floor Cavity Urinary Incontinence Computational Models In vivo biomechanical properties Sling


**Discussion** Computational simulations showed that there is a reduction of the displacement values in the bladder and in the bladder neck when was applied the meshes. However, there is a greater reduction in the displace-
ment of the bladder and urethra, when are applied of the material properties of incontinent women, being this variation of approximately 8.27% with the high stiffness mesh and 6.96% with the low stiffness mesh.

**Results** The computational model was able to discriminate the effect of using different types of support meshes to evaluate urethral mobility. The current abstract reports only results for urinary incontinence but work in progress will extend the virtual model to study the effect of meshes on prolapse correction.

**Clinical implications** The computational models coupled with inverse
FEA may help to estimate non-invasively the in vivo biomechanical properties of the structures of the PFM, including the pelvic ligaments. The knowledge of the in vivo biomechanical properties of the pelvic tissues, will help the development patient-specific meshes.

**Keywords:** Pelvic Floor Cavity Urinary Incontinence Computational Models In vivo biomechanical properties Sling


**B14**

**PROLAPSE-INDUCED NOCTURIA: ACTUAL SCIENTIFIC EVIDENCE**

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**Introduction:** Nocturia can be caused by nocturnal polyuria of different reasons, but it occurs also without polyuria. P. Petros (1997) mentioned first the association between pelvic organ prolapse (POP) and nocturia, which he could cured in 80 % by prolapse repair. In many actual publication this association is not mentioned. Therefore we analyzed the data of the Pro-

**Material and Methods:** In this prospective multicenter study 277 women were asked for bother from nocturia using the Pelvic floor disorder inven-
tory questionaires (PFDI) pre-, 6, 12 and 24 months postoperatively. Pel-

caviy, 277 women were identified as responders, 87 as non-responders. We compared women with successful reconstruction with women with failed reconstruction (POP-Q stage 0 or 1 at any follow up period at all compartments, ana
tomical markers (“responders”) to all other women (“non-responders”) regarding the bother of nocturia.

**Results:** 141 patients were identified as responders, 87 as non-responders. The outcome R2 (bother moderately or quite a bit) was evaluated separate-
ly because of its clinical relevance. Regarding the bother, we found that occur

**Introduction:** Nocturia can be caused by nocturnal polyuria of different reasons, but it occurs also without polyuria. P. Petros (1997) mentioned first the association between pelvic organ prolapse (POP) and nocturia, which he could cured in 80 % by prolapse repair. In many actual publication this association is not mentioned. Therefore we analyzed the data of the Pro-
pel-study (ClinicalTrials.gov Identifier:NCT00638235) to find evidence for this association.

**Material and Methods:** In this prospective multicenter study 277 women were asked for bother from nocturia using the Pelvic floor disorder inventory questionnaire (PFDI) pre-, 6, 12 and 24 months postoperatively. Pelvic Organ Prolapse Quantification system (POP-Q) stages were measured at the same times. We compared women with successful reconstruction (POP-Q stage 0 or 1 at any follow up period at all compartments, anatomical “responders”) to all other women (“non-responders”) regarding the bother of nocturia.

**Results:** 141 patients were identified as responders, 87 as non-responders. The outcome R2 (bother moderately or quite a bit) was evaluated separately because of its clinical relevance. Regarding the bother, we found that occurrence rates of R2 was significantly reduced after surgery in all subgroups. In the responders the cure rates were 83 % after 6 months and 69 % after 24 months, in the nonresponders 57 % and 39 % respectively.

**Conclusion:** These data strongly support the concept of prolapse-induced nocturia which can be cured by adequate pelvic floor surgery. Recurrence rates of R2 was significantly reduced after surgery in all subgroups. In the responders the cure rates were 83 % after 6 months and 69 % after 24 months, in the nonresponders 57 % and 39 % respectively.

**Keywords:** Conclusion: These data strongly support the concept of prolapse-induced nocturia which can be cured by adequate pelvic floor surgery.

**B15 VAGINAL AND LAPAROSCOPIC APPROACH FOR MASSIVE GENITAL PROLAPSE**

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We report a case with pictures (pre, intra and postoperative) of a woman 50 years-old with massive genital prolapse without urinary and faecal symptoms and signs. We decided to perform a vaginal hysterectomy with anterior wall reconstruction followed by laparoscopic colposuspension to utero-sacral ligaments and then a transvaginal reconstruction of posterior wall and perineum. In such cases vaginal and laparoscopic approach can be a valid option in non-prosthetic surgery.

**Keywords:** Pelvic organ prolapse, vaginal hysterectomy, colpopye, shall colposuspension, laparoscopy


**Interpretation of results:** The CESA technique could also be implemented laparoscopically and achieved the same clinical results (restoration of apical prolapse and urinary continence). In addition, the duration of surgery in laCESA could be reduced (learning curve) and the immediate postoperative mobilization shortened (from 5 days to 2 days).

**Conclusions:** The advantage of the bilateral USL replacement lies in the comprehensible, standardized - and thus reproducible – surgical technique and the minimum amount of material (no polypropylene). Besides, the laparoscopic CESA (laCESA) offers a shorter surgical time (85 min after laCESA vs. 122 min after CESA) and the mean surgery hospital stay (3 after laCESA vs. 6 days after CESA) and the mean surgery time (85 min after laCESA and 122 min after CESA). For these reasons, a laparoscopic procedure (laCESA) has been developed.

**References:**


**Acknowledgments:** With the help of Mrs. Elke Neumann this study would not have been possible.
B17
SACROPEXY FOR PELVIC ORGAN PROLAPSE USING MESH FIXATION DEVICE: SAFETY AND EFFICACY OUTCOMES
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Purpose: Abdominal mesh sacropecy (SP) is considered the gold standard treatment for pelvic organ prolapse (POP), particularly when vaginal vault prolapse is present [1]. To fasten and ease SP procedures, particularly when minimally invasive approaches are used, mesh fixation devices have been introduced, but very few data are available on the use of these devices.

Materials And Methods: A retrospective evaluation of patients with pelvic organ prolapse (POP) undergoing open (OSP) or robot-assisted (RASP) SP, from Sept. 2012 to Oct. 2018, was undertaken. Inclusion criteria were 1) primary or recurrent symptomatic POP (ICS POP-Q stage ≥2), including vaginal vault or uterus prolapse, with or w/o prolapse in other compartments, and 2) use of sacral promontory mesh fixation device. Patients with less than 12 mos follow-up were excluded. A macroporous monofilament tetanizing ultralight polypropylene mesh was used, Y-shaped for colposacropexy (TiLOOP® EndoPLUS) and T-shaped for hysterocacropexy (TiLOOP® Mesh; pfmmedicial, Köln, Germany). The proximal part of meshes was anchored to the promontory using four titanium spiral tacks, 5 mm apart, delivered with ProTackTM 5 mm (Covidien, New Haven, CT), a single-patient-use fixation device preloaded with 30 tacks. After ensuring optimal contact between the device tip and the underlying mesh, the device was activated by compressing the hand piece trigger to drive a tack through the mesh into the anterior longitudinal ligament.

Results: Thirty-two patients (median age 66 years) were evaluated. Four (12.5%), 21(65.6%) and 7(21.9%) patients had POP-Q stage 2, 3 and 4, respectively. Median follow-up was 45.7(37) months. Fifteen patients (46.9%) underwent a colposacropexy (3 RASP and 12 OSP) and 17 patients (53.1%) a hysterocacropexy (8 RASP and 9 OSP). Mean total skin-to-skin operating time was 88(358) minutes for OSP and 120(32) minutes for RASP. In one case the device was blocked and had to be replaced. The primary outcome (POP-Q point C < 5) was achieved in 100% of cases. The secondary composite outcome (POP-Q Stage ≤1 and no vaginal bulge symptoms, and/or re-treatment) was achieved by 29 patients (90.6%); three patients (9.4%) had recurrent POP (POP-Q Stage ≥2), but only one was symptomatic (3.1%) (de novo POP in untreated posterior compartment). At PGI-I, 93.8% subjective success (PGI-I ≤2) rate was achieved. ICQ-SF was unchanged after surgery. No intraoperative complications were observed. Mean estimated blood loss was 75(35) ml. The median duration of hospitalization was 4(1-25) days. The rate of early postoperative complications was low (9.4%) and no grade 2-5 complications were observed. There were no cases of mesh infection and erosion.

Conclusions: The results of this study provide evidence regarding the mid-term safety and efficacy of using ProTackTM device instead of suture for a reliable promontory mesh fixation to restore the apical support during colpo/hysteroacropexy in patients with POP. No patient relapsed at the long-term. The secondary composite outcome (POP-Q Stage ≤1 and no vaginal bulge symptoms, and/or re-treatment) was achieved by 65 patients (92.6%) (de novo POP in untreated posterior compartment). At PGI-I, 93.8% subjective success (PGI-I ≤2) rate was achieved. ICQ-SF was unchanged after surgery. No intraoperative complications were observed. Mean estimated blood loss was 75(35) ml. The median duration of hospitalization was 4(1-25) days. The rate of early postoperative complications was low (9.4%) and no grade 2-5 complications were observed. There were no cases of mesh infection and erosion.

Keywords: pelvic organ prolapse, mesh fixation, colposacropexy, hysterocacropexy


B18
UTEROSACRAL LIGAMENT AUGMENTATION (USLA) WITH ANTERIOR TRANSOBURTURATOR TAPES (ATOTS)
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2Faculty of Medicine, University of Maribor

Purpose: To evaluate efficacy and safety of apical and anterior vaginal prolapse repair using self-tailed tape implants with vaginal surgical approach.

Materials and methods: Between January 2017 and May 2019, 41 corrections of apical and anterior vaginal prolapse stage II-IV by ICS system (median age=60 years [42-79 years]) were performed with USLA and ATOTS by the same experienced surgeon. Polypropylene non-absorbable mesh (60g/m2) 10 cm x 15 cm was used to individually design tape implants. Two pairs of tapes were inserted transobturatorily (under urethra and bladder neck) through 1 dermal incision on each side. Two apical tapes for USLA had been individually moved laterally into the vesicovaginal space before being inserted completely tension free in the direction of both uterosacral ligaments (out of the penetration line during sexual intercourse). USLA with ATOTS was used with or without vaginal hysterectomy (30 and 7 cases, respectively). In 4 cases ATOTS were used for correction of vaginal cuff prolapse. The postoperative ICS stage was assessed on day 5, 3 months and 12 months after surgery. Urine, fecal continence, and sexual function were evaluated using a questionnaire 12 months postoperatively.

Results: On postoperative day 5 and 3 months after surgery all patients had an ICS stage zero. 28 out of 41 patients (68%) completed 1 year follow up and remained ICS stage zero, without any pelvic pain. During the first year of follow up no serious complications were observed.

Conclusion: Apical and anterior vaginal prolapse repair with USLA and self-tailed ATOTS is safe and offers excellent short-term anatomical/functional results.

Keywords: Uterosacral ligament; Pelvic Organe Prolapse; Self-tailed tape; Transvaginal tape; Surgical Procedures; Operative

B19
MESH OR NOT FOR PROLAPSE REPAIR, VAGINAL OR ABDOMINAL - PERSONAL VIEW
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1Clinic For Gynecology, Tettung, Germany

The aims of POP-surgery are an accurate anatomical reconstruction, optimal functional outcome, a durable result and without complications. Surgical methods vary greatly, depending on surgical expertise and patient demands, e.g. removal of the uterus or not, the use of alloplastic mesh/tape or native tissue repair. Moreover, three different surgical approaches are available: vaginal, abdominal or laparoscopic. Despite vast applications in the field of POP-surgery and numerous published studies, no single method has been validated as the best therapy. The FDA warnings of 2008 and 2011 on alloplastic meshes were based on complications that resulted from old meshes that have since been taken off the market. Recently, the FDA banished all meshes from the American market. At that time, two alloplastic meshes were available. This decision was not based on complications that had arisen due to these meshes, but was instead based on the fact that these two meshes lacked three-year results to show that their benefits outweigh their risks. This further inhibits international mesh-producing companies from trying to break into the American market. The banishment of meshes is not the solution. International studies have shown that the benefits of alloplastic implants in POP surgery outweigh the risks. Indeed, in case of recurrent prolapse or extreme POP, native tissue repair is incapable of resolving the problem and meeting patients’ demand for stable surgical results. There is no denying that alloplastic implants are associated with certain risks. The advantages of these implants in recurrent cases of POP or advanced stages of primary POP should not, however, be undermined. Given that there currently is no evidence regarding which POP surgery benefits which patient, we believe that only individual patient-based surgical decisions will result in satisfied patients with an improved quality of life. The choice of a surgeon is dependent on various factors, namely POP stage, the compartments affected, the age of the patients, previous surgeries, co-morbidities, required stability, sexual activity, patients’ wishes and the surgeon’s skills. This presentation demonstrates the decision-making process in choosing the optimal procedure to treat POP in accordance with the SCENHRI statement, the EUA and EUGA recommendations and the German, Swiss and Austrian guidelines. Longtime personal experience and consideration of evidence are the basis for a successfully treatment of POP. In Europe we have up to now all possibilities.
B20
TITANIUM «SILK» IN ANTERIOR AND APEXAL POP TREATMENT
Svetlana Kalmykova, Boris Slobodyanyak, Vera Petrova, Ekaterina Panova, Yulia Dobrokhотова
Moscow Obsetric and Gynecology Research Institute, Moscow, Russia.

Background: Today the main approach to POP treatment is based on wide use of mesh implants with good anatomical result. Nevertheless, there are mesh-associated complications. Therefore search for new materials for correction POP is in a high demand. Purpose: to estimate safety and efficiency of tissue “silk” implant in POP treatment. Methods and materials. This study was included 103 patients with anterior and apical POP between July 2017 and September 2018. All women were operated vaginally with tension suspension. Vaginal tacrocoagulation fixation with anterior fascia repair were performed using “Titanium Silk” - an implant by the sizes of 11.0x6.6 cm, made of titani GRADE 1 thread, with a diameter of 0.96 mm, area density of 24 g/m². The implant was fixed by Prolen 2/0. It should be noted particular advantages of an implant easily cut without loss of quality of structure, modeled and reverts to the original state, without changing the characteristics. Results: Intraoperative complications like bladder wound was in 2 (1.9%) patients. Anatomical results were evaluated with vaginal examination and USG pelvic floor after 6, 12 months after operation. Postoperative complications: POP recurrences - 6 (5.8%), dyspareunia - 1 (1.0%). Mesh erosion and vaginal shortening were not presented in our research. Conclusions: The implant of titani “silk” is an ideal material in POP correction because of the properties: creates arround presented without change of quality of strucure, modeled and reverts to the original state, without changing the characteristics. Results: Intraoperative complications like bladder wound was in 2 (1.9%) patients. Anatomical results were evaluated with vaginal examination and USG pelvic floor after 6, 12 months after operation. Postoperative complications: POP recurrences - 6 (5.8%), dyspareunia - 1 (1.0%). Mesh erosion and vaginal shortening were not presented in our research.

Keywords: mesh, “silk” implant, POP

Acknowledgments: the use of “titanium silk” implant proved to be safe and effective in treatment of apical vesical prolapse. “Titanium silk” mesh usage results in formation of structural connective tissue.

B21
AIMING FOR SAFE, MINIMALLY INVASIVE AND SUCCESSFUL TFS SURGERY
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Purpose: Proposal of a safer technique devised by looking back at the complications of TFS surgery

Materials and methods: 731 TFS surgeries based on integral theory were performed over 12 years. Among them, 103 cases of mesh erosion were concentrated at the beginning (4.9% of all 2070 meshes). Many of them improved with two-layer sutures (2016-19.8%). Three cases of incontinence due to intra-abdominal invasion (7) of USL sling (1 case was suspected 3%). USL 667 cases were improved by longer assisted procedure. Later, however, a patient was found whose intra-abdominal mesh was the cause of the abdominal pain. In the case, USL sling was performed after doing the peritoneum was released during USL sling procedure. Since then, we decided not to do USL sling when the peritoneum was performed during the procedure. Bladder damage was observed in 3 cases (0.4%, among USL 651 cases), but no urinary bladder perforation until now by using before USL darning and marking the direction of USL cases. Rectal perforation occurred in one case with USL sling, which was found at outpatient visit after surgery and could be managed by excision by pulling the mesh from the rectal wall. Seven cases of rectal body sling had to be removed due to consolidation or infection after several months. None of the patients had sepsis.

Results: 751 cases of mesh erosion and infection, ileus, bladder perforation, and rectal perforation complications were observed but improved with no sequelae.

Conclusion: We want to take complications seriously, consider countermeasures, prevent recurrence, and aim for TFS surgery with good treatment results to continue to be a safe and minimally invasive surgery for patients.

C URINARY INCONTINENCE

C1
EVIDENCE FOR A COMMON PATHOPHYSIOLOGY OF STRESS AND URGE INCONTINENCE IN WOMEN
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Purpose: We analyzed when patients with urgency urinary incontinence (UUI) actually lose urine.

Material and Methods: Patients with urgency urinary incontinence (UUI) were asked when and how they lose urine after feeling of urgency. When still sitting on the chair (symptom 0), When rising up from the chair (symptom 1). Results: 306 patients with UUI were evaluated. All patients reported that they lose urine immediately after feeling of urge. 179 patients (58%) reported urine loss when rising from the chair and 27 patients (13%) on their way to the toilet. None of these patients reported loss of urine when still sitting on the chair. Conclusions: The urge to void is induced by stretching receptors at the bladder base around the urethra-vesical junction (UVJ). When the bladder fills these receptors get stimulated and induce the feeling of urgency to void. Up to this point of time patients do not lose urine. However, when they bend forward to get up from the chair the vector of the full bladder wanders to the UVJ. In that moment, when the vector of the full bladder reaches the UVJ the pressure opens the bladder outlet.

So, it is justified to question if incontinence at that moment is a neurological disorder or a consequence of an anatomical instability of the UVJ. In other words, UUI could be explained as another form of stress urinary incontinence. So, urinary incontinence in women is a pathophysiological continuum from urge loss after coughing or sneezing to immediate urine loss when rising from a chair.

Keywords: Evidence for a common pathophysiology of stress and urge incontinence in women.

C2
SURGICAL TREATMENT OF OAB ASSOCIATED WITH LOW STAGE POP INTEGRAL THEORY IN ACTION
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Introduction. The overactive bladder (OAB) symptoms commonly occur in patients with pelvic organ prolapse (POP) stage II-III, where there are no obvious indications for surgical reconstruction. But the quality of life in this group of patients is decreased very significantly. There is no “gold standard” of the treatment for this disease at the present moment. This fact requires a search of new treatment options.

Methods. The study involved 49 menopausal (25-55 years) and 39 post-menopausal (65-72 years) women with POP stage II and OAB symptoms. Inclusion criteria: diminution of urge symptoms following insertion of a gauze tampon in the posterior fornix of vagina (“immobilization”). Exclusion criteria: stress urinary incontinence, prolapose grades 3-4. Post-operative assessment was performed at 3, 6, 12 and 18 months after the surgery and included: evaluation by state of prolapse (UDI-6, PFIQ-7, OAB-q, ICQ-5P, questionaires, voiding diary.

Results. At 3 months, cure rates for frequency, urgency, nocturia and prolapse were reasonably comparable for both groups. However, at every subsequent bimonth review, there was a major increased failure in the postmenopausal group, parallel for all parameters, slightly contrasting with the other group. At 18 months, cure rates for menopause patients were 76 (15.4%) for POP, 67.3 (20.5) for urgency, 87.7 (20.5) for nocturia and 39.2 (15.2%) for frequency.

Conclusion. We hypothesize the stepwise parallel recurrence of POP and symptoms was a consequence of ligament treatment, itself due to collagen leaking out of the tissues because of menopausal low estragen levels. The pllication of uterosacral cardinal ligament complex can be recommended as an alternative treatment option in that difficult group of pre-
menopausal women who have major OAB symptoms but only minimal prolapse.

**Keywords:** Overactive bladder, pelvic organ prolapse, surgical reconstruction of the pelvic floor, ligamentoplasty, aterosascular-cardinal ligament complex, Integral Theory

Fig. 1 - Step of the surgery – approximation of right and left ligamentous complexes using Ftores 1 suture.

**Acknowledgments:** This oral presentation is planning in Session 4

PETER PETROS

URINARY INCONTINENCE?

INTEGRAL THEORY OF FEMALE

HOW WELL RECOGNIZED IS THE

compasses organ prolapse, bladder, bowel and chronic pelvic pain dysfunc-

- tions comes not from the organ itself, but from weak ligaments inactivating
- difficulty in accepting that pathogenesis for bladder and bowel dysfunc-
- symptomatizatation of the pelvic floor, ligamentoplasty, uterosacral-cardinal ligament com-
- Our review indicates consistency with the Integral Theory in
- consistent with IT predictions, 26 (90%) manuscripts were regarded as being consistent with IT predictions.

**Conclusions** Our review indicates consistency with the Integral Theory in 90% of clinical papers, though almost 2/3 of these authors did not seem to be aware of the theory. Why? We can only speculate. One reason may be the difficulty in accepting that pathogenesis for bladder and bowel dysfunctions comes not from the organ itself, but from weak ligaments inactivating the opening and closure muscles which act on the ligaments.

**Keywords:** Integral Theory

References: 1. Petros PE & Ulmsten U. An Integral Theory of female uri-

narity incontinence. Acta Obstetricia et Gynecologica Scandinavica, Sup-


vic Floor Dysfunction in Females European J of Urology EURU[P]:738.

http://dx.doi.org/10.1016/j.eursup.2017.01.001. 3. Skilling PM; Petros PE


**C3 HOW WELL RECOGNIZED IS THE INTEGRAL THEORY OF FEMALE URINARY INCONTINENCE?**

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**Background, hypothesis and aim** The Integral Theory (IT) is a universal, ligament-based theory of pelvic floor function and dysfunction which en-

compasses organ prolapse, bladder, bowel and chronic pelvic pain dysfunc-

- tion. The aim was to systematically analyse the applicability of the Integral Theory System (ITS) to publications in a pelvic floor journal.

**Methods** We chose a journal Pelviperineology journal www.pelviper-

ineology.org (PPI) which encompasses all aspects of the Integral Theory System’s reach, Urology, Gynecology, Coloproctology, Perineology. We

scanned every publication in PPI over a two year period to check the appli-

ability of the ITS to the paper in hand.

**Results** An analysis of manuscripts published in Pelviperineology journal (Volume 36 and 37), only 29 clinical research articles were included as being suitable for analysis. Among the 29 clinical research articles, only 11 (37.9%) mentioned IT and/or related articles as a reference. However, according to evaluation of the clinical papers with respect to the concord-

ance with IT predictions, 26 (90%) manuscripts were regarded as being consistent with IT predictions.

**Conclusions** Our review indicates consistency with the Integral Theory in

90% of clinical papers, though almost 2/3 of these authors did not seem to be aware of the theory. Why? We can only speculate. One reason may be the difficulty in accepting that pathogenesis for bladder and bowel dysfunctions comes not from the organ itself, but from weak ligaments inactivating the opening and closure muscles which act on the ligaments.

**Keywords:** Integral Theory

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arity incontinence. Acta Obstetricia et Gynecologica Scandinavica, Supple-


http://dx.doi.org/10.1016/j.eursup.2017.01.001. 3. Skilling PM; Petros PE


**C4 INNOVATIVE VAGINAL CONES WITH VIBRATING BALL INSIDE IN PELVIC FLOOR DYSFUNCTION**

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1University of West Vasile Goldis, Arad (ro) 2University of Basque Country, Vizcaya (es) 3University of Rome "La Sapienza", Rome (it)

**Introduction** Pelvic floor muscle training (PFMT) is considered the first-line treatment for stress urinary incontinence (SUI) and urge urinary incontinence (UUI) [1]. Studies demonstrate that pelvic floor exercises, electrical stimulation and vaginal cones (VC) are equally efficacious treatments for SUI and far more effective than no treatment at all. [2][3]. VC are cheap non-surgical treatments for women with stress urinary incontinence and are able to manage also some sexual dysfunctions caused by pelvic muscle relaxation in an autonomous way. Opportunities for self-management by the women should be encouraged, as women can purchase VCs themselves or they can undertake PFMT without formal supervision. Therapies are most likely to be effective and cost-effective when women receive training in order to know how to perform the exercises correctly.[4] We decide to test a new type of vaginal cone (VC) that has a vibrating ball inside like the Ben Wa ball.

**Material and methods** The device is composed of a set of 3 vagi-
nal cones of different weights( Fig 1). 36 women took part of the study (range 26-78). The average number of vaginal deliveries per patient was 1.65±1.71 SD. The subject, was instructed to use the device for 15-30 min-
utes a day for three months. The patients were evaluated after 1 (T1) and 3 (T2) months. During the gynecological examination, the patients were classified according to PC test [5]. At the end of the first and the last eval-
uation the women filled a Qol questionnaire composed by 13 questions each with rating-answers from 1 to 5. Score 1 was considered the worst outcome, 5 was the best.[6]

**Results** Out of the 36 women involved, 18 were with urgency, 7 with ef-

fort, 5 with mixed problems and 3 with sexual dysfunction only (Fig 2). 10 dropped out from the study for lack of commitment and perseverance. Out of the 26 women left 24 reported an improvement of PC score between the first and last evaluation in all evaluation parameters. More specifically, the score parameter increased of 18% from T0 to T3, the endurance parameter increased of 22,6% from T0 to T3 and the fatigueability parameter increased of 17% from T0 to T3 (Fig 3). The Qol, shows an improvement. The av-

erage T0 score are 3,95±0,68 SD and the average T2 score are 4,29±0,59 SD (Fig 4).

No side effects such as pelvic pain, vaginal infections or other complaints was reported by patients during the last meeting.

**Conclusion** You may notice a complete training leads to an improvement of pathologies related to the weakness of the PF. The verifiable limit to the
treatment is the arbitrary level of commitment. Further studies are necessary.

**Keywords**: PFMT, Vaginal cones, pelvic floor, urinary incontinence, pelvic prolapses


**Results**: 206 patients were suffering from UUI. These 206 patients lost urine on their way to the toilet. 179 patients (87%) when rising from the chair, and 27 patients (13%) on their way to the toilet. From the treatment point of view 35% of the patients were cured by VASA or CESA. After an additional TOT the overall cure rate was 72%.

**Discussion**: The vast majority (87%) of the patients with UUI lost urine when rising from the chair. They all reported that in the normal sitting position they do not lose urine. Some cross their legs to prevent loss of urine, however, at the moment when they bend forward to stand up, they lose urine. The remaining 13% of the patients lost the urine on the way to the toilet. As it could be hypothesized that the upright body position leads to continence. The palpation of the bladder to the urethra and the “vagina” at the lateral pelvis to the sacral region.

**C6 URINARY INCONTINENCE IN MEN AND WOMEN - SAME ETIOLOGY AND PATHOGENESIS? SAME TREATMENT?**

**WOLFRAM JAEGERT**

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**Introduction**: Urinary incontinence (UI) is caused by an involuntary opening of the bladder into the urethra via the urethral-vesical junction (UVJ). In women the urethra and bladder base are otherwise stabilized by the upper vaginal wall and at the upper cervix. In men the intra-abdominal urethra and the bladder are in the same position. It has been demonstrated that the descent of the upper vaginal wall can lead to stress- and urgency urinary incontinence. That descensus is not found in quadrupeds. We therefore believe that UI is caused by the upright body position. The vertical traction leads to a diminishing suspension of the bladder usually between 40 and 50 years of age. The situation worsens within the following years leading to ever increasing incontinence. The same can be found in men. The anatomical position of the bladder is basically the same, however, the bladder base rests on the prostate. In men a prolapse will lead to a descent into the prostate leading to voiding obstruction and urgency. So far that is treated by prostate resection. The palpation of the bladder in women is caused by a diminishing function of the pubo-urethral ligament (PUL) and the utero-cervical ligament (USL) (according to the Integral Theory). We therefore hypothesized that UI in men is also caused by defect functions of the USL or PUL.

We therefore studied the anatomy of men in order to find a counterpart of the USL in men.

**Methods**: A male corpse was dissected during the student course of anatomy. The palpation below the urethra was incised after removal of the testes. Vertical incision of the pseudo-vagina was performed and the prostate exposed. The horizontal incision of the pseudo-vagina was performed and the bladder exposed. The incision on the bladder to the middle of the bladder base was performed. Therefore, he will experience difficulties to void. The anatomical position of the bladder is basically the same, however, the bladder base rests on the prostate. The vertical traction leads to a diminishing suspension of the bladder usually between 40 and 50 years of age. The situation worsens within the following years leading to ever increasing incontinence. The same can be found in men. The anatomical position of the bladder is basically the same, however, the bladder base rests on the prostate. A male corpse was dissected during the student course of anatomy. The palpation below the urethra was incised after removal of the testes. Vertical incision of the pseudo-vagina was performed and the bladder exposed. The horizontal incision of the pseudo-vagina was performed and the bladder exposed. The incision on the bladder to the middle of the bladder base was performed. Therefore, he will experience difficulties to void. The anatomical position of the bladder is basically the same, however, the bladder base rests on the prostate. The vertical traction leads to a diminishing suspension of the bladder usually between 40 and 50 years of age. The situation worsens within the following years leading to ever increasing incontinence. The same can be found in men. The anatomical position of the bladder is basically the same, however, the bladder base rests on the prostate. When the probe was elevated a perineal fold could be seen which extended from the left and right end of the “vagina” at the lateral pelvis to the sacral region. Therefore, he will experience difficulties to void. The anatomical position of the bladder is basically the same, however, the bladder base rests on the prostate. The vertical traction leads to a diminishing suspension of the bladder usually between 40 and 50 years of age. The situation worsens within the following years leading to ever increasing incontinence. The same can be found in men. The anatomical position of the bladder is basically the same, however, the bladder base rests on the prostate. The vertical traction leads to a diminishing suspension of the bladder usually between 40 and 50 years of age. The situation worsens within the following years leading to ever increasing incontinence. The same can be found in men. The anatomical position of the bladder is basically the same, however, the bladder base rests on the prostate. The vertical traction leads to a diminishing suspension of the bladder usually between 40 and 50 years of age. The situation worsens within the following years leading to ever increasing incontinence. The same can be found in men.
C7
THE NEW MINI SLING SURGERY KIT RESTORE PLUS® FOR STRESS URINARY INCONTINENCE
YUKI SEIKIGUCHI1, RYOKO NAKAMURA1, NORIKO NINOMIYA1, MASAHIRO YAO1
Women’s Clinic Lana Nextstage
1Women’s Clinic Lana Yokohama Motomachi
2Women’s Clinic Lana Shinsabashi
3Yokohama City University Graduate School of Medicine

Introduction: The Tissue Fixation System (TFS) is developed by PP.Petros who is the author of the Integral theory based for the development of the TVT method, aims to treat both stress urinary incontinence and pelvic organ prolapse only in intravaginal area in 2005. TFS consists of 8 mm non-stretchable polypropylene tape and small soft tissue polypropylene anchors that anchors the tape to tissues such as muscle and fascia for strengthens the pelvic floor ligaments and fascia with minimum volume of mesh, RESTORE PLUS® is the kit for treating urinary incontinence with a disposable applicator for implanting this TFS tape. We present the mid-urethral mini sling surgery for stress urinary incontinence using RESTORE PLUS®.

Surgery method: The TFS kit was approved for use by the Ethics Committee of the Women’s Clinic LUNA Group, and personally imported by the doctor with the approval of the Ministry of Health, Labor and Welfare. For surgery, a 1.5 cm longitudinal incision was placed after local anesthesia at the position of the middle urethra. The submucosal tissue on the anterior wall of the vagina was peeled off, and the urogenital septum was pierced with scissors. The disposable applicator was inserted along the scissors, the TFS anchor was placed on the urogenital diaphragm, the other side was subjected to the same operation, and the tape length was adjusted to be in close contact with the urethra. The wound was closed so that there was no slack on the front wall.

Conclusion: Transperineal pelvic floor plastic surgery using mesh is currently in the process of reflection. But for patients with pelvic floor disorders where congenital connective tissue is fragile, minimal mesh usage for ligament reinforcement is effective and needed. In order to safely transplanting minimal mesh, it is necessary to re-evaluate the integral theory.

Keywords: tfs, tissue fixation system, stress urinary incontinence, mini sling, mid urethral sling, restore plus®

Fig.1 - RESTORE PLUS

after 4 weeks from the last one. A cumulative intensity of GSM symptoms using a 10-cmVAS (dryness and/or burning and/or dyspareunia), the vaginal health index (VHI), the Female Sexual Function Index (FSFI) and Urinary Incontinence Short Form (ICIQ-UI SF) were also evaluated.

Results: Improvement in vaginal histological parameters for atrophy was demonstrated following the SSVL treatment. A melioration was also observed on VHS, VVA symptoms and sexual female function. Finally, after the SSVL treatment almost all patients affected by urinary incontinence obtained an important improvement of symptoms.

Conclusions: The evaluation of histological results indicates an absence of tissue damage (NO carbonization signs), a favorable effect of SSVL on vaginal atrophy in GSM as well as on the others symptoms as demonstrated using VHS, FSFI and IQ-UI SF scores and urinary incontinence. In particular, SSVL was showed more effective for treatment of mild SUI and of urge urinary incontinence.

Keywords: Atrophic Vaginitis, Genitourinary Syndrome of Menopause, Urinary Incontinence, Vulvo-vaginal Laser


C8
THE CLINICAL ROLE OF NON-ABLATIVE LASER (SSVL) IN THE TREATMENT OF GSM, FEMALE URINARY INCONTINENCE AND VAGINAL LAXITY
DANILLO DODERO1, FILIPPO MURINA1, MICHELA ANGELUCCI2, FEDERICA FRASCANI3, GLORIA TROCCHI1
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2Women’s Clinic Luna Shınsaıbashı
3Women’s Clinic Luna Yokohama Motomachi

Purpose: The purpose of this study is to evaluate the short-term effects of Solid State Vaginal Laser (SSVL) in the treatment of postmenopausal women (PMW) suffering from genitourinary syndrome of menopause (GSM), with sexual problems and urinary incontinence.

Materials and Methods: Eighty participants with GSM symptoms were treated with a total of 4 treatments in a two months timeframe (every 15-20 day) of a non-ablative SSVL (LASEmaR 1500™ - EUFOTON). Vaginal biopic samples were collected before the start of the first treatment and

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13
C10 ULTRASOUND OF BLADDER NECK HYPER MOBILITY IN THE CONTEXT OF SYSTEMIC POSTURE
ROSTYSLAV BUBNOV
Abstract not received.

C11 TUNABLE TENSION TAPE (TCT) AS PRIMARY TREATMENT OF UNCOMPlicated SUI
OLGA STAROSELETSVA1, DMITRY SHKARUPA1, NIKITA KUBIN1
1Saint-Petersburg State University Clinic of Advanced Medical Technologies N.A. N.I.Pirogov

Introduction: A minimally invasive midurethral sling is a favorite primary surgical method for treatment of stress urinary incontinence (SUI). One of its most common complications is voiding dysfunction associated with the excess tape tension. There are few methods that allow to decrease tape tension after the surgery, such as urethral dilatation, sling mobilization, sling incision, complete excision of the tape and urethrolysis. All these methods are invasive, poorly controlled by the surgeon and are associated with the risk of recurrence of SUI.

Design: The prospective study started in 2016 and involved 171 primary patients with uncomplicated SUI who underwent the transobturator tunable tension tape (TTT) procedure. The postoperative tension tuning depending on the results of cough stress test (CST), uroflowmetry and post void residual volume (PVR) was performed the day after surgery. Patients were monitored 1, 6, 12 months after the surgery and then annually by a vaginal examination, CST, uroflowmetry, PVR measurement and filling validated questionnaires (UDI-6, PISQ-12, ICQ-SF).

Results: The next day after the surgery 65 (38.0%) patients required tape tension tuning. All subjects were discharged after achieving continuity. No cases of voiding dysfunction were detected after the tape tuning. Three-year follow-up data were available for 127 (74.3%) patients. The objective and subjective cure rates were 91.3% (n=116) and 88.2% (n=112) respectively. No cases of wound infections or urinary obstruction were detected. The vaginal mesh extrusion was observed in 1 (0.8%) patient. The questionnaires scores showed 88.2% (n=112) patients to be very satisfied with improvement of quality of life (p<0,001).

Conclusions: The tunable tension tape allows to minimize the risk of postoperative voiding dysfunction. It proved as an effective, safe and reproducible technique for primary patients with SUI.

Keywords: Stress urinary incontinence, midurethral sling, urinary incontinence, voiding dysfunction

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C12 TISSUE FIXATION SYSTEM MINISLING PERFORMED UNDER LOCAL ANESTHESIA CURES INTRINSIC SPHINCTER DEFICIENCY – ONE YEAR DATA
RYOKO NAKAMURA1, NORIKO NINOMIYA1, YUKI SEIKUGUCHI1
1Women’s Clinic Luna, Japan

Objectives: Intrinsc sphincter defect is difficult to cure, especially in old- er women. In this study, we confirmed (or not) that a high cure rate for intrinsic sphincter dysfunction using the Tissue Fixation System tensioned minisling was possible by a retrospective review of all intrinsic sphincter deficiency patients operated in our clinic since 2008.

Methods: We studied a total of 96 intrinsic sphincter deficiency patients treated with Tissue Fixation System mid-urethral sling at Yokohama Me- tomachi Women’s Clinic, a free-standing clinic, from 2006 to 2015 retro- spectively. We evaluated intraoperative and one year postoperative results. Regarding cure rate, we divided patients into three groups, 17 patients with MUCP<20 and VLP<65 combined, 55 patients with MUCP>20 and 47 patients with VLP>65. We evaluated each group separately.

Results: Median age was 63 years (38-86). Median operating time includ- ed local anesthesia was 24 minutes (12-55 minutes) and median blood loss was 5.0ml (3-65ml). All operations were day surgery under local anesthe- sia. Post-operative pain was minimal. All patients discharged same day. There were no intraoperative complications except one bladder perforation. There were no tape rejections. One year postoperative cure rate among 17 patients with MUCP>20 and VLP<65 combined was 88.2%. Regarding 55 patients with MUCP>20, it was 90.9%. Regarding 47 patients with VLP>65, it was 85.1%.

Conclusions: The Tissue Fixation System mid-urethral sling operation is a simple, safe, and effective operation for older women with intrinsic sphinc- ter deficiency and can be performed under local anesthesia.

Keywords: Intrinsc sphincter deficiency, Local anesthesia, Minisling, Stress urinary incontinence, Tissue Fixation System

Acknowledgments: Conflicts of interest: None declared.

C13 THE FLOW CHART IN THE MANAGEMENT OF URINARY INCONTINENCE IN WOMEN BASED ON THE INTEGRAL SYSTEM
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1Department of Obstetrics and Gynecology Medical School, Mugla Sıtkı Koçman University, Turkey

The management of urinary incontinence, which is a very common health problem in women, is a matter of debate. In this regard, the learned soci- eties across the world are helping practitioners by developing their own flow charts. Hence, the urinary incontinence management flow chart based on the Integral System has also been developed and is being presented to practitioners.

In this flow chart, the test such as urodynamics, stress ped test, voiding diary are not actively suggested whereas pelvic floor ultrasonography has been highlighted. The Integral System places particular emphasis on uterosacral and cardinal ligaments and advocates the strengthening of ligaments in the treatment of pelvic floor disorders (3, 4). In particular, the strengthening of these liga- ments in the treatment of sudden voiding sensation / sudden voiding incontinence in women up to 85% surgical success has been demonstrated (5). On the other hand, strengthening of the uterosacral ligaments with a band aid (PIVS) not only eliminates prolapse but also cures symptoms such as incontinence, pelvic pain, nocturia (6).

Considering the time limitation in clinical practice, the necessity of ques- tioning the following 5 symptoms emerges:
1. Pain/or burning sensation during urination
2. Urgency / Urge urinary incontinence
3. Nocturia
4. Incontinence during physical exertion
5. Continuous incontinence

If an index case presents with any of these 5 symptoms or combinations, evaluation of the patient should be initiated. Following a focused history, the gynecological examination should be ini- tiated. Vaginal structures as well as uterus and adnexa should be palpated and if necessary cervical cultures and cotest should be performed. Stress and Q-test types are indispensable for urogynecological examination. It is important to objectively show incontinence (but may not be shown). Sub- sequently, genitalia should be evaluated for pelvic organ prolapse; graded objectively according to the Pelvic Organ Prolapse Quantification (POP-Q) system. Especially in women who have continuous incontinence, the vulva would have a urine smell. If there is a history of pelvic or vaginal surgery or difficult delivery, fistula should be considered. Urine pooling or direct urine flow should be investigated in these cases, especially in the posterior vaginal fornix. Methylen blue test is an effective method for the diagnosis of vesicovaginal fistula. The indirect findings of the continence should be
investigated by pelvic floor ultrasonography (bladder wall thickness, urethral vesical angle change, posterior urethrovésical angle).
The waste urine volume must be measured (with ultrasonography or Foley catheter), especially values above 100cc should be considered pathological. Urodynamics has no place especially in uncomplicated index patients. Quality of life scores (QoL) can be calculated to show patients’s affection from incontinence and/or prolapse. Complete urine analysis, urine culture, fasting blood glucose, liver and kidney function tests (SGOT, SGPT, Urea, Creatine) and calcium levels should be requested. If urinary infection, diabetes mellitus, hypercalceria and/or fistula are detected, appropriate treatment is initiated. The surgical approach should be of utmost importance and with a positive stress test. In this process, tension-free vaginal sling, single incision mini sling or transobturator sling should be preferred according to the case. In the case where the stress test is negative, a spectrum of treatment modalities ranging from low-intensity treatments to high-intensity treatments are preferred considering the patient’s condition and expectations. Lifestyle changes (eg. weight loss, bladder training) and medical therapy are low-intensity treatments. Pelvic floor muscle training (Kegel exercises, vaginal cones, biofeedback treatments, electrical stimulation, extracorporeal magnetic chair, sacral/tibial neuromodulation, mechanical devices) and surgery are high-intensity treatments. However, surgery is the the most effective treatment modality (midurethral slings should be preferred).
The women who has post voidal urine volume >100ml, stress test negative, no infection and endocrinological disorder, then vaginal apical and posterior compartment evaluation should be performed. If rectoenterocele is detected in the case as a result of this evaluation; surgical treatment of rectoenterocele (preferably plication of the rectovaginal fascia to the uterosacral ligaments) should be carried out. If no anatomic defect can be detected in a case, ‘Urge test’ (upon gently elevation of the base of a full bladder with 2 fingers or with a retractor, urge sensation disappears) or ‘Pessier test’ (when a cylinder pessary is inserted into vagina, nocturia does not happen or urgency stops) Whichever one of these tests is performed, the disappearance of nocturia and/or urgency means that the uterosacral/cardinal ligaments are lax and these ligaments should be strengthened through surgery (uterosacral ligament plication / cardinal ligament shortening, Cer-vicacroplasty –CESA, Vaginosacropexy -VASA, Posterior Intra vaginal Slingoplasty-PIVS). Antimuscarinic agents should be considered in the treatment of such a case if the symptoms do not disappear when the tests are performed.

The step-by-step approach is presented at below:

References:
1. Abrams P, Andersson KE, Birder L, et al. Fourth International Consultation on incontinence Recommendations of the International Scientific Committee: Evaluation and Treatment of Urinary Incontinence, Pelvic Organ Prolapse and Faecal Incontinence, Neurourol Urodyn. 2010;29(1):213-40. doi: 10.1002/nau.20670.  2. Abrams P, Cardozo L, Khoury S, Wein A, Incontinence, 5th edn. ICUD-EAU 2013.  3. Inoue H, Kohata Y, Fukuda T, Momma M, et al. Re- pair of damaged ligaments to enterocel (preferably plication of the rectovaginal fascia to the uterosacral ligament) should be carried out. If no anatomic defect can be detected in a case as a result of this evaluation; surgical treatment of rectoenterocele (preferably plication of the rectovaginal fascia to the uterosacral ligaments) should be carried out. If no anatomic defect can be detected in a case, ‘Urge test’ (upon gently elevation of the base of a full bladder with 2 fingers or with a retractor, urge sensation disappears) or ‘Pessier test’ (when a cylinder pessary is inserted into vagina, nocturia does not happen or urgency stops) Whichever one of these tests is performed, the disappearance of nocturia and/or urgency means that the uterosacral/cardinal ligaments are lax and these ligaments should be strengthened through surgery (uterosacral ligament plication / cardinal ligament shortening, Cer-vicacroplasty –CESA, Vaginosacropexy -VASA, Posterior Intravaginal Slingoplasty-PIVS). Antimuscarinic agents should be considered in the treatment of such a case if the symptoms do not disappear when the tests are performed.

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The step-by-step approach is presented at below:

References:
D - POSTERIOR COMPARTMENT

D1 METHODS OF SURGICAL TREATMENT OF RECURRENT RECTAL PROLAPSE

TOMASZ KOSCINSKI

1 University of Medical Sciences, Poznan, Poland

Aim of the study: to evaluate the effects of surgical treatment for recurrent rectal prolapse.

Material and methods: The study group comprised 14 female and 2 male patients aged from 37 to 92 years submitted to treatment last 20 years. Initial treatment consisted of abdominal mesh rectopexy /4 pts/, transanal Mikulicz rectal resection /4 pts/, Altmeyer’s technique /2 pts/, Thiersch’s anal construction /3 pts/, sigmoidal resection /1 pt/, Delorme’s technique /1 pt/, colopereineopexy /1 pt/. The relapses occurred between 2 and 30 months.

Results: Reoperations consisted of abdominal rectopexy /6 pts/ or resection colpoperineopexy /1 pt/. Eleven pts were cured /69%. Five pts developed subsequent recurrent rectal prolapse. They were successfully reoperated: 3 rectopexies and 2 transanal resections were performed.

Conclusions: Abdominal rectopexy has appeared to be effective method of treating recurrent rectal prolapse. In fragile, elderly pts good though less permanent results may be achieved following transanal techniques.

Keywords: Rectal prolapse, recurrent rectal prolapse, abdominal mesh rectopexy, transanal rectal resections

D2 PRESACRAL (RETRORECTAL) TUMOR CLASSIFICATION, SYSTEMATIC REVIEW

MOHAMMAD ALHARBI

1 Department of Surgery, Medical College, Al Imam Mohammad Ibn Saud Islamic University (imsu)

Background: Retrorectal presacral lesions and tumors are rare. More new tissues are reported in this area and many classification systems have been reported so far.

Aim: To assess the progress and the suitability of current classifications and their ability to cover most of retrorectal or presacral lesions, and tumor classifications.

Materials: The systematic review has been performed through PubMed, Medline and Scopus Search to identify all types of classifications of retrorectal/presacral tumors using PRISMA guidelines.

Result: A total of 26 article met the inclusion criteria. Six classification types have been identified. Two types were able to help in the prediction of surgical outcome and the ability to cover all types of lesions in the retrorectal space, “congenital/noncongenital +benign/malignant” and “germ line classification.”

Conclusion: classification based on congenital and tumor potentials and germ line classification would be more suitable to predict surgical outcome and new lesions in the area.

Keywords: presacral tumor, retrorectal tumor.

Figure: flow chart of systematic review

Tab.1

D3 RESEARCH PROPOSAL: NEW OUTPATIENT DIAGNOSTIC TEST FOR RECTOVAGINAL FISTULAS

DANIELE PASSANNANTE, MARIA CHIARA MENNUTI, DAVIDE TELESCO, FEDERICO VILLANP, FABIO GAFFIN

1 Department of General Surgery and Surgical Specialties “Paride Stafani”, Sapienza University of Rome, Azienda Policlinico Umberto I, Viale Del Policlinico 155, 00161, Rome, Italy.

Background: Rectovaginal fistulas (RVF) represent about 5% of all anorectal fistulas. Most RVF are caused by obstetrical or iatrogenic traumas, Crohn’s disease and tumors. Pregnancies and previous deliveries, oncological history and radiotherapy, previous suppurative pathologies, Crohn’s disease and surgical history should be investigated. Clinical assessment is essential to evaluate the characteristics of the fistula. Evaluation under anesthesia can be useful. Diagnostic tests are necessary in selected cases to complete the diagnostic assessment by investigating any associated diseases. We propose a study to evaluate the accuracy of the outpatient methylene blue test as a primary diagnostic approach for RVF.

Purpose: Rectovaginal fistulas (RVF) represent about 5% of all anorectal fistulas. Most RVF are caused by obstetrical or iatrogenic traumas, Crohn’s disease and tumors. Pregnancies and previous deliveries, oncological history and radiotherapy, previous suppurative pathologies, Crohn’s disease and surgical history should be investigated. Clinical assessment is essential to evaluate the characteristics of the fistula. Evaluation under anesthesia can be useful. Diagnostic tests are necessary in selected cases to complete the diagnostic assessment by investigating any associated diseases. We propose a study to evaluate the accuracy of the outpatient methylene blue test as a primary diagnostic approach for RVF.

Materials and methods: The test is performed by inserting a gauze in vagina. A solution containing methylene blue (50 ml) is injected into the anal canal. Patient stands for 20 minutes. The gauze is removed and the presence of colorant is assessed. If the test is negative; a new gauze is inserted. After six hours, the patient sends to the surgeon the photographic record via smartphone. All patients in the study will undergo pelvic MRI control.

Results: The preliminary study conducted on 5 patients showed the test’s ability to detect the presence of RVF. The accuracy and cost/benefit ratio are still to be evaluated.

Conclusions: We think that this test can be useful, mainly for its applicability in the outpatient setting and for its fast and easy execution. It can be a useful tool especially in developing countries. So, we propose a collaboration in order to implement this study proposal.

Keywords: Research Proposal, Diagnostic Techniques and Procedures, Rectovaginal Fistula, Methylene Blue, Outpatient Care.


Fig.1 - Materials used for the proposed test

Acknowledgments: standardization of retrorectal tumors classification are needed due to multiple versions of classification. this PRISMA based review will elaborate more about the best possible type of classification to be utilized in such conditions.
D4
SIMPLE AND SUCCESSFUL SURGICAL TREATMENT OF FECAL INCONTINENCE
SIDI MUCTAR1, NICOLAS FISCHER1, MARTIN FRIEDRICH1
1Helios Kliniken Krefeld, Department of Urology

Purpose: A new minimally invasive and very effective operation method for the treatment of fecal incontinence is presented.

Material and Methods: We have performed this operation in three patients so far. One with severely impaired nerve conduction speed of the pudendus nerve on both sides and two patients with insufficiently scarred muscle after severe vaginal births. Following the integral theory as in the treatment of stress incontinence of the woman, a preanal sling is placed to treat fecal incontinence. With this method, we reinforced the pre- and postanal ligaments. The applied pressure of the sling on the anus is adjusted digitally.

Results: Postoperative and in the short observation period of three to six months, all patients were very satisfied with the results. None of the patients needed pads.

Conclusion: This minimally invasive surgical method in the treatment of fecal incontinence complies with and completes the integral theory. More results with a larger cohort will be published soon. Furthermore, we will investigate if this method is also suitable for men.

Keywords: fecal incontinence, pelvic floor adaptation, MRI-defecography

D5
HEMORRHOIDS CLASSIFICATION: DO WE NEED A SMARTER ONE?
DANIELE PASSANNANTI1, MARIA CHIARA MENNUTI1, DAVIDE TESCONI1, FABIO GAJ1
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Purpose: The issue of classification of hemorrhoids has been widely debated. This led to the creation of the PATE 2006 classification, which considers anatomical parameters, quality of life and severity of symptoms. Although this and other classifications have been proposed, the Goligher classification continues to be the most widely used. According to these considerations, we wanted to collect the opinions of the experts on these two classifications.

Materials and methods: A questionnaire was submitted to 30 proctologists to investigate the usefulness in clinical practice of the Goligher and PATE 2006 classifications and their actuality in relation to current scientific knowledge. The possible need for improvement of the PATE 2006 classification was also investigated. Experts were asked if they would participate in a consensus conference on this topic.

Results: both classifications were considered useful in clinical practice by most experts (63.3% Goligher; 66.7% PATE 2006). Goligher classification was considered current for 26.6%, while PATE 2006 was considered current for 86.6%. The question on the possible improvement of the PATE 2006 classification was replied to as follows: 70% “yes much”, 23.3% “yes, little”, 6.6% “no”. All respondents said they were interested in participating in the consensus conference (100%).

Conclusions: This survey highlighted the need to revise the current classifications in order to make them more applicable in clinical practice and less obsolete. We think, this could be achieved by using the PATE 2006 classification as a starting point. According to the experts, a consensus conference on the subject is recommended.

Keywords: hemorrhoids, classification, Research Proposal, Proctology, Gastrointestinal Hemorrhage


Fig.1 - PATE 2006 Classification

D6
INITIAL EXPERIENCE OF MICROFRAGMENTED AUTOLOGOUS ADIPOSE TISSUE INJECTION TO TREAT ANAL INCONTINENCE
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Purpose: The aim is to evaluate the effect of the injection of micro-fragmented autologous adipose tissue on anal incontinence.

Method: In January 2019 five patients were enrolled to be treated. Inclusion criteria: passive incontinence, anal sphincter lesions <90°, with a Starck score < 8 , anal scar tissue.

Technique: The harvested fat from the lateral abdominal wall was processed with the sterile processing kit (Lipogems®). The total amount of harvested tissue need to be more than 130cc thus to obtain at least 30cc of final product ready to be injected at the level of sphincter lesion under direct control of transanal ultrasound.

The functional results was evaluated through the Vaizy score and the satisfaction grade (VAS 0-10).

Results: Five patients underwent the procedure. The mean operative time was 38 minutes. The homogeneous follow-up was 4 months. All the pa-

D7 ENDOSCOPIC TREATMENT OF COMPLEX ANAL FISTULAS (VAAFT) IN COMBINATION WITH OTHER SPHINCTER PRESERVING TECHNIQUES - RESULTS
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Background: The aim of this prospective observational study was to present our results in operative treatment of complex and fistulas using sphincter preserving techniques. All operations were performed with VAAFT procedure (Video-Assisted Anal Fistula Treatment). Other sphincter preserving techniques were used in combination with VAAFT when was necessary. Other techniques were LIFT (Ligation of Intersphincteric Fistula Track) and rectal advancement flap.

Material and methods: In period of three years (March 2016 - March 2019) 154 patients underwent VAAFT procedure. Postoperative follow up was 1 week, 2 weeks, 1 month, 2 months and 6 months. Only patients with complex cryptoglandular anal fistulas were included and others with simple fistulas and IBD were excluded. Internal fistula opening was identified in 82.23% patients and was palpated in conjunction with LIFT technique, rectal advancement flap or mattress suture.

Results: Primary healing occurred in 76.4%. Other patients had ongoing symptoms up to 4 months after the initial treatment and had to be retreated. Median primary healing rate was six weeks. There was no serious intra and postoperative complications. None of the patients reported any type of fecal incontinence (EI score - Fecal Incontinence Severity Index was used).

Conclusion: VAAFT (Video-assisted anal fistula treatment) is novel, sphincter preserving technique for treatment of anal fistula. It takes its place especially in treatment of complex fistulae because of possibility of multiple operative attempts in case of first failure until success is achieved. This technique can be used in combination with other sphincter preserving techniques with good results. However, it is necessary to do further investigation on larger group of patients with longer-term follow-up period.

Keywords: VAAFT, fistula, sphincter preserving, polypectomy

D8 ROLE OF ENDOANAAL AND TRANSANAL ULTRASOUND IN CHRONIC PROCTALGIA
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Purpose: To evaluate the role of endoanal (EAUS) and transanual ultrasound (TPUS) for morphological assessment of pelvic floor in female patients with chronic proctalgia (CP).

Materials and methods: 33 female patients (mean age 53.60 years) with CP underwent TPUS with a dynamic transrectal probe placed on the perineum, and images of pelvic floor were taken at rest and during Valsalva. In addition, 30 of the 33 CP patients (mean age 53.60 years) and 25 normal women (mean age 47.20 years) as controls underwent EAUS with a 3D ultrasound probe placed in the rectum. Thickness and length of internal anal sphincter (IAS), thickness of pubococcygeus muscle (PR), length of the external and anal sphincter (EAS) plus PR, and puborectalis angle were measured and compared between the two groups.

Results: Under the TPUS, 15 cases had the smaller anal orifices during Valsalva; 14 cases were found rectal intussusception, 11 cases were accompanied with cytosis. Compared to the normal individuals under the EAUS, patients with CP had shorter IAS length and greater PR thickness, and had the smaller puborectalis angle both in resting and straining phases.

Conclusions: EAUS and TPUS are simple and useful ultrasound techniques to assess female patients with CP. TPUS can show the whole pelvic floor anatomy and detect other pelvic floor disorders. EAUS allows the greater PR thickness and paradoxical contraction of PR are the potential clinical features of CP.

Keywords: Transperineal ultrasound, Endoanal ultrasound, Chronic Proctalgia, Female, Pelvic floor


Acknowledgements: Thanks to the conference committee for giving me this opportunity to share the research data from China.

D9 TRANSANAL ENDOSCOPIC MICROSCUREGY (ITEM): 10-YEAR EXPERIENCE AND RESULTS
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Background: The aim of this prospective observational study was to present our results and experience in treatment of rectal pathology using TEM (transanal endoscopic microsurgery). With this endoscopic technique, tumorous lesions can be successfully removed from anorectal region up to 18 cm in rectum. Even though indications are narrow, with this technique larger and rarer operations can be avoided, providing adequate presurgical staging is performed.

Materials and Methods: 231 patients of which 223 patients had tumors (154 males and 88 females). According to pathological finding there were 102 adenomas, 64 carcinoma in situ (Tis), 29 pT1, 18 pT2, 25 of which were palliative procedures and 1 had anterior rectal resection done afterwards, and 4 pT4 which were all palliative procedures. Out of patients that didn’t have tumorous lesions, 3 of them had rectal stenosis, 4 had anastomotic stenosis and 1 foreign body removal (intravaginal device that migrated into rectum). Results in 5 of out 233 cases (2.14%) metastatic margins were positive. Total number of patients with recurrent disease was 29 (13%). 11 adenomas out of 102 (10.76%), Tis 6 out of 64 (9.38%), pT1 1 out of 29 (3.45%), pT2 4 out of 11 (36.37%), pT3 3 out of 5 (60%) and pT4 4 (100%). During follow-up 10 patients have died due to illness progression. We had 27 patients (11.69%) with minor complications, while major complications as well as early postoperative mortality had not occurred. Average postoperative hospital stay was 2.3 days.

Conclusion: TEM is method of choice for treatment of larger adenomas, carcinomas in situ and T1 carcinoma in carefully selected patients. In T2 NO carcinomas that are smaller than 3cm, low grade and without lymphatic and neural invasion, results are comparable to open procedures, especially after neoadjuvant therapy. TEM is good as a palliative method and also as alternative approach in patients that otherwise have unacceptable operative risk.

Keywords: TEM, adenoma, carcinoma, transanal, endoscopy, microsurgery, polypectomy

D10 THE SURGICAL TIPS AND OVERLOOKED FACTORS OF THE POSTERIOR COMPARTMENT REPAIR
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"Magda Sits Kocman University, Department of Obstetrics and Gynecology

As for all pelvic organ prolapse surgeries, the goal of posterior compartment repair is to restore normal vaginal anatomy, maintain or restore the functionality. With this perspective, the pelvic surgeon must thoroughly understand the normal anatomic support, physiology and functionality of the pelvic floor and the vagina. Posterior prolapssure surgery can be performed via a variety of approaches with or without grafts, despite substantial data for the posterior compartment repair presenting long-term results. However, one should keep in mind that not all posterior prolapse cases are caused by posterior support.

Posterior colpourethraly has been the most common surgical technique for posterior compartment repair. But there are some serious deficits of this technique. The most important one is various defects often exerted and fixation in the midline of vagina may exacerbate the occasional defects. Also a simple topographic correction of the vagin...
inal bulging does not generally result in normal function of the vagina and surrounding organs.

The musculotendinous fibers that support posterior compartment span from the perineal body to the posterior fornix of the cervix. De Lancyey divided the supportive components of the posterior vagina into three levels. At level 1, the upper vagina is suspended by the cardinal-uterosacral ligament complex. The midvagina at level 2 is supported by lateral fibrous attachments to the ATFP and the fascia of levator ani. The supportive structures of the distal vagina at level 3 are composed by the fusion of the perineal membrane, levator ani muscles and perineal body to form a rectovaginal septum that connects the pelvic wall to perineal body. Even if the existence of the rectovaginal fascia is controversial, in surgical dissection one can see the presence of a fibro-elastis structure that extends from the perineal body to the rectouterine pouch. It becomes thinner near the uterosacral ligaments and prominent in the midline.

In traditional approaches tearing from uterosacral ligaments (level 1) and perineal body (level 3) are overlooked. But these defects are more serious than expected and are the major etiology of the posterior compartment defects. In this presentation, we aimed to focus on the importance of restoration of posterior compartment defects formed by tearing from uterosacral ligaments and perineal body along with surgical technique demonstration.

Keywords: Prolapse, Rectocele, Uterosacral ligaments and perineal body, Surgical technique demonstration.

References:

D11 LASER HEMORRHOIDOPLASTY: A MINIMAL INVASIVE AND PAINLESS PROCEDURE FOR HEMORRHOIDAL DISEASE

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Background: Hemorrhoidal disease (HD) represents a major medical and socioeconomic problem. The choice of the best treatment option remains controversial. Despite many progresses improving HD surgical treatments and the development of new techniques in the last three decades, postoperative pain and discomfort remain the major weaknesses. Laser Hemorrhoidoplasty (LHP) represents a new minimally invasive procedure for day-surgery treatment of HD, in which a diode laser determines the hemorrhoidal vessels shrinkage, leading to their subsequent coagulation. The aim of this study is to evaluate the feasibility and the efficacy of LHP in patients with II-III degrees hemorrhoids [1] in terms of postoperative pain and complications, time for the patients to return to their daily routine and resolution of symptoms reporting our initial experience with this new laser treatment.

Materials and Methods: According to the Goligher’s classification, we enrolled patients with II-III degree HD. We performed a specialized coloproctology evaluation, completed by a colonoscopy. All patients underwent a LHP treatment using a 1470-nm diode laser probe (Biolitec® Jena, Germany). We evaluated postoperative bleeding, pain, time needed to come back to their daily routine, need for analgesics, fecal incontinence and other postoperative complications.

Results: Forty patients (23 female and 17 males) with grade II-III HD were enrolled in the study. No significant intraoperative complications occurred. Intraoperative mean time was 15 minutes. Postoperative pain score (at 6, 12, 18, and 24 hours after surgery), we evaluated with visual analogue scale (VAS) and it was extremely low (mean value 2, range 0-3). The eventual administration of NSAIDs in postoperative time and after discharge was low. After surgery, no patient suffered of spontaneous bleeding, while 24 patients (60%) experienced a post defecatory bleeding on the first postoperative day, and 12 patients (30%) on postoperative day 3. From the seventh postoperative day on, no bleeding events occurred in our cohort. 16 patients (40%) came back to daily activity one day after surgery and our whole population in the second postoperative day. No patient experienced sero-mucous discharge and no patient reported fecal incontinence. At a mean follow up period of 8.6 months we reported a rate of recurrence of 0%.

Conclusion: LHP is a minimally invasive and safe procedure that in our initial experience demonstrated a large efficacy, especially in terms of postoperative pain and complications, in selected patients. The greatest strengths are the lack of peri-anal wounds associated with a very low postoperative pain, no need of medications or special anhygienic measures, a very short time needed to go back to work. No sero-mucous discharge and no cases of postoperative fecal incontinence was reported. These promising results point out a negligible postoperative discomfort, and make the LHP a painless, feasible and minimally invasive procedure.

Keywords: Hemorrhoidal disease, Laser, Laser Hemorrhoidoplasty, painless procedure.


Acknowledgments: N/A

D12 WHICH ANORECTAL DYSFUNCTIONS ARE PROLAPSE-INDUCED?

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Since the papers of P. Petros, M. Swash et al. (Pelviperineology 27:85-124.2008) more and more evidence has occurred that anorectal dysfunctions can be caused by pelvic organ prolapse. To answer the question which anorectal dysfunctions are prolapse-induced we analyzed the data of the Propel-Study registered in „ClinicalTrials.gov Identifier:NCT00638238“. In this multicentre (10 US, 6 EU) study the efficiency of Elevate anterior/apical and Elevate posterior/apical has been examined in 277 women with POP-Q-stages 2-4. Pre, 6, 12 and 24 months post surgery women were asked to answer 46 questions of the Pelvic Floor Disorder Inventory (PF-D)-questionnaire according the following kind of bother: No, yes-not at all, somewhat, moderate, quite a bit. We report the prevalences of moderate and quite a bit bother. 185 women answered 24 months after surgery. We report about 10 questions related to anorectal dysfunctions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Rel.-Frequency preoperative</th>
<th>Rel.-Frequency 24 months</th>
<th>p postop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defecation with pressure Vagina/rectum</td>
<td>42,6 %</td>
<td>19,8 %</td>
<td>&lt; 0,001</td>
</tr>
<tr>
<td>Feeling incomplete defecation</td>
<td>66,4 %</td>
<td>25,3 %</td>
<td>&lt; 0,001</td>
</tr>
<tr>
<td>Loss of gas under stress</td>
<td>36,1 %</td>
<td>20,9 %</td>
<td>&lt; 0,01</td>
</tr>
<tr>
<td>Fecal incontinence 3. degree</td>
<td>8,2 %</td>
<td>3,3 %</td>
<td>= 0,05</td>
</tr>
<tr>
<td>Fecal incontinence 2. degree</td>
<td>25,4</td>
<td>16,5 %</td>
<td>&lt; 0,05</td>
</tr>
<tr>
<td>Fecal incontinence 1. Degree</td>
<td>52,4 %</td>
<td>20,5 %</td>
<td>&lt; 0,001</td>
</tr>
<tr>
<td>Defecation with pain</td>
<td>31,1 %</td>
<td>7,7 %</td>
<td>&lt; 0,001</td>
</tr>
<tr>
<td>Urgesymptoms before defecation</td>
<td>43,4 %</td>
<td>20,9 %</td>
<td>&lt; 0,001</td>
</tr>
<tr>
<td>Bother by hemorrhoids</td>
<td>44,3 %</td>
<td>26,4 %</td>
<td>&lt; 001</td>
</tr>
<tr>
<td>Bother by rectum prolapse</td>
<td>15,6 %</td>
<td>6,6 %</td>
<td>&lt; 0,05</td>
</tr>
</tbody>
</table>

These results show – mainly high significant – reductions of the prevalence rates post versus pre surgery. This implies that many anorectal dysfunctions may be caused by pelvic organ prolapse.

Keywords: Which anorectal dysfunctions are prolapse-induced?
D13  THE MANAGEMENT OF STOMAL COMPLICATIONS OF BOWEL: STENOSIS, NECROSIS OR ISCHAEMIA, DERMATITIS, DEHISCENCE  
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We speak of stomal stenosis when there is a narrowing of the stomal lumen such as to hinder the escape of the effluents; The results of a recent systematic review indicate that the stenosis has an average incidence of 0.7% in the lateral ileostomies, of 2.6% and 2.5% in the lateral and terminal colostomies respectively. The conservative management of stenosis can include the prevention of constipation, irrigation for colostomies, the execution of stomal dilations for temporary ostomies, the correct education of the patient and caregiver for the recognition of symptoms from intestinal obstruction. Stoma necrosis can be defined as the death of the tissues that make up the stoma. It can be superficial, if it only affects the mucosa, deep, if it also affects the underlying tissues. In their review of the literature Krishnamurti et al. have shown that this early complication can affect up to 13% of people with ostomy and that it is more frequently associated with colostomies, urgent interventions and obesity. The management of edema and/or ischemia involves monitoring the color of the stomal mucosa in order to promptly detect the appearance of necrosis and warn the doctor who will investigate the extent and depth of the lesion; provides for the application of a protective barrier with a sufficiently wide opening so as not to compromise the blood flow to the intestinal loop. In case of superficial necrosis let the devitalized tissue fall spontaneously. For the Dermatitis there is the Irritative Contact Dermatitis and the Contact Allergic Dermatitis: one caused by the contact between the feces or the urine and the peristomal skin, the second between the peristomal skin and the materials the appliance is made of. Nursing stoma care is sufficient for the management and resolution of Irritative Contact Dermatitis. The treatment of Contact Allergic Dermatitis involves removing the product suspected of being the cause and replacing it with a similar one and a subsequent medical evaluation in the event of failure to resolve. By muco-cutaneous dehiscence we mean the separation of any skin alterations such as to hinder the escape of the effluents; The results of a recent systematic review of randomized controlled trials, Annals of the Royal College of Surgeons of England 2018; 100(7):501-8. Krishnamurti DM, Blatnick J, Mutch S. Stoma Complications. Clin Colon Rectal Surg 2017;30:193–200. Formijne Jonkers HA, van Overbeeke AJ, Broeders IAMJ, Consten ECI. Early complications after stoma formation: a prospective cohort study in 100 patients with 1-year follow-up. Int J Colorectal Dis 2012; 27:1095–1099. Barr JE. Stoma complications. Stoma Ostomy Wound Manage. 2004;50(9):50-67. Kwiat M, Kawata M. Avoidance and Management of Stomal Complications. Clin Colon Rectal Surg 2013;26:112–121. Burch J, Sica J. Common peristomal skin problems and potential treatment options. British Journal of Nursing, 2008; 17(17) (stoma care supplement): S4-S11. Colwell JC, Ratliff CR, Goldberg M, Baharestani MM, Bliss DZ, Gray M, Kennedy-Evans KL, Logan S, Black JM. MASD PART 3: peristomal moisture-assOCIated dermatitis and periwound moisture-associated dermatitis: a consensus. J Wound Ostomy Continence Nurs. 2011;38(5):541-53  

D14  FROM CARE TO SELF-CARE: THE ROLE OF STOMATHERAPIST  
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Introduction  Experts know that: living with the stoma is like living with a new organ. And the impact, visual, physical but above all, emotional is very strong. The right device definitely makes a difference. But that’s not enough. It takes a whole stage of emotional support, in which the stoma-therapist nurse plays a key action. The role of the stomatherapist is to guide the patient on the way to rehabilitation, which can be said complete only when he/she learns to manage the stoma properly and resumes full autonomy.  
Material and Methods  In describing this role of the stomatherapist from care to selfcare, we evaluated the path followed in our hospital structure.  
Results  We noticed in our outpatient activity, that the path for the stoma-carrying patient that starts from the stomatherapist’s mapping and the interview before the surgery followed with the training and the quarterly follow-up, brought our stoma-carrying patients to have few problems in their daily lives and to have a degree of acceptance of the new state.  
Conclusions  The stomatherapist is the central figure in the care and rehabilitation of the carrier patient. And the recent coding created and adopted in Piedmont has also given a new boost to the development of the stomatherapist’s figure.  
Keywords : Stomatherapy  
References : Marullo - Nursing Today, 1999 - area-c54. it - Needs and Rehabilitation Goals On the emotional level - Alteration of the state of health sphere ... due a - Excessive outwardization of the bowel - Mucus-cutaneous suture defect - Possible outcomes ... leveling (depending on the degree) of any skin alterations  

D15  BOWEL MANAGEMENT IN OSTOMATED PATIENTS THROUGH IRRIGATION SYSTEM  
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¹UO’s 2 Marca Trevisiana Trevixo  
Creation of a colostomy in colorectal (CRC) cancer patients results in a loss of control over bowel evacuation. Colostomy irrigation is a way of achieving faecal continence and it is offered as an alternative method of stoma care management to wearing and emptying a colostomy appliance. It is a method of stoma care management offering ‘control’ over bowel habit thus assisting the colostomist in the adjustment and adaptation towards their new way of life. The only way to re-establish some control is through irrigation, a procedure that involves instilling fluid (warm water, salt solutions, oily solutions, osmolar solutions), into the bowel to allow for gas and fecal output. Patient education and use of irrigation in the United States has decreased over the years, with no clear identification of why this change in practice has occurred. Those respondents who used irrigation had their surgery longer ago, and spent more time in colostomy care than those that did not irrigate. Reasons for the decrease in colostomy irrigation are unreported and present priorities for needed research. Irrigation reduced odor and flatus. Irrigation also improved the social and the working conditions. With modern apparatus the technique is safe. Regular irrigation is associated with reductions in pouch usage. In a old study of Padua’s University on 340 patients no one patient who irrigated his colostomy had any cutaneous problem, and this group had significantly better results in preventing leakage of gas and odors compared with those patients using natural evacuation. For most patients who irrigated, the ability to predict preventing leakage of gas and odors compared with those patients using natural evacuation. For most patients who irrigated, the ability to predict or control bowel movements overcome fears of “being dirty” and related psychological problems. These patients also had more normal social and working lives than did those patients not irrigating their colostomies.  
Keywords : ostomy irrigation  

Fig 1: Contact irritation dermatitis  
Fig 2: Macrocutaneous separation  
Fig 3: Necrosis  
Acknowledgments : Thanks to AI OSS and its scientific committee for the drafting of Guidelines in Stomatherapy which are the basis of my intervention in this workshop.
RECTAL TENESMUS IN THE OSTOMATE
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1Utsa2 Marca Trevigiana

Rectal tenesmus in the ostomates is a condition that can occur at times, from time to time, or constantly and leads to a situation of discomfort and deterioration in the quality of life. Causes are many: faecal diversion colitis, anastomosis, old still present stools, inflammation from radiotherapy. Diversion colitis is a complex, nonspecific inflammatory disease that occurs in an excluded colonic segment in almost all patients submitted to a fecal diversion, such as loop colostomy or Hartmann’s procedure (end colostomy with closure of the distal colonic segment) or such as loop temporary ileostomy. Clinical manifestations typically include tenesmus with abundant rectal discharge of mucus or blood and abdominal pain. Tenesmus is a disorder condition and it can affect QoL. Another cause of tenesmus in the ostomate is low anterior resection of the colon with very low colorectalostomy that is a procedure occasionally required in the surgical management of the patient with gynecologic malignancy or ulcerative rectocolitis with total proctocolectomy. Tenesmus could also be in sigma resection with Hartmann’s colostomy, due to the presence of mucus or old stools in rectum. Very low end-to-end anastomosis of the colon to rectum has been associated tenesmus in up to 70% of cases. The construction of a rectal J-pouch low pressure reservoir has been reported to have a salutary effect upon these symptoms.
Solution are instillations of short-chain fatty acids from an efficient ileostomy loop that reduce colitics by diversion facal, anal enemas with warm water or chamomile, support through counseling of the ostomy therapist, local anti-inflammatory. Keywords: tenesmus ostomy ostomate

THE REHABILITATION OF PATIENTS CANDIDATE TO STOMA CLOSURE
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1Utsa2 Marca Trevigiana

Although low anterior resection with the loop by an ileostomy (usually at the right of the abdomen) can prevent patients from having a permanent colostomy, bowel dysfunction may occur in 60% to 90% of patients. Bowel dysfunction symptoms may include fecal and gas incontinence, urgency, frequent bowel movements, clustering of stools, and difficulty emptying. The symptoms collectively are referred to as low anterior resection syndrome (LARS) and adversely affect quality of life. During the ostomy time it’s important to subject the patient to evaluation of the pelvic floor, with digital exploration and palpation, to discuss with the surgeon about the patient’s perineal history (number of parts, dysfunctions ...) before surgery, is very important.
Also patients with a colostomy could present faecal urgency and frequency, due to the many months spincter inactivity, radiotherapy or chemotheraphy. Pelvic floor rehabilitation is an important first-line treatment for patients with faecal incontinence and many published case reports and a small number of randomized controlled trials (RCTs) provide limited evidence for its efficacy. Pelvic floor rehabilitation approaches include pelvic floor muscle training, biofeedback, and volumetric training with rectal balloon catheters. Various forms of external electrical stimulation have also been described and may be of added benefit. It is not possible to use the intracavity probe if the patient is pregnant, and it also may be of added benefit. But it is possible to use the intracavity probe if the patient is pregnant. Behavioral bowel retraining is an important part of a good rehabilitative approach as well and it includes food advice. Several studies have been performed to prevent or treat LARS. Firstly, several surgeons have tried to change the necrectal configuration with diverse anastomotic techniques, including colonic J-pouch or colostomy. Though these techniques were tried to improve rectal compliance, there were no obvious long-term benefits of any particular technique. Secondly, stoma therapist can explain empirical and symptom-based treatment with loperamide after stoma closure that has frequently been used in the clinic. Loperamide acts directly on the intestine to inhibit peristalsis, lengthens the small intestinal and mouth to eccentric transit time, increases the sphincter tone and resting pressure, and reduces urgency, stool volume, and the frequency of bowel movements. It also reduces the sensitivity of the rectal sensory nerve. Loperamide also increases rectal perception in healthy subjects. But the ostomy nurse also can prescribe thickening supplements. BFT is an established treatment option for constipation and fecal incontinence and it would be important to subject the patient before surgery. With BFT, the patient gets information about activity of the pelvic floor muscles by way of a visual display. Generally, most surgeons may recommend pelvic muscle rehabilitation, such as Kegel exercises, to their patients during the anal resting phase with temporary stoma. The aim of Kegel exercises is to improve muscle tone by strengthening the pubococcygeus muscles of the pelvic floor. It is now known that with Kegel exercises, the components of the levator ani muscles contract and relax as one muscle. This type of exercise may be beneficial in cases of fecal incontinence. However, the correct execution of these exercises is not checked by medical staff, making it difficult to determine whether the training was ineffective owing to inherent deficiency, or because it was incorrectly performed. There is also the urgency exercise to be taught to the patient, which uses synergies such as breathing and abdominals. Another factor related to the “urgency to defecate” after stoma closure may be rectal or anal hypersensitivity. So inserting into the distal limb of the loop stool warm water or a padge or potato starch and rice starch also by transanal, that should be of similar consistency to the output from the proximal limb of the stoma and will thus form a comparable stool to that which the patient may expect if the stoma was reversed. A record is kept of the stool frequency/urgency, consistency and any incontinence. It can be repeated on sequential days so that both the patient and physician can get a reasonable idea of bowel function. The main advantage of this technique is that the colon delivers a “stool” to the distal rectum/anus, which, in a pragmatic sense, is much closer to reproducing the likely function following reversal of a stoma.
Keywords: pelvic floor rehabilitation stoma closure LARS

PREOPERATIVE STOMA MARKING AFFECT OUTCOME?
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The pre-operative drawing is a technique of valuation on the positioning of ostomy (urinary or fecal) that is performed by trained health care professional (stoma nurse or surgeon) and is strongly recommended by the most important clinical studies carried out in the surgical field and is the basis of articles 1 and 2 of the “Charter of Ostomates’ Rights”, which stresses the importance of receiving pre-operative information about the benefits of surgery and to have adequate news on the possibility to live with a well-made ostomy and situated in the most suitable position. Through the intervention without. Through the validated questionnaire “QOL”, in Person et al. study (2012), it was noted that 75.5% of patients who do not receive the pre-operative drawing suffer from skin irritation, 24.5% develop a parasomal hernia, of which 18.9% face other surgery related to complications of hernia, 7.5% encounter a stoma prolapse and 66% weekly meet specialized staff for advice.
Also Baykara et al. (2014), with a retrospective study on 748 people, shows that 46% of people who have not received the pre-operative drawing have a higher incidence of complications than the 22% of the investigated population who received the procedure recommended by the stoma nurse. In addition, people who have received education and the pre-operative drawing have developed less anxiety about the diagnosis, the surgery and the ostomy.
Keywords: Stoma, Ostomy, Colostomy, Ileostomy Site marking, Pre-operative site marking, Bowel surgery, Stomacare;


Acknowledgments: Infarmiere stomataterapia Gerotto Mauro, presso il Centro Incontinenze dell’unità operativa 4° Chirurgia dell’ospedale “Ca’ Foncello” di Treviso, A.A./s.n. n.2 “Marca Trevigiana” Email: Mauro. Gerotto@aul2s2.veneto.it
D19
ANAL CANCER SCREENING PROGRAM: THE VALUE OF HIGH RESOLUTION ANOSCOPY IN HIGH GRADE LESIONS DETECTION
ANDREA LAURETTA1, ORNELLA SCHIOPPA1, FERDINANDO MARTELLotta1, VINCENZO CANZONIERI1, EMANUELA VACCHER1
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Purpose: Early diagnosis and treatment of anal intraepithelial neoplasia (AIN) may prevent disease progression. The aim of this study is to evaluate the preliminary results of a screening program implemented by a multidisciplinary team.

Materials and Methods: The screening program used high-resolution anoscopy (HRA) as the gold standard for lesions detection. High-risk patients (HIV positive or solid transplant recipients) underwent HPV typing, anal cytology and HRA. Condylomas, moderate and severe dysplasia were treated through HRA-guided electrocautery or surgical excision.

Results: From May Since October 2017 to May 2019 a total of 85 high risk patients were submitted to the screening program. All patients but three had HIV infection; two were kidney transplant recipients, one had common variable immunodeficiency. HPV high-risk genotypes were encountered in 51 patients (58.62%). Thirty-four patients had anal pap smear negative, but in ten cases a lesion was documented by HRA (false negative rate of 29.41%). A total of 134 HRA were carried out and 120 biopsies were performed: 83.3% of HRA-guided biopsy resulted positive. Condylomas were found in 12 patients and AIN1 in 18 patients. Fifteen patients (17.64%) had high grade lesions: 9 AIN2, five AIN3, in situ carcinoma in 1 case. Thirty-one patients underwent either surgical excision or diathermy ablation. Progression of lesions was registered in 5 patients (two AIN II and three AIN III) at 17.63 months follow up.

Conclusion: HRA revealed high risk lesions in almost 20% of screened patients and can be regarded as a useful tool to interrupt the oncologic pathway in high-risk patients.

Keywords: Anal Cancer, Anal Intraepithelial Neoplasia, Screening, High Resolution Anoscopy

D20
HOW OSTOMY AFFECTS SEXUAL FUNCTIONING: PSYCHOLOGICAL SUPPORT
CATERINA BERTELLI

The packaging of a stoma changes the body pattern and fragments identity. The ostomate may no longer be able to carry out desired daily activities. The experience of man / woman is going to change. The quality of life may not be satisfactory for a long time. Failure of sexual needs can be a cause. Sexuality represents a healthy form of narcissism and social relations management. Objective assessments such as the StomaQol can bring out any discomfort and suffering related to the experience of sexual activity. The ostomy can become a cause of sexual dysfunctions. They hide a dysfunctionally anxiety and a depressive disorder. Individual psychological support becomes necessary in this context, in order to be aware of the problem, and therefore to improve self-esteem and a sense of efficacy. The psychologist can also become facilitator in mutual aid groups. These allow to develop coping strategies, increase empowerment and encourage social relations in a context in which all participants can be “helpers”.

Keywords: ostomy sexuality psychological support

D21
THE EXPERIENCE OF FLATUS INCONTINENCE FROM A BOWEL OSTOMY: A HERMENEUTIC PHENOMENOLOGY
SILVIA ZAMBELLO

Objective: To interpret and present possible meanings in the stories of people with bowel ostomies about their experience of impact of flatus incontinence on their life and being.

Design: Hermeneutic phenomenology guided by a Gadamerian perspective.

Setting and subjects: Six people with a bowel ostomy were recruited from a city in Australia.

Methods: nonstructured interviews generated rich text. Interviews were videotaped. Hermeneutic techniques were applied for text interpretation.

Results: Nine existential themes of meaning emerged. Through symbolic interpretation, writing, and re-writing, themes were encompassed in a short story: a creative synthesis of actual events and interpreted understandings for ostomates about possible meanings of experiencing flatus incontinence.

Conclusion: Flatus incontinence for people with bowel ostomies can be quite discommoding and impact on their interactions, self-image, sexuality, social activity, and psychological well-being. Nurses need to understand this for empathetic intervention, patient assessment, intervention selection, research planning, and pertinent education.

Keywords: bowel ostomy flatus incontinence nurse care


Embarassment

Social exclusion


D22
PERIANAL SQUAMOUS CELL CARCINOMA AND THE ROLE OF ENDOANAL ULTRASOUND
CHRISTIAN RAYMOND SANDELL MAGBOJOS1, MA. THESA ISA MILITAR CALIPUSAN1, ABOUBEN JAN ACAMPADO BALONDO1, ANDREA JOANNE ALERTA TORRE2
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Perianal or anal margin malignancies comprise only about 3 to 4% of all anorectal malignancies1. They are less common than carcinomas of the anal canal and have more favorable prognosis. Squamous cell carcinoma (SCCA) represents one fourth to one third of all SCCA of the anus and is considered the most common malignancy of the anal margin2,3.

This paper presents a case of a 54-year old female diagnosed with perianal squamous cell carcinoma at the anococcygeal area by incisional biopsy, with a size of 15x10cm. Abdominopelvic CT showed a posterior fistulous communication between the mass and the distal rectum. 3D endoanal ultrasound confirmed the presence of fistula in the distal rectum. Furthermore, a posterior transspincteric fistula at the middle anal canal was visualized. Patient was managed with combined radiotherapy (RT) (60 Gy in 32 fractions) and chemotherapy (Mitomycin 10mg IV at Day 1 and Day 20; Capcitabine 2 tablets PO on RT days) from March 13, 2019 to May 7, 2019. At 12 weeks post-treatment, the mass was reduced to a small ulcer at the intergluteal cleft measuring 3cm widest diameter. Repeat 3D endoanal ultrasound showed scarring of fistula tracts. With RT’s protracted effect, the plan is to reevaluate the patient 6 months post chemorT for possible complete response. This report aims to discuss the added advantage of 3D endoanal ultrasound in the assessment of perianal malignancies and the multidisciplinary approach to managing these types of anal cancers.

Keywords: anal margin cancer, perianal cancer, squamous cell cancer, 3D endoanal ultrasound, multidisciplinary team

D24
LASER TREATMENT FOR ANAL FISTULA (FiLaC)
PAOLO GIAMUNDO
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Introduction: “FiLaC” consists of closure of the fistula tract by means of laser energy emitted by a diode laser platform. Shrinkage and healing of fistula is contained within 4 mm from the acting laser fiber. This makes the procedure reproducible and sphincter-saving. Its main indication is for high and complex fistulas. However, it may be indicated also in more superficial fistulas where fistulotomies or other techniques may significantly alter continence.

Methods: The laser fiber is introduced into the fistula tract with a Seldinger manoeuvre. Laser energy is delivered at 360 degrees while pulling the fiber out of the tract at the speed of 1 mm/sec. 12 W of energy and 1470 nm of wavelength are the optimal parameters to induce the shrinkage of the tract.

Mucosal flaps or suture of the internal orifice may not be necessary as the orifice is involved in the shrinkage effect elicited by the laser beam.

Results: One hundred fifty four patients with mean age of 48 years treated with FiLaC procedure are currently evaluated. There were 130 transphincteric, 5 suprasphincteric and 19 high intersphincteric fistulas. Six patients had Crohn’s disease. Main length of the fistula tract was 4.5 cm (range, 2.5-8). No intraoperative complications were recorded. Direct suture of internal orifice was recorded in 35 patients. Postoperative morbidity included: pain requiring use of pain killer for more than one week in 9 patients (5.8%), light bleeding in 8 patients (5.2%), acute retention of urine in 3 patients (1.9%), perianal abscess in 2 patients (1.3%). At median follow-up is 45.4 months (range, 6-80), overall primary healing rate was 65% (100 out of 154). Fifteen patients were treated with a re-do FiLaC an average of 10 months after failure of FiLaC. Success rate was 40% (6/15). Twenty patients were treated with fistulotomy (and partial sphincter reconstruction where necessary) with a success rate of 95%. Nine patients were lost at follow-up. Of the 6 patients with Crohn’s disease, primary healing was achieved in 3 (50%). There was no clear correlation between the suture of the internal orifice and the healing rate.

Conclusion: The FiLaC procedure is a safe, easy to learn, minimally invasive, sphincter-saving and potentially repeatable procedure to treat anal fistulas. It is indicated in all cases of complex anal fistulas where a shiner-saving procedure is advised.

Keywords: laser, sphincter-saving procedure, minimally invasive procedure.

Fig. 1 - FiLaC

D23
USE OF STEM CELLS IN ANAL INCONTINENCE: IS THERE A FUTURE?
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1Surgical Department, University Hospital Ferrara

Anal incontinence causes negative effects on quality of life. Current treatment options show unsatisfactory results. Regenerative medicine could be an alternative to current treatments for fecal incontinence: human adipose-derived stromal/stem cells (hADSCs) are easier and safer to access, secrete high levels of growth factor, and have the potential to differentiate into muscle cells. The purpose of this pilot study is to evaluate the efficacy of the use of stem cells for relieving anal incontinence. The primary outcome measures are the efficacy and the safety of the cell treatment. Secondary outcome is pain evaluated by NRS.

Fifteen consecutive patients (14 women and 1 man) presenting with anal incontinence due to internal sphincter weakness occurred after surgery or brachy-therapy for anal cancer were recruited for the study from June 2017 to June 2019. The study design contemplated hADSCs harvesting using Coleman’s technique1. The injection of hADSCs was performed into sub-mucosa of internal anal sphincter under ultrasound guidance. The Wexner score, endorectal sonography, and anorectal manometry were recorded before and 2 months after surgery.

Results: No side effects were detected. No cancer recurrence were observed. Postoperative pain was null. Wexner scores significantly decreased. Endorectal sonography revealed the improvement in the amount of muscle. Anorectal manometry detected a significant improvement in anal sphincter pressures.

Conclusions: The results of the current study show that injections of hADSCs in fecal incontinence may cause replacement of fibrous tissue with muscle tissue.

Keywords: anal incontinence, regenerative medicine, human adipose-derived stromal/stem cells (hADSCs)

Introduction
Severe fecal incontinence describes a condition of complete loss of control over fundamental physiological functions and loss of abilities to fulfill psychosocial functions by the patients. The last-step procedure that is to restore hope for improvement of biopsychosocial functioning and quality of life is that determined by the patient’s health status is implantation of an artificial bowel sphincter.

Objective
The objective of the study was a comparative analysis of the effect of the employed surgical procedure upon the degree of defecation control and quality of life indices in its behavioral, mental and social aspects prior to and 3, 6 and 12 months postoperatively. The analysis also included the effect of the patient’s individual style of coping with stress and the functional outcome of the procedure.

Material and methods
The study included a group of 12 patients; 6 females and 6 males, aged from 36 to 60 years of life.

The tools consisted of scoring systems that measured symptom intensity (FISS and J and Wexner scale). In assessing the psychosocial functioning, the authors employed the Fecal Incontinence Quality of Life scale (Rockwood). The individual mode of coping with the disease was evaluated by the CISS scale by Endler and Parker.

Results: The analysis of results demonstrated that the procedure of implanting an artificial bowel sphincter affected the “continence” up to 50-60 % postoperatively and led to improvement in psychosocial functioning in all its assessed aspects, i.e. lifestyle, employment, preoccupation major measures, depression, anxiety-embrace. It was also noted that due to the specific character of the procedure (the necessity to operate an artificial implant), better mean results in assessment of the procedure functionality were achieved by patients presenting the goal-concentrated rather than emotions-concentrated mode of coping with the disease. Thus, is seems justified to state that assessment of biopsychological functioning may be a good criterion of the procedure effectiveness.

Keywords: extreme fecal incontinence, biopsychosocial functioning, artificial bowel sphincter
 Injectable Bulking Agents for Fecal Incontinence: An Age-Matched Retrospective Cohort Analysis of GateKeeper versus SphinKeeper.

Ugo Grossi, MD,1 Luigi Brusciano, PhD,2 Salvatore Tolone, PhD,2 Gianmatta Del Genio, PhD,2 Gian Luca Di Tanna, PhD,3 Claudio Gambardella, MD,4 Michele Schiavo Di Visconte, MD,4 Jacopo Martellucci, MD,4 Ludovico Docimo, PhD,2 Giano Luca Di Tanna, PhD;2 Claudio Gambardella, MD;2 Ugo Grossi, MD;1

Background: We aimed to evaluate morpho-functional changes of the sphincter complex after GateKeeper (GK) and SphinKeeper (SK) procedures and correlate these with symptoms improvement.

Methods: Ten consecutive females undergoing SK implant were age-matched with a cohort of 10 females who previously underwent GK procedure. Patients in the SK and GK group underwent implantation of 10 and 6 prostheses, respectively. Muscle tension (Tm), expressed in millinewtons per centimetre squared, mN(cm2)-1, was calculated using the equation

\[ Tm = \frac{P}{r_i - r_m} \]

where \( P \) is the average maximum squeeze pressure, \( r_i \) is the average maximum squeeze pressure, \( r_i \) is the inner radius of the EAS, \( r_m \) is EAS thickness.

Results: CCFIS significantly improved in both groups at 12 months post-implantation. Although not reaching statistical significance, symptom improvement after SK was 33% above that observed after GK (p=0.088). Compared to baseline, a significant increase in Tm was observed in both groups at 12 months (GK, 508.1 [478.8-568.0] vs. 864.4 [827.0-885.8] mN(cm2);p<0.001). Compared to the GK group, Tm was significantly higher in patients after SK implant (158.3 mN(cm2);95% CI, 109.6-207.0) after controlling for baseline values, at 12 months post-implantation.

Conclusions: GK and SK are safe and effective treatments for FI with good short-term clinical outcomes. Comparative analysis showed superiority of SK over GK in terms of gain in Tm, with borderline significantly better improvement in symptoms. Larger studies are needed to confirm these findings.

Keywords: fecal incontinence; GateKeeper; SphinKeeper; bulking agents; muscle tension; anal sphincters.

Tab. 1 - Patients’ characteristics at baseline.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>GateKeeper</th>
<th>SphinKeeper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>53 (45-62)</td>
<td>52 (47-61)</td>
</tr>
<tr>
<td>FI onset, years</td>
<td>3 (2-6)</td>
<td>3 (4-5)</td>
</tr>
<tr>
<td>No. vaginal deliveries</td>
<td>1 (1-2)</td>
<td>1 (1-2)</td>
</tr>
<tr>
<td>Obstetric trauma (%)</td>
<td>4 (40)</td>
<td>6 (60)</td>
</tr>
<tr>
<td>Starck score</td>
<td>0 (0-1)</td>
<td>1 (0-2)</td>
</tr>
<tr>
<td>Previous anal surgery*</td>
<td>1 (10)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Pudendal neuropathy</td>
<td>1 (10)</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1 (10)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>SNS in situ</td>
<td>1 (10)</td>
<td>3 (30)</td>
</tr>
</tbody>
</table>

CCFIS 12 (11-14) 13 (11-13)

IAS morphology (%)

| Normal | 6 (60) | 4 (40) |
| Atrophy | 4 (40) | 6 (60) |
| Defect | 0 (0) | 0 (0) |

EAS morphology (%)

| Normal | 8 (80) | 6 (60) |
| Atrophy | 0 (0) | 0 (0) |
| Defect | 2 (20) | 4 (40) |

Continuous data are expressed as median with first and third quartiles. FI: fecal incontinence; CCFIS: Cleveland Clinic Fecal Incontinence score; IAS: internal anal sphincter; EAS: external anal sphincter.*Referred to haemorrhoidectomy in all cases.

Tab. 2 - Study of the external anal sphincter (EAS) contractility at baseline and 12-month after GateKeeper** and SphinKeeper** implant.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Pre-implant</th>
<th>Post-implant</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>P, mN/mmHg</td>
<td>100.0 (97.5-112.5)</td>
<td>110.0 (103.8-112.5)</td>
<td>0.071</td>
</tr>
<tr>
<td>r_i, mm</td>
<td>13.0 (12.1-13.5)</td>
<td>18.2 (18.1-18.3)</td>
<td>0.005</td>
</tr>
<tr>
<td>r_m, mm</td>
<td>2.5 (2.5-2.7)</td>
<td>2.3 (2.2-2.4)</td>
<td>0.005</td>
</tr>
<tr>
<td>Tm, mN/cm(2)*</td>
<td>508.1 (478.8-568.0)</td>
<td>864.4 (827.0-885.8)</td>
<td>0.005</td>
</tr>
<tr>
<td>P, mN/mmHg</td>
<td>110.0 (105.0-112.5)</td>
<td>110.0 (108.8-118.5)</td>
<td>0.348</td>
</tr>
<tr>
<td>r_i, mm</td>
<td>12.8 (12.0-13.3)</td>
<td>19.2 (19.0-19.3)</td>
<td>0.005</td>
</tr>
<tr>
<td>r_m, mm</td>
<td>2.6 (2.5-2.7)</td>
<td>2.1 (2.0-2.1)</td>
<td>0.005</td>
</tr>
<tr>
<td>Tm, mN/cm(2)*</td>
<td>546.6 (472.7-576.7)</td>
<td>999.2 (968.6-1077.2)</td>
<td>0.005</td>
</tr>
</tbody>
</table>

All values are expressed as median with first and third quartiles. P = intraluminal pressure during average maximum voluntary contraction; r_i = inner radius of the EAS; Tm = EAS thickness; Tm = muscle tension, expressed in millinewtons per centimetre square by the equation Tm=P*ri/ri-rm.**R*<0.001

Tab. 3 - Linear and Poisson regression models to examine the extent of change in muscle tension (Tm) and Cleveland Clinic Fecal Incontinence score (CCFIS), respectively, after SphinKeeper** vs. GateKeeper**.

<table>
<thead>
<tr>
<th>Change in Tm*</th>
<th>Coef.</th>
<th>SE</th>
<th>P value</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>SphinKeeper</td>
<td>1.33</td>
<td>0.22</td>
<td>0.088</td>
<td>0.96</td>
</tr>
<tr>
<td>CCFIS at baseline</td>
<td>1.10</td>
<td>0.01</td>
<td>0.101</td>
<td>0.98</td>
</tr>
<tr>
<td>constant</td>
<td>1.90</td>
<td>1.41</td>
<td>0.384</td>
<td>0.45</td>
</tr>
</tbody>
</table>

IRR: incidence rate ratio; SE = standard error.

Fig. 1 - Morphofunctional changes of the external anal sphincter (EAS) detected by endoanal ultrasound before and after GateKeeper implant (demonstrative example). r_i = inner radius of the EAS; Tm = EAS thickness.
SYSTEMATIC CHARACTERISATION OF DEFAECOGRAPHIC ABNORMALITIES IN A CONSECUTIVE SERIES OF 827 CONSTIPATED PATIENTS AND IMPACT OF SEX

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⁴Centre for Trauma and Surgery, and GI Physiology Unit, Barts and the London School of Medicine and Dentistry, Queen Mary University of London, London, UK.

Background: The aim of this study was to systematically characterize defaecographic abnormalities in a consecutive series of patients presenting with moderate to severe symptoms of constipation. Secondary aims were to compare findings between genders.

Methods: Consecutive constipated patients scoring ≥12 on the Cleveland Clinic Constipation score (CCCS) and undergoing defaecography were included. Static and dynamic parameters were used to define a large spectrum of defaecographic abnormalities using cut-offs derived from studies on healthy volunteers. Eight binary variables (presence or absence) were used to identify a finite number of defaecographic phenotypes: functional abnormality, megarectum, excessive dynamic perineal descent, enterocoele, intussusception, structurally significant intussusception, rectocoele, structurally significant rectocoele.

Results: A total of 827 patients (median age, 49 years; range, 17-98) were identified, 725 (87.7%) of whom were female. No statistically significant differences were found between genders for all comparisons except for CCCS, with marginally higher mean symptom severity (<1 full point of the scale) demonstrated in females compared to males (18.6 [3.6] vs. 17.5 [3.1], respectively; p=0.002). The principal phenotypes encountered were normal defaecography (16%) and isolated functional abnormalities (13%), both significantly more prevalent in males than females. Coexistence of structural abnormalities was significantly more often encountered in females, reflecting global pelvic floor weakness. The number of phenotypes including at least 2% of patients were more limited in males (n= 10) compared to females (n= 16).

Conclusions: Multiple structural and functional abnormalities may coexist in the same subject, with degree of overlap greater than previously recognized.

WIDE EXCISION OF ANAL CANAL AIN III: A VIDEO

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¹Surgical Sciences Department, University Of Turin, Città Della Salute E Della Scienza Di Torino Hospital, Chief Prof Mario Morino.

Aim
Anal intraepitelial neoplasia (AIN) is often a precursor to invasive squamous anal carcinoma, especially in HIV patients.

Case report
We present a video regarding a male patient, 55 years old, affected by AIN III, associated with HIV (CD4 734) and HCV infection. The patient referred anal pain started two years ago. Rectal examination was negative. He was submitted to an anoscopy which revealed some suspicious lesions in the posterior anal canal. A high resolution anoscopy confirmed posterior or areas with mosaicism and punctation lesions. We performed a biopsy, which confirmed the diagnosis of AIN III. The patient underwent to a wide excision of the lesion. We performed surgery in spinal anesthesia. Patient was in lithotomy position. We performed a dissection of mucosa and submucosa planes after submucosal injection of saline solution. The dissection was performed up to dentate line of the posterior anal canal. The specimen was send to AP for definitive histological diagnosis. Finally we perfected the hemostasis and we placed anal spongostan. Patient received analgesic and antibiotics therapy. He was discharged the day after, without any
We present a video of a wide local excision of a Buschke-Löwenstein tumour (BLT), also known as giant condyloma acuminatum or verrucous carcinoma, is a very rare sexually transmitted disease due to human papillomavirus (HPV) subtypes 6 and 11 that affects the ano-genital region. BLT is characterized by a slow-growing cauliflower-like mass, locally aggressive and destructive behavior, with a high recurrence rate and malignant transformation occurring in 40-60% of cases. The treatment of BLT is controversial an includes imiquimod cream, podophyllin resin, cryotherapy, laser surgery and excision with electrocautery; wounds heal by secondary intention without postoperative histological exam and a value of surgical margins.


D31 WIDE LOCAL EXCISION OF A BUSCHKE-LOWENSTEIN TUMOUR

VALENTINA TESTA1, ANTONIO SALZANO1, SYLVIE MOCHET1, PAOLA SALUSSO1, MARIO MORINO1, MASSIMILIANO MISTRANGELO1

1Departement of Surgery Unit of Visceral And Colorectal Surgery Aulss 2 Marca

Introduction. Buschke-Löwenstein tumour (BLT), also known as giant condyloma acuminatum or verrucous carcinoma, is a very rare sexually transmitted disease due to human papillomavirus (HPV) subtypes 6 and 11 that affects the ano-genital region. BLT is characterized by a slow-growing cauliflower-like mass, locally aggressive and destructive behavior, with a high recurrence rate and malignant transformation occurring in 40-60% of cases. The treatment of BLT is controversial an includes imiquimod cream, podophyllin resin, cryotherapy, laser surgery and excision with electrocautery; wounds heal by secondary intention without postoperative histological exam and a value of surgical margins.

Conclusions. Considering the possible risk of degeneration and that many patients are HIV+ we suggest that the reconstruction is not necessary and could increase postoperative complications. The risk of anal stenosis is minimal because the lesion rarely is completely circumferential and the anal canal is rarely involved.

Keywords: Buschke-Löwenstein tumor, AIN, HPV infection, Surgery, Treatment

References:

D32 TYPES OF STOMA AND ASSOCIATED SURGICAL PROCEDURES

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1Department of Surgeys Unit of Visceral And Colorectal Surgery Aulss 2 Marca Trevigiana Conegliano Hospital

The word stoma derives from the Greek stoma, mouth. It therefore represents an external derivation (stoma) alternative, compared to the natural one of the digestive tract or urinary tract, created on the abdomen wall. The derivation outside of a tract of intestine or urinary tract comes defined as a “ostomy” while the mucosa attached to the skin is called “stoma”. The external intestinal derivations can affect the colonic intestinal tract and are defined: Colostomy, whereas for the small intestine: Enterostomies. In case there is instead a urinary derivation they are defined: Ureterostomies. The reasons that lead to the packaging of an intestinal stoma: colic or ileal. Regarding these topics the aim of this work is to recall two fundamental situations: in urgency or in election and to three groups of pathology: the tumors, the neoplastic pathology and the benign pathology represented by the latter: from diseases as chronic intestinal inflammation, to complications of diverticulitis and congenital anomalies of the digestive system. Ostomies of the urinary system are instead linked to tumors or neoplasms. In urgency they are mainly represented by ostomy performed following abdominal trauma or acute facts involving the digestive system that do not allow a direct self repair or from congenital anomaly conditions of the digestive tract that recommend its own temporary defunctionalization. In election there are to be considered mainly in the course of other surgeries for the purpose of defunctionalizing the digestive system to protect intestinal anastomoses with a high risk of deiscence, especially in neoplastic colorectal surgery. Stomas are also classifiable as temporary and permanent. Temporaries are generally susceptible to recanalization after about two or four months. The definitive are, as the word suggests, permanent. Considering the digestive system, ostomies are classified differently depending on the intestinal tract they affect:

- if they affect the colon in: Cecostomy, Colonostomy (right, transverse, left)
- if they involve the ileum in: Ileostomy.

The Cecostomy is packaged in the cecum, on the right iliac of the abdomen. The Colonostomy is instead packaged at the level of the colon and based on the part of the intestine which is taken into consideration we can differentiate between: Colonostomy on the descending colon, on the colon between the middle and the left, instead, the ileostomy represents the cutaneous occlusion of the ileum and may have a prevalent place in the right iliac as well as in the left ileum. If their packaging has provided for the section of the intestinal tract and its biting directly to the skin are called terminals, if instead there was an exteriorization on baguette then they are defined lateral stoma. The urinary ostomy can instead connect the urinary tract to the outside on the skin in the various sections:

- kidney: nephrostomy;
- ureter: ureterostomy;
- bladder: cystostomy.

Considering the intestinal ostomy, the techniques of realization can take place in laparotomy or laparoscopic surgery. For urinary ostomy their realization occurs by direct ultrasound guided puncture (nephrostomy or cystostomy), while ureterostomies are created by laparoscopy surgery. Precisely because of its anatomy, the ostomy does not have a sphincter of its own or a vice able to modulate a pressure effect on the intestinal tract or the urinary tract which is absorbed into the skin able to create an effect of continence, so that they are subject to the impossibility of voluntary controlling what is eliminated and require enterostomal collection facilities.

Keywords: Protective Stoma, Diverting Colostomy, Ileostomy surgical technique.

References:
Materials and methods: From September 2016 to July 2019, 100 patients aged between 18 and 80 years affected by complex anal fistulas, were selected and randomized into two groups: group 1 consisting of 50 patients who underwent fistulectomy, fistulotomy or VAAFT (Video Assisted Anal Fistula Treatment) with closure of the internal orifice; group 2, 50 patients undergoing to injection of ASCs into the perianal wound closed by first intention and in correspondence with the internal orifice after its closure. The ASCs were obtained in accordance with Coleman technique. A protolog-ical examination was carried out at 1 week, 2 weeks, 3 weeks, 1 month, 2 months, 3 months, 6 months and one year after the procedure. Pelvic MRI was performed before the operation and 6 months after surgery in all patients.

Results: In the group treated with ASCs, a shorter healing time and less post-operative pain were found with a similar recurrence rate in the two groups.

Conclusions: The use of ASCs considerably improves wound healing and post-operative pain and it is a safe and low-cost treatment.

Keywords: stem cell, anal fistula

D36
SYSTEMATIC REVIEW OF PERINEAL SURGICAL PROCEDURES FOR COMPLETE EXTERNAL RECTAL PROLAPSE
ANTONIO SALZANO1, VALENTINA TESTA1, SYLVIE MOCHET2, PAOLA SALUSO2, MARIO MORINO2, MASSIMILIANO MISTRANGELO1
1Surgical Science Department, University of Turin, Cità Della Salute e Della Scienza Hospital, Italy.

Aim. Many surgical techniques in the treatment of external complete rectal prolapse have been proposed.

Methods. We performed a systematic review using Pubmed, Embase and Cochrane central register of controlled trials. Key words were Rectal Prolapse (rectal OR rectum OR perineal OR anus OR anal) AND prolaps, Delorme, Altemeier ( OR rectosigmoidectomy OR proctosigmoidectom), PSP (perineal AND stapled ), Perineal Prolapse Stapled Resection, PSP and PSPr regarding PSP in the treatment of complete external rectal prolapsed. Duplicated data and abstracts were excluded from the study. Number of patients, intraoperative and postoperative results, complications and recurrences were evaluated.

Results. 54 papers were included in the review. Delorme was the safer surgical procedure, with lower postoperative complications, that are less serious than Altemeier. PSP was the technique with major incidence of complications and recurrences. Delorme’s has more recurrences than Altemeier. In all techniques we observed better incontinence and constipation scores than before surgery.

Conclusions. The systematic review of the Literature is not able to choose the best perineal surgical technique for complete external rectal prolapse. Altemeier’s procedure is better for young patients considering a lower incidence of recurrences. Delorme’s was better in patients with more associated diseases. PSP is yet under evaluation.

Keywords: Rectal Prolapse, Perineal Approach, Perineal Stapled Prolapse Resection, Contour Transtar, Delorme, Altemeier.


D37
THE MANAGEMENT OF STOMAL COMPLICATIONS OF BOWEL: PROLAPSE, GRANULOMAS, HEMORRHAGES
DIANA ROVERE1
1AULSS Marca Trevigiana

The creation of the intestinal or urinary ostomy is an actual surgical procedure performed for a wide range of gastrointestinal disorder or urinary tract problem. Despite the frequency with which they are performed the stomal or peristomal complications persist; in addition to creating morbidity for the ostomy person, they have health costs.

There are several types of stoma or peristomal complications; we will focus only about hemorrhage, prolapse and stomal granulomas. These common complications will be described and will explain how to avoid or prevent them.

A good surgeon and a good enterostomist have to give to the ostomate person the chance to live his life in the best possible way even with the stomia.

Keywords: Ostomy, Prolapse, Hemorrhages, Granuloma, Complications

E1
FASCIAL MANIPULATION: INTRODUCTION TO THE METHOD AND TREATMENT OF CHRONIC PELVIC PAIN
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The International Association for the Study of Pain defines pain as “a sensory and emotional experience associated with actual or potential tissue damage”. When pelvic pain does not have an obvious origin from a superficial lesion, it comes from the inner subcutaneous spaces related to the pelvis, and therefore can originate from the organs of the genital apparatus, from the lower urinary or intestinal tracts, from the neuro-muscular, vascular and osteoarticular structures located there. Recently the implications of the fascia in the possible cause of chronic pelvic pain have been evaluated: in fact, it has been shown that the deep fascia is very innervated and a lack of flow or densification of the loose connective tissue between the fascial layers can change the contractile capacity of the muscles. The concept of fascial continuity completes the “Integral Theory” according to which a normal functioning of the pelvic organs is in harmony with a balance of tensions of the pelvic floor. In the absence of organic problems it is necessary to release the densifications and fascial restrictions to recreate a good balance of forces. Fascial Manipulation® is a manual therapy that allows the evaluations and treatment of such densification and consists in the se-
lection of specific points of the fascia and their treatment in order to resolve the painful components of fascial structures.

**Key words: **Fascial Manipulation, Pelvic pain, Manual therapy.


E2

THE USE OF A SPECIFIC TRAINING IN THE TREATMENT FOR THE VAGINISMUS WITH HYPNOTIC PSYCHOTHERAPY

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**Introduction:** Aim of this research is to deepen the psychological and psychotropics aspects in order to help the specialist who choos- es the medical hypnosis for treating vaginismus. The work has been developed in 3 steps: 1) research of the literature 2) choice of theoreti- cal bases 3) selection of subjects with vaginismus. After the selection phase the patient were invited to hypnotic trainings of 8 sessions where ad-hoc trainings for the treatment of vaginismus were presented, and they were taught a self-hypnotic technique to be performed at home daily.

**Theoretical basis:** this study is based on: 1) two biopsychosocial models: a) an integrated approach to human behaviour developed by Engel (the multidimensional ideas of health, places the patient at the centre of a wide system influenced by multiple dimension: psychological, social, and do- mestic aspects b) the Benini’s model (biopsychosocial relations) 2) hyp- nosis in the medical area 3) the treatment of pain 4) the studies on body’s movement and emotions 5) the Freud’s theory 6) the MacLean’s model (‘Triune Brain’); the latter is based on the division of the human brain into three distinct regions: Reptilian brain, Paleomammalian or Emotional Brain and Neomammalian or Rational Brain. Reptilian Brain corresponds to the brain stem, including the rachid bulb and the midbrain. It governs primarily innate instincts and reflexes. The consequence of this evolution is that the human being, having three regions within the brain, also has three different mental levels called: biological, psychological and social minds.

**Patients Sample:** 16 women with vaginismus of II and III degree, since > 6 months. Works in hypnosis: At the subject is asked to visualize herself as a chimp and perform tasks like moving freely within a fabulous envi- ronment, living angry, running freely and jumping, taking care of her body, jumping on a big red ball, relating to the herd of other chimps.

**Results:** After 8 sessions, the subjects reported a significant change in their defenses, reduced thoughts, improved self-esteem, self-assertion capacity, reduction of postural pain, a marked reduction in vaginismus with a pas- sage from difficult-painful penetration to penetration with bearable pain or without any pain.

**Conclusions:** With hypnotherapy and the chimpanzee training, the bio- logical brain can be activated and helped in using adaptive and no more rigid defenses, finding a valid aid in dysfunctions such as vaginismus. The aspects of anxiety (anxiety of fragmentation and persecution) decrease by lowering ego defenses with a strong reduction of anxiety.

**Keywords:** hypnosis, vaginismus, psychotherapy, somatic symptoms, fe- male sexual dysfunctions, sexual pain disorders, muscular contraction of the pelvic floor during sexual penetration.


E3

ACUPUNCTURE WITH BIOFEEDBACK PRACTICE AND RESULT TO PELVIC FLOOR PAIN: A FIVE YEARS REPORT FROM CHINA CENTER

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**Objective:** To observe the short and long-term efficacy of acupuncture combined with biofeedback in the treatment of functional anorectal pain (FARP).

**Methods:** Clinical data of 142 patients who met the functional gastroin- testinal disorders and functional anorectal pain based on criteria of Rome III undergoing acupuncture with biofeedback therapy from August 2010 to November 2015 in retrospectively analyzed. Telephone and outpatient clinic recheck were used as standard follow-up. The clinical effect of short- term and long-term data collected from the disease- based database was evaluated with visual analogue pain scale(VAS)(0-10 points), short form health survey questionnaire(SF-36)(0-148 points) and Glazer’s surface electromyography (sEMG). The overall satisfaction and effectiveness( VAS >30%) were evaluated at the end of treatment (short-term) and during follow-up (long-term).

**Results:** The effective follow-up data were obtained from 71.1%(101/142) of patients and the median follow-up time was 28 (3-67) months. The VAS of 101 cases was 6.09 ±1.78, 1.99±1.89 and 3.55± 2.60 before treatment, at the end of treatment and during follow-up respectively. Though the VAS during follow-up was higher than that at the end of treatment, but still si- gnificantly lower than before treatment (P<0.05). The SF-36 score of 31 patients was 82.0 ±16.9, 94.0 ± 15.1 and 88.1 ± 15.3 before treatment, at the end of treatment and during follow-up respectively (P<0.05). The effective rates were 85.9% (122/142) at the end of treatment and 75.2% (76/101) during follow-up, and the patients satisfactory rates were 92.3% (131/142) and 84.2 (85/101), respectively. The differences of the surface electromyography (sEMG) between pre-treatment and on follow-up, in pre-baseline process, the mean amplitude (AVG) on follow-up was lower than before treatment (P<0.01), in flick contraction process, in tonic con- traction and Endurance processes, the peak AVG was higher (P<0.01), the Coefficient of Variance(CV) was lower (P=0.01) compared follow up to pre-treatment.

**Conclusion:** Acupuncture with biofeedback has significant short-term and long-term efficacy in treating functional anorectal pain, and its degree of satisfaction is high. It can reduce the pelvic floor muscle over activity and function. The existing defecation and urinary dysfunction symptoms im- proved simultaneously after treatment. It is promising and needs further study.

**Keywords:** Functional anorectal pain, Acupuncture, Biofeedback, Treatment outcomes

E4

THE ROLE OF PHYSICIAN GUIDED TRIGGER POINT SELF-MASSAGE FOR MYOFASCIAL PELVIC PAIN RELEASE

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**Purpose:** To report the effects of the transcutaneous electrical nerve stim- ulation (TENS) combined with physician guided trigger point self-massage on myofascial pelvic pain (MFP) by comparing pre- and posttreatment average pelvic pain scores, sEMG variables, and patient self-reported pel- vic pain.

**Study design:** Prospectively analyzed 27 patients diagnosed with MFP in...
Zhongda Hospital Affiliated to Southeastern University (China) from September 2018 to February 2019. Participants received TENs every other day and physician guided self-massage twice a day for 2 consecutive weeks. Pain was assessed using a numeric rating scale (NRS) and the Patient Global Impression of Improvement (PGI-I) scale. Future treatment was determined based on the percentage improvement in pain obtained from palpation of each pelvic floor muscle after 2 weeks of treatment. Additional myofascial trigger points (MTrP) injections were required if the treatment was ineffective (an increase, no change or improvement of less than 50% in pain). TENs and self-massage were still needed for 2 weeks unless it was cured (improvement in pain between 80% and 100%). Assessments were performed at baseline, 2, 4 and 12 weeks after treatment. The primary outcome was the average change in pelvic pain on palpation of each pelvic floor muscle pre- and posttreatment. Secondary outcomes included changes in measurement indexes of the Glazer pelvic floor muscle surface electromyography (sEMG) at 4, 12 weeks. Self-reported improvement in pain was also recorded.

Results: The NRS and sEMG variables were significantly improved post-treatment compared with pre-treatment ($p < 0.05$). In addition, 63% of the patients received myofascial injection 2 weeks post-treatment, and there were statistically significant differences in the effectiveness of treatment in the comparison of 4 weeks vs. 2 weeks, 12 weeks vs. 4 weeks post-treatment ($p < 0.05$), however, two cases were ineffective 12 weeks post-treatment. Using the PGI-I index, participants needed on average 3.8 weeks (SD 1.6) to report being at least “better”.

Conclusions: Transcutaneous electrical nerve stimulation combined with physician guided trigger point self-massage can be effective in treating women with myofascial pelvic pain.

Keywords: Transcutaneous electrical nerve stimulation; physician guided trigger point self-massage; myofascial pelvic pain

E5 TREATMENT OF POSTPARTUM VAGINAL RELAXING WITH DYSPAREUNIA: PFMT VS VIBRATING VAGINAL CONE

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2University of West Vasile Goldis, Arad (RO)

Purpose: After childbirth, women may present pelvic floor disorder which may promote comorbidities and have an adverse effect on quality of life (QoL). During the puerperium, Pelvic Floor Muscle Training (PFMT) can treat and prevent these conditions and increase QoL [2]. For increased efficacy, PFMT can be combined with vaginal devices such as cones [3]. The aim of the study was to compare the efficacy of the vaginal cone (VC) versus traditional PFMT in the treatment of women presenting perineal muscle relaxing and sexual dysfunction after delivery.

Materials and methods: The VC had a novel physiological shape within which a steel ball was loosely-contained in order to generate vibrations against the cavity walls during exercises [Fig. 1]. A randomised comparative study was conducted on 57 women during puerperium; the study group used the VC while the control practiced traditional PFMT. A gynaecological examination was conducted 3 (T0) and 6 (T1) months after delivery.

Results: Pa test showed a significant increase in every parameter for both groups (T0-T1) [Fig. 1]. However, a FSFI questionnaire revealed significant improvements in satisfaction and pain in the study group vs the control [Fig. 2]. Furthermore, the study group exhibited a 95.4% decrease in dyspareunia compared to a 37.5% in the control group (T0-T1) [Fig. 3]. Numerous additional gynaecological benefits were observed when using the VC versus traditional PFMT and 87.5% of women were satisfied with its comfort and ease of use.

Conclusion: VC should be considered an efficacious device to treat perineal relaxing and associated sexual disorders during the puerperium.

Keywords: Postpartum, puerperium, vaginal cones, PFMT, dyspareunia

E6 PROLAPSE-INDUCED PELVIC PAIN: CURE BY SURGICAL PROLAPSE REPAIR
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H. Martius (1946) and P. Petros (1996) recognized first that pelvic organ prolapse (POP) can induce pain which can be cured by prolapse repair. We analyzed the data from the Propel study (ClinicalTrials.gov Identifier: NCT00638235) to gain evidence for cure of pain symptoms by surgical prolapse repair.

In this prospective multicentre study, 277 women with POP stage 2-4 underwent surgical repair with either Elevate anterior/apical or Elevate posterior/apical. They were asked to answer 46 questions of the Pelvic Floor Disorder Inventory (PFDI) questionnaire for degree of bother: no, yes, not at all, somewhat, moderate, quite a bit. After 1 year and 2 years, 257 and 185 women answered the questionnaire.

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Pressure lower abdomen</td>
<td>32.9%</td>
<td>6.8%</td>
<td>5.4%</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Pain lower abdominal genital area</td>
<td>22.8%</td>
<td>5.6%</td>
<td>2.7%</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Heaviness or dullness in the pelvic area</td>
<td>27.1%</td>
<td>4.8%</td>
<td>2.7%</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Pelvic discomfort when standing or physically active</td>
<td>40.8%</td>
<td>6.0%</td>
<td>4.9%</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Pain in lower back most days</td>
<td>37.9%</td>
<td>19.4%</td>
<td>17.8%</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Abdominal or lower back pain when straining for any reason</td>
<td>24.6%</td>
<td>12.1%</td>
<td>10.3%</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

Prevalence rates of moderate and quite a bit pain symptoms pre-, 1 and 2 year postop:
- All symptoms of different locations could be cured significantly in high percentages. Analysis of subgroups showed that women after Elevate anterior/apical as well as those after Elevate posterior/apical, that women with 2 Stage POP and those with 3-4 stage POP suffered pain of different locations which all could be cured in similar proportions.
- New onset of pain after surgery was very seldom.
- It can be concluded that pain of different locations can be cured by mesh-supported pelvic floor surgery. A possible explanation for surgically curable pain symptoms is stretching of nerve fibers off the pelvic plexus (sympathetic nerves from Ts 12 – L2), parasympathetic nerves from S2-S4, autonomic nerves from S2 – S4.

Keywords: Prolapse-induced pelvic pain. Cure by surgical prolapse repair

E7 MAPPING CHRONIC UROGENITAL PAIN
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The term ‘pain mapping,’ refers to the process of localizing pain and establishing an objective relationship between pain source and symptoms experienced by patients. A systematic examination of points within the urogenital area, noting severity of pain, its temporal characteristics and spatial distribution has provided new insights into the role of peripheral mechanisms in chronic urogenital pain. The presentation summarizes the findings of a pain mapping study based on 320 volunteers consisting of controls and clients presenting with painful bladder and vulvar pain syndrome symptoms.

Keywords: (Key-Note Lecture) Mapping Chronic Urogenital Pain
tension in the diaphragm, primary pelvic stabilizers, induce greater pelvic basculation, and decrease venous engorgement visibly. No endopelvic trigger points or injections, or alterations in oral medication were performed during this treatment period. The same physiatrist, posturologist and osteopath treated all patients. Symptom reduction was measured by VAS and sitting tolerance, at initial and final therapy, 12-16 weeks later.

Results: Initial VAS: 6-10. Final VAS: 0-4. No patients had increased pain.

Conclusions: Pudendal nerve pain is often severe and functionally disabling. Alcock canal injections and endpelvic massage give variable success. In reviewing the comparative anatomy between thoracic outlet and pelvic outlet, we find that both outlets contain muscles, fascia, and bone, as well as the nervous and vascular structures which traverse them, and which can be the cause of compression. In addition, both these outlet areas are posturally important. In the thoracic outlet, studies evaluating treatment of posture and successful reduction of neurogenic symptoms exist, while in the pelvic outlet, where there is even greater postural stress due to its weight bearing during deambulation, we have found no comparative literature on postural treatments. The positive results from this study describe the benefits of not only detailed and complete, but also thoughtfully comprehensive clinical examination of the whole patient, not only their pelvic region. We hope that they also pave the way for greater attention to postural issues as causal to pelvic pain and more specific and integrated use of postural therapies as treatment.

Keywords: pelvic outlet, pudendal nerve, thoracic outlet, manual therapy, posturology


Abstracts - 12th ISPP Annual Congress

F1

UPDATE ON CERVICAL HPV RELATED DISEASES
CARLO ANTONIO LIVERANI1, ALESSANDRO BULFONI1
1Foundation Ircs Humanitas San Pio X

There is no cure currently available for HPV infections, although excisional treatment of high grade cervical lesions often leads to a clinical and virological cure. Effective control measures of HPV related diseases rely on prevention, at four different levels:

1. Primary prevention is realized through vaccines targeting the most frequent HPV types: negative attitudes towards HPV vaccination and high costs are the main obstacles.

2. Secondary prevention is achieved through early screening tests. If not properly informed, harms arising from unnecessary treatments, increased costs, work overload for second-level health services, and induced psychosocial distress, are causing on-going problems.

3. Prevention efforts of cervical HPV related diseases should concentrate in: (1) enhancing primary prevention through vaccination of all eligible subjects, (2) achieving high levels of adherence to routine screening programs, (3) treating precancerous lesions, and (4) monitoring current guidelines recommendations to avoid overtreatment.

Novel research projects should be designed to study the delicate mechanisms of immune response to HPV.

Keywords: Papillomavirus, HPV, Cancer, Screening, Prevention


F2

WHEN AND HOW TO TREAT AND FOLLOW-UP H-SIL LESIONS: THE POINT OF VIEW OF THE GYNECOLOGIST
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1Foundation Ircs Humanitas San Pio X

High grade cervical lesions (CIN 2 and CIN 3) need to be treated, regardless of the HPV DNA test results, in order to prevent invasive cancer. Certainly not all CIN 2 or CIN 3 lesions will always progress to cervical cancer. About 30-50% of untreated CIN 2 and 30% of CIN 3 regress spontaneously, while approximately 5% of CIN 2 and 14-31% of CIN3 progress to invasive cancer (although studies are rarely free from bias and the results must be interpreted with caution). Factors associated with higher regression rates of untreated H-SILs are young age (< 25 years) and pregnancy. Immune system disorders, HPV, and smoking, are associated with lesions more likely to progress.

For the adequate treatment of H-SILs, the entire lesion and transformation zone must be removed. Excisional methods such as loop electrosurgical excision procedure (LEEP) or LASER excision, need to be strictly performed under colposcopic guidance, in order to be able to remove the interested area. Hysterectomy should never be considered as a primary treatment for squamous intraepithelial lesions, in the absence of a specific indication. In certain circumstances, it is possible to adopt a “wait and see” approach, where patient compliance is ensured: young age (<25 years), pregnancy, CIN 2 lesions p16 negative, reassuring colposcopic patterns with entire cervical cytology and HPV DNA testing, while treatment is essentially surgical, through tailored excisional procedures.

Quaternary prevention comprises those actions aimed to mitigate or avoid unnecessary or excessive medical interventions, and may well be addressed in avoiding surgical interventions for low grade intraepithelial neoplasia. Though some gynecologists commonly recommend treatment for low grade disease, and also women tend to prefer active management if not properly informed, harms arising from unnecessary treatments, increased costs, work overload for second-level health services, and induced psychosocial distress, are causing on-going problems.

Preparation efforts of cervical HPV related diseases should concentrate in: (1) enhancing primary prevention through vaccination of all eligible subjects, (2) achieving high levels of adherence to routine screening programs, (3) treating precancerous lesions, and (4) monitoring current guidelines recommendations to avoid overtreatment.

Novel research projects should be designed to study the delicate mechanisms of immune response to HPV.

Keywords: Papillomavirus, HPV, Cancer, Screening, Prevention


Keywords:

Cervical intraepithelial neoplasia, HSIL, CIN, colposcopy, cervical cancer

F3
AGE BAROMETE - SOCIO-ECONOMIC REALITIES BEHIND AGEING-RELATED POLICIES
ELENA WEBER
'Age Platform Europe

If you want to understand which was the goal of AGE Platform Europe when we decided to work on AGE Barometer, you must think of all older people in Europe: the main goal of AGE Barometer is to reveal the complexity of socio-economic realities of older people in our continent. AGE Barometer is a way of monitoring the commitment of European Union as well as of the member states (or at least 10 of them: Austria, Belgium, Cyprus, France, Germany, Italy, Malta, the Netherlands, Spain, Sweden and the United Kingdom), to a European Pillar of Social Rights, b. United Nations Madrid International Plan of Action on Ageing (MIPAA) and c. Sustainable Development Goals (SDGs). For 2019 AGE Barometer is focussing on different subjects: gender equality, support to find employment, age-friendly workplaces, work-life balance, fight against poverty, social exclusion and loneliness and adequate pensions. AGE Barometer draws on a wealth of reliable statistical data and the qualitative assessment by AGE members from a group of countries representative of the diversity among EU member states. In its quantitative cross-country assessment, AGE Barometer also reveals the inadequacy of some statistics commonly used to describe the situation of older persons: very old people, such as the 75+, are often taken as one block while this age span covers very different situations and many statistics stop collecting data about persons aged 80+. The overall priorities are different: the two priorities we can focus on regarding the thematic of continence disorders is the protection of the right to live and to age in dignity through adequate person-centred health and long-term care accessible to all and the guarantee to healthy lives and the promotion of well-being for all ages. We can remember also that strong gender inequalities persist in the domain of health: while women have a life expectancy which is longer than for men, their healthy life expectancy is about equal, meaning that women spend a longer time of their lives with a disease or disability. Therefore, women are more exposed to problems and age restrictions in accessing health care. On the other side age-friendly environments and workplaces are widely recognized as key factors to support healthy ageing: adapting workplaces means more than finding ‘reasonable accommodation’ to older workers when they have developed a disability or health condition.

Keywords: Age Barometer - Socio-economic realities behind ageing-related policies

F4
THE PELVIC FLOOR FUNCTIONAL RESULTS AFTER PIVER III HYSTERECTOMY IN CERVICAL CANCER PATIENTS
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2Cancer Hospital Chinese Academy of Medical Sciences, Beijing, China

Purpose: To evaluate the quality of life (QoL) and pelvic organ function of cervical cancer patients after Piver III hysterectomy and detect the related risk factors.

Materials and methods: This is a multicenter, cross-sectional observation cohort study (NCT 02492542). Cervical cancer patients underwent Piver III hysterectomy were consecutively recruited from nine hospitals in Beijing between June 2013 and June 2018. Pelvic organ function was assessed with the Prolapse and Incontinence Sexual Function Questionnaire (PISQ-12). Of evident or occult pelvic floor injuries, which immediately or over time were related to perineal trauma after vaginal delivery showing a huge underestimation of sphincter damage, also to assess the damage to the Levator Ani muscle. The agreement rate between the clinical and ultrasound diagnosis was evaluated too.

Results: Forty patients underwent transanal/transvaginal 3D ultrasound. 16 patients classified as II degree by clinical examination after the ultrasound were reclassified as III degree (25% A, 31.2% B and 49.8% C). 24 patients classified as III A degree by clinical examination, after the ultrasound 58.3% were reclassified as III B degree and 41.7% as III C degree. Starck scoring system and all the results are reported in Table 1. Moreover, the transvagal ultrasound showed a partial detachment of the Levator Ani muscle in 13 patients. The underestimation rate was 100%, with 45% of 1 degree, 37.5% of 2 degrees and 17.5% of 3 degrees. Conclusions: Transanal/Transvaginal 3D ultrasound performed after vaginal delivery showed a huge underestimation of sphincter damage, also detecting occult lesions of the Levator Ani. An early and accurate diagnosis of obstetric trauma leads to a quick and adequate treatment plan.

Keywords: Perineal tear, Transanal Ultrasound, transvaginal ultrasound, chemo-radiotherapy, risk factor for sexual dysfunction.
### F6

**THE FUNCTIONAL MAGNETIC STIMULATION (TESLACARE): A NEW PELVIC-PERINEAL REHABILITATION BEFORE AND AFTER VAGINAL SURGERY**

**Purpose:** There is evidence that in nonsurgical populations, pelvic floor muscle training (PFMT) and lifestyle advice improves symptoms and stage of pelvic organ prolapse (POP). Some women, however, require surgery, after which de novo symptoms can develop or additional surgery is required due to recurrence. Robust evidence is required as to the benefit of perioperative PFMT in the postsurgical reduction of symptoms and POP recurrence. In our study we had use for muscle training Tesla CARE. The aim of this study was to assess the feasibility of and collect pilot data to inform sample size (SS) calculation for a multicentre randomised controlled trial (RCT) of perioperative PFMT following surgical intervention for POP.

**Methods:** Fifty-seven participants were recruited and randomised to a treatment group (six pre and ten postoperative PFMT sessions with Tesla CARE) or a control group (usual care). These new therapy exercises all the muscles of the pelvic floor to rebuild strength and endurance, reestablishing bladder control. The patients are sit fully clothed in a comfortable chair for 20 minutes. The primary outcome measure was the Pelvic Organ Prolapse Symptom Score (POP-SS) at 12 months; secondary outcome measures included measurement of prolapse, the pelvic floor and questionnairenaires relating to urinary and bowel incontinence. All outcomes were measured at 0, 6 and 12 months.

**Results:** Information on recruitment, retention and appropriateness of outcome measures for a definitive trial was gathered, and data enabled us to undertake an SS calculation. When compared with the control group (n=29), benefits to the intervention group (n=28) were observed in terms of fewer prolapse symptoms at 12 months [mean difference 3.94; 95% confidence interval (CI) 1.35-6.75; t=3.24, p=0.006]; however, these results must be viewed with caution due to possible selection bias. It also seems that patients present a faster and less painful recovery after surgery than before.

**Conclusion:** With modifications to design identified in this pilot study, a multicentre RCT is feasible.

**Keywords:** Pelvic Rehabilitation Perineal Rehabilitation, Functional Magnetic Stimulation, Vaginal Surgery.


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### Tab. 1 - Results

<table>
<thead>
<tr>
<th>Staging</th>
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<th>Post-US</th>
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<td>IIA</td>
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<td>IIB</td>
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### F7

**USEFUL PARAMETERS TO IDENTIFY PATIENTS WITH PELVIC FLOOR DISORDERS AMENABLE TO PELVIC FLOOR REHABILITATION**

**Background:** Only few studies referring about the use of an encoded diagnostic tool based on physiatric assessment in constipated or incontinent patients have been conducted. The field of properly setting pelvicperineal rehabilitation’s indication is still blurred, often leading to a wrong selection process of patients who might benefit from rehabilitation treatment.

**Methods:** Fifty-five among constipated and incontinent patients were submitted in our referral centre to a diagnostic standard protocol combining clinical-physiatric evaluation to proctologic and instrumental assessment over the last decade (anorectal manometry, anal US and dynamic defaecography). The clinical-physiatric evaluation consisted in evaluating different parameters as puborectalis contraction, pubococcygeal test, perineal defence reflex, muscular synergies, postural examination. Breathing dynamic was investigated leading to the differentiation of the two variants of diaphragmatic or costal breathing. That is, because in order to properly select those patients who would benefit the most from rehabilitation treatment, a global evaluation needs to be carried out. The intention was to evaluate through the abovementioned clinico-physiatric evaluation, whether certain parameters were found altered or not, and those patients with altered parameters topelviperineal rehabilitation in order to fix them, not merely to cure their symptoms. Patients were then offered pelvic floor rehabilitation (thora-abdominoperineal muscle coordination training, biofeedback, electrical stimulation and volumetric rehabilitation) as a resolutive tool able to fix the abovementioned parameters and restore symmetry and equilibrium not only to the pelvic floor itself, but also to its interaction with the diaphragm, the spinal cord and the abdominal wall.

**Results:** Of the 500 selected patients, 290 were affected by fecal incontinence while 310 were constipated. Our diagnostic protocol led to recognize muscular synergies in 72% of constipated patients, while 68% of them resulted positive to costal breathing. Moreover 67% of the constipated patients had postural hyperlordosis. Among the incontinent patients, the most frequently altered parameters were the devoid of perineal defense reflex (64%), postural alteration as an hyperlordosis attitude was reckoned in 57% of these patients, 84% of them were affected by agonist muscular synergies and antagonist muscular synergies were registered in 74% of incontinent patients.

**CONCLUSIONS** This diagnostic protocol might improve the selection of patients with defecatory disorders amenable for rehabilitation treatment.

**Keywords:** Pelvicperineal rehabilitation, fecal incontinence, constipation, clinical parameters.

**References:**


**Acknowledgments:** N/A

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**F8**

**THE “ICEBERG-PHENOMENON” IN PELVIC FLOOR DYSFUNCTIONS**

**References:**

1. Urologische Klinik Planegg

**Abstracts - 12th ISPP Annual Congress**

lyzed who answered preoperatively the Pelvic Floor Disorder Inventory (PFDI) questionnaire of different symptoms according the bother: no, yes-not at all, somewhat, moderate, quite a bit. Figure: A mosaic showing the intensity of baseline co-occurrence between various symptom-groups in a population of n=277 female patients suffering from a POP-Q stage ≥ 2.

Co-occurrence was calculated in the subpopulations of the patients showing in the baseline "moderate or quite a bit"-severity for the symptoms of a certain group (main or primary POPQ) symptomatic, while the symptoms of the other groups were considered as secondary. The prevalence rates of "moderate or quite a bit"-severity of the secondary symptoms in the mentioned subpopulations were used for the selection of the mosaic-stones of the figure.

The creation of the mosaic-figure was based on four mosaic stones colored according to the following co-occurrence prevalence rates: co-occurrence rate> 70% (color: deep blue), co-occurrence rate between 50% and 70% (color: blue), co-occurrence rate between 30% and 50% (color: light blue) and co-occurrence rate less than 30% (color: yellow). The figure shows frequencies of women with moderate an quite a bit bother by the symptom. If the main symptom was bladder emptying disorders, fecal incontinence, defecation disorders or pain, overactive bladder symptoms co-occurred in more than 50%, whereas the other symptoms occurred mainly in less than 50% or less than 30%.

So co-occurrence of symptoms in women with symptomatic pelvic organ prolapse is a usual phenomenon, even moderate and quite a bit symptoms of different disorders co-occur. This grouping of symptoms can be explained by the integral theory which states that the main muscles within the pelvic floor have integral functions for emptying and closing of bladder and bowel. Laxities/looseness of the supporting ligaments cause dysfunctions of bladder, bowel and pain.

Keywords: The “Iceberg-phenomenon” in pelvic floor dysfunctions

F9
SNS UNDER THE GUIDANCE OF 3D TECHNIQUE

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Aim To test the feasibility of a novel threedimensional (3D) printed guiding device for electrode implantation of sacral neuromodulation (SNS).

Method A 3D printed guiding device for electrode implantation was customized to patients’ anatomy of the sacral region. Liquid photopolymer was selected as the printing material. The details of the device designation and prototype building are described.

Results With the help of the device, the test needle for stimulation was placed in the target sacral foramen successfully at the first attempt of puncture. The time to implant a tined SNN electrode was less than 20 min and no complications were observed.

Conclusion The customized 3D printed guiding device for implantation of SNS is a promising instrument that facilitates a precise and quick implantation of the electrode into the target sacral foramen.

Keywords: Neuromodulation, 3D print, implantation

The knowledge of HPV biology and pathogenesis has clearly identified two basic pathways: low-risk HPV infection produces transient benign lesions, while high-risk HPV infection is responsible for precancerous lesions. These precancers are histologically and cytologically indistinguishable regardless of the gender of the individual or the site of the lesion. Despite these two well-established patterns of viral-epithelial interaction, disparate terminologies still exist due to miscommunication among the different specialties focused on specific body sites.

The vulva and vagina belong to the lower-anogenital tract, an anatomo-pathologic unit grouping different organs lined by the same squamous mucosal or cutaneous epithelium that represents the HPV action-field. In 2012 The Lower Anogenital Squamous Terminology (LAST) has been approved with the aim to standardize the HPV-associated squamous intraepithelial lesions (SIL) across all lower-anogenital tract sites and should be used in any pathology report. According to the LAST, LG (Low Grade)-SIL (formerly mild dysplasia or intraepithelial neoplasia-IN grade 1) identifies an HPV transient benign infection, while HG (High Grade)-SIL (formerly moderate-severe dysplasia, carcinoma in situ or IN grade 2-3) defines a precancerous lesion. All the vaginal and vulvar HPV related diseases are well identified with the LAST. However in the vulva an HPV-independent precancerous lesion, defined as Differentiated Vulvar Intraepithelial Neoplasia (DVIN) generally arising in the context of lichen sclerosus or planus, also exists. DVIN has been defined as Differentiated Vulvar Intraepithelial Neoplasia (DVIN) generally arising in the context of lichen sclerosus or planus, also exists. DVIN has been identified as an HPV transient benign infection, while HG (High Grade)-SIL (formerly moderate-severe dysplasia, carcinoma in situ or IN grade 2-3) defines a precancerous lesion. All the vaginal and vulvar HPV related diseases are well identified with the LAST. However in the vulva an HPV-independent precancerous lesion, defined as Differentiated Vulvar Intraepithelial Neoplasia (DVIN) generally arising in the context of lichen sclerosus or planus, also exists. DVIN has been defined as Differentiated Vulvar Intraepithelial Neoplasia (DVIN) generally arising in the context of lichen sclerosus or planus, also exists. 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Acknowledgments: The authors are especially indebted to miss Federica Rossi, nurse, and mrs. Vanessa Borghi, secretary, for their valuable support during the performance of examinations and booking service.
in 2014. The vaginal and vulvar surfaces of GSVM presents as thin, pale, and dry on examination. It is related to decreased blood flow from loss of estrogens, decrease in the number of mucous cells, and decreased number of surface epithelial cells. Vaginal signs and symptoms of GSVM are dryness, dyspareunia, etc. GSVM is treated by vulvar moisturizer, lubricant, hormone replacement, and CO2 fractional laser. Bladder pain syndrome (BPS) also known as interstitial cystitis (IC), is a type of chronic pain that affects the bladder. It is caused by pain and pressure in the bladder area without having an infection or other clear causes.

Symptoms range from mild to severe. The cause of BPS is unknown. Other conditions that can produce similar symptoms include urinary tract infection, (UTI), overactive bladder, sexually transmitted infections, endometriosis, etc. There is no reliable treatment method for BPS. Lifestyle changes may include stopping smoking and reducing stress. It is mainly for symptomatic treatment. Treatment includes bladder distention, nerve stimulation, or surgery. Women are affected about five times as often as men. Onset is typically in middle age. There are quite a few patients who are left with urethral syndrome after treatment for GSVM and BPS. Urethral syndrome is a condition that affects the urethra. People with urethral syndrome have an irritated or irritated urethra (as asymptomatic absence). The pathological condition of GSVM has been elucidated, it is possible that the urinary tract symptoms considered to be related to the vestibular mucosa. And if vestibular mucosa around the urethra presents fragility and irritability, patients could become urethral syndrome. The first urethral syndrome treatment is to apply testosterone ointment (contains 0.1% testosterone) to the topical area. Testosterone external application improves the mucosa of the vestibular mucosa. CO2 fractional laser is adapted in the 3rd treatment as next treatment. On the presentation, we will report investigations of the treatment effect of local testosterone therapy and CO2 fractional laser for urethral syndrome after treatment for GSVM or BPS.

Keywords: CO2 fractional laser, Genito-urinary syndrome of nongonococcal, local treatment.


F15 HANDS ON SEXUALITY: WHAT ABOUT INTIMACY?

DÉSIRÉE UGUCCIONI DEI BLUNDELLOMONTI

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When we talk about the pelvic floor, far too frequently the oldest of taboos still emerge, even when at the doctor’s surgery, as sexual images abound everywhere on the media, with “seeing” and “showing” being taken for granted.

However, for patients to feel that they are able to ask any specialist to help them improve the most important aspects of their sexuality, it still seems to fall far outside their expectations. And not just the physical ones, but also their relational, emotional, and love aspects.

What then, can we, as rehabilitators, offer to our patients, when can we, as specialists, work effectively with our patients? And what level of competence must a rehabilitator possess, in this regard? What kind of professional, therapeutic, research, and practical experience do we need to provide the best possible care in our work as therapists, both from the perspective of a functional physical outcome as well as an emotional, or affective one?

Can we remind ourselves that our bodies manifest emotions as a result of an ancient neurological expression, and of circulating hormones, which in turn move the glands, the bowels, and the nervous system and, alongside it, our posture and our body language too, as well as the way we relate to our therapist, our partner, and ourselves?

Can we also remind ourselves that in this century, which quantum physics has landed on the field of biology and medicine, we can no longer think of body and mind, as well as emotions and consciousness as separate. From this perspective, what can we ask to the rehabilitator, as far as the sexology field is concerned? And what need the rehabilitator ask him/herself? How can we relate to our patients and their own perception of what intimacy is for them subjectively?

Are we able to comprehend what intimacy may be for our patient, how much they value it, and also how much they wish to cherish it, in order to protect it, or even keep their intimacy a secret?

Before giving any answer, let us try asking ourselves the right questions. And in order to give correct answers, that completely meet with our patients’ needs, we must train physiotherapists that are able to identify all the “pelvipersonal” issues, and the physical emotion that governs them, from an overall perspective. Having done this first, then we can work alongside with other specialists, aiming together toward a high quality of the patient’s personal and relational life.

First, Desmond Morris to Willy Pasti, from Newton to quantum medicine, a comprehensive view of pelvis-perineal and sexual dysfunctions is needed, and which the physiotherapist him/herself feels able to face up to. A comprehensive view lying within the concept of intimacy, which persists in being precious, despite all the cultural and social changes that have occurred throughout the centuries.

Keywords: pelvic floor, rehabilitation, psychotherapy, sexuality, intimacy, quantum medicine


F16 HPV RELATED DISEASES AND PREGNANCY

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There are many women who wish to get pregnant to carry out cervical screening (pap test or high-risk HPV research) as a precautionary measure. Actually this does not happen routinely and, therefore, it is important to control at the first visit that the patient has really carried out a cytology or a high-risk HPV research with negative results. In the absence of a recent exam, it should be carried out as soon as possible in order to ensure the best diagnostic procedure at the beginning of the second trimester of the gestation which is the least risky period for any pregnancy complication.

Colposcopy in pregnancy remains an indispensable step for the diagnosis of pre-neoplastic and neoplastic cervical lesions, but it is understandable that, due to physiological changes of the cervix and vagina, we are talking about a “difficult” colposcopy which must be performed by an experienced specialist. The diagnostic process of an abnormal pap-test in pregnancy is the same as the non-pregnant one. However, women are recommended to perform a cervical biopsy in pregnancy for the fear of uncontrollable bleedings. Data in literature emphasize that this fear is absolutely unjustified. To find or rule out invasive neoplasia is the unique purpose of colposcopic examination in pregnancy different from non-pregnant women. In case of an histological diagnosis of CIN 1, 2 or 3, the chances of pregnancy do not change. In case of CIN 3 or worse, the appropriateness of deferring the treatment in pregnancy (6-12 weeks after delivery) is constantly debated; the patient by colposcopy every 3 months during pregnancy and repeating the biopsy when the colposcopic image suggests an invasive neoplasia. Hence colposcopy in pregnancy is recommended only when a micro-invasion is suspected. In this case colposcopy should be done after the first trimester, but, where possible, before the 20th week. What is more, current excisional techniques, allow to minimize potential complications as much as possible. The treatment of frankly invasive carcinomas diagnosed in pregnancy depends on a multiplicity of factors that influence the choice of treatment. Among them, the age of the patient, the size (stage) and the volume of the tumor; the gestational age; the desire to have a baby or another delivery; the possible pathology associated with pregnancy; the patient’s psychological state; the ethical convictions of the couple. The last large group of HPV-related diseases in pregnant women are genital warts. As it is known, warts are viral lesions due to low-risk HPV (predominantly 6 and 11) and only rarely caused by high-risk HPV (predominantly 16 and 18). As mentioned above, pregnancy does not alter the natural history of the HPV infection, nevertheless, during pregnancy, genital warts are more frequent and their spontaneous regression occurs in the puerperium. The decision to treat condylomata during pregnancy depends both on the characteristics of the lesions (size and location) and the gestational age of the patient. In principle, it should be borne in mind that condylomata does not necessarily require treatment during pregnancy, in fact delivery may be exported and treatment may be
Conclusions: The cause of bedwetting is unknown and there is no known cure.

Aim: To test the Integral Theory’s predictions that the ultimate cause of bedwetting is weak muscle/ligaments which cannot tension the organs sufficiently to prevent activation of the micturition reflex.

Methods: RCT 48 children, mean age 7.6 ± 2.5 years; 34 females and 14 males with both nocturnal enuresis and daytime incontinence had squatting-based pelvic floor exercises (PFR) to strengthen these muscles/ligaments against placebo. At 1st review 4 weeks, 12/24 from the treatment group reported total cure of both conditions, with zero effect from placebo group. Placebo arm immediately transferred to PFR and trial carried out to termination at 6 months.

PFR protocol (supervised) 10 squats and 10 bridge exercise morning and evening for 4 months.

Results: Were beyond our expectations. 41/48 children had daytime/nighttime enuresis (85% cured); 32 constipation (92% cured), 9 (19%) soil nighttime enuresis (85% cured); 32 constipation (92% cured), 9 (19%) soil and carboxy-therapy: our goal must be to confirm the link between Aesthesia and Functional, working in a multidisciplinary and open-minded way to improve the woman Quality of Life.

F19
A HAPPY TOILET TO MAKE EASIER AN UNSATISFACTORY OR OBSTRUCTED DEFECAITION. PRELIMINARY EVALUATION

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Background: The thin jet of water coming from a toilet accessory device has been indicated as a simple and effective stimulus to eliminate annoying faeces residues in the rectum at the end of defecation.

Aim: In cases of constipation definable as a form of obstructed defecation or characterized by difficulty in completing the expulsion of the faeces, a preliminary study was carried out in order to verify the effectiveness of the method in alleviating this symptom.

Methods: 12 subjects who complained of an unsatisfactory defecation in a retentive sense with a fractional expulsion of faeces and an average score of the CCS (Constipation Cleveland Score) of 8/30, were asked to use the Igiet® device for a month. The device, telescopic and retractable, is placed between the cover and the edge of the toilet. Connected with a 7mm diameter pipe to the tap of a nearby bidet or sink and equipped with a small 3-way manual diverter, the Igiet® can emit a thin jet of water whose temperature and intensity can be accurately adjusted. The diverter allows for the modulation of a single water jet, which, not being a spray, is capable of entering the distal rectum through the anal canal (which tends to open to varying degrees over the course of the straining experienced during defecation).

In the span of 30-120 seconds, the water jet stimulates the ano-rectal mucosa allowing for the completion of the evacuation in patients who have a form of obstructed or repeated defecation. The patient is advised to start with low jet pressure to avoid puncture pain, as the area is very sensitive.

Results: 8 out of 12 patients, who underwent digital rectal examination before treatment, showed a different degree of dyssynergia: 5 of them were unable to release following straining and 3 presented paradoxical contractions. Out of these 3 patients, only one did not experience improvements following treatment. A total of 11 patients found they had improved defecatory performance with a significant reduction in their CCS from 8 to 4/30 due to a reduction in criteria measuring their “use of enema” and “sense of incomplete defecation”. Five complained of initial pain, which was resolved in all cases by changing the intensity of the jet.

Comment: Obstructed defecation is attributed to various causes: dysynergia, anatomical obstacle (rectocele or occult prolapse), hyposensitivity of the proximal anal canal and/or of the distal rectum. Cases with a sense of incomplete emptying and repeated defecations are quite common. The culture of the “happy toilet” in recent years has found in Japan a fertile ground for the development of toilets that allow the achievement of different aims: better anal hygiene, ecologicism for not using toilet paper, and comfort or even pleasure. Almost only in Italy it is customary to equip the private toilets with the bidet where, however, toilet paper is essential. In the East, toilets are being spread with a built-in shower (that can also be used to wash female genitals), a heated seat, a jet of air to dry the washed parts and even, in public toilets, music to prevent the noise of flatulence from disturbing neighbors. The cost of these devices is significant and a small cold water shower next to the toilet cannot compete with the original product. A simple accessory called Igiet® connects any toilet to the tap of a nearby bidet or sink, and has achieved popularity as it allows for the emission of a thin jet of water, adjustable for temperature and intensity and also improves defecation when it is incomplete. Unlike small or large enemas that act or cause irritation from their use of glycerin, or stimulation by distension of the rectum, with this device the action is only mechanical and targeting the sensitive area of the ano-rectum. Let’s not forget that (almost) all mothers know that in the infant anal stimulation with the tip of the thermometer induces defecation when it seems to them too late.

Conclusions: This study has shown that a single thin water jet entering the rectum through the anal canal open when straining, is effective in inducing a complete defecation in cases where the process is incomplete, and is also effective in cases of dyssynergia. Last but not least the Igiet® also meets the environmental sustainability
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