IUGA
international urogynecological association
Advancing Urogynecological Knowledge Around the World

The Official Newsletter

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38th Annual Meeting

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A LETTER FROM THE PRESIDENT

Sunrise Over a New Era for IUGA

As I write this message to you, our members – my first as President of IUGA – I cannot help but wonder about the limits of the contributions we can make to the growing need for urogynecologic knowledge and services around the world. Up until now, we have focused our efforts in the education of our members and other interested clinicians. And, I believe we have done an excellent job by utilizing the breadth of our resources including our Journal, website, Roundtables, and educational programs including our annual meeting, regional symposia and eXchange programs. We have undoubtedly contributed in many significant ways to the raising of the standard of urogynecologic care for women around the world. As an association, we should be very proud of our accomplishments.

We are now entering a new phase in our history. We are evolving into an organization which will also be focusing on service to urogynecologic patients. This endeavor represents a major shift in our efforts, and I believe a major step in IUGA achieving the status of a mature multi-faceted association. The establishment of the IUGA Urogynecology training center for Sub-Saharan Africa in Accra, Ghana represents the culmination of massive efforts by a dedicated group of IUGA members led by our Past-President Peter Sand. I will leave it to Peter and the members of his leadership group to provide us more details about how we can all participate in this new program. There will be many opportunities for helping support this novel center, including volunteering as an on-site instructor or making a donation to the newly formed Foundation for International Urogynecological Assistance. We will certainly hear more details in Dublin. Very exciting times, indeed.

But first, we must take care of our house.

IUGA, as any medical professional association, is subject to all the challenges posed by the current changes in the economics of medicine around the world. Support for medical education and conferences from the typical sponsors has declined significantly. This should not come as a surprise to any of you as it is an international reality. As our budgets become tighter, IUGA must be nimble and adjust to the new economic reality of medical education. Fortunately, we recently had a number of very productive years and were able to build up significant reserves such that our viability as an association is not in question. How to adjust our business model to this new reality was a major focus of the first meeting of our new Executive Board.

Joining Harry Vervest (our Past President) and I, were the new members of our Board: Bob Freeman (VP), Ranee Thakar (Secretary) and Anna Rosamilia (Treasurer). I personally believe we have an excellent and varied group of colleagues to help lead IUGA over the next few years. Our first meeting was extremely productive and marked by stimulating exchanges of ideas and problem-solving approaches.

Complementing the energy and productivity of our new Board

is an effective IUGA office, now under the leadership of our new Executive Director, Chuck Shields. Chuck represents the cornerstone of our efforts at providing IUGA with a professional administrative staff to allow for smooth running of the association. If you have not met Chuck yet, please make the time to shake his hand while in Dublin. His broad past experience in running professional societies along with his varied international life-experiences make him an ideal manager for IUGA. Ask him what countries in the world he has not visited.

Among the actions of the Board during our initial meeting were:

1. Enacting means of alleviating the current budget concerns
    a. An increase in membership dues by $50 as of May 1, 2013.
    b. A temporary reduction in the number of grants and awards.
    c. A voluntary yearly automatic membership renewal process.
2. Fine tuning the directives resultant from the strategic planning exercise from 2011.
3. Approving 5 new affiliate societies.
4. Reviewing potential office space for our move to Washington, DC during late 2013.
5. Proactively assisting committee chairs in expanding the work and membership of their committees as needed.

Our planned move to Washington, DC is moving along as planned. Chuck has identified a number of office suites which would serve our needs well within Washington, DC proper. As our international activities continue to expand, having our office located in this world hub of international associations, governmental agencies, and development banks puts us in the midst of innumerable cooperative project possibilities and funding options for ourselves, our foundation and other projects to come. In fact, Chuck has already had meetings at PAHO and the IDB to start placing us on the radar screen for DC-based entities. We hope to welcome you to our new office space when we have our annual meeting in DC in 2014.

Membership dues have been unchanged since IUGA started enrolling members. The costs of the expanded publication IUJ (and shipping) consume the vast majority of each membership dollar. Thus, the Board felt that the membership would not see the mild dues increase as inappropriate and would support such a move. Please let us know if you disagree with this dues increase.

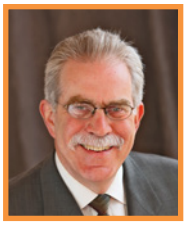
So, while IUGA, along with other medical associations, faces significant challenges, I hope you can share with me in the optimism I feel as I look towards our future as a multi-faceted contributor to Urogynecology around the world. We are achieving a level of maturity most associations would only hope to reach. Please join me in Dublin for our annual meeting where we can talk about all the ongoing projects. I will be very happy to suggest means through which you can contribute to this growth.

Until then, warmest regards.

G. Willy Davila

A LETTER FROM THE EXECUTIVE DIRECTOR

By Charles A. Shields, Jr.



With the annual meeting fast approaching, I'm looking forward to the opportunity to meet more of our membership and to renew acquaintances started at last year's meeting in Brisbane. Since then I've had the opportunity to meet members in several countries, both through work and personal travel, and have always found them gratifying and extremely important to give a direct sense of the needs, hopes and desires of our membership. These opportunities to connect with members are always extremely valuable for me and others in the IUGA staff team. Because many others on the team don't have the chance to travel during the year, the annual meeting is a particularly important time for them to meet members, learn more about their work and to learn what IUGA can do to make their membership more valuable.

This annual meeting promises to be a very full and rewarding time for members, with the 4 ½ days from Tuesday, May 28, to Saturday, June 1, filled with educational, scientific and social sessions. Physiotherapists and others with an interest in pelvic floor rehabilitation are even starting a day early with a special session on Monday.

The workshops on Tuesday and Wednesday are always a highlight of the meeting and again feature a strong range of 27 choices for meeting participants to delve into important subjects in greater depth.

The scientific program on Thursday through Saturday afternoon will feature 199 presentations as either oral podium, poster or video. In addition, there will be plenary sessions that will include John Martin presenting, 'Titanic 101: The Assistant Surgeon's Story', a fascinating look at this important page of history and Pamela Moalli addressing 'Exposing the science of prolapse meshes: A foundation for future products' in the Ulf Ulmsten Lecture. New this year, IUGA and FIGO (the International Federation of Gynecology and Obstetrics) are collaborating to offer the debate which will feature Don Wilson and James Dornan on the pro and Hans Peter Dietz and Michael Turner for the con regarding the proposition: This house believes that instrumental delivery should be abandoned in favour of caesarean section. There will also be stimulating roundtables on: 'Native tissue prolapse repair - How I do it/tips and techniques' and 'The Role of Urodynamics before Sling Surgery'.

But the meeting will also give attendees plenty of time to enjoy Irish hospitality at the Welcome Reception and the Gala Dinner. With the conference facilities and hotels just steps from historical and cultural sites as well as restaurants, pubs and clubs, participants will be sure to understand why Dublin has been voted Europe's most friendly city.

We on the IUGA staff team are looking forward to welcoming many members to Dublin. If you see one of us, please say hello and let us know what we can do to make your IUGA membership even more meaningful.

CHARITABLE ACTIVITIES OF THE IUGA

By Peter K. Sand, Board Member, Foundation for International Urogynecological Assistance

IUGA Forms a Foundation

In order to provide the possibility of charitable support for activities that further the mission of the IUGA, the IUGA Board authorized the formation of a foundation. The charitable foundation was established in January 2013 as a tax-free, charitable organization with close ties to the IUGA and named the "Foundation for International Urogynecological Assistance (FIUGA)". This is an independent foundation that will work to support not only the project to help establish a urogynecology fellowship program and center of excellence in West Africa, but also (see below) other educational and research activities of the IUGA.

By charter, the foundation's board will include up to 9 members with at least 3 board members being from the IUGA Board. Currently these positions are being held by Willy Davila, Harry Vervest, and Anna Rosamilia. Chuck Shields is serving as the Executive Director of the FIUGA and as an ex-officio member of the Board. I am currently serving as the Chairman of the Board with Dr. Vervest as the Vice-Chairman and Dr. Davila as the Secretary. The board's goal is to raise $2 million over the next 3 years to support the Ghana project and research grants.

The board is actively seeking other potential members of the board from industry, other charitable foundations and from among those with experience that relates to the work of the foundation. If you know of any suitable applicants, please let the board or Chuck Shields know about your suggestions.

In the meanwhile, the Ghana project is moving forward successfully with two IUGA faculty having been onsite in Accra at the Korle Bu Medical Center. The project is being guided by a steering group that is chaired by Dr. Lauri Romanzi of New York and includes Dr. Andrew Browning of Arusha, Tanzania, Dr. Stephen Jeffery of Cape Town, Dr. Anyatei Lassey of Accra, Dr. Peter Sand of Chicago, Dr. Jules Schagen van Leeuwen of Houten, The Netherlands and Dr. Harry Vervest of Benschop, The Netherlands.

Thanks to generous donations from Laborie and T-Doc the project plans to move urodynamic equipment into a new lab at Korle Bu later this year and to begin instructing the fellows and faculty there in the performance of urodynamic testing. Drs. Lauri Romanzi and Stephen Jeffery are vetting potential faculty and we are actively seeking members who want to participate in teaching and performing surgery in Accra by undertaking a two week placement. This is a great opportunity for all of IUGA members to contribute to education of colleagues in Ghana and subsequently all of West Africa. By training physicians there how to evaluate and treat women with incontinence and prolapse the project will be helping to fulfill the mission that all IUGA members share to improve the care of women suffering from pelvic floor dysfunction and pelvic health worldwide. Please contact Lauri Romanzi at the IUGA office through Maureen at Maureen@iuga.org or Chuck at chuck@iuga.org if you wish to participate in this work in Ghana or more about the foundation.

THE EXPERT OPINION LEADER CORNER

LAPAROSCOPIC SACROCOLPOPEXY: GETTING ONTO THE LEARNING CURVE.

By Dr. Stephen Jeffery

The vaginal mesh kit controversy has forced pelvic floor reconstructive surgeons to consider alternatives for their patients with advanced pelvic organ prolapse, and for many, the sacrocolpopexy is the most obvious option. The abdominal placement of mesh is far more forgiving than the vaginal approach with as much as a fourfold reduction in post-operative mesh related complications. Sacrocolpopexy is also associated with superior sexual function and better anatomical cure rates. The problem is that in many centres straight stick laparoscopy or robotic skills are not available and surgeons are still performing a laparotomy or offering women an inferior vaginal procedure.

It has become essential for modern, high volume pelvic floor surgeons to acquire the skills to perform minimally invasive sacrocolpopexy, whether it is using straight sticks or a robotic system. So how does the busy, post-fellowship and experienced urogynaecologist become competent in straight stick sacrocolpopexy?

Firstly, it is essential to be comfortable in the open technique, which will ensure familiarity with the anatomy and enable easy conversion from laparoscopic approach if necessary. A large number of robotic and laparoscopic videos are now available and time spent watching these will enable the surgeon to develop an approach that appeals to him or her. Laparoscopic suturing is, without a doubt, the most important skill requirement and this should be practiced in a simulator and a simple and inexpensive light-box system is all that is required. Prior to embarking on a live case, it is important that all the steps are rehearsed. A useful exercise is to practise suturing a piece of mesh onto a linen-covered EEA sizer in the light box. Peritoneal closure is easily simulated by suturing a plastic shopping bag.

For the first few live cases, it is important that one is assisted by a competent laparoscopic surgeon. The availability of a colleague who is competent in sacrocolpopexy is not essential but the person should be comfortable with the anatomy of the pelvis (and sacral promontory) and also competent at laparoscopic suturing. Most of us will be able to obtain assistance from an urologist, gynaecologist or colorectal surgeon who may be happy to move up the learning curve with us. Having a competent

assistant means that suturing can be shared and thereby avoiding the inevitable fatigue that sets in during a long case. More importantly, it will improve the safety of the procedure at the early stages of the learning curve.

There are a number of factors that also make the procedure easier for the novice. This includes using a generous head down positioning of the patient that draws the bowels out of the pelvis and away from the vault and promontory. If the theatre is not equipped with shoulder bolsters, then a simple plaster strapping technique can be used to prevent the patient from sliding down the table. A trial tilt should be performed prior to draping the patient, enabling the surgeon and anaesthetist to negotiate the maximum tilt before the operation is commenced. Generous port use is also recommended for the first few cases, including a peri-umbilical camera port and two working ports on either side. This enables the assistant to adequately retract, cut and suture, which will save valuable time, which is essential at the bottom of the learning curve. Port numbers can be reduced as one gains experience. Consideration should also be given to placement of the camera port 5-10cm above the umbilicus in women with who have a particularly large vault prolapse or where the symphysis-umbilicus distance is less than 15cm.

Laparoscopic sacrocolpopexy is associated with minimal post-operative pain and predictable prolapse outcomes. Most surgeons (and patients!) are adequately rewarded after making an effort to perform it using a minimally invasive technique.

Dr. Stephen Jeffery

Department of Urogynaecology and Pelvic Floor Reconstruction
University of Cape Town

THE FISTULA CORNER

REPORT ON THE 4TH BI-ANNUAL ISOFS MEETING IN BANGLADESH

By Sohier Elneil

The 4th International Society of Obstetric Fistula Surgery (ISOFS) bi-annual meeting took place in Dhaka in Bangladesh from 15th – 17th November 2012, under the chairmanship of Professor Sayeba Akhter. Over 300 participants from all over Africa, Asia and the Middle East attended. Previous ISOFS conferences took place in Addis Ababa in Ethiopia in 2008, Nairobi in Kenya in 2009, and Dakar in Senegal in 2010.

The main themes of the meeting included preventative care of the bladder after obstructed labour, the role of the Martius fat graft in fistula surgery, an update of the FIGO training program, social reintegration of patients and a review of national strategies in streamlining the management of fistula patients. There was a great deal of interaction by colleagues and many of the participants have forged links between themselves and their differing national programmes.

The inspiration for the creation of the International Society of Fistula Surgeons (ISOFS) sprang from the recommendations of a conference held in Addis Ababa, Ethiopia in April 2007 among prominent fistula surgeons who were working in Africa. It was formally created in Addis Ababa in September 2008. It is an organization of professionals committed to the treatment and rehabilitation of victims of child birth injuries all over the world. Realizing that there are a high number of fistula patients around the world, in difficult and poor health and social conditions, the organization was established to contribute to improving their state by providing a holistic approach to care. The meeting in Dhaka did manage to live up to these aspirations.

It is well known that there are more than two million fistula patients in the world, and that there are few skilled and dedicated surgeons who can operate on them. Thus the membership of ISOFS realised that there was a need for a concerted effort to streamline and optimize care for fistula patients. The main shortcoming noted was the lack of training and hence the development of the Global Competency-based Training Programme produced in tandem with the International Federation of Gynaecology and Obstetrics. ISOFS also noted that there was a tremendous need for research, audit and prevention strategies. Together with non-government organizations such as EngenderHealth (supported by US AID) and the Fistula Foundation, they are starting to tackle these strategies. Thus, ISOFS has fulfilled a great need for specialists in the field by providing a platform for them to provide a unified and strong voice for affording advocacy for their patients. Its members are committed to providing a guiding light in the treatment, rehabilitation and prevention of obstetric fistula. The new president, elected for the next three years, is Dr. Thomas Rassen who has urged everyone who looks after fistula patients to join the campaign to help improve their lives.

The ISOFS meeting was preceded by the International Obstetric Fistula Working Group (IOFWG) meeting on November 13-14, 2012, hosted by the United Nations Population Fund (UNFPA). This is a forum set up in 2003. It is composed of fistula experts from around the world and members of non-governmental organisations working in fistula care. There are 4 subcommittees within the IOFWG including advocacy and partnerships, data indicators and research, prevention and, treatment and training. Each sub-group has a defined remit and aims to facilitate unification of work within the different national groups, to eventually drive policy change and direct government strategy in maternal health care. It is through the auspices of these groups, in tandem with financial support and procedural modification that the changes seen over the last decade have happened in fistula care. This union of purpose, and work accomplished, between ISOFS, IOFWG, UNFPA and all other fistula care bodies will be celebrated this year as the 'decade of achievement in fistula care'. A celebratory meeting, hosted by UNFPA, will be held in New York in May 2013.

Sohier Elneil

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CONTROVERSIES IN UROGYNECOLOGY

VAGINAL HYSTERECTOMY FOR PROLAPSE

PRO

By Michele Meschia, MD

In most countries, vaginal hysterectomy is still the leading treatment method for patients with symptomatic uterine prolapse. However, recently there has been a move towards uterine preserving surgery with the objective to decrease peri-and postoperative morbidity including mesh related complications and also to meet patients' preferences based on emotional, cultural and social motivation. Some of the benefits of conserving the uterus such as quicker postoperative recovery and fewer bladder symptoms have been documented in studies comparing hysteropexy with vaginal hysterectomy but overall the literature is inconclusive and there is a lack of adequate randomized trials.

Two retrospective and one prospective study comparing vaginal hysterectomy to sacrospinous fixation demonstrate no significant difference in anatomical outcome. The only randomised trial available comparing both procedures found a higher rate of recurrences after one year in patients undergoing sacro-spinous hysteropexy (21% vs 3% recurrence in patients with vaginal hysterectomy).

Fewer studies compare vaginal hysterectomy with other conservative surgical procedures such as the Manchester Fothergill and utero-sacral ligament hysteropexy. Although they show similar rates of recurrence between groups, all are retrospective with several selection biases such as surgeon's preference, different degree of preoperative prolapse, and demographic differences. As a consequence, there exists a paucity of data in the literature and we cannot make well-supported conclusions about the best procedure to perform.

Regarding the use of mesh for treating pelvic organ prolapse, there is some evidence that avoiding hysterectomy at the time of surgery reduces the rate of post-operative complications, and therefore one can argue that preserving the uterus is a mesh-driven indication. Several mesh kits were introduced into the surgical market, promoting a minimally invasive alternative to the conventional armada of surgical techniques to repair vaginal and uterine prolapse. Although studies suggest benefit from the use of synthetic vaginal mesh for anterior compartment, data are limited on the use of mesh for apical compartment. A systematic review on the efficacy of mesh kits in the treatment of prolapse of the vaginal apex was inconclusive on the benefit of preserving the uterus because data were not compared between patients having hysterectomy or not.

Finally, when preserving the uterus at prolapse surgery there is a risk, albeit small, of missing an early endometrial carcinoma, especially in postmenopausal women, and screening for endometrial cancer in the postmenopausal population is not currently recommended. Moreover endometrial cancer is the most common invasive gynecologic cancer in U.S. women with an estimated 47,130 new cases expected to occur in 2012 and an estimated 8,010 women expected to die of the disease.

In conclusion, until solid evidence exists to support better anatomic outcomes or lower complication rates with uterine preservation, I will continue to endorse hysterectomy at the time of surgical repair of apical prolapse.

Dr. Michele Meschia
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IN FAVOR OF PRESERVING THE PROLAPSED UTERUS

CON

By Prof. Menahem Neuman, MD

Hiatal lump, with or without uterine prolapse, is a classic presenting sign of pelvic floor herniation and should be treated appropriately to improve quality of life. The management of choice for pelvic floor herniation is an appropriate repair of the architectural defects of the pelvic floor, with special attention to the suspension ligamentary breakages. Maintenance of long term cure frequently requires mesh implants that substitute for the weakened fascial pelvic floor components that caused the herniation process in the first place. Surgeons should adhere to standard, well-proven surgical principles of herniation repair, which include the "tension free" technique, secure fixation to solid, supportive structures, and good tissue coverage of mesh implants. Nevertheless, there are substantial differences between abdominal wall and pelvic floor herniation. For example, the relative paucity of covering tissue and surrounding anchorage possibilities in the latter need to be understood and addressed in order to obviate operative failures.

Another important issue is the nature of the pelvic floor architecture, which is ligamentary rather than fascial. Hence, one should aim at using sling mesh implants, rather than mesh sheets, to avoid mesh-related complications. The cervical fibrotic ring, made up of the cardinal, utero-sacral and anterior ligaments, and attached to the vaginal apex, provides the ideal centro-apical suspensory point. By supporting it at the sacro-spinous ligament or to the pre-sacral fascia one recruits and reinforces the whole ligamentary pelvic floor architecture and at the same time suspends the vaginal apex. These techniques differ from the traditional approach for treatment of uterine prolapse: the vaginal hysterectomy. In fact, hysterectomy offers no advantage in the surgical cure of pelvic organ prolapse.

Furthermore, hysterectomy carries with it substantial risks and complications, which are by no means rare and may be very serious. They include blood loss, visceral injuries, infections, sexual discomfort, psychological sequelae and post-hysterectomy vaginal vault prolapse, which affect approximately half of patients. These operative complications, potentially obviated if the uterus is not

removed, frequently require further surgery, can severely affect the patient's health, and may even be life-threatening.

Numerous reports recommend preservation of the prolapsed uterus while reconstructing the pelvic floor. Apart from avoiding the adverse effects of hysterectomy, the surgical outcome is better. Preservation of the uterine cervix allows it to be used as the central insertion point for the pelvic ligamentary architecture, as well as providing an anchor for the vaginal apex, thus providing reinforcement.

Hysterectomy is performed much less often these days: uterine myomas, endometrial polyps and ovarian cysts can be removed; menorrhagia is treated by endometrial ablation; cervical dysplasia is treated conservatively etc. The same holds true for uterine prolapse: more prolapsed uteri are preserved, providing a centro-apical supportive anchor. This anatomy is in contrast to the situation in post-hysterectomy vaginal vault prolapse, where the vaginal apex anchor is rather poor and does not provide a long-term supportive tissue. Uterine preservation also avoids the psychological effects of hysterectomy and the negative effects upon blood supply and innervation of the pelvic floor components. Hysterectomy has been shown to increase the frequency of mesh implant exposure 15-fold; concomitant hysterectomy and mesh implantation is not recommended.

Patients should be informed of the option of preserving the prolapsed uterus and the benefits of this approach, and surgeons should undergo proper training in this technique. The operative cure and complication rates are related to level of skill; hence such procedures are best carried out by high volume surgeons.

The surgical training program and reimbursement policy must allow for these conceptual changes in the treatment of uterine prolapse.

Prof. Menahem Neuman, MD

In charge of Urogynecology, Ob-Gyn, Western Galilee MC, Nahariya
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CHRONIC PELVIC PAIN IN WOMEN: FROM A BIOMEDICAL TO BIOPSYCHOSOCIAL MODEL OF CARE, PART 2

By Melissa Cohen, Rebecca McLoughlan, Dr. Sarah Edwards, and Dr. Natasha Curran

Part 1 of this Article (July 2012 edition) reflected on the difficulty of managing chronic pelvic pain syndrome (CPPS) in women. The traditional biomedical approach places the responsibility for reducing pain on the clinician, and fails to address the complexities of CPPS. Part 2 of this article suggests ways to introduce a biopsychosocial model from the first point of contact. We believe that the early introduction of this model of care will help clinicians to form patient- centred treatment plans which better address the numerous effects of CPPS and improve patient outcomes.

When a woman with CPPS is referred for your clinical advice, it is reasonable that they perceive you as an expert in this field. Unfortunately, this may create a position whereby you, the clinician, are seen to hold all the responsibility for solving their pain problem. This perspective fails to take into account the interplay between individual, biological and psychosocial factors, which may influence their treatment outcome. An alternative approach is to develop a collaborative working relationship, early in the treatment pathway, that acknowledges the numerous factors which impact on pain experience.

A comprehensive biopsychosocial consultation will address potential pathology and identify appropriate medical management while also considering the wider impact of CPPS in women. As a consequence of the considerable 'cross talk' between structures of the pelvis, women presenting with CPPS frequently present with referred pain, secondary muscle hyperalgesia and viscero-visceral hyperalgesia. These changes frequently impact on bladder, bowel, sexual function and general movement. Change in mood, work, socialising and role are common additional and understandable consequences. Discussing chronic pain mechanisms and the presentation of chronic pain within the pelvis should enable the clinician to acknowledge and normalise the broad impact of CPPS on function and quality of life. This may enable discussion of strategies to reduce the impact of pain, including pain management, as well as medical interventions. Introducing the option of pain management at this stage, as something to think about, may make it easier to return to later down the line.

Many patients hold a theory or belief about the cause of their pain or the factor/s maintaining their pain. Resolving unwarranted fears about sinister disease and pain equating with damage can be challenging at the early stages of investigation. However, discussing the patients' thoughts and beliefs about the cause of their pain can provide a helpful opportunity to explain how and why you feel that certain causes can be eliminated. This discussion can increase the patients' sense of having been 'heard', which is known to reduce distress and anxiety and contribute helpfully to a collaborative relationship.

Orientating patients towards helpful strategies they can use to maintain function is an aim of biopsychosocial assessment, for example acknowledging the benefit of continued engagement in activity, despite the presence of pain. Discussing this can provide an opportunity for the patient to identify or consider ways in which they can help themselves during the process of investigation and treatment.

While this model does not 'take the pain away' it does enable health care professionals to understand the wider components which influence treatment outcomes and encourages the patient with CPPS to consider how they might be able to begin to help themselves. It also enables a greater understanding of the individuals' needs, helping the professional to identify when a referral to a multidisciplinary pain service is warranted.

Melissa Cohen, Clinical Nurse Specialist
Rebecca McLoughlin, Physiotherapist
Dr. Sarah Edwards, Clinical Psychologist
Dr. Natasha Curran, Consultant in Anesthesia and Pain Medicine
The Urogenital, Visceral and Pelvic Pain Management Team
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SUMMARY OF THE UROGYNAECOLOGICAL SOCIETY OF AUSTRALASIA (UGSA) – 4TH ANNUAL SCIENTIFIC MEETING IN SYDNEY

By Dr. Nir Haya and Dr. Chris Maher

The Urogynaecological Society of Australasia (UGSA) 4th Annual Scientific Meeting was held on March 14-16, 2013 at the Garvan Institute, St Vincent's Hospital Sydney. The meeting was chaired by Professor Kate Moore and Associate Professor Bernie Haylen and brought together national and international experts to discuss the latest discoveries and advances in Urogynaecology. Over 220 delegates enjoyed 3 days of workshops, lectures, debates and social interaction with colleagues.

We were honored to have Prof. Matthew Barber, the president of The American Urogynaecology Society (AUGS) as the international visitor. Professor Barber presented the evidence based literature on the role of Sacrocolpopexy in prolapse surgery and discussed the 1 Million Dollar question: will Vaginal Biological Meshes provide what native tissue cannot?

Mesh complications and urinary incontinence were the major topics discussed in the meeting. Dr. Jan-Paul Roovers provided a valuable insight into research on vaginal function and pliability. Dr. Peter Rosenblatt reviewed the role of Tibial Nerve Stimulator for bladder overactivity and experts provided a valuable review of chronic pelvic pain and vulvodynia. Podium and oral poster sessions presented the latest studies in Urogynaecology.

Legal issues were also part of the discussion relating to transvaginal mesh and the impact of childbirth on the pelvic floor. On the second day the podium transformed into a mock court room and the case involved an obstetrician being sued for the damage to a patient's pelvic floor following an instrumental delivery. The patient and her husband (Prof. Kate Moore and A. Prof Malcolm Frazer) were furious and kept asking "Why didn't you perform a simple Cesarean Section". Judge Rane attempted to keep order. The debaters, (pictured) Michelle Atherton and Lynsey Hayward presented the case for elective caesarian section and the case for

vaginal deliveries was argued by Alison de Souza and Jenny King. The debate was hilarious as the debaters relished the oppourtunity of letting their hair down and expressing themselves way too freely! The audience voted by the finest of margins in favour of vaginal deliveries.

The main social event was a Dinner Cruise in the beautiful Sydney harbor overlooking the Opera house and the lovely city's skyline. A lifetime award was given to Dr. Peter Glenning from Melbourne for being a pioneer as well as for his great contribution to the knowledge and practice in Urogynaecology in Australia. The visiting speakers pictured really seemed to be enjoying the friendship and fun of a memorable night cruising on Sydney harbour.

The UGSA-AMS 2013 Traveling Scholarship was awarded to Dr. Vivien Wong and Dr. Lynsey Hayward was judged the best presentation for her work on the development of an intravaginal pressure transducer.

Dr. Peter Glenning receiving his RANZCOG Lifetime Award from Prof. Kate Moore.

The meeting was a great success and we wish to acknowledge the generous support of platinum sponsors American Medical Systems and Boston Scientific. A special acknowledgment must go to Dr. Yik Lim, Ms. Debra O'Brien and Lyn Johnson for their tireless work prior to and during the meeting.

We look forward to seeing you all again in Melbourne 2014 for the 5th UGSA Annual Scientific Meeting.

Peter Rosenblatt, Matthew and Heather Barber, Christopher Maher and Jan Paul Roovers at the UGSA dinner.

Dr. Nir Haya
Urogynaecology Unit
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IUGA FELLOWS' RESEARCH NETWORK – UPDATE

By Alexandros Derpapas, FRN Subcommittee Chairperson

With the 38th Annual IUGA Meeting in Dublin fast approaching, the Fellows' Committee is ready to share with fellows from around the world the inaugural IUGA Fellows' Research Network project. After screening 9 stimulating projects submitted by fellows, the FRN and Advisory Board members attending the 37th Annual Meeting in Brisbane last year voted for a randomised controlled trial from King's College Hospital, London, U.K to win the $20,000 grant. The POP^2 study (Post-Operative Pain after Pelvic Organ Prolapse surgery) is a two-arm parallel double blind randomised multicentre study to assess the effect of local anaesthesia during vaginal hysterectomy. The aim of the study is to compare the effect of combined local anaesthetic and adrenaline infiltration vs. saline infiltration at vaginal hysterectomy on post-operative pain, operative blood loss, operating time, and post-operative recovery.

The idea of the IUGA Fellows' Research Network was born soon after the 2011 Annual IUGA Meeting in Lisbon and was quickly embraced by the members of the Fellows' Committee and senior IUGA faculty. The purpose of the IUGA FRN is to enable fellows to work together cooperatively and conduct multi-centre pelvic floor research projects. The FRN Grant is designed to fund development of multi-centre research coordinated by fellows and conducted under the mentorship and supervision of the Advisory Board which consists of senior members of the IUGA.

In the months following the Brisbane meeting, the IUGA FRN Steering Committee has worked closely with the Advisory Board and the grant winning team to finalise the protocol for the POP^2 study and set the specifications for participating centres. The primary investigator's team is currently registering the study with the U.K national research regulatory body (MHRA) and recruitment is set to commence at the primary site (King's College Hospital, London, U.K) as soon as IRB approval is granted.

The IUGA FRN Steering Committee is now calling for recruiting centres for the POP^2 study to apply for participation in the project. A short summary of the POP2 study protocol along with an application form for participation as a recruiting centre are posted on the IUGA web site under the Fellows section. All IUGA Fellows are invited to submit an application form providing details about their training centre and their mentors. For updates on the study recruitment progress fellows are encouraged to check regularly on http://www.iuga.org/?frn. For more information please contact the FRN team via amy@iuga.org and akderpapas@gmail.com.

Fellows are also invited to actively participate in the Fellows Research Network Meeting at this year's IUGA Meeting in Dublin, when an update on the study protocol and site recruitment will be discussed. The timeline for the 2014 FRN Grant will also be announced. The FRN meeting is scheduled for Wednesday May 29th 2:30 – 4:00 pm, following what is anticipated to be an exciting Fellows' Day program. The full Fellows' Day activities program is available on line on http://www.iuga2013.com/fellowsactivities.

We are hoping to see you all in Dublin!

FELLOWS' DAY AT IUGA MEETING, DUBLIN 2013

By Fiona Lindo and Vijaya Gopalan

At this year's annual IUGA meeting an entire day is dedicated to the IUGA fellows, which encompasses education, research and networking opportunities. The fellows' day is organized enthusiastically by the fellows. It gives an opportunity for fellows and trainees within the field of urogynecology to interact and foster international relationships with each other and to stimulate international dialogues on current issues in our field. This is also aimed in facilitating mentorship by bringing fellows and renowned academics, and urogynecologists together and stimulating collaboration.

An exciting program has been organized this year for the IUGA meeting in Dublin on Wednesday, May 29th under the theme "Optimizing Prolapse Management through surgical and non-surgical approaches" with speakers from experts in this field. Internationally renowned speakers including Dr. G. Willy Davila, Dr. Mark Slack, Dr. Bob Shull, and Prof. Kari Bo have been invited to provide lectures in relation to their expertise and theme of the day. A stimulating debate, led by Dr. Charles Nager and Dr. Dudley Robinson, is also scheduled to be one of the highlights of this session. The opposing teams will be represented by a fellow and their supervisor, debating for and against the motion: "This house believes that invasive urodynamics are recommended in women if invasive or surgical treatment is considered". The debate is constructed on the International Urogynecological Association guideline on stress urinary incontinence evaluation, which will hopefully evoke an interactive session on this controversial and important issue.

An excellent opportunity is provided for fellows to present their research, from abstracts that were not accepted for oral presentation at the fellows' paper session. During this forum the fellows will receive critique on their presentation from prominent urogynecologists. The aim of this informal exercise is to provide the fellows with a chance to practice their oral presentation and learn tips on their presentation skills and scientific content.

There will also be a Fellows' Research Network meeting on Wednesday, May 29th from 2:30 to 4:00 pm. Details about this meeting and the FRN project are provided in the article above

Fellows are strongly encouraged to explore the fellows' lounge, which will be available exclusively for the fellows from Thursday,

May 30th. Coffee, snacks, and Wi-Fi facilities will be available during the conference for the fellows at the lounge. Come along, relax and share ideas and experiences with colleagues from around the world!

There is also an amazing opportunity to socialize at the official fellows' reception on Thursday, May 30th where drinks and hors d'oeuvres are provided. Do not miss this exciting prospect to mingle and network with peers from all around the world. If you are a fellow please register for the Fellows' Day and the Fellows' Reception through the 2013 registration system. If you have already registered for the meeting and forgot to sign-up for the fellows activities, please e-mail amy@iuga.org.

We hope to see you in Dublin, as it definitely will be a wonderful time to widen your educational and social horizons.

Fiona Lindo, Chair, Fellows' Social Planning Subcommittee
Vijaya Gopalan, Fellows' Social Planning Subcommittee Member

PHYSIOTHERAPISTS' CORNER

CHILDBIRTH, PREGNANCY AND THE PELVIC FLOOR: THE ROLE OF PHYSIOTHERAPY

By Bary Berghmans, PhD, MSc, RPT and Pytha Albers-Heitner, PhD, RPT

One in three women will be affected by urinary incontinence (UI) during their lives, evoking substantial individual morbidity, loss in quality of life and socio-economic costs. The most provocative factors for UI are first pregnancy and childbirth. In the short term, preventive Pelvic Floor Muscle Training (PFMT) during pregnancy greatly reduces UI in advanced pregnancy and in the first months after childbirth.

Persistent post-partum UI is also treatable by PFMT, but may be initiated too late and to date it is not known whether or not the effects of PFMT persist. Standard peripartum care pays little if any attention to UI and only a minority of pregnant women are actively aware of the preventable risk of pregnancy and birth related UI and how to avoid the problem. We designed Motherfit, which is more than just preventative PFMT; it is a multidisciplinary strategy to raise awareness for women, during and after their first pregnancy. The program also stresses the importance of PFMT as a normal part of a healthy life style and general well-being, necessary for lifelong prevention of UI and chronic diseases.

Besides coordination and strength training, women are taught to use and incorporate their PFM function during normal daily life activities (in bladder and bowel control, abdominal pressure rise, etc), in order to maintain long-term effects of PFMT after finishing their supervised intervention. Motherfit is in line with the recent trend and introduction of life style programs for at risk groups such as the elderly or obese people.

Motherfit provides women with individual instruction in pelvic floor anatomy and how to contract and relax the PFM correctly. Women are assessed and instructed in this by a midwife/gynaecologist or by the pelvic physiotherapist if further instruction is needed.

The Motherfit PFMT protocol to prevent and treat UI follows the recommendations for general training to increase strength of skeletal muscles and the recommendations concerning physical activity during and after pregnancy according to the American College of Obstetricians and Gynecologists and the World Health Organization (WHO). Efficacy of PFMT to prevent and treat UI is dependent on an adequate dose-response (intensity of PFMT) relationship.

Following referral at 12 weeks gestation women attend an 8 session intensive pre partum group training session supervised by registered Motherfit physiotherapy trainers from 20 weeks gestation. All women will receive an individual PFM home training program and general advice on physical activity for the lifelong prevention of urinary incontinence and chronic diseases, considering the intensity and type of physical activity appropriate for pregnant women.

At 6 weeks post-partum all women allocated to Motherfit are again counseled by their midwife/gynaecologist on prevention of PFD. Following the same individual assessment and referral procedure women attend 8 intensive post-partum group training sessions.

The Pelvic Care Centre, Maastricht of the Maastricht University Medical Centre, The Netherlands, has initiated Motherfit. We are now ready to launch a randomized clinical trial comparing the long-term effects of Motherfit against the long-term effects on women who have not participated in Motherfit to study long-term results of the program. The endpoint is to assess urinary incontinence prevalence 18 months post partum measured by the ICIQ-UI SF.

There has been huge interest to participate in the Motherfit clinical trial.

University hospitals, physiotherapy associations in several countries such as Brazil and the Netherlands, midwife organisations and multidisciplinary societies like IUGA and EUGA support this initiative in order to study optimal prevention programming and its effects and efficiency for one of the major proven risk factors for pelvic floor dysfunctions.

Time to take care of the mother!! Not only the baby.

Bary Berghmans, PhD, MSc, RPT
Pytha Albers-Heitner, PhD, RPT
Pelvic Care Center Maastricht
The Netherlands

Post IUGA Congress

Montpellier, France,
June 13, 2013

International Urogynecology Journal

Things are Happening at the Blue Journal

We are proud to announce a new feature: "Editor's Choice". Peter Dwyer and I will pick three to four articles each year which may be either original research studies or reviews. These will be selected on their originality, quality, potential for high citation, and finally their clinical interest to our readers. The Editors' Choice articles will have a prominent position in the journal and will be granted months' free access by Springer, our publishers, in order to achieve the widest possible dissemination and readership. The authors will receive a certificate with acclamation at the Annual Scientific Meeting of the International Urogynecological Association.

For our first Editors' Choice we have selected an original research article by R. Freeman et al. entitled "A randomized controlled trial of abdominal versus laparoscopic sacrocolpopexy for the treatment of post-hysterectomy vaginal vault prolapse: LAS study". This is the first randomized study comparing open to laparoscopic colposacropexy.

We welcome a new editor from South America, Maria Augusta Bortolini from São Paulo, Brazil. She was a clinical research fellow at Mount Sinai Hospital in Toronto, Canada, for 3 years and currently is Coordinator of the Cell Culture Laboratory, Department of Gynecology, Federal University of Sao Paulo (UNIFESP) in addition to her clinical work at the Hospital Bandeirantes. We are very glad to have her on the team of editors.

Thank you for your support of the Blue Journal. As always we invite you to send us your best work to make the IUJ the best journal in urogynecology. For those of you who have not yet signed up I invite you to follow me on twitter (@iuj_eic) to receive updates and links to interesting articles from the IUJ.

Paul Riss
Co-Editor-in-Chief
International Urogynecology Journal

eXchange

Shanghai, China
October 10-11, 2013

Regional Symposia

Bali, Indonesia
November 7-9, 2013

PUBLIC RELATIONS COMMITTEE UPDATE

By Lynsey Hayward, PR Committee Chairperson

New BOTOX Leaflet

Have you checked the Patient Information section of the IUGA site recently? We are constantly adding new patient leaflets to our collection. Recently added topics include *Constipation: A Patient Guide, A Patient Guide to Postoperative Recovery* and *Uterosacral Ligament Suspension*. Our newest leaflet, *Botulinum Toxin A (BOTA): A Patient Guide* is now available online as well. Take a look by visiting www.iuga.org and selecting patient information from the resources tab!

We are very grateful to our dedicated team of translators; we now have some leaflets translated in up to 10 different languages. If you would like to help with translation and have leaflets available to your patients in your language please contact amy@iuga.org. All translators will be acknowledged for their contribution.

IUGA Online Store: Your Source for Patient Education Materials

IUGA online store items are available at a 50% discount to IUGA members. Stock includes attractive posters for the office, patient information brochures in a trifold format, very handy for the office, POPQ sticks for POPQ examinations and IUGA branded apparel. Visit www.iugastore.com to place your order today.

Visit the IUGA booth in Dublin to avoid shipping costs and purchase patient education materials from the online store!

IUJ App

NOW AVAILABLE

The IUJ App is now available for any Android or Apple mobile device. Visit the Google Play store or the Apple App store to download the app. For a limited time only, everyone can enjoy free access to read full text articles dating back to 1990. Following the introductory period free access will only be available to IUGA members.

IUGA PHYSIOTHERAPY/PELVIC FLOOR REHABILITATION SEMINAR: SCIENTIFIC-BASED CLINICAL PRACTICE OF PELVIC FLOOR REHABILITATION MAY 27, 2013

By Bary Berghmans, PhD, MSc, RPT and Maeve Whelan, IUGA Pelvic Floor Rehabilitation Special Interest Group.

Together with the Local Organizing Committee of the IUGA Annual Meeting in Dublin, Ireland, the IUGA Pelvic Floor Rehabilitation Special Interest Group will organize a pre-IUGA meeting on May 27, 2013.

This meeting is open to every IUGA member interested in not only meeting and greeting but, above all, learning and experiencing clinical practice of pelvic floor rehabilitation, based on scientific evidence.

Forget any pre-conceived ideas and beliefs of what the pelvic physiotherapist is capable of and join the master classes to really see what happens during assessment and treatment!!

During the morning sessions, theoretical concepts and biological rationale and evidence for the different topics will be presented.

Each master class will have maximum of 15 people. The IUGA ambassador couples will present life demonstrations (either on volunteers, professional models or patients, depending on what can be realized locally). In case this is not possible they will use videos and other materials to demonstrate how to perform the clinical assessment, evaluation, analysis and treatment related to their topic in a very practical way teaching skills and knowledge, according to guidelines, standards, protocols.

So, do not say later that you have no clue what they do……??

Venue: School of Nursing and Midwifery, Trinity College Dublin, D'Olier St., Dublin 2

IUGA Pelvic Floor Rehabilitation Special Interest Group Speakers

Pelvic Organ Prolapse
Kari Bo (Norway)
Marijke Slieker–ten Hove (Netherlands)
Pelvic Floor Muscle Education & Functional Training
Baerbel Junginger (Germany)
Maura Seleme (Brazil)
Assessment & Evaluation
Teresa Cooke (United Kingdom)
Maeve Whelan (Ireland)
Bowel Dysfunction
Ulla Due (Denmark)
Jacqueline de Jong (Switzerland)
Peri Partum Prevention
José Mikel Amostegui (Spain)
Bary Berghmans (Netherlands)

Timetable

9.00	Registration
9.15	Opening Address - Bary Berghmans (The Netherlands)
9.30 -12.30	Evidence Based Theory (Lecture Theatre – 1 presentation on each topic)
12.30-13.30	Lunch
13.30 – 16.30	Evidence Based Practical Master Classes (Five - Seven Practical Rooms)
16.30 – 17.30	Concluding Session (Lecture Theatre)

Costs: US$100 per delegate + US$350 day rate or regular annual meeting registration rate.

DUBLIN 2013 Special Interest Groups Meetings

Wednesday 1:30 pm - 2:30 pm	Laparoscopic Surgery Special Interest Group
Wednesday 3:00 pm - 4:00 pm	Urogenital Pain Interest Group Meeting
Thursday 12:30 pm - 1:30 pm	Pelvic Floor Rehabilitation Special Interest Group

Attendance is free for all IUGA members. Please join any of the above groups if you have a special interest in one of these topics and are keen to actively contribute to its development and growth.

Welcome To Dublin 2013

By Declan Keane, Congress Chair

Now that the St. Patrick's day celebrations are over, wherever you are in the world, it is time to start thinking about IUGA 2013 and coming to Dublin. Over the last few years the local organising committee, our conference organisers and the IUGA office have been carefully planning to make this year's meeting a truly memorable event. Let me outline why it will be so special.

2013 marks the year of "the Gathering" – a yearlong event sponsored by the Irish government and the Irish tourist board to attract visitors to the emerald isle. It is marked by over 1,000 social and cultural events to encourage tourists, both new and old, to visit the country and get a flavour of what it means to be Irish. We hope to capture this in many of the social events planned for IUGA. The opening reception, President's Dinner and Gala Dinner will have a distinctly Irish theme which should appeal to all. In addition, we have included a partner's program and post-conference tours which will give those who register the ability to take in the history, culture and beauty of Dublin and its surroundings.

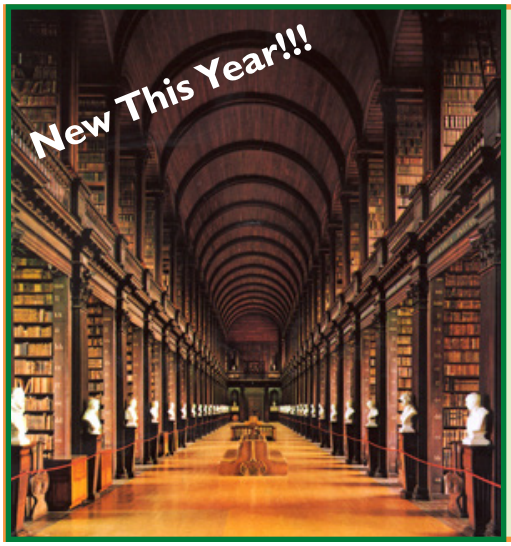
This year also sees the inaugural IUGA golf classic. Ireland has more golf courses per capita than any other country in the world, and is blessed with stunning parkland and links courses. We shall be hosting our event at the Royal Dublin golf course, a championship course which has held the Irish Open numerous times, where previous winners include Severiano Ballesteros and Bernhard Langer. Register early to avoid disappointment!

Dublin is an easy city to get around by foot and all of the conference hotels are within easy access to the Convention centre and the city centre, where one can get a chance to experience the lively bars and social life, as well as the fashionable shopping district of Grafton street.

However, one must remember that you are coming for the science first and the fun after and IUGA 2013 will not disappoint. The first two days include a varied workshop program, which include a cadaveric workshop, "almost-live" surgery, OASIS workshops and also a specific workshop for our physiotherapy colleagues. These workshops are followed by a fascinating two and a half days of scientific presentations; meet the experts sessions, and interactive debates. These debates and roundtable discussions focus on the topical subjects of instrumental delivery and its effects on the pelvic floor and also a roundtable on the role of urodynamics

before continence surgery. Active audience participation will be expected! We shall also have an engrossing historical lecture on doctors and the Titanic – significant as it was just 100 years when the infamous ship left these shores for the US.

As chair of the meeting, I look forward to welcoming you to Dublin to enjoy the 'craic' – an all encompassing Irish word that means fun and enjoyment. We have no doubt that you will find IUGA 2013 educational and entertaining. See you in May!!

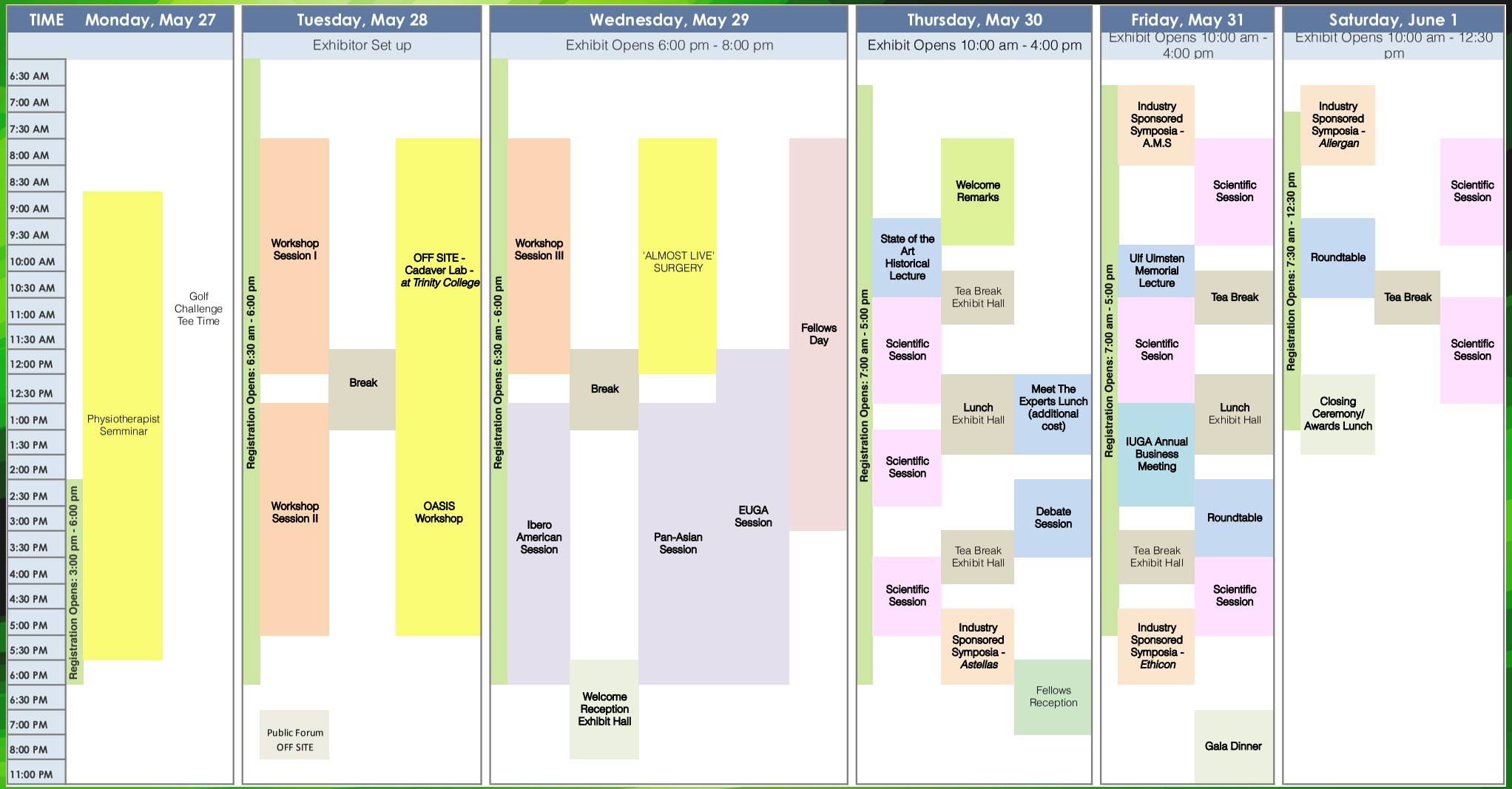


ACCOMPANYING PERSONS' PROGRAMME

If you are planning to bring someone with you to the meeting, make sure you check out the Accompanying Persons Program. Starting Wednesday evening, this 2-day program includes the welcome reception, a tour of Georgian Dublin and Powerscourt Estate and Gardens, a walk through Trinity College Dublin, lunch at the Merrion Hotel and more. For more information visit **www.iuga2013.com**

IUGA DUBLIN 2013 CFI

PROGRAM TIMETABLE



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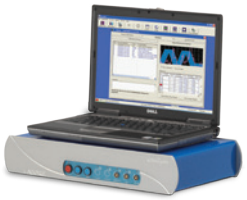

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Advancing Urogynecological Knowledge Around the World

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