O-GYN-008

A RANDOMIZED TRIAL OF LAMINARIA VERSUS VAGINAL MISOPROSTOL FOR CERVICAL DILATION PRIOR TO SURGICAL TERMINATION

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Objectives: To compare laminaria tents with misoprostol for cervical ripening prior to first trimester surgical termination.

Methods: In a prospective, open-label, randomised trial, 70 women were assigned to have an intracervical laminaria tent or vaginal misoprostol 200ug the day prior to suction D&C. Cervical dilation and operating time were measured by the surgeon performing the D&C. Ease of surgery was rated subjectively by the surgeon. Study subjects were interviewed just prior to the D&C with regard to pain, vaginal bleeding and dilator preference.

Results: Laminaria produced significantly ($p<.001$) greater dilation of the cervix (34.9 Pratt, SD=6.2) than did misoprostol (28.4 Pratt, SD=5.8). There was no demonstrable difference in ease of surgery or operating time. Laminaria patients reported significantly more pain on insertion than did misoprostol patients ($p<.001$). On the other hand, misoprostol patients reported more vaginal bleeding ($p<.01$). Pain following insertion was similar in the two groups. One patient aborted completely after misoprostol alone. Overall, the stated patient preference for cervical dilator was more likely to be misoprostol ($p<.01$).

Conclusions: Laminaria are more effective cervical dilators than vaginal misoprostol inserted the day prior to suction D&C. Misoprostol insertion is likely to be more comfortable for the patient although it is associated with more vaginal bleeding and may abort the pregnancy. Vaginal misoprostol is a viable alternative for cervical preparation prior to suction D&C.

O-GYN-010

OPERATING ROOM TIME QUALITY ASSURANCE AUDIT

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Objectives: The aims of this study were to evaluate the efficiency of booked operating room time and reasons for delays.

Methods: Prospective recording of times for anesthesia, preparation, surgery and cleanup was undertaken from May 17 to October 11, 2000(1) and from May 1 to July 30, 2003(2). Reasons for delays were recorded. Where appropriate, times were compared and delays evaluated as controllable or uncontrollable.

Results: In time period (1), 64 of 71 (90%) cases were completed on 28 booked days. Seven (25%) days had delayed starts, seven (25%) had delayed endings. Eight (29%) days ended early. In time period (2), 31 of 35 (89%) cases were completed on 12 booked days. Two (16%) were delayed starts, three (25%) ended late and seven (58%) ended early. In time period (1), time (in minutes) was distributed as: anesthetist 1643 (13%), preparation 1042 (9%), surgery 7436 (61%), and cleanup 185 (1.5%). Total time used/booked was 10,306/12,270 (84%). In time period (2), time (in minutes) was distributed as: anesthetist 570 (13%), preparation 389 (9%), surgery 1759 (41%), and cleanup 90 (2.1%). Total time used/booked was 2808/4260 (66%). Controllable reasons for delays included: poor communication, poor assessment of surgical time required, inadequate staffing and personal reasons. Uncontrollable reasons for delays included: icy road conditions, unexpected severe intraoperative hemorrhage, failed anesthetic procedures and the "bumping process".

Conclusions: Booked operating room time is inefficiently used for multifactorial reasons. Controllable delays need to be eliminated to improve efficiency, potentially reduce wait times and improve public image.

O-GYN-JM-016 BEST OF FOUR PAPERS

ALIMENTATION PRÉCOCE VS TARDIVE APRÈS CHIRURGIE GYNÉCOLOGIQUE MAJEURE : ÉTUDE RANDOMISÉE

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Objectifs : Comparer l'alimentation précoce versus tardive chez des femmes ayant subi une chirurgie gynécologique majeure en regard de la durée d'hospitalisation et de la satisfaction générale des patientes.

Méthodes : Étude randomisée contrôlée incluant des femmes ayant subi une chirurgie gynécologique majeure. Les patientes ont été randomisées en deux groupes: l'alimentation précoce qui offrait une diète de liquides clairs dans les 6 premières heures postopératoires, suivie d'une diète solide selon tolérance versus l'alimentation tardive où seulement de la glace était permise pour les 12-24 premières heures, suivie des liquides clairs le 1er jour postopératoire et de la nourriture solide le 2ième et 3ième jours postopératoires.

Résultats : 119 femmes ont été randomisées. 61 femmes ont été assignées au groupe d'alimentation précoce et 58 au groupe d'alimentation tardive. Les caractéristiques démographiques étaient comparables dans les deux groupes incluant l'âge, le poids et le tabagisme. La durée d'hospitalisation était comparable (précoce 86.4 ±21.0 heures versus tardive 85.6 ±26.2 heures). Un nombre comparable de patientes ont souffert de nausées dans les deux groupes. La satisfaction générale s'est révélée être comparable dans les deux groupes.

Conclusions : L'introduction d'une alimentation précoce chez des femmes ayant subi une chirurgie gynécologique majeure semble bien tolérée. La satisfaction générale et la durée d'hospitalisation sont comparables dans les deux groupes.

O-GYN-JM-009 BEST OF FOUR PAPERS

A PREVALENCE STUDY OF SUBJECTIVE AND OBJECTIVE URINARY INCONTINENCE AND PELVIC ORGAN PROLAPSE IN NORTH AMERICAN FIRST NATIONS WOMEN

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Objectives: To determine the cross-sectional prevalence of stress urinary incontinence (SUI) and pelvic organ prolapse (prolapse) in First Nations (Cree) women.

Methods: All First Nations (Cree) women (15 - 50 years old) reporting for routine gynaecologic assessment in Moose Factory, Ontario, were offered participation. Women with prior surgery for SUI or prolapse were excluded. Participants completed standardized questionnaires and physical examinations. Outcomes included subjective SUI (urine loss with physical activity, coughing or sneezing), objective SUI (positive paper towel test preceding a void (150mL), and prolapse (Pelvic Organ Prolapse); Quantification Stage (2). Risk factors for SUI and prolapse were evaluated using logistic regression analysis.

Results: 51 women were recruited to participate. Mean age was 33 years (95% CI [30.2 - 35.9]). Eighty percent were parous (mode = 3). The average largest birth weight was 4033g. The average body mass index was 32.5 kg/m^2 with 60% of women defined as obese. Subjective and objective SUI and significant prolapse were reported in 63%, 59% and 58% of women, respectively. Parity predicted subjective SUI (OR=2.3, 95% CI [1.36-3.97] for each delivery). Age predicted objective SUI (OR=11.3, 95% CI [1.02-1.26] for every ten years). Age (OR=1.09, 95% CI [0.99-1.20] for every ten years), parity (OR=1.38, 95% CI [0.81-2.37] for every delivery) and presence of abdominal wall striae (OR= 14.77, 95% CI [1.77-122.49]) predicted prolapse (age and parity had a collinear relationship).

Conclusions: In our study population, significant prolapse was strikingly prevalent, as well as both subjective and objective SUI. We speculate that this may be due to an underlying genetic predisposition for the development of pelvic floor dysfunction in First Nations women. To test this hypothesis, further work is planned to compare these findings to prevalence rates in matched White female controls.

O-GYN-012

OFFICE BASED GLOBAL ENDOMETRIAL ABLATION: FEASIBILITY AND OUTCOME FOR 3 MODALITIES

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Objectives: To evaluate the safety, feasibility and efficacy of office based global endometrial ablation technologies under local anaesthesia.

Methods: Office based global endometrial ablation techniques were evaluated prospectively since 1998 employing a local anaesthesia regimen. 259 patients have been treated for intractable menorrhagia. Pre-procedure evaluation included sonohysterography to ensure normal cavitary geometry, endometrial biopsy. Patients received a preop oral

dose of oxycodone/acetaminophen combination and a paracervical block immediately before the ablation consisting of a 50/50 mix of marcaine 0.25% and lidocaine 1%. Visual analog pain scales measured the patient pain tolerance during and post procedure. The clinical outcomes for the three modalities were measured by pictorial menstrual blood loss calendars.

Results: Novasure (122 patients): ammenorrhea-37% hypomenorrhea-54% eumenorrhea-7% failure-2%. Gynelase (95 patients): ammenorrhea-32% hypomenorrhea-61% eumenorrhea-5% failure-2%. Thermablate (42 patients): ammenorrhea-35% hypomenorrhea-50% eumenorrhea-12% failure-3%.

Conclusions: Global ablation technologies evaluated are equally efficacious, safe and well tolerated in an office setting under local anaesthesia.

O-SCC-002 BEST OF FOUR PAPERS

HPV DNA DETECTION AS A PREDICTOR OF LESION PROGRESSION AMONG WOMEN WITH ASCUS CYTOLOGICAL DIAGNOSIS

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Objectives: To determine the main predictors of cytological progression to squamous intraepithelial lesions (SIL) from atypical cells of undetermined significance (ASC-US).

Methods: Cohort study of 2528 Brazilian women followed with Pap cytology and HPV DNA testing at 4 to 6-month intervals for up to 5 years. Those with a new diagnosis of ASC-US and at least 2 years of follow up were included in this analysis (N=146). Women with SIL cytology within 2 years prior to the ASC-US were excluded.

Results: Most ASC-US regressed in the following visit (84%), 11 progressed to LSIL (8%), and 7 to HSIL (5%), within the two years following the first diagnosis of ASC-US. The Odds Ratio (OR) of progression to any SIL and to HSIL were 5.8 [95% CI: 1.6-21.5] and 6.5 [95% CI: 1.1-38.8] respectively for oncogenic HPV positive women compared to HPV negative women. The OR of progression to any SIL and to HSIL for (ASCUS cannot rule out HSIL) ASC-H versus ASC-US cytology favouring benign cellular changes were 2.6 [95% CI: 0.7-9.5] and 3.2 [95% CI: 0.4-27.6], respectively.

Conclusions: Presence of oncogenic HPVs in the context of ASC-US cytology is a better predictor of progression to LSIL or HSIL than a diagnosis of ASC-H alone.

O-CSURPS-004 BEST OF FOUR PAPERS

PELVIC RECONSTRUCTIVE SURGERY FOR GENITAL PROLAPSE A COMBINED VAGINAL APPROACH WITH TENSION FREE VAGINAL TAPE AND SACROSPINOUS LIGAMENT SUSPENSION: A PROSPECTIVE STUDY

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Objectives: The association of genital prolapse and stress incontinence is very high regardless of patient's symptoms. Many pelvic surgeons thus during surgical correction of genital prolapse would plan a concomitant anti-incontinence procedure based on urodynamic findings with reduction of prolapse. Sacrospinous ligament suspension, a vaginal approach technique for surgical correction of pelvic organ prolapse, has a reported success rate of >90%. TVT, a minimally invasive technique for SUI, similarly has shown excellent immediate and long-term success rate. A combined surgical approach utilizing these two techniques will thus eliminate the need of abdominal incision and morbidity associated with this. To evaluate combined technique of sacrospinous ligament suspension and tension free vaginal tape in surgical correction of pelvic organ prolapse with associated urinary stress incontinence.

Methods: From September 2002 to January 2004, a total of 70 patients with genital prolapse and urinary stress incontinence underwent sacrospinous ligament suspension of vagina and TVT procedure. Mean age 59 years (range 34-76), parity 3.35 (range 1-10), 31 patients (44%) had simultaneous vaginal hysterectomy while 39 (56%) had previous hysterectomy. 11 patients (15.7%) had previous incontinence surgery. A full gynecological and multichannel urodynamic assessment was carried out on all patients. Postoperatively all patients had gynecological assessment, post void residuals and exclusion of urinary tract infections. Patient satisfaction was assessed on a visual analogue scale.

Results: Surgery was successfully carried out on all patients. Febrile morbidity was recorded in four patients (5.7%) and urinary tract infections in 13 (18%). All patients were cured from apical support defects. Recurrent cystoceles were seen in two patients (2.9%) with one requiring a repeat surgical correction. Persistent voiding dysfunction was seen in three patients (4.3%). Two patients (2.9%) had postoperative vaginal hematomas, both drained spontaneously. One patient had vaginal erosion of TVT mesh. Three patients (4.3%) required incision of TVT mesh and two developed recurrent incontinence. Surgical correction of incontinence was achieved in 66 patients (94.3%).

Conclusions: A combined vaginal approach of pelvic reconstructive surgery for prolapse and incontinence is safe and effective. The vaginal approach with sacrospinous ligament suspension and TVT is justified for surgical correction of prolapse and associated incontinence.

O-CSURPS-006

ABDOMINAL OR VAGINAL APPROACH FOR PELVIC RECONSTRUCTIVE SURGERY IN URINARY INCOTINENCE AND PROLAPSE, CHANGING TRENDS AND HEALTH ECONOMICS

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Objectives: Traditionally over the years, the abdominal approach has been a standard for correction of genital prolapse and incontinence. Burch culposuspension has been the gold standard for surgical correction for urinary stress incontinence with success of >85% and abdominal sacral colpopexy similarly for correction of genital prolapse with a success of >90%. The suburethral slings were reserved for treatment of recurrent SUI. In the past few years with the introduction of minimally invasive technique for suburethral sling this trend is changing. The objective of the study is to assess abdominal versus vaginal approach and its impact on health economics and patient satisfaction.

Methods: A prospective review of the year 2003 with vaginal approach for treatment of prolapse and urinary stress incontinence was compared to a retrospective review of the year 2000 when traditionally the abdominal approach was used.

Results: 197 patients underwent vaginal approach for treatment of incontinence and prolapse from a period of September 2002 to September 2003. 129 patients underwent pubovaginal slings (TVT) only and 68 with pubovaginal slings (TVT) and other adjuvant surgery for prolpase. 133 women similarly underwent surgery with abdominal approach in 2000 with 106 for incontinence (90 Burch colposuspensions and 16 suburethral slings) and 27 abdominal sacral colpopexies. 97 out of 129 TVT (75%) had same day discharge. The mean inpatient stay for TVT was .38 day compared to 4 days for Burch culposuspension. The mean in patient stay for the whole year of 2003 was 1.5 days compared to 6 days in the year 2000. This changing trend resulted in a reduction of 5 beds in gynecology service with a net saving of 1.28 million dollars annually. The overall success was seen to be >95% (5 failures in TVT and 2 in prolapse).

Conclusions: The changing trend from abdominal to vaginal approach has been seen to be very economical with comparable success rate.

O-CSURPS-005 BEST OF FOUR PAPERS

PUBOVAGINAL SLING TECHNIQUE WITH TOTALLY REUSABLE SLING DEVICE IN TREATMENT OF FEMALE URINARY STRESS INCONTINENCE — A PROSPECTIVE STUDY

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Objectives: Since the introduction of TVT, many techniques of surgical slings have been described in the surgical treatment of female urinary stress incontinence. All these techniques use disposable equipment, which makes cost an important factor to consider. We did a pilot project comparing this technique of reusable device to the standard Gynecare TVT with equally good results. This analysis is a prospective study on patients who have since then undergone pubovaginal sling with reusable device. A prospective analysis of patients who have undergone pubovaginal sling with reusable pubovaginal sling device to assess its safety and efficacy.

Methods: In a period from August 2002 to December 2003, 144 patients underwent pubovaginal sling using a reusable pubovaginal sling device. All patients had full urogynecological assessment including history, examination, uroflometry with post void residuals, multichannel cys-