



Good Samaritan Hospital



Practice Patterns Amongst Obstetrician/Gynecologists Regarding Participation in Urogynecologic Procedures: A National Survey

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OBJECTIVE

- To describe the variation in urogynecology practice amongst obstetrician/gynecologists in the United States

BACKGROUND

- Obstetrician/gynecologists are often the first line for diagnosis and treatment of pelvic floor disorders
- Residency guidelines and educational objectives outline competency
 - Nature of urogynecology practice amongst obstetrician/gynecologists is poorly understood
 - Such information is of interest in assisting with areas of focus for residency training as well as to aid our understanding of how surgeons obtain competency in new skills

METHODS

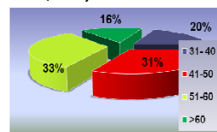
- Cross-sectional survey of a random sample of 3,225 obstetrician/gynecologists
 - Utilizing the American Medical Association's (AMA) physician database
 - Sample was equally distributed for gender, geographical location of practice and age group
 - Subspecialists were excluded
- 32 item questionnaire was administered
 - Management regarding stress urinary incontinence and pelvic organ prolapse was the focus
- The study received IRB approval

RESULTS

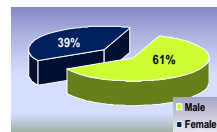
- 261 (8%) responded to the survey
 - Majority were male, over the age of 50, and in private practice
 - Majority cited residency as source of training for urodynamics, management of stress incontinence and pelvic organ prolapse (Table 1 and 2)
 - 81% and 88% described performing surgical correction for stress incontinence and pelvic organ prolapse
- The majority perform cystoscopy after surgery for stress incontinence (Figure 1)
- However, only 46% perform cystoscopy following ureterosacral ligament suspension, 29% after McCall's culdoplasty and 34% after anterior repair (Figure 2)
- A sizable number of respondents use transvaginal mesh kits for repair of pelvic floor disorders (Figure 3)

DEMOGRAPHICS

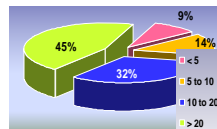
AGE (Years)



GENDER



YEARS IN PRACTICE



TYPE OF PRACTICE

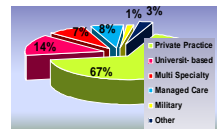


TABLE 1: PRACTICE PATTERNS REGARDING STRESS INCONTINENCE	
	N (%)
Perform urodynamics	132 (54.3)
Training in urodynamics	
Residency	73 (56.6)
Perform surgery for stress incontinence	164 (80.8)
Surgical training for stress incontinence	
Residency	128 (80.5)
Procedures performed for stress incontinence	
Transobuturator midurethral sling	102 (74.5)
Retropubic midurethral sling	106 (72.6)
Burch bladder neck suspension	98 (69.0)

FIGURE 1: RESPONDENTS WHO PERFORM CYSTOSCOPY AFTER STRESS INCONTINENCE SURGERY

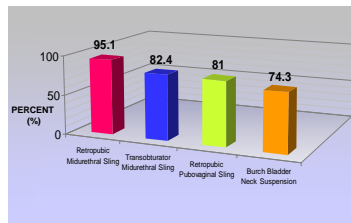


TABLE 2: PRACTICE PATTERNS REGARDING PELVIC ORGAN PROLAPSE	
	N (%)
Manage pelvic organ prolapse (surgical or medical)	195 (99.0)
Perform surgery for prolapse	204 (88.3)
Surgical training for prolapse	
Residency	190 (93.1)
Procedures performed for prolapse	
Total vaginal hysterectomy	188 (97.9)
Posterior repair	185 (96.3)
Anterior repair	184 (96.3)
McCall's culdoplasty	134 (73.2)
Uterosacral ligament suspension	132 (71.7)
Sacrospinous ligament suspension	113 (61.7)
Sacrocolpopexy	87 (48.3)

FIGURE 2: RESPONDENTS WHO PERFORM CYSTOSCOPY AFTER PROLAPSE SURGERY

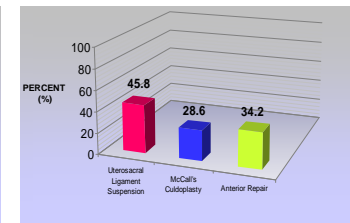
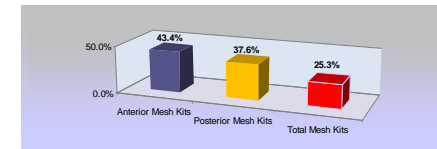


FIGURE 3: RESPONDENTS WHO USE TRANSVAGINAL MESH FOR PROLAPSE SURGERY



CONCLUSIONS

- A large number of obstetrician/gynecologists surveyed:
 - Diagnose and treat conditions such as pelvic organ prolapse and urinary incontinence
 - Residency was listed most often as the means of education and training in this field
- Nevertheless, a large number reported use of mesh kits and do not routinely perform cystoscopy after prolapse repair

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