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UCLA School of Medicine, Los Angeles, California, U.S.A.

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Title (type in
CAPITAL
LETTERS)**INCISIONLESS PUBOVAGINAL SLING USING TRANSVAGINAL
BONE ANCHORS AND CADAVERIC FASCIA.**

Aims of Study: Pubovaginal sling surgery for stress urinary incontinence (SUI) can have significant morbidity including bleeding, infection, erosion, urinary retention, pain and de novo instability. In an effort to reduce this potential morbidity, we have devised a technique, which provides the same suburethral support as our standard anterior vaginal wall sling (AVWS), but without a vaginal or suprapubic incision. This support is accomplished in a minimally invasive fashion that encompasses the use of transvaginal bone anchors and cadaveric fascia lata.

Methods: From April, 1998 to February, 1999, 85 women underwent an incisionless suburethral fascial sling procedure for stress urinary incontinence. Patient age range was 38 to 85 years old (mean = 54.2 years). All patients had been evaluated preoperatively with history and physical exam, voiding cystourethrography, and/or videourodynamics. Additionally, a large subset of the patients had concomitant vaginal prolapse and underwent fast spin echo T2 weighted magnetic resonance imaging for evaluation.

A suburethral fascial sling was performed alone in (36/85) patients or in combination with rectocele repair (44/85), vaginal hysterectomy (15/85), enterocele repair (6/85) and four-corner bladder suspension (8/85). The procedure entailed use of a transvaginal bone drill to place a titanium bone anchor loaded with #1 prolene suture into the inferior aspect of the posterior pubic symphysis on either side of the urethra. The poke hole created as the anchor pierced the vaginal epithelium was widened to accommodate the sling end. A subepithelial tunnel was created at the level of the bladder neck towards the contralateral incision. A 4 x 7 cm segment of cadaveric fascia lata folded lengthwise (2 x 7 cm) and placed through the subepithelial tunnel. The prolene sutures were passed through the fascial segment 5 mm

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from either edge, effectively creating a 6.0 cm wide hammock of support. Finally, the sutures are tied up to the pubic symphysis. The vaginal incisions are closed with a 2-0 polyglycolic acid suture.

Results: Follow-up was via self-administered questionnaire and patient interview. With a mean follow up of 4.8 months (range = 1 to 11 months) recurrent SUI was noted in 4/85 (5 %) patients undergoing the procedure. New onset urge incontinence was present in 2/85 (3%) patients. Permanent urinary retention has not occurred. No operative complications have occurred and no patient has required a blood transfusion.

Conclusions: The early results for the incisionless sling compare favorably with the results for other sling procedures. This minimally invasive approach has thus far not been associated with any significant complications. Elimination of the vaginal and suprapubic incisions has not compromised efficacy, and appears to reduce the incidence of urge incontinence. Long term follow-up will establish the lasting efficacy of this novel surgical technique.