FORUM
Evidence-Based Guidelines?
Wille-Jorgensen P
Dis Colon Rectum 2005 Jun 24;.

Teaching evidence-based medicine: should we be teaching information management instead?
Slawson DC, Shaughnessy AF
Acad Med 2005 Jul;80(7):685-9.
To encourage high-quality patient care guided by the best evidence, many medical schools and residencies are teaching techniques for critically evaluating the medical literature. While a large step forward, these skills of evidence-based medicine are necessary but not sufficient for the practice of contemporary medicine. Incorporating the best evidence into the real world of busy clinical practice requires the applied science of information management. Clinicians must learn the techniques and skills to focus on finding, evaluating, and using information at the point of care. This information must be both relevant to themselves and their patients as well as being valid. The authors discuss the need to teach the applied science of information management along with, or perhaps even instead of, teaching the basic science of evidence-based medicine. All students, residents, and practicing physicians need three skills to practice the best medicine: the ability to select foraging-"keeping up"-tools that filter information for relevance and validity, the skill to select and use a hunting-"just in time"-information tool that presents prefiltered information easily and in a quickly accessible form at the point of care, and the ability to make decisions by combining the best patient-oriented evidence with patient-centered care, placing the evidence in perspective with the needs and desires of the patient. This teaching of information management skills will prepare students and residents for a practice of medicine that requires lifelong learning.

1 – THE PELVIC FLOOR

Why are women deterred from general surgery training?
Park J, Minor S, Taylor RA, Vikis E, Poenaru D
Am J Surg 2005 Jul;190(1):141-6.
BACKGROUND: This study explored the factors contributing to the low application rates to general surgery (GS) residency by female students and compared perceptions of GS between students and female surgeons. METHODS: We distributed surveys to final-year students at 4 medical schools and nationwide to every female general surgeon in Canada. RESULTS: Of students who were deterred from GS, women were less likely than men to meet a same-sex GS role model and more likely to experience gender-based discrimination during their GS rotation ($P < .05$). Female students had the perception that GS was incompatible with a rewarding family life, happy marriage, or having children, whereas female surgeons were far more positive about their career choice. CONCLUSIONS: Both real and perceived barriers may deter women from a career in GS. Real barriers include sex-based discrimination and a lack of female role models in GS. There are also clear differences in perception between students and surgeons regarding family and lifestyle in GS that must be addressed.

Concerns regarding pelvic reconstructive surgery.
Shull B, Karram MM
Int Urogynecol J Pelvic Floor Dysfunct 2005 Jun 22;.

Advances in urogynecology.
Klingele CJ
Int J Fertil Womens Med 2005 Jan-Feb;50(1):18-23.
Pelvic floor disorders include urinary incontinence, pelvic organ prolapse, and bowel dysfunction, all of which can cause considerable disability and anxiety. One third of all women will suffer from these disorders at some point in their life. All are often embarrassing and may act as barriers to healthy living as many women suffer in silence. The field of urogynecology has evolved over time to meet the needs of women who struggle with disorders of the pelvic floor. An increase in the awareness and treatment of these disorders has led to improved scientific research in the form of prospective randomized clinical trials to develop a unified understanding of their epidemiology, biology, and treatment. This review explores the literature that has promoted advances in the understanding of pelvic floor disorders and discusses some of the new technology and research that is being done in the field.

Lidocaine Anal Block Limits Autonomic Dysreflexia During Anorectal Procedures in Spinal Cord Injury: A Randomized, Double-Blind, Placebo-Controlled Trial.
Cosman BC, Vu TT

Dis Colon Rectum 2005 Jun 24;.
PURPOSE: Autonomic dysreflexia is a common and potentially dangerous hypertensive response to stimulation below the level of injury that occurs in patients with spinal cord injury at T6 or above. Rectosigmoid distention and anal manipulation are among the stimuli that may precipitate autonomic dysreflexia. Instillation of topical local anesthetic into the rectum is the recommended prophylaxis against autonomic dysreflexia of anorectal origin. However, a previous randomized, double-blind, placebo-controlled trial showed that topical lidocaine in the rectum does not blunt the autonomic dysreflexia response to anorectal procedures. The purpose of this study was to determine whether lidocaine anal sphincter block would be effective in limiting anorectal procedure-associated autonomic dysreflexia. METHODS: We enrolled patients with chronic, complete spinal cord injury above T6, who were having anorectal procedures (flexible sigmoidoscopy and/or anoscopic hemorrhoid ligation). In a double-blind fashion, patients were randomized for intersphincteric anal block with 1 percent lidocaine or normal saline (placebo) before the procedure. Blood pressure was measured before, during, and after the block and procedure. RESULTS: Thirteen patients received lidocaine, and 13 received placebo. The groups were similar in age, level of injury, duration of spinal cord injury, type of procedure, and procedure duration. The mean maximal systolic blood pressure increase for the lidocaine group was 22 +/- 14 mmHg, significantly lower than the placebo group's 47 +/- 31 mmHg (P = 0.01). CONCLUSIONS: Lidocaine anal block significantly limits the autonomic dysreflexia response in susceptible patients undergoing anorectal procedures.

2 – FUNCTIONAL ANATOMY

A Role for the P2X Receptor in Urinary Tract Physiology and in the Pathophysiology of Urinary Dysfunction.

Rapp DE, Lyon MB, Bales GT, Cook SP
Eur Urol 2005 Jun 14;.
OBJECTIVE:: We provide a historical perspective of the P2X receptor class in bladder physiology and the pathophysiology of urinary dysfunction. METHODS:: A literature search was performed using the MEDLINE database. RESULTS:: Evidence suggests that P2X receptors serve a combined function in sensory and motor activity of human bladder. P2X receptors mediate excitation of sensory neurons and evoke muscle contraction in response to ATP release. Anatomical and functional defects in the P2X receptor signaling are associated with a variety of urologic diseases. CONCLUSION:: Current research underscores the importance of P2X receptors in urologic physiology. Potential applications exist in relation to the diagnosis and treatment of urinary dysfunction. However, the detailed mechanism of P2X receptor function in bladder physiology and in urinary tract disease remains unknown and warrants further investigation.

[Cystomanometric study of bladder sensation during sacral neuromodulation test]

Leclers F, Mourey E, Galas JM, Cormier L, Mangin P
Prog Urol 2005 Apr;15(2):238-43.
PURPOSE: Prospective clinical and urodynamic study evaluating modification of bladder sensation during sacral neuromodulation (SNM). MATERIALS AND METHODS: 24 consecutive patients with non-neurological hyperactive bladder underwent an SNM test. Questioned about their symptoms before and during the test by the urinary handicap assessment scale, patients were divided into two groups: A (improved) and B (not improved). Group A consisted of patients obtaining 50% improvement of their symptoms with SNM followed by return of symptoms at the end of the test, while the other patients constituted group B. We then compared the cystomanometric results according to their clinical response. RESULTS: The mean age was 53 years: 10 patients with a good response constituted group A (n=10, i.e. 42%) and 14 patients with a poor response constituted group B (n=14, i.e. 58%). Clinically, in patients with a good response, SNM decreased urge incontinence by 100%, day-time frequency by 89% and protections by 55%. Urodynamic assessment in group A during the test demonstrated a significant increase of +23% of bladder capacity ($p<0.01$), +57% of the volume of onset of the first unstable contraction ($p<0.004$), +83% of bladder volume to the first urge to urinate BI ($p<0.001$) and +46% to urgency B3 ($p<0.04$). During SNM, cystometry revealed that 1 or 2 bladder filling volumes were increased at B1 and/or B3 in 100% of improved subjects. In contrast, 1 or 2 volumes decreased at B1 and/or B3 in 58% of non-improved subjects. No significant difference of intensity of unstable contractions was observed between the 2 groups during SNM ($p=0.31$). CONCLUSION: A significant correlation was observed between the two methods of clinical and urodynamic assessment. Our results suggest the use of the cystomanometric increase of bladder volume at B1 and B3 as selection criterion for candidates for SNM with non-neurological hyperactive bladder.

Sitz Bath: Where Is the Evidence? Scientific Basis of a Common Practice.

Tejirian T, Abbas MA

Dis Colon Rectum 2005 Jun 16;.
PURPOSE: This study was designed to determine if evidence exists to justify and support the recommendation of sitz bath in the management of anorectal disorders. METHODS: A Medline search was conducted using the key words "sitz bath" and "hot bath." RESULTS: Thirty-six articles were found which highlighted the physiology, benefits, risks, complications, and techniques of sitz bath. Most of the studies were published in gynecologic or nursing journals. One randomized study comparing sitz bath to placebo was found. Two articles speculated that sitz bath induces relaxation of the internal sphincter muscle. Cold sitz bath was reported to decrease perineal edema more than warm sitz bath, although patients tended to prefer the latter. Five articles reported complications of sitz bath, including dissemination of herpes, maternal-neonatal Streptococcus outbreak, and skin burns. CONCLUSION: A review of the literature demonstrated a lack of scientific data to support the use of sitz bath in the treatment of anorectal disorders. Additional randomized and controlled clinical studies are needed to investigate whether this time consuming recommendation is beneficial to patients.

VSL#3 Probiotic-Mixture Induces Remission in Patients with Active Ulcerative Colitis.
Bibiloni R, Fedorak RN, Tannock GW, Madsen KL, Gionchetti P, Campieri M, De Simone C, Sartor RB
Am J Gastroenterol 2005 Jul;100(7):1539-46.
BACKGROUND AND AIMS: Intestinal bacteria have been implicated in the initiation and perpetuation of IBD; in contrast, "probiotic bacteria" have properties possibly effective in treating and preventing relapse of IBD. We evaluated the safety and efficacy of VSL#3 and the components, and the composition of the biopsy-associated microbiota in patients with active mild to moderate ulcerative colitis (UC). METHODS: Thirty-four ambulatory patients with active UC received open label VSL#3, 3,600 billion bacteria daily in two divided doses for 6 wk. The presence of biopsy-associated bacteria was detected using a nucleic acid-based method and the presence of VSL#3 species confirmed by DNA sequencing of 16S rRNA. RESULTS: Thirty-two patients completed 6 wk of VSL#3 treatment and 2 patients did not have the final endoscopic assessment. Intent to treat analysis demonstrated remission (UCDAI </= 2) in 53% (n = 18); response (decrease in UCDAI >/= 3, but final score >/=3) in 24% (n = 8); no response in 9% (n = 3); worsening in 9% (n = 3); and failure to complete the final sigmoidoscopy assessment in 5% (n = 2). There were no biochemical or clinical adverse events related to VSL#3. Two of the components of VSL#3 were detected by PCR/DGGE in biopsies collected from 3 patients in remission. CONCLUSION: Treatment of patients with mild to moderate UC, not responding to conventional therapy, with VSL#3 resulted in a combined induction of remission/response rate of 77% with no adverse events. At least some of the bacterial species incorporated in the probiotic product reached the target site in amounts that could be detected. (Am J Gastroenterol 2005;100:1539-1546).

3 – DIAGNOSTICS 2005 06
Dynamic magnetic resonance imaging of the pelvic floor in patients with idiopathic combined fecal and urinary incontinence.
Siegel C
J Urol 2005 Jul;174(1):220-1.

Re: Bryan NP, Chapple CR. Frequency volume charts in the assessment and evaluation of treatment: How should we use them? Eur Urol 2004;46:636-40.
Govindaraju SK, Neilson D
Eur Urol 2005 Jul;48(1):171-2. Epub 2005 Feb 12.

The effect of fluid intake on urinary symptoms in women.
Swithinbank L, Hashim H, Abrams P
J Urol 2005 Jul;174(1):187-9.
PURPOSE: We determined the effect of caffeine restriction and fluid manipulation in the treatment of patients with urodynamic stress incontinence and detrusor overactivity. MATERIALS AND METHODS: This was a 4-week randomized, prospective, observational crossover study in 110 women with urodynamic stress incontinence (USI) or idiopathic detrusor overactivity (IDO) to determine the effect of caffeine restriction, and of increasing and decreasing fluid intake on urinary symptoms. Data were recorded in a urinary diary for the entire study period on urgency episodes, frequency, pad weight increase, wetting episodes and quality of life. RESULTS: A total of 69 women with a mean age of 54.8 years completed the study, including 39 with USI and 30 with IDO. In the IDO group decreasing fluid intake significantly decreased voiding frequency, urgency and wetting episodes with improved quality of life. In the USI group there was a significant decrease in wetting episodes when fluid intake was decreased. Changing from caffeine containing to decaffeinated drinks produced no improvement in symptoms. CONCLUSIONS: Conservative and life-style interventions are first line treatments in the management of incontinence and storage lower urinary tract symptoms. This

study shows that a decrease in fluid intake improves some of these symptoms in patients with USI and IDO and, therefore, it should be considered when treating such patients.

Posterior compartment prolapse on two-dimensional and three-dimensional pelvic floor ultrasound: the distinction between true rectocele, perineal hypermobility and enterocele.
Dietz HP, Steensma AB
Ultrasound Obstet Gynecol 2005 Jul;26(1):73-7.
OBJECTIVES: Posterior compartment descent may encompass perineal hypermobility, isolated enterocele or a 'true' rectocele due to a rectovaginal septal defect. Our objective was to determine the prevalence of these conditions in a urogynecological population. METHODS: One hundred and ninety-eight women were clinically evaluated for prolapse and examined by translabial ultrasound, supine and after voiding, using three-dimensional capable equipment with a 7-4-MHz volume transducer. Downwards displacement of rectocele or rectal ampulla was used to quantify posterior compartment prolapse. A rectovaginal septal defect was seen as a sharp discontinuity in the ventral anorectal muscularis. RESULTS: Clinically, a rectocele was diagnosed in 112 (56%) cases. Rectovaginal septal defects were observed sonographically in 78 (39%) women. There was a highly significant relationship between ultrasound and clinical grading ($P < 0.001$). Of 112 clinical rectoceles, 63 (56%) cases showed a fascial defect, eight (7%) showed perineal hypermobility without fascial defect, and in three (3%) cases there was an isolated enterocele. In 38 (34%) cases, no sonographic abnormality was detected. Neither position of the ampulla nor presence, width or depth of defects correlated with vaginal parity. In contrast, age showed a weak association with rectal descent ($r = -0.212$, $P = 0.003$), the presence of fascial defects ($P = 0.002$) and their depth ($P = 0.02$). CONCLUSIONS: Rectovaginal septal defects are readily identified on translabial ultrasound as a herniation of rectal wall and contents into the vagina. Approximately one-third of clinical rectoceles do not show a sonographic defect, and the presence of a defect is associated with age, not parity. Copyright (c) 2005 ISUOG. Published by John Wiley & Sons, Ltd.

Abnormal appearance of the internal anal sphincter at ultrasound: a specific feature of progressive systemic sclerosis?
Daniel F, De Parades V, Cellier C
Gastroenterol Clin Biol 2005 May;29(5):597-9.
Endosonography is now an effective tool for the assessment of anorectal pathologies. We present a case of rectal prolapse in a patient with progressive systemic sclerosis, with low resting anal pressure, no rectoanal inhibitory reflex in manometry, and a thin, heterogeneous, difficult to delineate, internal sphincter on endoanal ultrasound. We also provide a review of the literature on anorectal involvement in progressive systemic sclerosis.

Colonoscopy vs CT colonography to screen for colorectal neoplasia in average-risk patients.
Hardacre JM, Ponsky JL, Baker ME
Surg Endosc 2005 Mar;19(3):448-56.

Clinical utility of diagnostic tests for constipation in adults: a systematic review.
Rao SS, Ozturk R, Laine L. Am J Gastroenterol 2005 Jul;100(7):1605-15.
BACKGROUND AND AIMS: Because symptoms alone do not identify pathophysiology or differentiate subgroups of constipation, diagnostic tests are generally recommended. However, their utility is not known. We performed a systematic review of diagnostic tests commonly used in constipation. METHODS: We searched the English literature using MEDLINE and PUBMED databases from 1966 to 2004 for studies in adults published as full manuscripts whose methodological quality was above a minimum score. RESULTS: No studies assessed the routine use of blood tests or abdominal x-ray. One retrospective endoscopic study showed that cancer and polyp detection rate was comparable to historical controls. Two studies of barium enema were unhelpful in diagnosis of constipation. Physiological studies showed differences in study population, methodology, and interpretation, and there was no gold standard. Ten colonic transit studies showed prevalence of 38-80% in support of slow transit constipation. Nine anorectal manometry studies showed prevalence of 20-75% for detecting dyssynergia. Nine studies of balloon expulsion showed impaired expulsion of 23-67%. Among 10 defecography studies, abnormalities were reported in 25-90% and dyssynergia in 13-37%. CONCLUSIONS: Evidence to support the use of blood tests, radiography, or endoscopy in the routine work up of patients with constipation without alarm features is lacking. Colonic transit, anorectal manometry, and balloon expulsion tests reveal physiologic abnormalities in many selected patients with constipation, but no single test adequately defines pathophysiology. Large, well-designed, prospective studies are required to examine the utility of these tests.

Measurement of gastrointestinal transit.

Lin HC, Prather C, Fisher RS, Meyer JH, Summers RW, Pimentel M, McCallum RW, Akkermans LM, Loening-Baucke V
Dig Dis Sci 2005 Jun;50(6):989-1004.
An abnormality in transit is commonly considered to account for unexplained gastrointestinal (GI) symptoms. Since the symptoms of delayed transit overlap with those of accelerated transit, direct measurement of GI transit is needed to establish an accurate diagnosis. Similarly, since symptoms originating from one part of the gut may overlap with symptoms from another, localizing transit abnormality to one organ vs. another using direct measurement is an important part of diagnostic evaluations. Consequently, noninvasive tests of GI transit should be done early in the evaluation to guide therapy. We now have tools to measure transit accurately; results of transit tests often depend on the conditions selected for the test, so test results will match clinical expectations most closely when test conditions are selected to reproduce the circumstances for symptom production. This review describes the most commonly used methods for the measurement of GI transit including the gastric emptying test for some dyspeptic symptoms, small bowel transit test for dyspeptic symptoms and diarrhea, colonic transit test for constipation, and factors that influence the result of these studies. As we make progress in our understanding of the pathophysiology of transit disorders, the clinical usefulness of these diagnostic tests will be further enhanced.

4 – PROLAPSES 2005 06

Uterus Preservation in Surgical Correction of Urogenital Prolapse.
Costantini E, Mearini L, Bini V, Zucchi A, Mearini E, Porena M
Eur Urol 2005 Jun 15;.
OBJECTIVE:: This study aimed to evaluate the efficacy of colposacropexy with uterine preservation as therapy for uterovaginal prolapse. Surgical techniques, efficacy and overall results are described. METHODS:: In this prospective, controlled study, 34 of the 72 consecutive patients with symptomatic uterovaginal prolapse were treated with colposacropexy with uterus conservation (hysterocolposacropexy, HSP) and the other 38 with hysterectomy followed by sacropexy (CSP). Anchorage was achieved with two rectangular meshes in CSP and with one posterior rectangular and one anterior Y-shaped mesh in HSP. Check-ups were scheduled at 3, 6 and 12 months and then yearly. Pre-operative patient characteristics, operative and post-operative events and follow-up results were recorded. Mean follow-up was 51 months (range 12-115). RESULTS:: No significant differences emerged in demographic and clinical characteristics between the HSP and CSP groups. Mean operating times, intra-operative blood loss and hospital stay were significantly less after HSP ($p<0.001$). At follow-up success rates were similar in the two groups in terms of uterine and upper vaginal support (100%). Recurrent low-grade cystoceles developed in 1/38 (2.6%) in the CSP group and in 5/34 (14.7%) in the HSP group (p=NS), recurrent low-grade rectocele developed in 6/38 (15.8%) and in 3/34 (8.8%) patients respectively (p=NS). No patient required surgery for recurrent vault or uterus prolapse. Urodynamic results showed that pressure/flow parameters improved significantly ($p<0.001$) in both groups. Thirty-one of the 34 patients (91%) in the HSP group and 33/38 (86.8%) in the CSP group were satisfied and would repeat surgery again. CONCLUSIONS:: Colposacropexy provides a secure anchorage, restoring an anatomical vaginal axis and a good vaginal length. HSP can be safely offered to women who request uterine preservation. Whether the uterus was preserved or not, patients had similar results in terms of prolapse resolution, urodynamic outcomes, improvements in voiding and sexual dysfunctions. HSP has shorter operating times and less blood loss.

[Factors for voiding dysfunction and cystocele]
Salinas Casado J, Adot Zurbano JM, Dambros M, Virseda Chamorro M, Ramirez Fernandez JC, Moreno Sierra J, Marcos Diaz J, Silmi Moyano A
Arch Esp Urol 2005 May;58(4):316-23.
OBJECTIVES: To evaluate the clinical and urodynamic features of a series of women with post void residual urine (disbalanced voiding) and various degrees of associated cystocele. METHODS: 119 female patients were studied by clinical evaluation, urodynamics, and imaging tests (VCUG). All patients underwent history and genitourological examination (evaluating cystoceles from grade o to 3), neuro-urological examination, and complete urodynamic study. Fifty patients (42%) underwent radiological studies of the upper urinary tract. Disbalanced voiding was defined as existence of post void residual greater than 20% of the voided volume. Urethral resistance was measured by URA. Structural obstruction was characterized by PURR (CHESS classification). Functional obstruction was studied by DURR and perineal EMG (associated with flowmetry). Detrusor contractile power was evaluated by W max, W 80-20, and duration of contraction. Urodynamic terminology and measurements complied with the International Continence Society (ICS) standards. Statistical significance was established at 0.05. Statistical analysis was done by Student's t for quantitative variables, and Pearson's chi-square for non parametric variables. RESULTS: 119 patients were enrolled. Mean age was 55.84 yr. (range 15-87). Regarding post void residual (114 valid uroflowmetry studies), 25 patients were classified as voiding disbalance (21.9%) and 89 as balanced (74.8%). Regarding

clinical data, there were only significant differences between groups in voiding difficulty. For uroflowmetry, only the percentile of the Maximal flow (Qmax) showed significant differences (35 vs. 22 for balanced/disbalanced voiding respectively, p = 0.02). Pressure/volume studies demonstrated bladder hyperactivity in 16 cases (64%) in the group of disbalanced voiding and 31 cases (34.8%) in the normal voiding group (p = 0.008), which presented associated with increased urethral resistance (URA)(p = 0.01) . In the pressure/flow study, there were significant differences in the URA (14.7 vs. 25.3, p = 0.001). There were statistically significant differences in the degree of constrictive (0.5 vs. 1.1, p = 0.009) and compressive (0.5 vs. 1.1; p = 0.04) obstruction (Chess classification). There were not significant differences in the analysis of isometric contractility (Wmax), but there were in the isotonic contractility (W80-20) and detrusor contraction duration. These latter differences presented significant association with the degree of cystocele. DURR and perineal EMG data did not show differences between groups. Radiological abnormalities of urethral morphology were statistically different between groups, presenting in 10% of the patients with normal voiding and 50% of the disbalanced voiding group, although there was not statistical association with obstruction (p = 0.64). The existence of cystocele did not show a statistical association with these variables either. CONCLUSIONS: Disbalanced voiding appeared with organic obstruction of the lower urinary tract (constrictive most significantly), as well as detrusor abnormal contractility, but whereas the first was not significantly associated with presence and grade of cystocele, the second showed such association.

The use of laparoscopic sacrocolpopexy in the management of pelvic organ prolapse.
Gadonneix P, Ercoli A, Scambia G, Villet R
Curr Opin Obstet Gynecol 2005 Aug;17(4):376-380.
PURPOSE OF REVIEW: This paper aims to review and comment on the developments in laparoscopic sacrocolpopexy published during the last year. RECENT FINDINGS: We classified the findings reported recently in the literature for laparoscopic sacrocolpopexy as technical or tactical findings. Technical findings concern the material of the mesh, the methods of mesh fixation, the use of adapted vaginal retractors and the interest in robotic assistance. Tactical findings consist of specific modifications to the standard surgical procedure aimed at reducing the side effects and complications and ameliorating the effectiveness of this intervention. These modifications include the possibility of avoiding the placement of a posterior mesh and the fixation of the posterior mesh to the puborectal muscles or the perineal body instead of the posterior vaginal wall. A specific section has been dedicated to reviewing and commenting on those interventions associated routinely with laparoscopic sacrocolpopexy. SUMMARY: Laparoscopic sacrocolpopexy is a safe surgical procedure in constant evolution which allows excellent results in the treatment of utero-vaginal prolapse. Large prospective, randomized studies comparing the different technical and tactical modifications recently introduced are needed in order to further enhance the effectiveness of this intervention.

A Randomized Controlled Trial Comparing Fascia Lata and Synthetic Mesh for Sacral Colpopexy.
Culligan PJ, Blackwell L, Goldsmith LJ, Graham CA, Rogers A, Heit MH
Obstet Gynecol 2005 Jul;106(1):29-37.
Objective: To compare the objective anatomic outcomes after sacral colpopexy performed with cadaveric fascia lata and polypropylene mesh. Methods: Patients undergoing a sacral colpopexy were randomized to receive either fascia lata or polypropylene mesh in a double-blinded fashion. Data were collected at 6 weeks, 3 months, 6 months, and 1 year postoperatively. The main outcome measures were pelvic organ prolapse quantification (POP-Q) system stage and individual POP-Q points over time. Objective anatomic failure was defined as POP-Q stage 2 or more at any point during the follow-up period. Proportions of patients with objective anatomic failure at 1 year in each group were compared using the chi(2) test. Mean POP-Q points and stage at 1 year were compared by using the independent samples t test. Results: One hundred patients were randomized to receive either fascia (n = 46) or mesh (n = 54). Of the 89 patients returning for 1-year follow-up, 91% (41/45) of the mesh group and 68% (30/44) of the fascia group were classified as objectively cured (P = .007). We found significant differences between the mesh and fascia groups with respect to the 1-year postoperative comparisons of points Aa, C, and POP-Q stage. There were no differences between the 2 groups with respect to points TVL (total vaginal length), GH (genital hiatus), PB (perineal body), Ap or Bp (2 points along the posterior vaginal wall). Conclusions: Polypropylene mesh was superior to fascia lata in terms of POP-Q points, POP-Q stage, and objective anatomic failure rates. Level of Evidence: I.

Colpocleisis: a review.
Fitzgerald MP, Richter HE, Siddique S, Thompson P, Zyczynski H
Int Urogynecol J Pelvic Floor Dysfunct 2005 Jun 28;.
Objective: To summarize published data about colpocleisis and to highlight areas about which data are lacking. Data sources: We conducted a literature search on Medline using Ovid and PubMed, from 1966 to January 2004, using search terms "colpocleisis", "colpectomy", "vaginectomy", "pelvic organ prolapse (POP) and surgery", and "vaginal vault prolapse and surgery" and included articles with English-language abstracts.

We examined reference lists of published articles to identify other articles not found on the electronic search. Methods of study selection: We examined all studies identified in our search that provided any outcome data on colpocleisis. Because of the heterogeneity of outcome measures and follow-up intervals in case series, we did not apply meta-analytic techniques to the data. Results: Colpocleisis for POP is apparently successful in nearly 100% of patients in recent series. The rate of reoperation for stress incontinence or POP after colpocleisis is unknown. Concomitant elective hysterectomy is associated with increased blood loss and length of hospital stay, without known improvement in outcomes. Few studies systematically assess pelvic symptoms. The role of preoperative urodynamic testing to direct optimal management of urinary incontinence and retention remains to be established in this setting. Conclusions: Colpocleisis is an effective procedure for treatment of advanced POP in patients who no longer desire preservation of coital function. Complications are relatively common in this group of elderly patients. Prospective trials are needed to understand the impact of colpocleisis on functional outcomes and patient satisfaction.

Stapled hemorrhoidectomy.
Nunoo-Mensah JW, Kaiser AM
Am J Surg 2005 Jul;190(1):127-30.
Stapled hemorrhoidectomy has rapidly evolved and become the procedure of choice for primarily internal hemorrhoids. Even though the technique is relatively straightforward, only strict adherence to its principles will avoid serious complications and preserve the previously described benefits of this method. Recurring questions during teaching courses as well as several pitfalls that might result in suboptimal outcomes have prompted us to highlight some important details and modifications of the surgical technique.

Stapled Hemorrhoidopexy Versus Milligan-Morgan Hemorrhoidectomy: A Prospective, Randomized, Multicenter Trial With 2-Year Postoperative Follow Up.
Gravie JF, Lehur PA, Huten N, Papillon M, Fantoli M, Descottes B, Pessaux P, Arnaud JP
Ann Surg 2005 Jul;242(1):29-35.
PURPOSE:: The purpose of this study was to compare the outcome of stapled hemorrhoidopexy (SH group) performed using a circular stapler with that of the Milligan-Morgan technique (MM group). The goals of the study were to evaluate the efficacy and reproducibility of stapled hemorrhoidopexy and define its place among conventional techniques. METHODS:: A series of 134 patients were included at 7 hospital centers. They were randomized according to a single-masked design and stratified by center (with balancing every 4 patients). Patients were clinically evaluated preoperatively and at 6 weeks, 1 year, and a minimum of 2 years after treatment. Patients completed a questionnaire before and 1 year after surgery to evaluate symptoms, function, and overall satisfaction. RESULTS:: The mean follow-up period was 2.21 years +/- 0.26 (1.89-3.07). Nine patients (7%) could not be monitored at 1 or 2 years, but 4 of these 9 nevertheless filled in the 1-year questionnaire. The patients in the SH group experienced less postoperative pain/discomfort as scored by pain during bowel movement ($P < 0.001$), total analgesic requirement over the first 3 days (according to the World Health Organization [WHO] class II analgesics [$P = 0.002$]; class III [$P = 0.066$]), and per-patient consumption frequency of class III analgesics ($P = 0.089$). A clear difference in morphine requirement became evident after 24 hours ($P = 0.010$). Hospital stay was significantly shorter in the SH group (SH 2.2 +/- 1.2 [0; 5.0] versus MM 3.1 +/- 1.7 [1; 8.0] $P < 0.001$). At 1 year, no differences in the resolution of symptoms were observed between the 2 groups, and over 2 years, the overall incidence of complications was the same, specifically fecaloma ($P = 0.003$) in the MM group and external hemorrhoidal thrombosis ($P = 0.006$) in the SH group. Impaired sphincter function was observed at 1 year with no significant difference between the groups for urgency (12%), continence problems (10%), or tenesmus (3%). No patient needed a second procedure for recurrence within 2 years, although partial residual prolapse was detected in 4 SH patients (7.5%) versus 1 MM patient (1.8%) ($P = 0.194$). CONCLUSION:: Stapled hemorrhoidopexy causes significantly less postoperative pain. The technique is reproducible and can achieve comparable outcomes as those of the MM technique as long as the well-described steps of the technique are followed. Like with conventional surgery, anorectal dysfunction can occur after stapled hemorrhoidopexy in some patients. Its effectiveness in relieving symptoms is equivalent to conventional surgery, and the number of hemorrhoidal prolapse recurrences at 2 years is not significantly different. Hemorroidopexy is applicable for treating reducible hemorrhoidal prolapse.

The safety and efficacy of stapled hemorrhoidectomy in the treatment of hemorrhoids: a systematic review and meta-analysis of ten randomized control trials.
Lan P, Wu X, Zhou X, Wang J, Zhang L
Int J Colorectal Dis 2005 Jun 22;.
AIMS: The objective of this study was to compare the safety and efficacy outcomes of stapled hemorrhoidectomy (PPH) with Milligan-Morgan hemorrhoidectomy (MMH) in the treatment of severe hemorrhoids. METHODS: A meta-analysis pooled the effects of the safety and efficacy outcomes on PPH,

and MMH in ten randomized control trials was presented using a fixed effects model or a random effects model (via RevMan Version 4.2). RESULTS: There was reasonably clear evidence in favor of PPH for operating time, length of hospital stay, pain, anal discharge, and patient satisfaction. However, skin tags and prolapse occurred at higher rates in the PPH group. PPH was not more superior than MMH as to postoperative bleeding, urinary retention, difficulty in defecating, anal fissure and stenosis, sphincter damage, resumption of normal activities, incontinence, pruritus, anal resting and squeeze pressures, and analgesia. CONCLUSIONS: PPH may be at least as safe as MMH. However, the efficacy of PPH compared with MMH could not be determined absolutely. More rigorous studies with longer follow-up periods and larger sample sizes need to be conducted.

Emergency stapled haemorrhoidectomy for haemorrhoidal crisis.
Kang JC, Chung MH, Chao PC, Lee CC, Hsiao CW, Jao SW
Br J Surg 2005 Jul 4;.

Laparoscopic Resection Rectopexy for Rectal Prolapse.
Kessler H, Hohenberger W
Dis Colon Rectum 2005 Jun 27;.
INTRODUCTION: The laparoscopic approach in suture rectopexy with sigmoid resection is appealing as surgery is mainly confined to the pelvis. METHODS: The procedure is performed in modified lithotomy position using five trocars. In the case reported, the inferior mesenteric artery is divided distally to the left colic artery branch. The sigmoid colon is mobilized medially and may be mobilized laterally up to the descending colon, depending on the extent of resection. The splenic flexure remains in place. The rectum is mobilized from the presacral fascia down to the pelvic floor, sparing the hypogastric nerves. The rectum is transected in its upper third and the colonic stump pulled outside after enlarging the left lower abdominal incision to a length of 5 cm. The colorectal anastomosis is established intracorporeally in a double-stapling technique. Three 2-0 braided nonabsorbable sutures are placed to attach the right lateral stalks of the rectum to the presacral fascia. Proctoscopic examination has to ensure that there is no luminal compromise or air leakage. RESULTS: The videotape reports about a 37-year-old male patient with a rectal prolapse of 8 cm in length. First symptoms had occurred in childhood. He reported about temporary constipation and repeated rectal bleeding. During surgery, an elongated sigmoid was found. Laparoscopic sigmoid resection and suture rectopexy were carried out. There were no intraoperative or postoperative complications. The patient was discharged from the hospital on the sixth postoperative day. CONCLUSION: Laparoscopic resection rectopexy is safely feasible as a minimally-invasive treatment option for rectal prolapse.

The Authors Reply.
Boccasanta P, Venturi M, Stuto A, Bottini C, Caviglia A, Mascagni D, Sofo L, Carriero A, Mauri R, Landolfi V
Dis Colon Rectum 2005 Jun 24;.

Management of Rectal Prolapse in Children.
Antao B, Bradley V, Roberts JP, Shawis R
Dis Colon Rectum 2005 Jun 16;.
PURPOSE: Rectal prolapse in children is not uncommon and usually is a self-limiting condition in infancy. Most cases respond to conservative management; however, surgery is occasionally required in cases that are intractable to conservative treatment. This study was designed to analyze the outcomes of rectal prolapse in children and to propose a pathway for the management of these cases in children. METHODS: A retrospective analysis of all cases of rectal prolapse referred to our surgical unit during a period of five years was performed. End point was recurrence of prolapse requiring manual reduction under sedation or an anesthetic. Results are presented as median (range) and statistical analysis was performed using chi-squared test; $P < 0.05$ was considered significant. RESULTS: A total of 49 children (25 males) presented with symptoms of rectal prolapse at a median age of 2.6 years (range, 4 months -10.6 years). All children received an initial period of conservative treatment with watchful expectancy and/or laxatives. Twenty-five patients were managed conservatively without any additional procedures (Group A), and 24 patients had one or more interventions, such as injection sclerotherapy, Thiersch procedure, anal stretch, banding of prolapse, and rectopexy (Group B). Management of rectal prolapse was successful with no recurrences in 24 patients (96 percent) in Group A vs. 15 patients (63 percent) in Group B at a median follow-up period of 14 (range, 2-96) months. An underlying condition was found in 84 percent of patients in Group A vs. 54 percent in Group B ($P = 0.024$). The age at presentation was younger than four years in 88 percent of patients in Group A vs. 58 percent in Group B ($P = 0.019$). CONCLUSIONS: Rectal prolapse in children does respond to conservative management. A decision to operate is based on age of patient, duration of conservative management, and frequency of recurrent prolapse (>2 episodes requiring manual reduction) along with symptoms of pain, rectal bleeding, and perianal excoriation because of recurrent prolapse. Those cases

presenting younger than four years of age and with an associated condition have a better prognosis. The authors propose an algorithm for the management of rectal prolapse in children.

A Comparison of Open vs. Laparoscopic Abdominal Rectopexy for Full-Thickness Rectal Prolapse: A Meta-Analysis.

Purkayastha S, Tekkis P, Athanasiou T, Aziz O, Paraskevas P, Ziprin P, Darzi A
Dis Colon Rectum 2005 Jun 20;.

PURPOSE: Using meta-analytical techniques, this study was designed to compare open and laparoscopic abdominal procedures used to treat full-thickness rectal prolapse in adults. METHODS: Comparative studies published between 1995 and 2003, cited in the literature of open abdominal rectopexy vs. laparoscopic abdominal rectopexy, were used. The primary end points were recurrence and morbidity, and the secondary end points assessed were operative time and length of hospital stay. A random effect model was used to aggregate the studies reporting these outcomes, and heterogeneity was assessed. RESULTS: Six studies, consisting of a total of 195 patients (98 open and 97 laparoscopic) were included. Analysis of the data suggested that there is no significant difference in recurrence and morbidity between laparoscopic abdominal rectopexy and open abdominal rectopexy. Length of stay was significantly reduced in the laparoscopic group by 3.5 days (95 percent confidence interval, 3.1-4; $P < 0.01$), whereas the operative time was significantly longer in this group, by approximately 60 minutes (60.38 minutes; 95 percent confidence interval, 49-71.8). CONCLUSIONS: Laparoscopic abdominal rectopexy is a safe and feasible procedure, which may compare equally with the open technique with regards to recurrence and morbidity and favorably with length of stay. However large-scale randomized trials, with comparative, sound methodology are still needed to ascertain detailed outcome measures accurately.

Long-Term Results of Delorme's Procedure and Orr-Loygue Rectopexy to Treat Complete Rectal Prolapse.

Marchal F, Bresler L, Ayav A, Zarnegar R, Brunaud L, Duchamp C, Boissel P
Dis Colon Rectum 2005 Jun 16;.

PURPOSE: The aim of this study was to assess long-term outcome of Orr-Loygue rectopexy and Delorme's procedures in total rectal prolapse management. METHODS: Data were collected retrospectively from 1978 to 2001. Statistical analysis was performed by chi-squared test and Student's t -test. RESULTS: One hundred nine patients underwent either a Orr-Loygue rectopexy (49 patients) or a Delorme's procedure (60 patients). Mean follow-up was 88 (range, 1-300) months. In the rectopexy group, the overall complication rate and the recurrence rate were 33 percent and 4 percent, respectively. In patients with preoperative constipation, this symptom was improved or completely resolved in 33 percent and worsened in 58 percent postoperatively. Seventy-three percent of patients with preoperative incontinence were continent or had continence improvement postoperatively. In Delorme's group, overall complication and recurrence rates were 15 percent and 23 percent, respectively. Mortality was 7 percent. In patients with preoperative constipation, this symtom was improved or completely resolved in 54 percent and worsened in 12.5 percent of patients postoperatively. Forty-two percent of patients with preoperative incontinence were continent or had continence improvement postoperatively. CONCLUSIONS: In this study, Orr-Loygue rectopexy had a lower long-term recurrence rate. However, this surgical procedure is associated with a higher complication rate. We believe that Delorme's procedure is still a valuable option in selected patients with postoperative minimal morbidity but higher recurrence rate.

Mucosal Flap Excision for Treatment of Remnant Prolapsed Hemorrhoids or Skin Tags After Stapled Hemorrhoidopexy.

Koh PK, Seow-Choen F
Dis Colon Rectum 2005 Jun 16;.

Stapled hemorrhoidopexy may leave residual skin tags or external components following its use in large prolapsed piles. Excision of redundant mucosa above the dentate line and reconstitution to the staple line reduces these prolapsed elements. We describe a novel technique that removes residual skin tags and piles while remaining true to the spirit of stapled hemorrhoidopexy.

5 – RETENTIONS 2005 06

Do Prostatic Infarction, Prostatic Inflammation and Prostate Morphology Play a Role in Acute Urinary Retention?

Tuncel A, Uzun B, Eruyar T, Karabulut E, Seckin S, Atan A
Eur Urol 2005 Jun 15;.

OBJECTIVE:: To investigate whether there is a role of prostatic infarction, prostatic inflammation and prostate morphology in acute urinary retention (AUR) etiology. METHODS:: Ninety-eight consecutive male

patients who were admitted to our clinic with either AUR or lower urinary tract symptoms (LUTS) were involved in the study. Patient age ranged from 43 to 88 years (median age 70). Group 1 consisted of 53 (54%) patients with AUR, and Group 2 consisted of 45 (46%) patients with LUTS. In Group 1 and Group 2, 58.4% (n:31) and 62.2% (n:28) of the patients underwent transurethral prostate resection, 41.6% (n:22) and 37.8% (n:17) of the patients underwent suprapubic transvesical prostatectomy, respectively. Each patient was asked about the factors: smoking habits, taking previous general anesthesia and preexisting cardiovascular disease such as hypertention and atherosclerotic coronary vascular disease which may lead to AUR via prostatic infarct. Prostatic infarction, prostatic inflammation and prostatic morphology were examined in the patients' specimen. RESULTS:: Mean age, median serum prostate-specific antigen (PSA) level, and prostatic inflammation ratio were significantly higher in Group 1. There were not significant differences between the groups regarding prostate volume, prostatic infarction ratio and a type of prostatic morphology. In the present study, except for taking previous general anesthesia and preexisting cardiovascular disease, only prostatic inflammation was found important contributory factor on AUR. AUR risk was 3.03 times higher in the patients with prostatic inflammation (95%CI 1.28-7.15) (p=0.01). CONCLUSIONS:: No significant effect of prostatic infarction was found on occurence of AUR which was more frequent in elderly patients. Prostatic inflammation may have an important risk factor in AUR etiology. Additionally, serum PSA levels were higher in AUR group. No association was found between a type of prostatic morphology and AUR.

Stapled transanal rectal resection for obstructed defaecation and evidence-based practice.
Jayne DG, Finan PJ
Br J Surg 2005 Jul;92(7):793-794. No Abstract.
ulness of these diagnostic tests will be further enhanced.

The Dark Side of Double-Stapled Transanal Rectal Resection.
Binda GA, Pescatori M, Romano G
Dis Colon Rectum 2005 Jun 29;.

Colonic response to food in constipation.
Bouchoucha M, Devroede G, Faye A, Le Toumelin P, Arhan P, Arsac M
Int J Colorectal Dis 2005 Jun 21;.
OBJECTIVES: Colonic response to food is possibly abnormal in constipation. METHODS: The colonic response to food was evaluated in 323 patients and 60 healthy subjects by following the movements of radiopaque markers after ingestion of a standard 1,000-cal test meal. Constipated patients were divided into four groups: one with a normal, and three with a delayed colorectal transit time. When the delay was found mainly in the ascending colon, the group was labeled as suffering from "colonic inertia". In "hindgut dysfunction", the delay was predominantly found in the descending colon, whereas the term "outlet obstruction" was reserved for constipated patients whose major site of delay was the rectosigmoid area. Colonic response to food was quantified by evaluating the variation of markers in a given abdominal region and the evolution of the geometric center on the entire plain film of the abdomen. RESULTS: Emptying of the caecum-ascending colon and filling of the rectosigmoid area characterize the colonic response to food in healthy subjects. Constipated patients also filled the rectosigmoid, but different patterns were found in the colon. In constipated patients with transit in the normal range, there was a frequent (41%) absence of colonic response to food as compared to controls (13%) and constipated patients with delayed transit ($p<0.0001$). The response to food of patients with colonic inertia was similar to that of healthy subjects in terms of distal progression, but less marked. The hindgut dysfunction group emptied the entire left colon but failed to empty the caecum and ascending colon. In the outlet obstruction group, there was no distal progress of the geometric center after meal. CONCLUSIONS: Abnormal colonic response to food is frequently found in constipated patients, with different patterns according to the type of constipation.

Impaired Proximal Colonic Motor Response to Rectal Mechanical and Chemical Stimulation in Obstructed Defecation.
Dinning PG, Bampton PA, Kennedy ML, Lubowski DZ, King D, Cook IJ
Dis Colon Rectum 2005 Jun 16;.
PURPOSE: Both motor and sensory dysfunction have been implicated in the pathogenesis of obstructed defecation. We have found that despite preservation of a defecatory urge, patients with obstructed defecation have lost the normal predefecatory augmentation in frequency and amplitude of colonic propagating pressure waves. This observation might be explainable by either altered rectal sensory thresholds or by dysfunction in the colonic motor apparatus. By measuring rectal sensory thresholds and proximal colonic motor responses to rectal mechanical and chemical stimuli, we tested the hypotheses that central perception of rectal stimuli is enhanced and that the proximal colonic motor response to rectal

stimulation is attenuated. METHODS: In seven patients with obstructed defecation and ten healthy volunteers we measured proximal colonic motor responses and sensory thresholds in response to both rectal balloon distention and rectal instillation of chenodeoxycholic acid. RESULTS: In controls, but not in patients, rectal mechanical distention significantly reduced and chemical stimulation significantly increased the frequency of proximal colonic propagating sequences (P = 0.01). There was no significant difference in rectal sensory thresholds between patients and controls. Prior instillation of chenodeoxycholic acid significantly reduced (P < 0.03) maximum tolerated balloon volume and defecatory urge volume to comparable degree in both patients and controls. CONCLUSIONS: In obstructed defecation, 1) the normal rectocolonic pathways mediating stimulation-induced proximal colonic propagating pressure waves are nonfunctioning, and. 2) central perception of these rectal stimuli is normal.

6 – INCONTINENCES

Long-Term Consequences of First Vaginal Delivery-Induced Anal Sphincter Defect.

Damon H, Bretones S, Henry L, Mellier G, Mion F

Dis Colon Rectum 2005 Jun 16;.

PURPOSE: This study was designed to investigate the long-term consequences of anal sphincter defects detected after a first vaginal delivery. METHODS: A cohort of 197 primiparous females was evaluated for anal continence and anal sphincter defects in 1997. In June 2003 (6 years later), a postal questionnaire was sent to 74 females of this cohort, and answers from 54 (73 percent) were analyzed. RESULTS: In 1997, a transanal ultrasound found 66 anal sphincter defects (33.5 percent). Twenty-one females (10.6 percent) had persistent signs of anal incontinence 12 weeks after the index delivery. There was a significant correlation between the presence of anal sphincter defect and anal incontinence. Six years later, 11 of 54 females reported signs of anal incontinence: 50 percent of females with anal sphincter defect and only 8.1 percent of females without (P = 0.002). Large defects were more frequently associated with anal incontinence. Anal incontinence after the index vaginal delivery also was significantly associated with anal incontinence six years later. Multivariate analysis showed anal sphincter defect to be the only variable predictive of anal incontinence (odds ratio, 10.5; 95 percent confidence interval, 2.1-52.4). CONCLUSIONS: Anal sphincter defects detected after the first vaginal delivery appear as the main risk factor for anal incontinence six years later.

An Open, Multicentre Study of NASHA/Dx Gel (Zuidextrade mark) for the Treatment of Stress Urinary Incontinence.

Chapple CR, Haab F, Cervigni M, Dannecker C, Fianu-Jonasson A, Sultan AH

Eur Urol 2005 Jun 17;.

OBJECTIVE:: The Zuidextrade mark system facilitates non-endoscopic urethral injection for stress urinary incontinence (SUI). It comprises four pre-filled syringes of non-animal stabilised hyaluronic acid/dextranomer (NASHA/Dx) gel and an Implacertrade mark device. This open, 12-month study was performed to evaluate the safety and efficacy of this system in women with SUI. METHODS:: Patients were aged >/=18 years with a history of SUI for >/=12 months (hypermobility and/or intrinsic sphincter deficiency), had failed prior non-invasive therapy and were invasive-therapy naive. Up to two treatments with NASHA/Dx gel were permissible (re-treatment was offered at week 8). Positive response to treatment was defined as a reduction in provocation test leakage of >/=50% compared with baseline. Efficacy was also measured by 24-hour pad weight test leakage, and number of incontinence episodes/24hours. RESULTS:: A total of 142 patients were enrolled, with a mean age of 55.7 years. The response rate was 78% at week 12, and 77% at month 12. Significant reductions in median provocation test leakage, 24-hour pad-weight test leakage and number of incontinence episodes/24hours were observed at all time-points. At month 12, the median decreases from baseline in these three variables were 93%, 89% and 67%, respectively. Treatment-related adverse events were of a nature expected with urethral injection - most were transient, and of mild or moderate intensity. CONCLUSIONS:: Treatment with NASHA/Dx gel produced large, statistically significant reductions in urinary leakage sustained over 12 months and was well tolerated. These findings suggest that NASHA/Dx gel could be considered as an early intervention in treatment-naive cases of SUI.

Urethral sensitivity in incontinent women.

Kinn AC, Nilsson BY

Eur Urol 2005 Jul;48(1):116-20. Epub 2005 Mar 8.

OBJECTIVES:: The aim of this study was to ascertain whether frequent voiding and urge incontinence are associated with supersensitivity to electrical stimulation in the posterior urethra. METHODS:: Current perception thresholds (CPT) were tested at four stimulus frequencies (1, 3, 20, and 100Hz; duration 0.5ms) using a square-wave constant current electrical stimulator connected to ring electrodes on a urethral catheter. The strength of the current at the first tingling sensation was regarded as the CPT. CPT analysis and cystometry were performed on 61 women (ages 28-89 years). RESULTS:: CPTs were significantly higher at lower than at elevated stimulus frequencies, and they were also generally higher in old than in

younger patients. Seven women repeated the CPT test after two months, and the thresholds were unchanged. There were no significant differences in sensitivity between patient groups with stress incontinence, urge, or mixed symptoms. Moreover, CPT was not significantly related to bladder volume at first sensation of filling. CONCLUSION:: Measuring CPT is an easy and reproducible method of testing urethral sensibility, but our results do not support the suspicion that urethral hypersensitivity is involved in increased voiding frequency and urge incontinence.

Prevalence of the Overactive Bladder Syndrome by Applying the International Continence Society Definition.
Temml C, Heidler S, Ponholzer A, Madersbacher S
Eur Urol 2005 Jun 15;.
PURPOSE:: To determine the prevalence of the overactive bladder (OAB) syndrome in an urban population by using the International Continence Society (ICS) definition and to determine its impact on quality of life and sexual function. METHODS:: Women and men participating in a health screening project in the area of Vienna completed the Bristol Lower Urinary Tract Symptoms (LUTS) questionnaire. To assess the prevalence of OAB the 2002 ICS definition was applied. In addition, all participants underwent a detailed health examination, including physical assessment, evaluation of life style factors, laboratory study and urinalysis. RESULTS:: A total of 1199 men and 1219 women aged 20-91 years were analysed. The prevalence of OAB in men (48.5+/-13.1 years) was 10.2% (OAB(dry): 8.4%; OAB(wet): 1.8%) and 16.8% in women (49.5+/-13.5 years; OAB(dry):10.3%; OAB(wet): 6.5%). In women, the prevalence of OAB(dry) remained fairly stable over 6 life decades, while OAB(wet) increased substantially after the age of 40 years. In men OAB(wet) and OAB(dry) increased after the third life decade. In men with OAB, 48% did not report a negative impact on quality of life, 36% had minimal, 9.8% moderate and 2.5% severe impairment; the respective percentages for women were 53%, 33%, 7.3% and 6.3%. OAB(wet) had a more profound impact on quality of life. A negative impact of OAB on sexuality was reported by 24% of men and 31% of women. CONCLUSION:: The high prevalence of OAB in this population, its negative impact of quality of life and sexuality underline the importance of this syndrome.

Weight loss: a novel and effective treatment for urinary incontinence.
Subak LL, Whitcomb E, Shen H, Saxton J, Vittinghoff E, Brown JS
J Urol 2005 Jul;174(1):190-5.
PURPOSE: We evaluated the effect of weight loss on urinary incontinence (UI) in overweight and obese women. MATERIALS AND METHODS: A randomized, controlled clinical trial was conducted among overweight and obese women experiencing at least 4 UI episodes per week. Women were randomly assigned to a 3-month liquid diet weight reduction program (24 in the immediate intervention group) or a wait-list delayed intervention group (24 in the wait-list control group). Participants in the wait-list control group began the weight reduction program in month 3 of the study. All women were followed for 6 months after completing the weight reduction program. Wilcoxon tests were used to compare intergroup differences in change in weekly UI episodes and quality of life scores. RESULTS: A total of 48 women were randomized and 40 were assessed 3 months after randomization. Median (with 25% to 75% interquartile range [IQR]) baseline age was 52 years (IQR 47 to 59), weight was 97 kg (IQR 87 to 106) and UI episodes were 21 weekly (IQR 11 to 33). Women in the immediate intervention group had a 16 kg (IQR 9 to 20) weight reduction compared with 0 kg (IQR -2 to 2) in the wait-list control group ($p < 0.0001$). The immediate intervention group experienced a 60% reduction (IQR 30% to 89%) in weekly UI episodes compared with 15% (IQR -9% to 25%) in the wait-list control group ($p < 0.0005$) and had greater improvement in quality of life scores. Stress ($p = 0.003$) and urge ($p = 0.03$) incontinent episodes decreased in the immediate intervention vs wait-list control group. Following the weight reduction program the wait-list control group experienced a similar median reduction in weekly UI episodes (71%). Among all 40 women mean weekly UI episodes decreased 54% (95% CI 40% to 69%) after weight reduction and the improvement was maintained for 6 months. CONCLUSIONS: Weight reduction is an effective treatment for overweight and obese women with UI. Weight loss of 5% to 10% has an efficacy similar to that of other nonsurgical treatments and should be considered a first line therapy for incontinence.

Long-Term Results With Tension-Free Vaginal Tape on Mixed and Stress Urinary Incontinence.
Holmgren C, Nilsson S, Lanner L, Hellberg D
Obstet Gynecol 2005 Jul;106(1):38-43.
Objective: To compare outcome of the tension-free vaginal tape (TVT) procedure in women with urinary mixed and stress incontinence. Methods: A mailed questionnaire was answered by 760 of 970 women who had undergone TVT surgery 2-8 years ago (78% response rate). Seventeen women had unclassified incontinence, and 51 women who developed de novo urgency were excluded, giving 580 (83.8%) with stress incontinence and 112 (16.2%) women with mixed incontinence eligible for analysis. Demographic,

reproductive factors, and medical history were obtained. The questionnaire included detailed questions about urinary symptoms. Analysis of outcome was done for cohorts by number of years since the operation. Results: The women with stress incontinence had a persistent cure rate of 85% from 2 to 8 years after the TVT procedure. The women with mixed incontinence had a persistent cure rate of 60% up to 4 years postoperatively, but the cure rate then steadily declined to 30% from 4 to 8 years after surgery. The increased rate of incontinence was due to urgency symptoms. Conclusion: The results of this study indicate that initial good cure rates of TVT for mixed incontinence do not persist after 4 years. Level of Evidence: III.

Botulinum-A Toxin for Treatment of Overactive Bladder Without Detrusor Overactivity: Urodynamic Outcome and Patient Satisfaction.

Schulte-Baukloh H, Weiss C, Stolze T, Sturzebecher B, Knispel HH

Urology 2005 Jun 29;.

OBJECTIVES: To investigate the effect of botulinum toxin type A bladder injections in the treatment of overactive bladder syndrome in the absence of detrusor overactivity. METHODS: The subjects were 7 women (average age 61.1 years, range 51 to 79) who presented with overactive bladder symptoms. Their disorder had been refractory to several classic treatment options. Urodynamic examination excluded detrusor overactivity. A total of 300 U BTX-A (Botox) was injected, of which 50 to 75 U was injected as quadrant injections into the external sphincter muscle to avoid the postoperative need for catheterization in the case of high postvoid residual urine volume. For follow-up, complete urodynamic studies were performed, and a bladder diary and validated incontinence questionnaires were given to patients at all visits at 1, 3, and 6 months. RESULTS: The bladder diaries indicated a clear reduction in daytime frequency and nocturia and a reduction in pad use. The maximal voiding volume increased significantly. The urodynamic examinations showed a significant increase in volume when the first and the strong desire to void were expressed. The maximal bladder capacity increased by 20% in 3 months. In the questionnaires, 5 of the 7 patients reported better urine control after therapy, and 6 would have chosen this therapy again for their condition. The overall satisfaction score (on a scale of 0 to 10) averaged 6.8. No side effects, such as urine retention, occurred. CONCLUSIONS: Botulinum-A toxin injection has positive effects in treating overactive bladder symptoms without detrusor overactivity. The effects were seen not only in urodynamic measures but also in patient satisfaction.

A new technique combining both polypropylene and vaginal wall sling procedures: can it minimize the risk of urethral and vaginal erosion occurring with synthetic materials?

Emir L, Erol D, Ak H, Sunay M

World J Urol 2005 Jul 5;.

We describe a new technique combining in situ vaginal wall and polypropylene mesh slings that may decrease potential erosive complications caused by synthetic materials. A folded mucosal patch harboring the polypropylene mesh was placed between mid-urethra and bladder neck. Using this technique, 12 consecutive women (age range 44-66 years) were operated. Preoperative evaluation included a detailed history, pelvic examination, stress test, cystourethroscopy, basic urodynamic evaluation (cystometry, Valsalva leak point pressure measurement), and urine culture. Based on these evaluations, three, seven, and two patients had type I, II, and III stress urinary incontinence, respectively. A paraurethral cyst excision was carried out in one patient and anterior colporrhaphy in four patients during the same operation. No ischemia or sloughing at the operation site occurred in any case. Pelvic examination was repeated in all patients after 3 and 6 months of follow-up and symptoms were determined after 12 months of follow-up in eight patients by telephone interview. Average follow-up was 10 months (range: 6-14 months). None of the patients were incontinent, or complained of sexual dysfunction or erosive complications after 1 year. Since there are two distinct barriers between the sling and both urethra and vagina, our technique covers all advantages of a sling procedure with synthetic materials and avoids the risk of urethral and vaginal erosion. The other advantage of this technique is the concomitant utilization of the vaginal wall as sling material.

New tined lead electrode in sacral neuromodulation: experience from a multicentre European study.

Spinelli M, Weil E, Ostardo E, Del Popolo G, Ruiz-Cerda JL, Kiss G, Heesakkers J

World J Urol 2005 Jun 30;.

The use of a new tined lead electrode for sacral neuromodulation (SNS) was evaluated in a European study including 127 patients with chronic voiding dysfunction. The tined lead can be implanted during the first stage of the SNS procedure, which makes a longer test period possible before implanting the pulse generator in a second stage. Implantation of the tined lead was performed under local anaesthesia in 89% of patients. Screening lasted on average 30 days. Screening with the tined lead was considered successful by the physicians in 77% of patients (n=72). In 74% of first stage patients (n=70), at least 50% improvement in the main symptoms versus baseline was obtained. This was sustained for up to 6 weeks. All of these patients received the pulse generator in a second stage. The outcome of this study supports the use of the tined lead

electrode as a screening tool in SNS therapy.

The overactive bladder and quality of life.
Epstein LB, Goldberg RP
Int J Fertil Womens Med 2005 Jan-Feb;50(1):30-6.
Overactive bladder (OAB) affects 16.6% of the U.S. population, or 33 million adults, in some form. Despite the prevalence of OAB, almost 60% of those affected seek no medical assistance for the condition either because of embarrassment or the misconception that it represents an inevitable function of aging. A recent surge of interest on the subject has uncovered the dramatic effect that OAB can have on social interactions, sleep, depression, sexual health, and overall health-related quality of life (HRQoL). The introduction of validated, condition-specific QOL questionnaires has enhanced our ability to measure these subjective dimensions of OAB, and to assess their response to therapeutic interventions.

Stress incontinence: alternatives to surgery.
Kielb SJ
Int J Fertil Womens Med 2005 Jan-Feb;50(1):24-9.
Although surgery is commonly performed to alleviate or cure stress incontinence, there are non-surgical options that might well be explored and tried before a woman undergoes surgery, for which many are poor candidates. The least drastic treatments are behavioral therapies, chiefly pelvic floor muscle training (Kegel exercises), alone or with biofeedback. This method is effective but has the drawback of poor patient compliance. Another therapy, almost noninvasive, is electrical stimulation via needle or surface electrodes of the pudendal nerve and the pelvic plexus in order to treat detrusor instability. Some studies show good results for many patients; and there is no need for long-term compliance. Medical management has included hormone replacement therapy and alpha-adrenergic agonists, but questionable results and intolerable risks have shifted this mode to serotonin-norepinephrine reuptake inhibitors, which have CNS action. Finally, there are urethral occlusive devices, which have poor acceptance owing to side effects and difficulty of use, and vaginal pessaries, theoretically attractive but inexplicably poor performers in the marketplace.

Long-term chronic complications from Stamey endoscopic bladder neck suspension: a case series.
Smith A, Rovner E
Int Urogynecol J Pelvic Floor Dysfunct 2005 Jun 18;.
Purpose/objective Long-term complications from anti-incontinence surgical procedures are rarely reported. We report on delayed presentation of complications relating to the synthetic bolster placed for the Stamey bladder neck suspension. Materials and methods: Patients undergoing re-operative surgery following prior Stamey endoscopic bladder neck suspension were selected from a surgical database. Four women with lower urinary tract and/or vaginal symptoms following prior Stamey endoscopic bladder neck suspension were identified. All patients had undergone removal of the bolster material by a single surgeon (ESR) at re-operation. Preoperative, operative, and postoperative inpatient and outpatient records were reviewed. Results: Patients presented with a variety of symptoms including urinary incontinence, recurrent cystitis, vaginitis, and urinary frequency at 9, 11, 11, and 12 years after Stamey bladder neck suspension. In addition, two patients presented with recurrent, intermittent bloody vaginal discharge and two patients complained of recurrent urinary tract infections and irritative voiding symptoms. All patients underwent transvaginal excision of the Dacron bolster. Three patients also underwent placement of an autologous pubovaginal sling for symptomatic recurrent stress urinary incontinence. At a mean follow-up of 30 months all four patients were improved. There was no recurrence of vaginal discharge or urinary tract infections. Irritative voiding symptoms resolved. Conclusions: Delayed complications from surgically implanted synthetic materials can present many years after initial implantation. The clinical findings are often subtle and require a high degree of suspicion. Vaginal discharge and irritative urinary symptoms in patients with even a remote history of Stamey bladder neck suspension should prompt a thorough vaginal exam and cystoscopy. Excision of the bolsters can be performed and is usually followed by symptomatic improvement.

Concomitant pelvic organ prolapse surgery with TVT procedure.
Huang KH, Kung FT, Liang HM, Chen CW, Chang SY, Hwang LL
Int Urogynecol J Pelvic Floor Dysfunct 2005 Jun 18;.
The aim of this study is to evaluate the efficacy and feasibility of concomitant pelvic reconstructive surgery with tension-free vaginal tape (TVT) procedure to treat pelvic organ prolapse women with urodynamic stress incontinence (USI) or occult USI. Seventy-five women with pelvic organ prolapse and diagnosed as USI or occult USI were enrolled in this study. All patients with USI or occult USI underwent TVT treatment under general anesthesia, combined with transvaginal total hysterectomy (VTH), anterior-posterior colporrhaphy (APC), and/or right sacrospinous ligament suspension (SSS) reconstructive surgeries. The subjective assessment was evaluated by using a visual analog scale (VAS) score and a urinary symptomatic

questionnaire. The objective assessment was carried out with a 1-h pad test, cough stress test, and urodynamic examination. Of the 75 patients, 35 patients with grade III uterine prolapse underwent VTH and APC, 30 patients with grade IV uterine prolapse underwent VTH, SSS, and APC, and the other 10 patients who had previous hysterectomy with total vaginal vault prolapse underwent SSS and APC. The mean follow-up interval was 25 months (12-42 months). The mean hospitalization was 5.9 days and the mean catheterization time was 3.8 days. The subjective success rate for the treatment of urine incontinence was 88%, and the objective complete cure rate was 84%. The rate of postoperative complications with persistent urinary urgency, de novo detrusor overactivity, dysfunctional voiding, and tape erosion were 50, 8, 12, and 1.3%, respectively. There were no bladder perforations during the TVT procedure and no perioperative complications requiring conversion to laparotomy. Pelvic organ prolapse women with USI or occult USI can be treated by reconstructive surgeries combined with a TVT procedure to treat and prevent postoperative USI.

Continence pads: have we got it right?
Uchil D, Thakar R, Sultan AH, Seymour J, Addison R
Int Urogynecol J Pelvic Floor Dysfunct 2005 Jul 6;.
Women listed in the Croydon Community Continence database were contacted with a self-assessment questionnaire regarding continence pad usage and quality of life. Completed questionnaires were received from 763 of 1509 (51%) participants. Pads were used for bladder dysfunction (88.1%) and bowel dysfunction (44%). The majority (82.5%) had concurrent medical disorders and problems with mobility with 77.5% being on one or more types of medication. Nearly 39% of women claimed that they would be happy to continue pad use indefinitely and only 28% expressed interest in seeking further help. Compared to bowel dysfunction, bladder dysfunction appeared to have a greater impact on women's quality of life ($P < 0.001$). Containment products make a substantial contribution in improving the quality of lives of women with bowel and bladder dysfunction. The financial burden of containment products has a major impact on the health budget and therefore, comprehensive clinical evaluation should be mandatory before relegating women to pads as a final resort.

Fecal incontinence: a review of prevalence and obstetric risk factors.
Wang A, Guess M, Connell K, Powers K, Lazarou G, Mikhail M
Int Urogynecol J Pelvic Floor Dysfunct 2005 Jun 23;.
Anal incontinence (AI) is a significant problem that causes social and hygienic inconvenience. The true prevalence of AI is difficult to estimate due to inconsistencies in research methods, but larger studies suggest a rate of 2-6% for incontinence to stool. There is a significant association between sonographically detected anal sphincter defects and symptoms of AI. The intrapartum factors most consistently associated with a higher risk of AI include: forceps delivery, third or fourth degree tears, and length of the second stage of labor. Fetal weight of > 4,000 g is also associated with AI. Repair of the sphincter can be performed in either an overlapping or an end-to-end fashion, with similar results for both methods. The role of cesarean delivery for the prevention of AI remains unclear, and further study should be devoted to this question.

The colon flap/extension Malone antegrade continence enema: an alternative to the Monti-Malone antegrade continence enema.
Herndon CD, Cain MP, Casale AJ, Rink RC
J Urol 2005 Jul;174(1):299-302.
PURPOSE: In situations where the appendix is not available for the Malone antegrade continence enema (MACE) procedure a Yang-Monti channel or a colon flap conduit can be created. We report our experience with colonic flap conduits used for the MACE. MATERIALS AND METHODS: A total of 169 MACE procedures were performed between February 1997 and March 2003. In 11 patients 12 colon flaps or cecal extensions were used to construct the MACE conduit. Diagnoses included myelomeningocele (8 patients), caudal regression (1), sacral agenesis (1) and gunshot wound (1). Mean age at creation of MACE was 11.3 years (range 4.4 to 16.9). Seven cecal flaps, 1 descending colon flap and 4 cecal extension flaps were created. RESULTS: Average followup was 22.8 months (range 2.6 to 34.6). Indications for colon flap MACE were appendicovesicostomy (6 patients), short appendix (2), shortened mesentery (1), retrocecal appendix (1), prior appendectomy (1) and right hemicolectomy (1). Initially all patients easily catheterized and flushed the MACE once daily. All 11 patients achieved fecal continence. Complications occurred in 3 cases. One obese patient could not visualize the umbilical stoma and it stenosed, requiring conversion to a spiral Monti-MACE. One patient with a cecal extension had development of a false passage, resulting in complete channel stenosis. One patient had development of stomal leakage, which was successfully treated with dextranomer/hyaluronic acid copolymer injection. CONCLUSIONS: A colon flap MACE conduit is a simple technique to provide access to the colon for irrigation. When faced with situations were the appendix is not available for the MACE procedure the colon flap can be a good option.

Diagnosis of anal sphincter tears to prevent fecal incontinence: a randomized controlled trial.
Faltin DL, Boulvain M, Floris LA, Irion O
Obstet Gynecol 2005 Jul;106(1):6-13.
Objective: Maternal anal sphincter tears after vaginal delivery are frequently not diagnosed clinically and are associated with subsequent fecal incontinence. This study examined whether diagnosis of these tears by ultrasonography, followed by immediate surgical repair, reduces the occurrence of incontinence. Methods: We conducted a randomized trial involving 752 primiparous women without a clinically evident anal sphincter tear to evaluate the benefit of adding endoanal ultrasonography immediately after vaginal delivery to the standard clinical examination of the perineum. When a sphincter tear was diagnosed, the perineum was surgically explored and the sphincter sutured. The main outcome evaluated was fecal incontinence 3 months postpartum graded by the Wexner incontinence scale, which measures incontinence to flatus and liquid or solid stools, need to wear a pad, and lifestyle alterations. Results: Among women assessed by ultrasonography, 5.6% had a sphincter tear. Severe incontinence was reported 3 months after childbirth by 3.3% of women in the intervention group compared with 8.7% in the control group (risk difference -5.4%; 95% confidence interval -8.9 to -2.0; P = .002). The benefit of the intervention persisted 1 year after delivery, with 3.2% severe incontinence in the intervention group compared with 6.7% in the control group (risk difference -3.5%; 95% confidence interval -6.8% to -0.3%; P = .03). Ultrasonography needs to be performed in 29 women to prevent 1 case of severe fecal incontinence. Conclusion: Ultrasound examination of the perineum after childbirth improves the diagnosis of anal sphincter tears, and their immediate repair decreases the risk of severe fecal incontinence. Level of Evidence: I.

7 – PAIN
Peripheral nerve blocks and peri-operative pain relief.
Davies JA
Anaesthesia 2005 Jul;60(7):735.
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A randomized clinical trial of acupuncture compared with sham acupuncture in fibromyalgia.
Assefi NP, Sherman KJ, Jacobsen C, Goldberg J, Smith WR, Buchwald D
Ann Intern Med 2005 Jul 5;143(1):10-9.
BACKGROUND: Fibromyalgia is a common chronic pain condition for which patients frequently use acupuncture. OBJECTIVE: To determine whether acupuncture relieves pain in fibromyalgia. DESIGN: Randomized, sham-controlled trial in which participants, data collection staff, and data analysts were blinded to treatment group. SETTING: Private acupuncture offices in the greater Seattle, Washington, metropolitan area. PATIENTS: 100 adults with fibromyalgia. INTERVENTION: Twice-weekly treatment for 12 weeks with an acupuncture program that was specifically designed to treat fibromyalgia, or 1 of 3 sham acupuncture treatments: acupuncture for an unrelated condition, needle insertion at nonacupoint locations, or noninsertive simulated acupuncture. MEASUREMENTS: The primary outcome was subjective pain as measured by a 10-cm visual analogue scale ranging from 0 (no pain) to 10 (worst pain ever). Measurements were obtained at baseline; 1, 4, 8, and 12 weeks of treatment; and 3 and 6 months after completion of treatment. Participant blinding and adverse effects were ascertained by self-report. The primary outcomes were evaluated by pooling the 3 sham-control groups and comparing them with the group that received acupuncture to treat fibromyalgia. RESULTS: The mean subjective pain rating among patients who received acupuncture for fibromyalgia did not differ from that in the pooled sham acupuncture group (mean between-group difference, 0.5 cm [95% CI, -0.3 cm to 1.2 cm]). Participant blinding was adequate throughout the trial, and no serious adverse effects were noted. LIMITATIONS: A prescription of acupuncture at fixed points may differ from acupuncture administered in clinical settings, in which therapy is individualized and often combined with herbal supplementation and other adjunctive measures. A usual-care comparison group was not studied. CONCLUSION: Acupuncture was no better than sham acupuncture at relieving pain in fibromyalgia.

Musculoskeletal Causes of Chronic Pelvic Pain: A Systematic Review of Existing Therapies: Part II.
Tu FF, As-Sanie S, Steege JF
Obstet Gynecol Surv 2005 Jul;60(7):474-483.
Chronic pelvic pain is a common clinical problem with many causes. In addition to gynecologic causes, it is important to evaluate other potential etiologies, including the pelvic musculoskeletal system. There have been few published studies on musculoskeletal causes of pelvic pain and its treatment. The objective of this study was to evaluate treatment of pelvic musculoskeletal pain among women with chronic pelvic pain. We used a set of key words pertaining to pain and the pelvic musculoskeletal structures to initially review the PUBMED database. Additional articles were sought by discussion with a clinician specializing in this field and review of relevant textbook bibliographies. Study inclusion was restricted to English-language

publications that reported a patient-related chronic pelvic pain outcome measure. Each report must have described at least four patients. For each selected article, two investigators separately summarized pertinent data on study characteristics, patient profiles, intervention characteristics, and treatment outcomes. Discrepancies were resolved by discussion. Twenty-nine treatment studies met entry criteria. The existing literature largely consists of retrospective, uncontrolled observational studies. The two studies that feature control groups lack sufficient size and scope to allow generalizability. Properly designed and executed randomized, controlled trials are urgently needed to determine the true effectiveness of treatments for pelvic musculoskeletal pain. TARGET AUDIENCE:: Obstetricians & Gynecologists, Family Physicians LEARNING OBJECTIVES:: After completion of this article, the reader should be able to summarize the current data on musculoskeletal causes of chronic pelvic pain, to outline the various techniques used to treat musculoskeletal causes of chronic pelvic pain, and to recall the lack of evidence based data on the subject and need for randomized controlled trials.

Functional abdominal pain.
Matthews PJ, Aziz Q
Postgrad Med J 2005 Jul;81(957):448-55.
Functional abdominal pain or functional abdominal pain syndrome (FAPS) is an uncommon functional gut disorder characterised by chronic or recurrent abdominal pain attributed to the gut but poorly related to gut function. It is associated with abnormal illness behaviour and patients show psychological morbidity that is often minimised or denied in an attempt to discover an organic cause for symptoms. Thus the conventional biomedical approach to the management of such patients is unhelpful and a person's symptom experience is more usefully investigated using a biopsychosocial evaluation, which necessarily entails a multidisciplinary system of healthcare provision. Currently the pathophysiology of the disorder is poorly understood but is most likely to involve a dysfunction of central pain mechanisms either in terms of attentional bias, for example, hypervigilance or a failure of central pain modulation/inhibition. Although modern neurophysiological investigation of patients is promising and may provide important insights into the pathophysiology of FAPS, current clinical management relies on an effective physician-patient relationship in which limits on clinical investigation are set and achievable treatment goals tailored to the patient's needs are pursued.

Recognition and Treatment of Irritable Bowel Syndrome Among Women With Chronic Pelvic Pain.
Williams RE, Hartmann KE, Sandler RS, Miller WC, Savitz LA, Steege JF
Obstet Gynecol Surv 2005 Jul;60(7):439-440.
This paper presents a series of 970 women who reported to the Chronic Pelvic Pain Clinic at the University of North Carolina between July 1993 and December 2000 with pelvic pain of at least 6 months duration. The authors investigated the prevalence of irritable bowel syndrome (IBS) in these patients and what, if any, treatment they had received.Participants completed the Beck Depression Inventory, the McGill Questionnaire for measuring pain level, and a general health questionnaire. Symptoms reported in the general health form were used to determine a diagnosis of IBS according to the Rome I criteria. These include abdominal pain that is relieved by defecation or that is associated with a change in frequency or consistency of stool, and 2 or more of the following symptoms experienced at least one fourth of the time: a change in stool frequency, stool form, or stool passage; passage of mucus; and bloating or feeling of abdominal extension. Treatments included lower gastrointestinal drugs and/or referral to a gastroenterologist.Most of the women were under 40 years of age, and 68% had at least mild depression. In the total group of 970 women, 336 (35%) were diagnosed with IBS. Among these patients, 136 (40%) had not been diagnosed with IBS before and two thirds (67%) had not received either lower gastrointestinal drugs or referral to a gastroenterologist.Compared with women without IBS, women with IBS were more likely to be receiving antidepressants (51% vs. 40%), lower gastrointestinal (28% vs. 11%) or upper gastrointestinal medications (16.0 vs. 6.8%), hormone replacement (19.4% vs. 13.6%), and anticonvulsant, sedative-hypnotic, or anxiolytic drugs (17.3% vs. 11%). Oral contraceptives were more common among women without IBS (22.1%) compared with those with IBS (15.8%). There were no significant differences between women with and without IBS in numbers or kinds of previous surgeries. Only 6.5% of patients with IBS had been referred to a gastroenterologist.Women with IBS who scored in the lower 3 quartiles on the McGill Pain questionnaire were more likely to be receiving IBS treatment than women in the highest quartile.

What is the pain of interstitial cystitis like?
Fitzgerald MP, Brensinger C, Brubaker L, Propert K
Int Urogynecol J Pelvic Floor Dysfunct 2005 Jul 2;.
To describe the characteristics of pain experienced by patients with interstitial cystitis (IC) in terms of pain site, severity, and character, we performed a secondary analysis of data from the IC database (ICDB), which was a prospective, longitudinal, cohort study of IC patients. We analyzed the cross-sectional baseline data

from 629 patients who had a completed baseline symptom questionnaire. Patients answered questions about whether they had pain or discomfort associated with urinary symptoms over the past 4 weeks and if so, about the location, characteristics, intensity, and frequency of their pain. Logistic regression examined associations between pain location and the presence of urinary symptoms. Analyses were performed using SAS version 8.2 (SAS Institute, Cary, NC, USA) and considered significant at the 5% level. Five hundred and eighty-nine (94%) patients with a mean age of 45 years (SD 14 years) reported baseline pain or discomfort associated with their urinary symptoms. The most common baseline pain site was lower abdominal (80%), with urethral (74%) and low back pain (65%) also commonly reported. The majority of patients described their pain as intermittent, regardless of the pain site. Most patients reported moderate pain intensity, across all pain sites. There was a statistically significant link between pain in the urethra, lower back, and lower abdomen, and urinary symptoms. Patients with IC report pain at several sites other than the bladder, possibly arising from the previously well-described myofascial abnormalities of pelvic floor and abdominal wall present in patients with IC and other chronic pelvic pain syndromes.

Integration of myofascial trigger point release and paradoxical relaxation training treatment of chronic pelvic pain in men.
Anderson RU, Wise D, Sawyer T, Chan C
J Urol 2005 Jul;174(1):155-60.
PURPOSE: A perspective on the neurobehavioral component of the etiology of chronic prostatitis (CP) and chronic pelvic pain syndrome (CPPS) is emerging. We evaluated a new approach to the treatment of CP/CPPS with the Stanford developed protocol using myofascial trigger point assessment and release therapy (MFRT) in conjunction with paradoxical relaxation therapy (PRT). MATERIALS AND METHODS: A total of 138 men with CP/CPPS refractory to traditional therapy were treated for at least 1 month with the MFRT/PRT protocol by a team comprising a urologist, physiotherapist and psychologist. Symptoms were assessed with a pelvic pain symptom survey (PPSS) and National Institutes of Health-CP Symptom Index. Patient reported perceptions of overall effects of therapy were documented on a global response assessment questionnaire. RESULTS: Global response assessments of moderately improved or markedly improved, considered clinical successes, were reported by 72% of patients. More than half of patients treated with the MFRT/PRT protocol had a 25% or greater decrease in pain and urinary symptom scores, as assessed by the PPSS. In those at the 50% or greater improvement level median scores decreased 69% and 80% for pain and urinary symptoms, respectively. The 2 scores decreased significantly by a median of 8 points when the 25% or greater improvement was first observed, that is after a median of 5 therapy sessions. PPSS and National Institutes of Health-CP Symptom Index showed similar levels of improvement after MFRT/PRT protocol therapy. CONCLUSIONS: This case study analysis indicates that MFRT combined with PRT represents an effective therapeutic approach for the management of CP/CPPS, providing pain and urinary symptom relief superior to that of traditional therapy.

Vulvar disease: a pelvic floor pain disorder?
Kennedy CM, Nygaard IE, Saftlas A, Burns TL, Torner JC, Galask RP
Am J Obstet Gynecol 2005 Jun;192(6):1829-34; discussion 1834-5.
OBJECTIVE: The purpose of this study was to compare the rates of painful bladder syndrome and functional bowel disorders in women with vulvar disease and control subjects. STUDY DESIGN: In this cross-sectional survey, a questionnaire that contained validated outcome measures was administered to women who were seeking care in a vulvar disease clinic and in general gynecology clinics. RESULTS: Women who were seen at a vulvar disease clinic were 2.18 (95% CI, 1.19, 3.97) times more likely to have painful bladder syndrome and 2.13 (95% CI, 1.35, 3.35) times more likely to have functional bowel disorders than general gynecology clinic control subjects after multivariable analyses. CONCLUSION: Painful bladder syndrome and functional bowel disorders are more prevalent in women who are seen at a vulvar disease clinic than gynecology clinics control subjects. These associations may reflect a common origin for these disorders in certain women. These findings lay the groundwork for future research to investigate a potential "pelvic floor pain disorder," which is a disease entity that would combine the diagnostic criteria for vulvar, bladder, and bowel pain disorders.

Outcomes and treatment options in rectovaginal endometriosis.
Emmanuel KR, Davis C
Curr Opin Obstet Gynecol 2005 Aug;17(4):399-402.
PURPOSE OF REVIEW: This review aims to explore the recent literature surrounding the role of colorectal surgery in rectovaginal endometriosis. RECENT FINDINGS: Recent findings would suggest that excision of a portion of the rectum along with complete excision of surrounding endometriosis is beneficial in terms of improvement in quality of life and recurrence of disease. However, further randomized controlled trials are needed to clarify this finding. SUMMARY: The optimal management of women with deeply infiltrating

rectovaginal endometriosis remains a challenge to physicians involved in this disease process. The choice between medical and surgical treatments is not clearly defined, and neither is the role of adjunctive medical therapy prior to or following surgery. It is only when these questions have been asked in the context of well conducted clinical trials, with good outcome data, can the answers be given.

Efficacy of Functional Electrical Stimulation-Biofeedback with Sexual Cognitive-Behavioral Therapy as Treatment of Vaginismus.
Seo JT, Choe JH, Lee WS, Kim KH
Urology 2005 Jun 29;.
OBJECTIVES: To report 12 cases of vaginismus that were successfully treated with functional electrical stimulation (FES)-biofeedback with sexual cognitive-behavioral therapy (SCBT) to determine the efficacy of FES-biofeedback with SCBT as a standard therapy for vaginismus. Vaginismus is an involuntary spasm of the musculature of the outer third of the vagina that leads to impossible vaginal penetration, causing personal distress. Various therapeutic approaches, both physiologic and psychological, have been considered. METHODS: Twelve women with vaginismus referred from a checkup outpatient clinic participated in this study. The patients enrolled in this study had vaginismus according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders. The patients were assessed before and after treatment with gynecologic examinations and structured interviews pertaining to sexual function and psychological adjustment. After the diagnosis of vaginismus, we conducted weekly pelvic floor muscle relaxation using FES-biofeedback. Once the patients became tolerable to vaginal manipulation, the eight-stage SCBT (eight-stage gradual desensitization described by Kaplan using vaginal self-dilation with fingers and vaginal probe insertion) was added for 8 weeks. RESULTS: After 8 weeks of treatment, all 12 couples had completed the program, had become tolerable to vaginal insertion of larger size probes, and could achieve satisfactory vaginal intercourse. CONCLUSIONS: FES-biofeedback with SCBT is an effective aid for patients with vaginismus to learn muscle control. Therefore, it may increase the success rate of treatment of vaginismus.

Irritable bowel syndrome: the possible benefits of probiotics.
Isselbacher KJ
Postgrad Med 2005 May;117(5):7.

8 – FISTULAE

Is Routine Cavity Drainage Necessary in Karydakis Flap Operation? A Prospective, Randomized Trial.
Gurer A, Gomceli I, Ozdogan M, Ozlem N, Sozen S, Aydin R
Dis Colon Rectum 2005 Jun 24;.
PURPOSE: Different surgical techniques for pilonidal disease have been described in the literature. In this study our aim was to evaluate the influence of routine cavity drainage in the Karydakis flap technique. METHODS: Fifty patients with pilonidal sinus who underwent the Karydakis flap operation were evaluated prospectively. The patients were assigned randomly into two groups-with and without suction drainage of the cavity-and the effects of drains were studied in terms of wound complications, hospital stay, and recurrence rate. RESULTS: There was no significant difference between groups in term of length of hospital stay. Complication rate was 20 percent and the complications were caused exclusively by fluid collections. Wound infection, dehiscence, or failure was not observed in any of the patients. There has been no recurrence in any of the patients during the follow-up period. There was a significant increase in the number of fluid collections in patents without a suction drain. CONCLUSION: The present study indicates that routine cavity drainage reduces the incidence of fluid collection after the Karydakis flap operation.

9 – BEHAVIOUR, PSYCHOLOGY, SEXOLOGY

The Treatment Satisfaction Scale: A Multidimensional Instrument for the Assessment of Treatment Satisfaction for Erectile Dysfunction Patients and Their Partners.
Dibenedetti DB, Gondek K, Sagnier PP, Kubin M, Marquis P, Keininger D, Fugl-Meyer AR
Eur Urol 2005 Jun 15;.
BACKGROUND:: The development of the Treatment Satisfaction Scale (TSS) was previously reported (Kubin et al., 2004). OBJECTIVE:: This article describes the psychometric validation process and psychometric properties (e.g., reliability, validity, and responsiveness) of TSS. METHODS:: Initial patient and partner questionnaires were administered in a multi-national clinical trial. On the basis of exploratory analyses, iterative psychometric testing, and consideration of face validity and interpretability, the number of items was reduced, and six scales were constructed: "Satisfaction with Medication," "Ease with Erection,"

"Satisfaction with Erectile Function," "Pleasure from Sexual Activity," "Satisfaction with Orgasm," and either "Sexual Confidence" (for patients) or "Confidence in Completion" (for partners). RESULTS:: Multi-item scales had good internal consistency reliability and concurrent validity with the IIEF. All patient scales and most partner scales were valid in relation to clinical criteria, and all tested scales were responsive to change over time. CONCLUSION:: The TSS is brief, culturally valid, and the most comprehensive multidimensional measure of satisfaction with ED treatment for patients and their partners, and addresses some of the shortcomings of existing measures.

Gastrointestinal Symptoms in Spinal Cord Injury: Relationships With Level of Injury and Psychologic Factors.

Ng C, Prott G, Rutkowski S, Li Y, Hansen R, Kellow J, Malcolm A

Dis Colon Rectum 2005 Jun 16;.

INTRODUCTION: Previous surveys of gastrointestinal symptoms after spinal cord injury have not used validated questionnaires and have not focused on the full spectrum of such symptoms and their relationship to factors, such as level of spinal cord injury and psychologic dysfunction. This study was designed to detail the spectrum and prevalence of gastrointestinal symptoms in spinal cord injury and to determine clinical and psychologic factors associated with such symptoms. METHODS: Established spinal cord injury patients (>12 months) randomly selected from a spinal cord injury database completed the following three questionnaires: 1) Rome II Integrative Questionnaire, 2) Hospital Anxiety and Depression Scale, and 3) Burwood Bowel Dysfunction after spinal cord injury. RESULTS: A total of 110 patients participated. The prevalence of abdominal bloating and constipation were 22 and 46 percent, respectively. Bloating was associated with cervical (odds ratio = 9.5) and lumbar (odds ratio = 12.1) level but not with thoracic level of injury. Constipation was associated with a higher level of injury (cervical odds ratio = 5.6 vs. lumbar) but not with psychologic factors. In contrast, abdominal pain (33 percent) and fecal incontinence (41 percent) were associated with higher levels of anxiety (odds ratio = 6.8, and odds ratio = 2.4) but not with the level of injury. CONCLUSIONS: There is a high prevalence and wide spectrum of gastrointestinal symptoms in spinal cord injury. Abdominal bloating and constipation are primarily related to specific spinal cord levels of injury, whereas abdominal pain and fecal incontinence are primarily associated with higher levels of anxiety. Based on our findings, further physiologic and psychologic research studies in spinal cord injury patients should lead to more rational management strategies for the common gastrointestinal symptoms in spinal cord injury.

The effect of total hysterectomy on specific sexual sensations.

Goetsch MF

Am J Obstet Gynecol 2005 Jun;192(6):1922-7.

OBJECTIVE: Assess whether women note a change in aspects of arousal because of removal of the uterus and cervix. STUDY DESIGN: Between 1990 and 1992, 105 women were asked to report on their sexual function before and at 3, 8, and 18 months after undergoing a total hysterectomy. Results were analyzed by chi 2 . RESULTS: Hysterectomies were abdominal or vaginal, and 42% of subjects had ovaries removed and initiated estrogen replacement. Ease of arousal diminished in 24% and improved in 11%. Intensity of orgasms decreased in 15% and increased in 14%. Effects of nipple stimulation were usually preserved. Sexual satisfaction increased significantly. Seven women noted distinctly worse sexual function. CONCLUSION: An indicated total hysterectomy will likely increase sexual satisfaction and not change the effect of breast stimulation. The few women with disturbingly reduced sexual sensation deserve assessment and treatment.

Circulating androgen levels and self-reported sexual function in women.

Davis SR, Davison SL, Donath S, Bell RJ

JAMA 2005 Jul 6;294(1):91-6.

CONTEXT: It has been proposed that low sexual desire and sexual dysfunction are associated with low blood testosterone levels in women. However, evidence to support this is lacking. OBJECTIVE: To determine whether women with low self-reported sexual desire and sexual satisfaction are more likely to have low serum androgen levels than women without self-reported low sexual desire and sexual satisfaction. DESIGN, SETTING, AND PARTICIPANTS: A community-based, cross-sectional study of 1423 women aged 18 to 75 years, who were randomly recruited via the electoral roll in Victoria, Australia, from April 2002 to August 2003. Women were excluded from the analysis if they took psychiatric medication, had abnormal thyroid function, documented polycystic ovarian syndrome, or were younger than 45 years and using oral contraception. MAIN OUTCOME MEASURES: Domain scores of the Profile of Female Sexual Function (PFSF) and serum levels of total and free testosterone, androstenedione, and dehydroepiandrosterone sulfate. RESULTS: A total of 1021 individuals were included in the final analysis. No clinically significant relationships between having a low score for any PFSF domain and having a low serum total or free testosterone or androstenedione level was demonstrated. A low domain score for sexual responsiveness for

women aged 45 years or older was associated with higher odds of having a serum dehydroepiandrosterone sulfate level below the 10th percentile for this age group (odds ratio [OR], 3.90; 95% confidence interval [CI], 1.54-9.81; P = .004). For women aged 18 to 44 years, having a low domain score for sexual desire (OR, 3.86; 95% CI, 1.27-11.67; P = .02), sexual arousal (OR, 6.39; 95% CI, 2.30-17.73; P<.001), and sexual responsiveness (OR, 6.59; 95% CI, 2.37-18.34; P<.001) was associated with having a dehydroepiandrosterone sulfate level below the 10th percentile. CONCLUSIONS: No single androgen level is predictive of low female sexual function, and the majority of women with low dehydroepiandrosterone sulfate levels did not have low sexual function.

[Erectile dysfunction: a sentinel symptom?]
Costa P, Grivel T, Giuliano F, Pinton P, Amar E, Lemaire A
Prog Urol 2005 Apr;15(2):203-7.
Erectile dysfunction (ED) is a frequent disorder affecting the man's sexual and relational quality of life. French epidemiological studies estimate that the prevalence of ED is between 11% and 44% and prevalence surveys show a correlation between ED and age: the relative risk of erectile dysfunction increases by a factor of 2 to 4 between the ages of 40 and 70 years. Few patients consult their doctor and only a small proportion of them receive treatment and few doctors take the initiative to discuss the question of their patients' sex life. Doctors should now have a good understanding of erectile dysfunction and must be aware of the importance of detecting or at least investigating any erectile dysfunction, which can be the first symptom of an underlying disease such as cardiovascular disease, diabetes, depression, benign prostatic hyperplasia, prostate cancer, androgen deficiency or a drug-induced effect. Demonstration of erectile disorders therefore represents an excellent opportunity to conduct a general work-up, as more than one-third of patients with ED ignore their underlying health problem and management of ED is therefore an integral part of preventive medicine.

The impact of age, body mass index and testosterone on erectile dysfunction.
Kratzik CW, Schatzl G, Lunglmayr G, Rucklinger E, Huber J
J Urol 2005 Jul;174(1):240-3.
PURPOSE: Erectile dysfunction (ED) may be associated with low serum total testosterone (T), low serum bioavailable testosterone (BAT) and high body mass index (BMI) in aging men. MATERIALS AND METHODS: A total of 675 workers (age range 45 to 60 years old) were entered into this study. Investigations were performed directly at their place of work. Exclusion criteria were abnormal urogenital status, antihypertensive drugs, medication possibly affecting the endocrine function and a history of previous pelvic trauma. T and sex hormone-binding globulin were measured with commercially available assays, and BAT was calculated from T and sex hormone-binding globulin. BMI was assessed and every individual completed a self-administrated questionnaire for erectile function (International Index of Erectile Function [IIEF-5]). RESULTS: T and BAT showed a significantly negative correlation with age and BMI. Each additional year of increase in age caused a decrease in the IIEF-5 score of 0.195 (p <0.001). Increase in BMI by 1 kg/m reduced IIEF-5 by 0.141, independent of age (p =0.005). Multiple logistic regression analyses confirmed the influence of increased age and higher BMI on the risk of ED. The corresponding odds ratio for ED was 1.082 (p <0.001) and 1.076 (p <0.001), respectively. These data indicate an increase in ED risk by 8.2% per year and by 7.6% per kg/m BMI. Severe cases of ED (IIEF-5 score 7 or less) were significantly associated with a decrease in T and BAT. Individuals with low BAT (1 ng/ml or less) had a 3 times higher risk of severe ED compared with men with BAT greater than 1 ng/ml (odds ratio 3.045, 95% CI 1.088 to 8.522, p =0.034). The result of the multiple logistic regression analysis was adjusted to age and BMI, and did not show a significant influence on the incidence of severe ED. CONCLUSIONS: BMI contributes strongly to ED. Low T or BAT are only relevant if IIEF-5 questionnaire results in severe ED.

Impact of tension-free vaginal tape on sexual function: results of a prospective study.
Ghezzi F, Serati M, Cromi A, Uccella S, Triacca P, Bolis P
Int Urogynecol J Pelvic Floor Dysfunct 2005 Jun 23;.
The purpose of this study was to prospectively assess the impact of a TVT insertion for the treatment of stress urinary incontinence (SUI) on coital incontinence and overall sexual life. Sexually active women with pure SUI and without concomitant pelvic organ prolapse scheduled for TVT procedure completed a sexual function questionnaire at baseline and 6 months after surgery. Fifty-three patients were enrolled. Preoperatively 23 (43.4%) women experienced urine leakage during intercourse, 21 (91%) during penetration and 2 (9%) on orgasm. The objective cure rate for SUI was 98%. Coital incontinence was cured in 20 of 23 patients (87%). Thirty-three (62.2%) women reported no change in sexual function after surgery and 18 (34%) reported an improvement. Of the latter, 17 (94%) were of those cured from coital incontinence. No significant difference in the incidence of dyspareunia was found postoperatively. Two patients (3.8%) reported intercourse to be worse following surgery, one because of a vaginal erosion and one cited de novo

anorgasmia as the main reason.

The impact of pelvic organ prolapse on sexual function in women with urinary incontinence.
Ozel B, White T, Urwitz-Lane R, Minaglia S
Int Urogynecol J Pelvic Floor Dysfunct 2005 Jun 22;.
The aim of the study is to evaluate the impact of pelvic organ prolapse (POP) on sexual function in women with urinary incontinence (UI). In this retrospective, case-cohort study, we reviewed the medical records of all women evaluated for UI between March and November 2003. All patients completed the short forms of the Urogenital Distress Inventory, Incontinence Impact Questionnaire, and Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire. Women with stage two or greater POP, as determined by the pelvic organ prolapse quantification (POPQ) system, were compared to women with stage 0 or 1 POP. Sixty-nine women with POP and 47 women without POP were included. Patient demographics did not differ between the two groups. Women with POP were significantly more likely to report absence of libido (53% versus 30%, P=0.02), lack of sexual excitement during intercourse (46% versus 27%, P=0.05), and that they rarely experienced orgasm during intercourse (49% versus 30%, P=0.05). In conclusion, women with POP in addition to UI are more likely to report decreased libido, decreased sexual excitement, and difficulty achieving orgasm during intercourse when compared to women with UI alone.

10 – MISCELLANEOUS

In patients with early prostate cancer, is surgery better than watchful waiting?
Alibhai SM, Gogov S
CMAJ 2005 Jun 21;172(13):1682.

Birth rate and its correlation with the lunar cycle and specific atmospheric conditions.
Morton-Pradhan S, Bay RC, Coonrod DV
Am J Obstet Gynecol 2005 Jun;192(6):1970-3.
OBJECTIVE: This study was undertaken to use the Arizona State birth certificate database for Phoenix metropolitan hospitals, in conjunction with National Weather Service records to determine whether there is a relationship between birth rate and meteorologic or lunar conditions. This study attempts to dispel or lend significance to beliefs among hospital staff that the phase of the moon and/or meteorologic conditions are related to birth rate. STUDY DESIGN: Birth records were limited to spontaneous vaginal deliveries, 37 to 40 weeks' gestation, in Phoenix, between 1995 and 2000 (n = 167,956). Daily birth counts were merged with daily surface weather statistics from the National Weather Service for Sky Harbor Airport, and records of lunar phase for the same period. RESULTS: The analyses revealed no significant correlates of birth rate. CONCLUSION: Although there exists a popular belief that the phase of the lunar cycle and weather conditions affect birth rate, no such evidence was found in this study.

Intestinal vaginoplasty: is it optimal treatment of vaginal agenesis? A pilot study Surgical method of sigmoid colon vaginoplasty in vaginal agenesis.
Karateke A, Gurbuz A, Haliloglu B, Kabaca C, Koksal N
Int Urogynecol J Pelvic Floor Dysfunct 2005 Jul 5;.
The outcome of 11 cases with vaginal agenesis who underwent intestinal vaginoplasties are presented. Patients were between 18 and 37 years old. Ileum vaginoplasty and sigmoid colon vaginoplasty were carried out in two and nine cases, respectively. Ileum necrosis at donor site requiring ileum resection and bilateral ileostomy encountered in one of the cases was the major complication. Mild stenosis responsive to finger dilatation had been detected in two women with sigmoid vaginoplasty. Excess mucous production, long operation time, and shortness of mesentery of ileum led us to abandon ileum vaginoplasty, and sigmoid colon vaginoplasty was performed in the following cases with vaginal agenesis. All of the neovaginas were patent and functional. We suggest sigmoid colon vaginoplasty as the treatment of choice because of its large lumen, thick walls resistant to trauma, adequate secretion allowing lubrication, not necessitating prolonged dilatation, short recovery time compared with ileum vaginoplasties; and in patients reluctance to prolonged use of dilatators or in those who experienced previous failure of the other treatment modalities.

Predictors of colorectal cancer screening: A comparison of men and women.
McGregor SE, Bryant HE
Can J Gastroenterol 2005 Jun;19(6):343-9.
BACKGROUND: New Canadian guidelines recommend screening average-risk adults to reduce mortality from colorectal cancer, the second most common cause of cancer death among Canadians. The present study examined the self-reported prevalence of colorectal cancer testing and sex-specific predictors of having had a fecal occult blood (FOB) test for screening, among a cohort of Alberta residents aged 50 to 69

years. METHODS: Subjects (n=5009) enrolled in a geographically based cohort study completed a Health and Lifestyle Questionnaire between October 2000 and June 2002 that ascertained their colorectal cancer detection practices, as well as demographic and other health and lifestyle characteristics. RESULTS: Patterns of FOB testing, and sigmoidoscopy or colonoscopy, were similar for men and women. The majority of subjects (83.3%) reported no first-degree family history of colorectal cancer or bowel conditions, and they were considered to be at average risk. Few average-risk subjects reported having a screening FOB test within the past two years (7.7% [95% CI 6.7% to 8.7%] of subjects aged 50 to 59 years and 12.5% [95% CI 10.9% to 14.3%] of subjects aged 60 to 69 years). In men, the strongest predictors of having a screening FOB test in the past two years were a recent history of prostate-specific antigen testing and educational attainment. Among women, the strongest predictors were a recent history of having had a Pap test, a recent mammogram, employment status and educational attainment. CONCLUSIONS: Screening for colorectal cancer in average-risk adults was infrequent in this sample and lagged behind screening for other cancers. Screening of average-risk adults occurred primarily in people already accessing the health care system, suggesting that public education programs will be required to increase screening rates.

Screening methods for high-grade dysplasia in patients with anal condyloma(1).
Papaconstantinou HT, Lee AJ, Simmang CL, Ashfaq R, Gokaslan ST, Sokol S, Huber PJ Jr, Gregorcyk SG
J Surg Res 2005 Jul 1;127(1):8-13.
Human papilloma virus (HPV) is one of the most common sexually transmitted diseases in the United States. HPV infection can cause anal condylomas and is a risk factor for dysplasia. High-grade dysplasia may progress to squamous cell carcinoma. Currently, biopsy and histological examination are required to grade dysplasia. The purpose of this study is to determine whether anal cytology, morphological characteristics, and/or the presence of high-risk oncogenic HPV-types are effective noninvasive methods to detect high-risk anal condylomas. PATIENTS AND METHODS: From November 2003 to June 2004, all patients with anal condyloma were prospectively evaluated for anal cytology, high-risk oncogenic HPV-types, and tissue biopsies. The Bethesda classification system was used to classify cytologic findings and histological examination, which were grouped as high-risk (HRL) and low-risk (LRL) lesions. Histology results served as true disease for all comparisons. RESULTS: Forty-seven patients with anal condyloma were studied; 43 (91.5%) were men, and the mean age was 39 +/- 11 years. Histology showed 19 (40.5%) patients with HRL, and 28 (59.5%) patients with LRL. Cytology correctly identified 8 patients with HRL and 27 patients with LRL (sensitivity 42% and specificity 96%). High-risk oncogenic HPV-types were found in 84.2% of HRL and 39.3% of LRL (P = 0.0029). Combining cytology with oncogenic HPV-testing, the sensitivity of detecting HRL increased to 89%, and specificity decreased to 42%. CONCLUSION: Anal cytology alone is not accurate for detecting HRL in patients with anal condylomas. Combining oncogenic HPV-testing with cytology is more sensitive in detecting HRL in patients with anal condyloma, and therefore, a more effective screening tool.

Early results of a rotational flap to treat chronic anal fissures.
Singh M, Sharma A, Gardiner A, Duthie GS
Int J Colorectal Dis 2005 Jul;20(4):339-42. Epub 2004 Nov 20.
BACKGROUND: Treatment of anal fissures has changed dramatically in the past decade. Only a few fail to respond to medical therapy. Sphincterotomy and anal dilatation have fallen out of favour due to the risk of incontinence. Island flaps have been proposed to address this, but 60-70% of flap donor sites break down with complications. We proposed that using a rotational flap would overcome this problem.METHODS: Twenty-one patients (14 women,7 men) with chronic anal fissures were treated with rotation flap from perianal skin. The median age was 43 (range 21-76) years. All patients had failed chemical sphincterotomy and showed no signs of improvement following at least a 3-month course of topical GTN 0.2% ointment.RESULTS: The median hospital stay was 2 days. Seventeen patients had complete resolution of symptoms. Only one patient continued to have severe pain. Two developed a recurrent fissure. One patient had a combined fistula-fissure complex at diagnosis and suffered from a breakdown of the flap and donor site. Another patient had had haemorrhoidectomy and an advancement flap in the past. He developed problems with the donor site, which was successfully managed conservatively. One patient had persistent mild pain after surgery, but the cause could not be found. None of the patients suffered continence defects after surgery.CONCLUSION: Use of a rotational flap is a simple, safe and successful treatment for anal fissures. Donor site problems are minimised using this approach. It should be a treatment of choice when surgery is required for chronic anal fissures, particularly in patients in whom there is a risk of incontinence.

The effect of physical activity and body size on survival after diagnosis with colorectal cancer.
Haydon AM, Macinnis R, English D, Giles G
Gut 2005 Jun 21;.
BACKGROUND: Physical inactivity and obesity increase the risk of colorectal cancer, but little is known about whether they influence prognosis after diagnosis. METHODS: Incident cases of colorectal cancer were

identified among participants of the Melbourne Collaborative Cohort Study, a prospective cohort study of 41,528 Australians recruited from 1990 to 1994. Participants diagnosed with their first colorectal cancer between recruitment and August 1, 2002 were eligible. At the time of study entry, body measurements were taken and participants were interviewed about their physical activity. Information on tumor site and stage, treatments given, recurrences and deaths were obtained from systematic review of the medical records. RESULTS: 526 cases of colorectal cancer were identified. Median follow up among survivors was 5.5 years, and 208 deaths had occurred, including 181 from colorectal cancer. Exercise was shown to improve outcomes, whereas increasing percent body fat and waist circumference were associated with poorer survival. After adjusting for age, sex and tumor stage, exercisers had improved disease-specific survival (hazard ratio 0.73, 95 percent confidence interval 0.54 to 1.00). The benefit of exercise was largely confined to stage II-III tumors (hazard ratio 0.49, 95 percent confidence interval 0.30 to 0.79). Increasing percent body fat resulted in an increase in disease-specific deaths (hazard ratio 1.33 per 10 kg, 95 percent confidence interval 1.04 to 1.71). Similarly, increasing waist circumference reduced disease- specific survival (hazard ratio 1.20 per 10 cm, 95 percent confidence interval 1.05 to 1.37. CONCLUSIONS: Increased central adiposity and a lack of regular physical activity prior to the diagnosis of colorectal cancer is associated with poorer overall and disease-specific survival.

Randomised, controlled trial, of azathioprine and 5- aminosalicylic acid for treatment of steroid-dependent ulcerative colitis.

Ardizzone S, Maconi G, Russo A, Imbesi V, Colombo E, Bianchi Porro G

Gut 2005 Jun 21;.

BACKGROUND AND AIMS: There are limited evidence- based data concerning the use of azathioprine in ulcerative colitis. We aimed to compare the efficacy of azathioprine and oral 5-aminosalicylic acid in inducing remission of steroid-dependent ulcerative colitis. METHODS: 72 patients with steroid-dependent ulcerative colitis were admitted to this investigator- blind study. Steroid-dependence was defined as a requirement for steroid therapy at >/=10 mg/day during the preceding 6 months, with at least two attempts to discontinue the medication. The disease had to be clinically and endoscopically active at study entry, and all patients were taking systemic prednisolone (40 mg/day). Patients were randomized to receive azathioprine 2 mg/kg/day or oral 5-aminosalicylic acid, 3.2 g/day, for a 6-month follow-up period. The outcome of the treatment was defined as (1) success, indicating induction of clinical and endoscopic remission and steroid discontinuation, (2) failure, indicating the need for at least one further cycle of systemic steroids to control symptoms, apart from the initial one, or colectomy. RESULTS: Significantly more patients in the azathioprine than in the 5-aminosalicylic acid group had clinical and endoscopic remission, and discontinued steroid therapy, both at the intention-to-treat [azathioprine vs 5-aminosalicylic acid: 19/36 patients (53%) vs 7/36 (21%), OR = 4.78, 95%CI 1.57-14.5], and per protocol analysis [azathioprine vs 5-aminosalicylic acid: 19/33 patients (58%) vs 7/34 (21%), OR = 5.26; 95% CI 1.59-18.1]. CONCLUSIONS: Azathioprine is significantly more effective than 5-aminosalicylic acid in inducing clinical and endoscopic remission and avoiding steroid requirement in the treatment of steroid-dependent ulcerative colitis.