FORUM 2006 01

Senior original author's response to: High risk of lower limb neuropraxia and litigations for a better view of the perineum.
Mackie C
Ann R Coll Surg Engl. 2005 Nov;87(6):481.

Health industry practices that create conflicts of interest: a policy proposal for academic medical centers.
Brennan TA, Rothman DJ, Blank L, Blumenthal D, Chimonas SC, Cohen JJ, Goldman J, Kassirer JP, Kimball H, Naughton J, Smelser N
JAMA. 2006 Jan 25;295(4):429-33.

Guidelines for Interactions between Clinical Faculty and the Pharmaceutical Industry: One Medical School's Approach.
Coleman DL, Kazdin AE, Miller LA, Morrow JS, Udelsman R
Acad Med. 2006 Feb;81(2):154-60.

A program to provide regulatory support for investigator-initiated clinical research.
Arbit HM, Paller MS
Acad Med. 2006 Feb;81(2):146-53.

Differences in review quality and recommendations for publication between peer reviewers suggested by authors or by editors.
Schroter S, Tite L, Hutchings A, Black N
JAMA. 2006 Jan 18;295(3):314-7.

Propensity scores and the surgeon.
Adamina M, Guller U, Weber WP, Oertli D
Br J Surg. 2006 Jan 9;.
The purpose of this paper is to provide a comprehensive overview of propensity score analysis, allowing the surgeon to understand the role, advantages and limitations of propensity scores, boosting their development in surgical investigations.

Beyond the myth: The mermaid syndrome from Homerus to Andersen A tribute to Hans Christian Andersen's bicentennial of birth.
Romano S, Esposito V, Fonda C, Russo A, Grassi R
Eur J Radiol. 2006 Jan 16;.
Beyond the Myth, may the Siren really exist? It can be hypothesized that these creatures probably were individuals affected by sirenomelia. Syrenomelia is a condition not compatible with the normal life, however nine cases of "mermaid" survived to reconstructive surgery have been reported until now. In our report we also presented a case of survival baby girl affected by sirenomelia, before and after surgery, with correlative radiologic imaging findings. The most important characteristic that seems to allow survival of the affected individuals is the presence of one functional kidney, displaced in pelvis.

Sacral neuromodulation: long-term experience of one center.
Wein AJ
J Urol. 2006 Feb;175(2):632.

1 – THE PELVIC FLOOR 2006 01

Optimizing pelvic surgery outcomes.
Davila GW
Cleve Clin J Med. 2005 Dec;72 Suppl 4:S28-32.
Most perioperative complications related to graft use can be prevented by appropriate preoperative and postoperative tissue management. Intraoperative cystoscopy should be a routine part of most pelvic reconstructive procedures. A rectal examination should be performed at the end of each surgical procedure to document rectal integrity. Under most circumstances, graft erosions can be managed without the need to remove the entire graft or jeopardizing the surgical repair.

Textbook recommendations for preventing and treating perineal injury at vaginal delivery.

Stepp KJ, Siddiqui NY, Emery SP, Barber MD
Obstet Gynecol. 2006 Feb;107(2):361-6.

Learning outcomes of a group behavioral modification program to prevent urinary incontinence.
Sampselle CM, Messer KL, Seng JS, Raghunathan TE, Hines SH, Diokno AC
Int Urogynecol J Pelvic Floor Dysfunct. 2005 Nov-Dec;16(6):441-6

The state of rehabilitation research: art or science?
Tate DG
Arch Phys Med Rehabil. 2006 Feb;87(2):160-6.
The state of rehabilitation research: art or science? Rehabilitation research has been criticized as not standing up enough to the rigors of scientific method to be called "science." The field has been portrayed as slow to promote its scientific achievements and to include them under the rubric of evidence-based rehabilitation. Following in the footsteps of psychology, rehabilitation as a broad-based discipline has faced many similar obstacles in achieving scientific status. Controversy exists about what exactly constitutes rehabilitation science versus its art and its respective multidisciplinary domains. The conception of these domains is directly related to current methods available to assess the state of the discipline and its research accomplishments. I used quantitative methods, such as randomized clinical and/or controlled trials (RCTs) and systematic reviews, to assess the status of rehabilitation research. Findings suggest that, as a field, rehabilitation makes significant contributions to science, measurable by the number and quality of RCTs and systematic reviews conducted so far on topics of critical importance for clinical care. In "artful" complement, qualitative approaches can be used as research tools to aid investigators in seeking knowledge beyond that obtained by quantitative methods, assessing many complexities associated with the various contexts of rehabilitation research. Other requirements to develop a common vision of rehabilitation science are also discussed.

A multicentre study of the management of disorders of defecation in patients with spina bifida.
Lemelle JL, Guillemin F, Aubert D, Guys JM, Lottmann H, Lortat-Jacob S, Moscovici J, Mouriquand P, Ruffion A, Schmitt M
Neurogastroenterol Motil. 2006 Feb;18(2):123-8.

2 – FUNCTIONAL ANATOMY 2006 01
Contemporary views on female pelvic anatomy.
Barber MD
Cleve Clin J Med. 2005 Dec;72 Suppl 4:S3-11.

Three-dimensional study of pelvic asymmetry on anatomical specimens and its clinical perspectives.
Boulay C, Tardieu C, Benaim C, Hecquet J, Marty C, Prat-Pradal D, Legaye J, Duval-Beaupere G, Pelissier J
J Anat. 2006 Jan;208(1):21-33.
The aim of this study was to assess pelvic asymmetry (i.e. to determine whether the right iliac bone and the right part of the sacrum are mirror images of the left), both quantitatively and qualitatively, using three-dimensional measurements. Pelvic symmetry was described osteologically using a common reference coordinate system for a large sample of pelvises. Landmarks were established on 12 anatomical specimens with an electromagnetic Fastrak system. Seventy-one paired variables were tested with a paired t-test and a non-parametric test (Wilcoxon). A Pearson correlation matrix between the right and left values of the same variable was applied exclusively to values that were significantly asymmetric in order to calculate a dimensionless asymmetry index, ABGi, for each variable. Fifteen variables were significantly asymmetric and correlated with the right vs. left sides for the following anatomical regions: sacrum, iliac blades, iliac width, acetabulum and the superior lunate surface of the acetabulum. ABGi values above a threshold of +/- 4.8% were considered significantly asymmetric in seven variables of the pelvic area. Total asymmetry involving the right and the left pelvis seems to follow a spiral path in the pelvis; in the upper part, the iliac blades rotate clockwise, and in the lower part, the pubic symphysis rotates anticlockwise. Thus, pelvic asymmetry may be evaluated in clinical examinations by measuring iliac crest orientation.

Comparison of Rectoanal Axial Forces in Health and Functional Defecatory Disorders.
Bharucha AE, Croak AJ, Gebhart JB, Berglund LJ, Seide BM, Zinsmeister AR, An KN
Am J Physiol Gastrointest Liver Physiol. 2006 Feb 2;.
Anal manometry measures circumferential pressures, but not axial forces, which are responsible for defecation and contribute to fecal continence. Our aims were to investigate these mechanisms by measuring

axial rectoanal forces with an intra-rectal sphere or a latex balloon, fixed at 8, 6, or 4 cm from the anal verge, and connected to axial force and displacement transducers. Rectoanal forces and rectal pressures within a latex balloon were measured at baseline (i.e., at rest) and during maneuvers (i.e., squeeze, simulated evacuation, and a Valsalva maneuver) in 12 asymptomatic women and 12 women with symptoms of difficult defecation. Anal resting and squeeze pressures were also assessed by manometry and were similar in controls and patients. At rest, axial rectoanal forces were directed inward and increased as the device approached the anal verge. Controls augmented this inward force when they squeezed and exerted an outward force during simulated expulsion and a Valsalva maneuver. The force change during maneuvers was also affected by device location and was highest at 4 cm from the verge. In patients, the force at rest and the change in force during all maneuvers was lower than in controls. The rectal pressure during a Valsalva maneuver was also lower in patients than in controls, suggestive of impaired propulsion. In conclusion, a subset of women with defecatory symptoms had weaker axial forces not only during expulsion but also during a Valsalva maneuver and when they squeezed (i.e., contracted) their pelvic floor muscles, suggestive of generalized pelvic floor weakness.

Role of the rectosigmoidal junction in fecal continence: concept of the primary continent mechanism.
Shafik A, Shafik AA, El Sibai O, Ahmed I, Mostafa RM
Arch Surg. 2006 Jan;141(1):23-6.
HYPOTHESIS: At mass contraction of the descending colon, the colonic contents stop at the sigmoid colon (SC) and do not pass directly to the rectum. We investigated the hypothesis that a continent mechanism seems to exist at the rectosigmoidal junction (RSJ), preventing the direct passage of stools from the descending colon to the rectum. METHODS: The SC in 16 healthy volunteers (mean +/- SD age, 38.6 +/- 10.2 years; 9 men and 7 women) was distended with an isotonic sodium chloride solution-filled balloon, and the pressure response of the RSJ and the rectum was recorded at rapid and gradual filling of the balloon. The test was repeated after the SC and RSJ were anesthetized separately. RESULTS: Rapid SC balloon distension with a mean +/- SD of 52.1 +/- 3.6 mL of isotonic sodium chloride solution effected an RSJ pressure increase to a mean +/- SD of 67.8 +/- 18.4 cm H(2)O (P<.01) with no rectal pressure response (P>.05). Slow SC filling produced a progressive increase in RSJ pressure but no rectal pressure change. At a mean +/- SD SC distending volume of 86.3 +/- 4.1 mL, the RSJ pressure decreased to 9.6 +/- 2.8 (P<.01), and the balloon was dispelled to the rectum; rectal pressure increased (P<.001), and the balloon was expelled to the exterior. The RSJ pressure did not respond to distension of the anesthetized SC. CONCLUSIONS: Contraction of the RSJ at rapid SC distension with big volumes implies a reflex relationship that we call the RSJ guarding reflex. This reflex seems to prevent the descending colon contents from passing directly to the rectum. It is considered the first continent reflex and may serve as an investigative tool in the study of fecal incontinence.

3 – DIAGNOSTICS 2006 01
Videomanometry of the pelvic organs: A comparison of the normal lower urinary and gastrointestinal tracts.
Ito T, Sakakibara R, Uchiyama T, Zhi L, Yamamoto T, Hattori T
Int J Urol. 2006 Jan;13(1):29-35.
Background: Both the lower urinary tract (LUT) and the caudal part of the lower gastrointestinal tract (LGIT) are innervated by the sacral spinal cord. We aimed to compare the normal physiology of the LUT and LGIT using the same videomanometry method. Methods: We recruited fifteen healthy volunteers (eight men and seven women; mean age, 60 years). The videomanometric measures included fluoroscopic images, subtracted bladder/rectal pressures, urethral/anal sphincter pressures, sphincter electromyography, and urinary/fecal flow. Results: During the resting phase, the urethral/anal sphincter pressures showed almost the same values (mean, 70 cmH(2)O and 68 cmH(2)O, respectively). During the storage phase, the volumes at first sensation and maximum capacity for the LGIT (129 mL and 320 mL) were slightly smaller than those for the LUT (170 mL and 405 mL). Compliance of the LGIT (65 mL/cmH(2)O) was almost as high as that of the LUT (99 mL/cmH(2)O). However, the LGIT showed spontaneous phasic rectal contractions (SPRC) that were never seen in the bladder. None of the subjects experienced leakage during bladder/rectal filling. During the evacuation phase, rectal contraction on defecation (14 cmH(2)O) was present, but was weaker than bladder contraction on micturition (42 cmH(2)O; P < 0.01). Abdominal strain on defecation (70 cmH(2)O) was greater than that on micturition (25 cmH(2)O; P < 0.01). Sphincter pressure increase on defecation (13 cmH(2)O) was greater than that on micturition (-52 cmH(2)O). An illustrative case of SPRC that were seen during urodynamic recording was shown. Conclusion: SPRC and abdominal strain are features of the LGIT, whereas micturition bladder contraction is a feature of the LUT. These features can aid

in understanding the possible rectal 'artifacts' of videourodynamics and neurogenic pelvic organ dysfunction.

Is nocturia equally common among men and women? A population based study in Finland.
Tikkinen KA, Tammela TL, Huhtala H, Auvinen A
J Urol. 2006 Feb;175(2):596-600.

The aging lower urinary tract.
Dubeau CE
J Urol. 2006 Mar;175(3 Suppl):S11-5.
PURPOSE: Age related changes in continence and the GU system, and how they affect the management of LUT dysfunction are discussed. Guidelines are offered regarding the diagnosis and management of incontinence in the elderly population. MATERIALS AND METHODS: Published literature and current treatment practice specific to elderly patients with LUT dysfunction were reviewed. RESULTS: LUT symptoms in the elderly population are affected by the high prevalence of comorbidity and polypharmacy. In addition, the GU system undergoes age related changes that increase the risk of LUT dysfunction. CONCLUSIONS: Incontinence in older persons is almost always caused by multiple factors, of which not all are directly related to the GU system. Issues such as polypharmacy, comorbidity, and the increased risk of medication side effects must be considered in planning treatment. The primary care physician and urologist or gynecologist should establish a partnership to co-manage the broad spectrum of factors affecting continence in elderly patients.

Maximal urethral closure pressure < 20 cm H2O: does it predict intrinsic sphincteric deficiency?
Krissi H, Pansky M, Halperin R, Langer R
J Reprod Med. 2005 Nov;50(11):824-6.
OBJECTIVE: To assess whether the large discrepancy in the literature in the incidence of intrinsic sphincteric deficiency (ISD) is due to different methods by which maximal urethral closure pressure (MUCP) is measured. STUDY DESIGN: We compared the measurement of MUCP in the supine position with 300 mL saline in the bladder, according to International Continence Society guidelines, to that in the sitting position (full bladder) in 54 consecutive patients who were diagnosed as having stress urinary incontinence. RESULTS: In the supine position the mean MUCP was 38.4 +/- 2.85 cm H2O as compared to 22.80 +/- 3.22 cm H2O in the sitting position ($p < 0.0001$). The mean difference was 15.65 +/- 2.11 cm H2O. MUCP < or = 20 cm H2O was observed in 14 of 54 (25.9%) patients in the sitting position as compared to 1 of 54 (1.8%) in the supine position. CONCLUSION: When MUCP is measured in the supine position, according to International Continence Society guidelines, the cutoff point for diagnosis of ISD should be 35 rather than 20 cm H2O.

The PSA Conundrum.
Barry MJ
Arch Intern Med. 2006 Jan 9;166(1):7-8.

Meal-induced recto-sigmoid tone modification: a low-caloric meal accurately separates functional and organic gastrointestinal disease patients.
Di Stefano M, Miceli E, Missanelli A, Mazzocchi S, Corazza G
Gut. 2006 Jan 24;.
BACKGROUND AND AIMS: Diagnosis of irritable bowel syndrome is based on arbitrary criteria due to the lack of an accurate diagnostic test. The aim of this study was to evaluate whether recto-sigmoid tone modification after a meal represents an accurate diagnostic approach. METHODS: In a secondary care setting, 32 constipation-predominant and 24 diarrhoea-predominant IBS patients, 10 functional diarrhoea and 10 functional constipation patients, 29 organic gastrointestinal disease patients and 10 healthy volunteers underwent a rectal barostat test in order to measure fasting and post- prandial recto-sigmoid tone. Recto-sigmoid response was assessed following three meals containing different amounts of calories, 200 Kcal, 400 Kcal and 1000 Kcal. A post-prandial reduction of recto- sigmoid tone of at least 28% of fasting value after a low- caloric meal accurately separates organic and functional gastrointestinal disease patients. This parameter may, therefore, be used in the positive diagnosis of IBS.

Barostat Measurement of Rectal Compliance and Capacity.
Fox M, Thumshirn M, Fried M, Schwizer W
Dis Colon Rectum. 2006 Jan 20;.
PURPOSE: Fecal continence requires relaxation of the rectal wall and a reservoir of adequate capacity. Rectal compliance provides an assessment of rectal wall stiffness; however, compliance is also affected by

rectal capacity. We developed and validated a barostat measurement of rectal capacity. By accounting for variation in rectal capacity, we aimed to improve the inconsistent relationship between rectal compliance, sensation, and continence reported in the literature. METHOD: Barostat measurements of rectal compliance and capacity were validated in 41 healthy, continent subjects. Slow staircase (0-40 mmHg) and rapid phasic (12-40 mmHg) distentions were performed on two separate days, filling sensations were assessed by visual analog score. A stool substitute retention test of rectal filling sensation and continence was performed. RESULTS: Variance of volume measurements decreased with pressure comparing conditioning vs. index distentions, staircase vs. phasic distentions, and measurements on different days (all $P < 0.001$). Correction for rectal capacity measured at 40 mmHg reduced the "normal range" of compliance measurements ($P < 0.01$) but not vice versa. Compared with unadjusted volume measurements, normalized rectal volume (percentage filling relative to rectal capacity) improved the description of rectal sensation visual analog score ($P < 0.01$). Rectal capacity correlated with filling sensations and the volume retained on retention testing ($P < 0.01$). CONCLUSION: Barostat measurements of rectal capacity at 40 mmHg are highly reproducible and not affected by distention protocol. The assessment of rectal capacity complements that of rectal compliance. Correction for rectal capacity provides an assessment of rectal wall stiffness independent of rectal geometry and improves the association of barostat volume measurements with rectal sensitivity and continence.

Does fecal occult blood testing really reduce mortality? A reanalysis of systematic review data.
Moayyedi P, Achkar E
Am J Gastroenterol. 2006 Feb;101(2):380-4.
INTRODUCTION: Colorectal cancer (CRC) is a common cause of cancer mortality. A variety of CRC screening strategies are being adopted in many developed countries. Fecal occult blood testing (FOBT) is one option for screening that has the most evidence for efficacy and is also the cheapest approach. Systematic reviews suggest that FOBT is effective in reducing CRC mortality but the data on overall mortality from any cause has rarely been synthesized. METHODS: Randomized controlled trials identified by a Cochrane review of the efficacy of FOBT were reanalyzed. Trials that reported on biennial FOBT with all cause mortality assessed at similar follow-up periods were analyzed. CRC, non-CRC, and all cause mortality were evaluated using a random effects model. RESULTS: Three trials were analyzed, involving 245,217 subjects with 2,148 CRC deaths after almost 3 million patient-years follow-up. The relative risk (RR) of CRC death in the FOBT arm was 0.87 (95% CI = 0.8-0.95). The RR of non-CRC death in the FOBT group was 1.02 (95% CI = 1.00-1.04, p= 0.015). The increase in non-CRC in the FOBT group balanced the decrease in CRC mortality with no overall impact on mortality (RR of dying in the FOBT arm = 1.002, 95% CI = 0.989-1.015). CONCLUSION: The impact of FOBT in reducing mortality from any cause is uncertain and efficacy of this strategy for CRC screening needs reevaluation.

Fecal occult blood test screening in the United kingdom.
Steele RJ
Am J Gastroenterol. 2006 Feb;101(2):216-8.

Colorectal Cancer Screening with Fecal Occult Blood Testing (FOBT): An International Perspective.
Achkar E, Moayyedi P
Am J Gastroenterol. 2006 Feb;101(2):212.

Colorectal cancer screening: practices and attitudes of gastroenterologists, internists and surgeons.
Hilsden RJ, McGregor E, Murray A, Khoja S, Bryant H
Can J Surg. 2005 Dec;48(6):434-40.
BACKGROUND: The Canadian Task Force on Preventive Health Care has recommended the use of annual or biennial fecal occult blood testing (FOBT) and flexible sigmoidoscopy in the periodic health examination of asymptomatic people over 50 years of age. Therefore, we decided to ascertain the current colorectal cancer (CRC) screening practices and attitudes of surgeons, gastroenterologists and internists. METHODS: In June 2002 (with a final mailing in December 2002), a questionnaire was sent to all gastroenterologists, internists and surgeons in Alberta. It included items on demographic and practice characteristics, CRC screening practices and opinions about CRC screening. RESULTS: Responses were received from 42 gastroenterologists, 83 internists and 68 surgeons. Overall, 141 of 187 respondents (75.4%, 95% confidence interval [CI] 68.6%-81.4%) recommended that average-risk adults undergo CRC screening. Internists were less likely to recommend screening than either gastroenterologists or surgeons (95% CI for the difference 7.2%-32.8%). The most commonly recommended screening test was colonoscopy (70%), followed by FOBT (65%), flexible sigmoidoscopy (47%) and air-contrast barium enema (31%). Colonoscopy was the only test recommended by 7 (22.6%) of 33 gastroenterologists, 9 (16.4%) of 59 surgeons and 3 (6.1%) of 49 internists. Respondents were more likely to list barriers to the use of colonoscopy (mean 5 barriers) for

screening than for either FOBT or flexible sigmoidoscopy (mean 2 barriers for both tests). Only 3 respondents indicated that they themselves would not undergo screening. Colonoscopy was the only screening test that 135 (70.0%) of the 193 would themselves undergo. CONCLUSIONS: The majority of Alberta specialists recommend CRC screening for average-risk adults. Colonoscopy was the most commonly recommended test, despite the perception of more barriers to that technique and the 2001 guidelines prepared by the Canadian Task Force for Preventive Health Care, which did not support colonoscopy.

Fecal occult blood testing options.
Lastella VP
Gastroenterology. 2006 Jan;130(1):285; author reply 285.

Reply.
Ebara M
Gastroenterology. 2006 Jan;130(1):282.

The case for direct colonoscopy screening for colorectal cancer.
Bond JH
Am J Gastroenterol. 2006 Feb;101(2):263-5.
Recent large series of direct colonoscopy screening for colorectal cancer increase our understanding of the advantages of this approach, and have indirectly confirmed efficacy. When performed by well-trained, experienced endoscopists, colonoscopy screening is successful and safe. The prevalence of advanced neoplasia is low under the age of 50 yr but increases substantially with each decade of life thereafter at least until the age of 80 yr. Most detected cancers are at an early, curable stage. A substantial number of proximal advanced neoplasia are detected that would be missed by screening flexible sigmoidoscopy. Widespread population-based colonoscopy screening would markedly decrease the incidence and mortality of this major malignancy. Issues of compliance and capacity related to direct colonoscopy have not yet been adequately addressed.

Colonoscopy, tumors, and inflammatory bowel disease - new diagnostic methods.
Kiesslich R, Hoffman A, Neurath MF
Endoscopy. 2006 Jan;38(1):5-10.
Accurate detection of premalignant lesions and early cancers in the colon is essential for curative endoscopic or surgical therapy, since the prognosis for the affected patients is closely related to the size and stage of the neoplastic lesion. Total colonoscopy is the accepted gold standard for screening and surveillance of colorectal cancer. This review summarizes recently published diagnostic developments and key findings in the areas of colonoscopy, colonic tumors, and inflammatory bowel diseases. Relevant findings have been reported for chromo-endoscopy in the diagnosis of colitis-associated neoplasia, as well as flat and depressed adenomas. Real-time Doppler capabilities have now been added to endoscopic optical coherence tomography; the results of large-scale testing of narrow-band imaging endoscopy in the colon are being awaited; and fluorescence imaging has recently been added to the facilities available in video endoscopy. Most importantly, endomicroscopy now for the first time allows single-cell subsurface imaging during ongoing colonoscopy procedures, opening the way to in-vivo molecular and functional imaging.

Diagnostic and therapeutic impact of double-balloon enteroscopy.
Monkemuller K, Weigt J, Treiber G, Kolfenbach S, Kahl S, Rocken C, Ebert M, Fry LC, Malfertheiner P
Endoscopy. 2006 Jan;38(1):67-72.

Preliminary comparison of capsule endoscopy and double-balloon enteroscopy in patients with suspected small-bowel bleeding.
Nakamura M, Niwa Y, Ohmiya N, Miyahara R, Ohashi A, Itoh A, Hirooka Y, Goto H
Endoscopy. 2006 Jan;38(1):59-66.

Ileus secondary to wireless capsule enteroscopy.
Magdeburg R, Riester T, Hummel F, Lohr M, Post S, Sturm J
Int J Colorectal Dis. 2006 Jan 13;:1-4.

Double-balloon enteroscopy: indications, diagnostic yield, and complications in a series of 275 patients with suspected small-bowel disease.
Heine GD, Hadithi M, Groenen MJ, Kuipers EJ, Jacobs MA, Mulder CJ
Endoscopy. 2006 Jan;38(1):42-8.

Study of the role of the transverse perineal muscles during rectal filling.
Shafik A, Shafik AA, Shafik I, El-Sibai O
Int J Colorectal Dis. 2006 Jan 13;:1-7.
BACKGROUND: The function of perineal muscles at defecation is poorly addressed in the literature. We investigated the hypothesis that rectal distension effects reflex contraction of four perineal muscles. PATIENT/METHODS: After rectal balloon distension with carbon dioxide in increments of 20 ml, the responses of electromyographic (EMG) activity of superficial (STPM) and deep (DTPM) transverse perineal muscles as well as the rectal pressure were recorded in 22 healthy volunteers (14 men, age 37.2+/-6.3 years). Responses were registered again after individual anesthetization of rectum and transverse perineal muscles. Tests were repeated using saline instead of lidocaine. RESULTS/FINDINGS: Rectal balloon distension in big volumes effected increase of the transverse perineal muscles' EMG activity and rectal pressure. The more the rectum was distended, the more the rectal pressure and EMG activity of the transverse perineal muscles were increased. The latency showed a gradual decrease upon incremental rectal distension increase. Transverse perineal muscles did not respond to rectal distension after the rectum and perineal muscles had been individually anesthetized, but it responded to saline administration. Response of the muscles was similar in both sides. INTERPRETATION/CONCLUSION: Increase of rectal pressure increases EMG activity of transverse perineal muscles. This action seems mediated through a reflex which we call 'recto-perineal reflex'. Contraction of transverse perineal muscles at defecation presumably supports the perineal floor. It also protects transverse perineal muscles against straining-produced high pressure that is transmitted through the recto-vaginal/-vesical cul de sac to the perineum which may sag down and share in genesis of perineocele, enterocele, or sigmoidocele.

4 – PROLAPSES 2006 01
Pelvic organ prolapse: is it time to define it?
Swift S
Int Urogynecol J Pelvic Floor Dysfunct. 2005 Nov-Dec;16(6):425-7.

Expression of lysyl oxidase and transforming growth factor beta2 in women with severe pelvic organ prolapse.
Kobak W, Lu J, Hardart A, Zhang C, Stanczyk FZ, Felix JC
J Reprod Med. 2005 Nov;50(11):827-31.
Patients with severe pelvic organ prolapse (grade > or = 3) have a significant reduction in the mRNA expression of lysyl oxidase as compared to asymptomatic controls. The mRNA expression of TGF beta2 was not statistically different between the 2 groups. These findings lend further credence to the concept of specific biochemical changes in the pelvic floor in women with pelvic organ prolapse.

Perineocele: symptom complex, description of anatomic defect, and surgical technique for repair.
Schlunt Eilber K, Rosenblum N, Gore J, Raz S, Rodriguez LV
Urology. 2006 Jan 25;.
OBJECTIVES: To describe the patient characteristics, physical examination and magnetic resonance imaging findings, and method of surgical repair of perineocele. A perineocele is a rare condition of an isolated central defect and herniation of the posterior perineum in patients without diffuse vaginal prolapse. Posterior levator defects can result in perineal hernia with perineal body attenuation, separation of the transverse perineal and anal sphincter musculature, and development of a perineocele. The relief of symptoms and correction of the anatomic defect can be achieved by reapproximation of these structures.

Severity of pelvic organ prolapse associated with measurements of pelvic floor function.
Ghetti C, Gregory WT, Edwards SR, Otto LN, Clark AL
Int Urogynecol J Pelvic Floor Dysfunct. 2005 Nov-Dec;16(6):432-6. Epub 2005 Jan 20.
This study tested the hypothesis that clinical measurements of the superficial perineum and of pelvic floor muscle (PFM) function correlate with the severity of pelvic organ prolapse. This retrospective cross-sectional study assessed 1037 women in an academic urogynecologic practice. Greatest descent of prolapse, by the Pelvic Organ Prolapse Quantification system, was correlated with two assessments of levator function--the Oxford grading scale and levator hiatus (LH) size measured by digital examination. Correlations were calculated using Pearson's correlation for continuous variables and Kendall's tau-b. Severity of prolapse correlated moderately with genital hiatus (GH) ($r = 0.5$, $p<0.0001$) and with LH (transverse $r = 0.4$, $p < 0.0001$; longitudinal $r = 0.5$, $p < 0.0001$), but weakly with the Oxford grading scale ($r = -0.16$, $p < 0.0001$). LH correlated with GH ($r = 0.5$, $p < 0.0001$) but not with perineal body ($r = 0.06$, $p = 0.06$). Both GH and LH size are associated with the severity of prolapse. LH size correlates more strongly to prolapse severity than

assessment of PFM function by the Oxford grading scale.

Roles of estrogen receptor, progesterone receptor, p53 and p21 in pathogenesis of pelvic organ prolapse.
Bai SW, Chung da J, Yoon JM, Shin JS, Kim SK, Park KH
Int Urogynecol J Pelvic Floor Dysfunct. 2005 Nov-Dec;16(6):492-6. Epub 2005 May 25.
ER, PR, p53, and p21 were significantly lower in the study than control group ($p<0.0001$). Positive correlations were found among all proteins in the prolapse group. Further researches are needed to elucidate the interrelationship among these proteins and their precise roles in pathogenesis of POP.

Uterosacral ligament in postmenopausal women with or without pelvic organ prolapse.
Gabriel B, Denschlag D, Gobel H, Fittkow C, Werner M, Gitsch G, Watermann D
Int Urogynecol J Pelvic Floor Dysfunct. 2005 Nov-Dec;16(6):475-9. Epub 2005 Apr 22.
The uterosacral ligaments are thought to contribute to pelvic support. Our findings suggest that the higher collagen III expression might be a typical characteristic of POP patients' connective tissue. The considerable amount of smooth muscle cells in uterosacral ligaments may provide pelvic support.

The asymptomatic hernia: "if it's not broken, don't fix it".
Flum DR
JAMA. 2006 Jan 18;295(3):328-9

Watchful waiting vs repair of inguinal hernia in minimally symptomatic men: a randomized clinical trial.
Fitzgibbons RJ Jr, Giobbie-Hurder A, Gibbs JO, Dunlop DD, Reda DJ, McCarthy M Jr, Neumayer LA, Barkun JS, Hoehn JL, Murphy JT, Sarosi GA Jr, Syme WC, Thompson JS, Wang J, Jonasson O
JAMA. 2006 Jan 18;295(3):285-92.

[Choice of prosthesis in genital prolapse surgery]
Roumeguere T
Prog Urol. 2005 Dec;15(6):1042-5.

Which bowel symptoms are most strongly associated with a rectocele?
Dietz HP, Korda A
Aust N Z J Obstet Gynaecol. 2005 Dec;45(6):505-8.
Abstract Background: Posterior vaginal wall prolapse is common in parous women and may be due to rectocele, enterocele or perineal hypermobility. Translabial ultrasound can be used to detect defects of the rectovaginal septum, that is, a 'true rectocele', potentially avoiding the need for defecation proctography. However, it is currently unknown whether specific sonographic appearances are associated with bowel symptoms. Aims: To correlate symptoms of bowel dysfunction and sonographic findings. Methods: In a prospective observational study, 505 women were seen during attendance at tertiary urogynaecological clinics and underwent a standardised interview, which included a set of questions regarding bowel function. They were assessed clinically and by translabial ultrasound, supine and after voiding. The presence of a rectocele was determined on maximal Valsalva. Results: Clinically, 314 women (64%) were found to have a rectocele. There were associations between clinical staging and ampullary descent on ultrasound ($P < 0.001$), the presence of a true rectocele ($P < 0.001$) and the depth of a defect ($P < 0.001$). Defects of the rectovaginal septum ('true rectocele') were identified in 54%. They were associated with symptoms of incomplete bowel emptying ($P < 0.001$) and digitation ($P = 0.002$), and less so with dyschezia ($P = 0.01$), faecal incontinence ($P = 0.02$) and chronic constipation ($P = 0.04$). Conclusions: True rectoceles are found in more than half of women presenting with pelvic floor disorders. This finding correlates strongly with clinical prolapse grading - large clinical rectoceles are more likely to be caused by a fascial defect. Incomplete bowel emptying and digitation are significantly associated with such defects detected on ultrasound.

[Transvaginal treatment of anterior vaginal prolapse with collagen implant transobturator fixation]
Miaadi N, Ferhi K, Descargue G, Grise P
Prog Urol. 2005 Dec;15(6):1110-3.

Anterior vaginal wall prolapse: innovative surgical approaches.
Walters MD, Paraiso MF
Cleve Clin J Med. 2005 Dec;72 Suppl 4:S20-7.

Vaginal vault prolapse: identification and surgical options.
Biller DH, Davila GW
Cleve Clin J Med. 2005 Dec;72 Suppl 4:S12-9.
Reconstructive surgeons should be familiar with the identification and treatment of vaginal vault prolapse. Most utilized techniques can be effective in terms of suspension of the vaginal apex. New technology has allowed for the performance of vaginal-approach techniques with increasingly physiologic anatomic and functional outcomes (Figure 8).

Fiber for the treatment of hemorrhoids complications: a systematic review and meta-analysis.
Alonso-Coello P, Mills E, Heels-Ansdell D, Lopez-Yarto M, Zhou Q, Johanson JF, Guyatt G
Am J Gastroenterol. 2006 Jan;101(1):181-8.
Trials of fiber show a consistent beneficial effect for symptoms and bleeding in the treatment of symptomatic hemorrhoids.

First 100 Cases With Doppler-Guided Hemorrhoidal Artery Ligation.
Greenberg R, Karin E, Avital S, Skornick Y, Werbin N
Dis Colon Rectum. 2006 Jan 31;.
Doppler-guided hemorrhoidal artery ligation is safe and effective and can be performed as an outpatient procedure with local or regional anesthesia and with minimal postoperative pain and early recovery.

Doppler-guided hemorrhoidal artery ligation.
Scheyer M, Antonietti E, Rollinger G, Mall H, Arnold S
Am J Surg. 2006 Jan;191(1):89-93.
HAL is painless, effective, and has a low rate of complications. It can be applied in an outpatient setting and is an good alternative to all other hemorrhoid treatment methods.

Improvement of wound healing after hemorrhoidectomy: a double-blind, randomized study of botulinum toxin injection.
Patti R, Almasio PL, Muggeo VM, Buscemi S, Arcara M, Matranga S, Di Vita G
Dis Colon Rectum. 2005 Dec;48(12):2173-9.
Botulinum toxin injection into internal anal sphincter after hemorrhoidectomy is effective in reducing maximum resting pressure, time of healing, and postoperative pain both on resting and during defecation in absence of complications or side effects.

5 – RETENTIONS 2006 01

Urinary retention during sacral nerve stimulation for faecal incontinence: report of a case.
Michelsen HB, Buntzen S, Krogh K, Laurberg S
Int J Colorectal Dis. 2006 Jan 13;:1-3.
Sacral nerve stimulation (SNS) was proposed for the treatment of patients with urologic symptoms in 1967 but was not used until 1981. SNS has also proven to be a promising treatment in idiopathic faecal incontinence when conventional treatments have failed. The modality has been used for faecal incontinence since the mid-1990s. Eighty percent of the patients who were selected for percutaneous nerve evaluation (PNE) because of faecal incontinence report an improvement in the symptoms and qualify for a permanent implantation. Accordingly, SNS is now used for faecal incontinence and urologic symptoms. Reflex interactions between the bladder and the distal gastrointestinal tract are well known. The present case shows that SNS for faecal incontinence may significantly influence bladder function.

Various surgical approaches to treat voiding dysfunction following anti-incontinence surgery.
Segal J, Steele A, Vassallo B, Kleeman S, Silva AW, Pauls R, Walsh P, Karram M
Int Urogynecol J Pelvic Floor Dysfunct. 2006 Jan 21;:1-6.
OBJECTIVE: The aims of this study are to report the efficacy of retropubic urethrolysis, vaginal urethrolysis, and cutting of synthetic suburethral slings in treating postoperative voiding dysfunction that occurs after anti-incontinence surgery and to report the recurrence rate of stress urinary incontinence (SUI). METHODS: All patients from January 1996 to October 2003 who presented with voiding dysfunction following an anti-incontinence procedure and who subsequently underwent either retropubic urethrolysis, vaginal urethrolysis, or synthetic suburethral sling takedown were included in the study. Pre- and postoperative irritative symptoms (urinary frequency or urgency), obstructive symptoms (hesitancy, voiding difficulty, and incomplete emptying), and stress urinary incontinence symptoms were obtained in a standardized fashion. The Incontinence Impact Questionnaire and Urogenital Distres Invetory quality of life (QOL) questionnaires

were also obtained to objectify these symptoms. Other objective postoperative analysis included simple uroflowmetry, measurement of postvoid residual (PVR), and simple or subtracted cystometry. RESULTS: Forty-four patients were included in the study (suburethral sling takedown=14, vaginal urethrolysis=20, and retropubic urethrolysis=10), 77% of whom had objective follow-up. Preoperatively, 31 patients (70.5%) had irritative symptoms, 41 (93.2%) had obstructive symptoms, and 6 (13.6%) had symptoms of stress urinary incontinence (SUI), while postoperatively, these symptoms were found in 30 (68.2%), 11 (25.0%), and 18 (40.9%), respectively. Postoperatively, 6 patients (17.6%) had a PVR> 100 cc, 5 patients (14.7%) had a bladder contractions, and 16 patients (47.1%) demonstrated the sign or diagnosis of (SUI). Additionally, there was a statistically significant improvement in both QOL questionnaires. CONCLUSIONS: Various surgical approaches may be used to treat voiding dysfunction following an anti-incontinence procedure. Following a vaginal or retropubic urethrolysis or takedown of a synthetic suburethral sling, obstructive symptoms are likely to improve, irritative symptoms may remain unchanged, and almost half will develop recurrence of SUI.

Urinary retention following tension-free vaginal tape successfully treated by sacral neuromodulation.
Adam RA
Int Urogynecol J Pelvic Floor Dysfunct. 2006 Jan 12;:1-2.
Postoperative urinary retention following anti-incontinence surgery has traditionally been thought to be due to overcorrection. There is increasing evidence, however, that a neurogenic component may also play a significant role. This is a case report of a 72-year-old woman who developed delayed partial urinary retention following a tension-free vaginal tape which resolved with initial sacral neuromodulation.

Colectomy for colonic inertia: successful relief of constipation is not enough.
Ringel Y
Gastroenterology. 2006 Jan;130(1):273-4; discussion 274-5.
Reply.
Wexner SD
Gastroenterology. 2006 Jan;130(1):274-5.

Cecostomy in children with defecation disorders.
Mousa HM, Den Berg MM, Caniano DA, Hogan M, Di Lorenzo C, Hayes J
Dig Dis Sci. 2006 Jan;51(1):154-60.

New insight into rectal function in pediatric defecation disorders: disturbed rectal compliance is an essential mechanism in pediatric constipation.
Voskuijl WP, van Ginkel R, Benninga MA, Hart GA, Taminiau JA, Boeckxstaens GE
J Pediatr. 2006 Jan;148(1):62-7.
OBJECTIVE: To evaluate rectal sensitivity in patients with pediatric constipation (PC) and nonretentive fecal soiling (FNRFS) using pressure-controlled distention (barostat). STUDY DESIGN: Thresholds for rectal sensitivity (first sensation, urge to defecate, and pain), and rectal compliance were determined using a barostat. RESULTS: A total of 69 patients with PC (50 males; mean age, 10.9 +/- 2.2 years) and 19 patients with FNRFS (15 males; mean age, 10.0 +/- 1.9 years) were compared with 22 healthy volunteers (HVs) (11 males; mean age, 12.7 +/- 2.6 years). Sensitivity thresholds were not significantly different among the 3 groups. Rectal compliance was increased in 58% of the patients with PC ($P < .0001$ vs HVs). Rectal compliance did not differ between patients with FNRFS and HVs. Children with PC with abnormal rectal function required significantly larger rectal volumes at urge to defecate. CONCLUSIONS: Increased compliance is the most prominent feature in patients with PC. Because of higher compliance in these children, larger stool volumes are required to reach the intrarectal pressure of the urge to defecate. Children with FNRFS have normal rectal function.

6 – INCONTINENCES 2006 01
Five cases of tape erosion after transobturator surgery for urinary incontinence.
Robert M, Murphy M, Birch C, Swaby C, Ross S
Obstet Gynecol. 2006 Feb;107(2):472-4.
BACKGROUND: Before introducing the transobturator tape into our practice we undertook 52 transobturator tape procedures. The transobturator tape procedures were undertaken with an "outside-in" approach, using nonwoven polypropylene mesh with average pore size of 50 mum. CASES: Five cases of vaginal erosions have been identified, 1 complicated by a groin abscess. All cases required further procedures to trim (n = 3), resect (n = 1) or remove (n = 1) the tape. One woman had a tension-free vaginal tape procedure. To date, 3 women remain incontinent. CONCLUSION: Possible reasons for the complications include 1) surgical

inexperience (unlikely, given that we have undertaken more than 2000 tension-free vaginal tape procedures without similar complication rates); 2) inherent susceptibility of the "hammock" position of the transobturator tape; or 3) the nonwoven polypropylene tape with mesh size of 50 mum itself may predispose to erosion or abscess.

Differences in prevalence of urinary incontinence by race/ethnicity.
Thom DH, van den Eeden SK, Ragins AI, Wassel-Fyr C, Vittinghof E, Subak LL, Brown JS
J Urol. 2006 Jan;175(1):259-64.
Significant differences in the adjusted risk of stress incontinence among Hispanic, white, black and Asian-American women suggest the presence of additional, as yet unrecognized, risk or protective factors for stress incontinence.

Severe mesh complications following intravaginal slingplasty.
Molloy WB
Obstet Gynecol. 2006 Feb;107(2):423.

Severe mesh complications following intravaginal slingplasty.
Richardson PA
Obstet Gynecol. 2006 Feb;107(2):422.

Life with incontinence.
Gartley C
Lancet. 2006 Jan 7;367(9504):68.

Urinary incontinence in women.
Norton P, Brubaker L
Lancet. 2006 Jan 7;367(9504):57-67.
Urinary incontinence is common in women, but is under-reported and under-treated. Urine storage and emptying is a complex coordination between the bladder and urethra, and disturbances in the system due to childbirth, aging, or other medical conditions can lead to urinary incontinence. The two main types of incontinence in women, stress urinary incontinence and urge urinary incontinence, can be evaluated by history and simple clinical assessment available to most primary care physicians. There is a wide range of therapeutic options, but the recent proliferation of new drug treatments and surgical devices for urinary incontinence have had mixed results; direct-to-consumer advertising has increased public awareness of the problem of urinary incontinence, but many new products are being introduced without long-term assessment of their safety and efficacy.

Overactive bladder: a better understanding of pathophysiology, diagnosis and management.
Wein AJ, Rackley RR
J Urol. 2006 Mar;175(3 Suppl):S5-S10.
PURPOSE: We reviewed current information regarding the updated definitions, prevalence, etiologies, disease burden, and management of OAB from a number of perspectives, including professional impact and patient quality of life. MATERIALS AND METHODS: Published literature and current treatment concepts were reviewed regarding the understanding and management of OAB. RESULTS: OAB is a symptom syndrome including urinary urgency with or without urinary incontinence, usually with frequency and nocturia. Approximately 17% of the adult population experience OAB. There are evolving theories regarding its pathophysiology and the mechanism of action of the most commonly prescribed pharmacological therapy (antimuscarinic agents). Treatment primarily revolves around improving quality of life. CONCLUSIONS: Behavioral therapy combined with pharmacological therapy often will bring about acceptable outcomes for patients with OAB. Modalities such as botulinum toxin injections, neuromodulation, and various surgical interventions also are showing encouraging results in more refractory patients.

Behavioral treatment options for urinary incontinence.
Wein AJ
J Urol. 2006 Feb;175(2):630-1.

The role of pelvic floor muscle training in urinary incontinence.
Wein AJ
J Urol. 2006 Feb;175(2):630-1.

Who will benefit from pelvic floor muscle training for stress urinary incontinence?
Wein AJ
J Urol. 2006 Feb;175(2):629-31.

Pelvic floor muscle training is effective in treatment of female stress urinary incontinence, but how does it work?
Wein AJ
J Urol. 2006 Feb;175(2):629-31.

Comparison of the long-term outcomes between incontinent men and women treated with artificial urinary sphincter.
Petero VG Jr, Diokno AC
J Urol. 2006 Feb;175(2):605-9.

Do extracellular matrix protein expressions change with cyclic reproductive hormones in pelvic connective tissue from women with stress urinary incontinence?
Wen Y, Polan ML, Chen B
Hum Reprod. 2006 Feb 1;.
BACKGROUND: To evaluate differential expression of transforming growth factor (TGF-beta1), latent transforming factor-binding proteins (LTBP-1, LTBP-2) and elastin microfibril components (fibrillin-1 and fibrillin-2) in vaginal tissue from women with stress urinary incontinence (SUI). METHODS: In this case-control study, vaginal tissue from women in both phases of the menstrual cycle was obtained. Messenger RNA (mRNA) expressions of LTBP-1, LTBP-2, fibrillin-1, fibrillin-2 and TGF-beta1 were determined by relative real-time quantification PCR. Tissue localization was analysed by immunohistochemistry, and semiquantitative protein expression was evaluated by Western blot analysis. RESULTS: Vaginal wall fibroblasts synthesized all proteins tested. LTBP-1, LTBP-2 and TGF-beta1 co-localized with elastin microfibrils, fibrillin-1 and fibrillin-2 in the extracellular matrix. LTBP-1 mRNA and protein expressions were higher in control versus women affected with SUI in the proliferative phase ($P = 0.04$), while in the secretory phase, mRNA expression in cases was higher ($P = 0.04$). Fibrillin-1 mRNA was higher in women affected by SUI versus controls in both phases, but no statistical differences in fibrillin-1 protein expression were observed between the two groups in either phase. LTBP-2 and TGF-beta1 mRNA expressions showed the same trends as LTBP-1. CONCLUSION: LTBP-1, LTBP-2, TGF-beta1, fibrillin-1, and fibrillin-2 expressions are hormonally regulated in vaginal wall fibroblasts and differ in women affected by SUI when compared to controls. These data suggest a mechanism to regulate TGF-beta1 activity in pelvic connective tissue.

Transobturator SAFYRE sling is as effective as the transvaginal procedure.
Palma P, Riccetto C, Herrmann V, Dambros M, Thiel M, Bandiera S, Netto NR Jr
Int Urogynecol J Pelvic Floor Dysfunct. 2005 Nov-Dec;16(6):487-91. Epub 2005 May 12.

Management of polypropylene mesh erosion after intravaginal midurethral sling operation for female stress urinary incontinence.
Huang KH, Kung FT, Liang HM, Chang SY
Int Urogynecol J Pelvic Floor Dysfunct. 2005 Nov-Dec;16(6):437-40. Epub 2005 Jan 15.

Vaginal wall erosion after transobturator tape procedure.
But I
Int Urogynecol J Pelvic Floor Dysfunct. 2005 Nov-Dec;16(6):506-8. Epub 2005 Jan 12.
Transobturator Prolene tape insertion represents a new method of operative treatment for stress urinary incontinence. The first results show that it is a simple and effective procedure accompanied by a minimum number of complications. Since February 2004, 30 Monarc procedures were done at our department and no intraoperative complications were observed. However, two cases (6.7%) of vaginal wall erosion due to the Prolene tape were noted 6 weeks after surgery. In a subsequent surgical procedure, the periurethral portion of the tape was removed and a new Prolene tape was placed through the retropubic space. Three months after secondary surgery both patients were continent, with no sign of erosion. The transobturator approach was introduced to minimize the risk of complications. However, the greater prevalence of vaginal wall erosion after this procedure found in our series demands a scrupulous search for this complication and for the mechanisms leading to its occurrence.

Transobturator tape, bladder perforation, and paravaginal defect: a case report.
Smith PP, Appell RA

Int Urogynecol J Pelvic Floor Dysfunct. 2006 Jan 26;:1-3.
Transobturator midurethral slings (TOT) have been shown to have less risk of vascular and visceral injury than tension-free midurethral slings. Routine cystoscopy has therefore not been felt to be necessary. A case of bladder perforation unrecognized at the time of TOT placement is presented. Findings at sling removal suggested that a clinically nonapparent paravaginal defect may have been instrumental in the injury. Consideration should be given to routine cystoscopy at the time of transobturator sling placement.

Proposed Mechanism for the Efficacy of Injected Botulinum Toxin in the Treatment of Human Detrusor Overactivity.
Apostolidis A, Dasgupta P, Fowler CJ
Eur Urol. 2006 Jan 4;.
BACKGROUND: Treatment of human bladder overactivity with intradetrusor Botulinum-A neurotoxin (BoNT/A) injections temporarily blocks the presynaptic release of acetylcholine from the parasympathetic innervation and produces a paralysis of the detrusor smooth muscle. The efficacy of the treatment exceeds that expected from simple detrusor muscle paralysis, however, and its effect of reducing urgency is greatly welcomed by patients. OBJECTIVES: To examine whether BoNT/A has a complex effect on sensory mechanisms by inhibiting vesicular release of multiple excitatory neurotransmitters by urothelial and suburothelial nerves and reducing axonal expression of SNARE-complex dependant proteins. METHODS: A literature review. CONCLUSIONS: We propose that a primary peripheral effect of BoNT/A is the inhibition of release of acetylcholine, ATP, substance P, and reduction in the axonal expression of the capsaicin and purinergic receptors. This may be followed by central desensitization through a decrease in central uptake of substance P and neurotrophic factors. The summation of these effects is a profound and long-lasting inhibition of those afferent and efferent mechanisms that are thought to be the pathophysiological basis for DO.

Selecting an outcome measure for evaluating treatment in fecal incontinence.
Deutekom M, Terra MP, Dobben AC, Dijkgraaf MG, Felt-Bersma RJ, Stoker J, Bossuyt PM
Dis Colon Rectum. 2005 Dec;48(12):2294-301.
PURPOSE: Various outcome measures exist to evaluate treatment in fecal incontinence, including descriptive, severity (fecal incontinence scoring systems), and impact (quality-of-life questionnaires) and diagnostic measures. We studied associations between changes after treatment for a number of outcome measures and compared them to patients' subjective perception of relief. METHODS: We analyzed data of 66 patients (92 percent female; mean age, 62 years) (Vaizey score, Wexner score, two impact scales, utility, resting pressure, and maximal incremental squeeze pressure) at baseline and after physiotherapy. In a standardized interview by phone, we asked patients to compare their situation before and after treatment. Correlations between changes in outcome measures were calculated. These changes were compared with patients' subjective perception. RESULTS: There was a high correlation between the changes in the Vaizey and the Wexner scores ($r = 0.94$, $P < 0.01$). Changes in Vaizey and Wexner scores correlated moderately with changes in maximum incremental squeeze pressure ($r = -0.29$, -0.30, both $P < 0.05$). Changes in utility and resting pressure were not correlated with changes in any of the other measurements (all r values between -0.086 and 0.18). Average severity scores (Vaizey and Wexner) were 1 point lower for patients who rated their situation as worse or equal (62 percent), 4 points lower for patients who reported their situation to be better (21 percent), and 9 points lower in patients who rated their situation much better (17 percent) ($P < .05$). CONCLUSION: Severity measures are best related to patients' subjective perception of relief.

7 – PAIN 2006 01
Relations between pregnancy-related low back pain, pelvic floor activity and pelvic floor dysfunction.
Pool-Goudzwaard AL, Slieker ten Hove MC, Vierhout ME, Mulder PH, Pool JJ, Snijders CJ, Stoeckart R
Int Urogynecol J Pelvic Floor Dysfunct. 2005 Nov-Dec;16(6):468-74. Epub 2005 Apr 1.
To assess the occurrence of pelvic floor dysfunction (PFD) in pregnancy- related low back and pelvic pain (PLBP) patients, a cross-sectional study was performed, comprising 77 subjects. Each subject underwent physical assessment, and filled in the Urogenital Distress Inventory completed with gynaecological questions. Differences in the presence of PFD between PLBP patients and healthy controls as well as differences in pelvic floor muscle activity were tested for significance. Interaction by age and vaginal delivery were tested. PFD occurred in 52% of all PLBP patients, significantly more than in the healthy control group. In PLBP patients a significantly increased activity of the pelvic floor muscles could be demonstrated with respect to healthy controls. The occurrence of PFD and PLBP was influenced by a confounding effect of age. Clinicians should be aware of the relation between PLBP and PFD and hence address both problems at the same time.

High incidence of chronic pain following surgery for pelvic fracture.
Meyhoff CS, Thomsen CH, Rasmussen LS, Nielsen PR
Clin J Pain. 2006 Feb;22(2):167-72.

Symptoms and cystoscopic findings in patients with untreated interstitial cystitis.
Lamale LM, Lutgendorf SK, Hoffman AN, Kreder KJ
Urology. 2006 Jan 24;.
OBJECTIVES: To examine the relationships between symptoms and cystoscopic findings in women newly diagnosed with interstitial cystitis who had not previously received treatment. METHODS: Twelve newly diagnosed and not previously treated women with interstitial cystitis completed a bladder symptom questionnaire the day before undergoing cystoscopy, hydrodistension, and biopsy. The daily voiding frequency was reported. Cystoscopic findings were converted to a numerical scale, and the data were analyzed using Pearson correlations. RESULTS: Pain symptoms had consistent positive correlations with the cystoscopic findings. An increase in pain with bladder filling was associated with inflammation (P = 0.011), ulceration, and smaller bladder capacity. Pain relief after voiding correlated with smaller bladder capacity (P = 0.019), hematuria, and total cystoscopic score. Pain intensity in the urethra was related to ulceration and hematuria, and pain in the lower abdomen was related to a smaller bladder capacity (P = 0.047), glomerulations, and a larger total cystoscopic score. Daytime frequency correlated negatively with most cystoscopic findings, and nocturnal frequency had a positive relationship with most cystoscopic findings and was significantly associated with a smaller bladder capacity (P = 0.010). Urgency showed no strong associations with any cystoscopic findings. CONCLUSIONS: In patients with untreated interstitial cystitis, a strong correlation between pain and cystoscopic findings was observed. The differences between our results and those of previous studies that found no relationship between symptom reports and cystoscopic findings suggest possible effects of treatment on pain perception and therapeutic influence on cystoscopic findings.

Surgical Treatment for the Vulvar Vestibulitis Syndrome.
Traas MA, Bekkers RL, Dony JM, Blom M, van Haren AW, Hendriks JC, Vierhout ME
Obstet Gynecol. 2006 Feb;107(2):256-262.
OBJECTIVE: To study the outcome and complications of surgical treatment for vulvar vestibulitis syndrome and to identify patient characteristics that may have influenced the outcome. METHODS: Relevant patient characteristics were extracted retrospectively from the medical records of 155 women aged 40 years or younger who had received surgical treatment for vulvar vestibulitis syndrome. To assess outcome and complications, 126 of these 155 women (81%) participated in a telephone interview, conducted 1 to 4 years after surgery. RESULTS: After surgery 93% of the patients could have sexual intercourse compared with 78% before surgery; this increase was statistically significant (Mantel-Haenszel odds ratio 3.43, 95% confidence interval [CI] 1.48-7.96). In 62% of the women (95% CI 53-70%), sexual intercourse was painless after surgery. Eighty-nine percent (95% CI 84-95%) would recommend surgical treatment to other women experiencing vulvar vestibulitis syndrome. There were no major complications. Decreased lubrication during sexual arousal was the most frequently reported adverse effect (24%, 95% CI 16-32%), followed by the development of a Bartholin's cyst (6%, 95% CI 2-10%). More of the women aged 30 years or younger reported that they could have sexual intercourse after surgery, and more of them would recommend surgical treatment to other patients than women aged 31 years or older. CONCLUSION: Surgical treatment for vulvar vestibulitis syndrome achieved high success rates with an acceptable rate of complications. Age of 30 years or younger was associated with a better outcome. LEVEL OF EVIDENCE: III.

Brain imaging in IBS: drawing the line between cognitive and non-cognitive processes.
Naliboff BD, Mayer EA
Gastroenterology. 2006 Jan;130(1):267-70.

Altered 5-hydroxytryptamine signaling in patients with constipation- and diarrhea-predominant irritable bowel syndrome.
Atkinson W, Lockhart S, Whorwell PJ, Keevil B, Houghton LA
Gastroenterology. 2006 Jan;130(1):34-43.
d-IBS is characterized by reduced 5-HT reuptake, whereas impaired release may be a feature of c-IBS. These results also provide a rational basis for current pharmacologic approaches involving modulation of different 5-HT receptors in c- and d-IBS.

Novel evidence for hypersensitivity of visceral sensory neural circuitry in irritable bowel syndrome patients.
Lawal A, Kern M, Sidhu H, Hofmann C, Shaker R

Gastroenterology. 2006 Jan;130(1):26-33.
BACKGROUND & AIMS: Visceral hypersensitivity in irritable bowel syndrome (IBS) patients has been documented by evaluation of perceived stimulations that can reflect abnormalities of both sensory neurocircuitry and cognitive processes. The presence of actual neurohypersensitivity in human beings has not been documented separately. Because subliminal stimulations are free from the influence of stimulus-related cognitive processes, functional magnetic resonance imaging (fMRI) cortical response to these stimuli can be considered a measure of activity of the neural circuitry alone. The aim of this study was to compare quantitatively the cerebral cortical fMRI activity response to equal subliminal stimulations between IBS patients and age-matched controls. METHODS: We studied 10 IBS patients and 10 healthy controls using a computerized barostat-controlled rectal distention device. fMRI activity volume and percent maximum signal intensity change for equal subliminal distention pressures were compared between controls and patients. RESULTS: Three levels of subliminal distention pressures (eg, 10, 15, and 20 mm Hg), were represented in both controls and patients and were analyzed for fMRI response. In all 3 distention levels the fMRI activity volume in IBS patients was significantly larger than age- and sex-matched controls ($P < .05$). The percent maximum signal intensity change was similar between IBS patients and controls. CONCLUSIONS: The volume of cerebral cortical activity response to equal subliminal distention pressures in IBS patients is significantly larger than in controls, documenting the existence of hypersensitivity of the neural circuitry in this patient group irrespective of stimulus-related cognitive processes.

A randomized double-blind placebo-controlled trial of rifaximin in patients with abdominal bloating and flatulence.
Sharara AI, Aoun E, Abdul-Baki H, Mounzer R, Sidani S, Elhajj I
Am J Gastroenterol. 2006 Feb;101(2):326-33.
A nonabsorbable antibiotic, Rifaximin is a safe and effective treatment for abdominal bloating and flatulence, including in IBS patients. Symptom improvement correlates with reduction in H(2)-breath excretion. Future trials are needed to examine the efficacy of long-term or cyclic rifaximin in functional colonic disorders.

The incidence of abdominal and pelvic surgery among patients with irritable bowel syndrome.
Cole JA, Yeaw JM, Cutone JA, Kuo B, Huang Z, Earnest DL, Walker AM
Dig Dis Sci. 2005 Dec;50(12):2268-75.
Rates of abdominopelvic surgery, with a particular focus on gallbladder procedures, were measured in patients with irritable bowel syndrome (IBS) (n = 108,936) and compared with those in a general population sample (n = 223,082). The patient sample was selected from persons who were members of a managed care organization during the years 1995-2000. Medical records from a randomly selected subset of IBS patients were reviewed to confirm the diagnosis. Crude and standardized rates and adjusted rate ratios for surgery were calculated. The incidence of abdominopelvic surgery, excluding gallbladder procedures, was 87% higher in patients with IBS than that for the general population. The incidence of gallbladder surgery was threefold higher in IBS patients than the general population. Patients with IBS have an increased risk for abdominopelvic and gallbladder surgery and, thus, an associated risk for experiencing morbidity and mortality associated with these surgical procedures.

A controlled cross-over study of the selective serotonin reuptake inhibitor citalopram in irritable bowel syndrome.
Tack J, Broekaert D, Fischler B, Van Oudenhove L, Gevers A, Janssens J
Gut. 2006 Jan 9;.

Local anesthesia in anal surgery: a simple, safe procedure.
Argov S, Levandovsky O
Am J Surg. 2006 Jan;191(1):111-3.

A symptom-based approach to making a positive diagnosis of irritable bowel syndrome with constipation.
Malagelada JR
Int J Clin Pract. 2006 Jan;60(1):57-63.
In this review we present an 'identify, eliminate, probe' algorithm that may be appropriate to establish a positive diagnosis of patients with IBS-C, as symptoms characteristic of patients in this IBS subgroup are least likely to be confused with symptoms reflecting serious organic disease.

Possible role of nitric oxide in visceral hypersensitivity in patients with irritable bowel syndrome.
Kuiken SD, Klooker TK, Tytgat GN, Lei A, Boeckxstaens GE

Neurogastroenterol Motil. 2006 Feb;18(2):115-22.

Ultrasound examination of the sigmoid colon: possible new diagnostic tool for irritable bowel syndrome.
Crade M, Pham V
Ultrasound Obstet Gynecol. 2006 Feb;27(2):206-9.
Transvaginal ultrasound was used in 175 female patients undergoing pelvic ultrasound studies for a variety of reasons, none specifically for bowel complaints. We measured the wall of the sigmoid colon and then obtained the history of positive or negative for IBS. RESULTS: The majority of those 27 reporting a history of IBS had thickening of the wall of the sigmoid colon. A cut-off of 3.0 mm gave a sensitivity for this group of patients of 70%, specificity of 95%, positive predictive value of 73% and negative predictive value of 95%.

Role of partially hydrolyzed guar gum in the treatment of irritable bowel syndrome.
Giannini EG, Mansi C, Dulbecco P, Savarino V
Nutrition. 2006 Jan 12;.
Partially hydrolyzed guar gum decreased symptoms in constipation-predominant and diarrhea-predominant forms of IBS and decreased abdominal pain.

8 – FISTULAE 2006 01
Spontaneous Intrapartum Vesicouterine Fistula.
Kaaki B, Gyves M, Goldman H
Obstet Gynecol. 2006 Feb;107(2):449-450.

Rectourethral fistula associated with two short segment urethral strictures in the anterior and posterior urethra: single-stage reconstruction using buccal mucosa and a radial forearm fasciocutaneous free flap.
Erickson BA, Dumanian GA, Sisco M, Jang TL, Halverson AL, Gonzalez CM
Urology. 2006 Jan;67(1):195-8.

Vesicouterine fistula as a complication of forceps delivery: a case report.
Nouira Y, Feki W, Rhouma SB, Salah IB, Horchani A
Int Urogynecol J Pelvic Floor Dysfunct. 2005 Nov-Dec;16(6):512-4. Epub 2005 Apr 5.

Bulbocavernosus muscle flap in the repair of complicated vesicovaginal fistula.
Xu Z, Fu Q
Int J Urol. 2005 Dec;12(12):1037-40.

Delayed post-traumatic prostatic-urethrorectal fistula: Transperineal rectal sparing repair - Point of technique.
Singh I, Mittal G, Kumar P, Gangas R
Int J Urol. 2006 Jan;13(1):92-4.
Abstract We describe the outcome and management of an unusual and interesting case of delayed post-traumatic prostatorectal fistula in a 40-year-old man. The fistula was repaired successfully via transperineal access without rectal or sphincteric transgression. We found the transperineal surgical approach simple, effective and useful in approaching the prostatorectal region for rectourinary fistulas. The transperineal approach is useful and should be considered in such select cases. We describe our technique that may be beneficial to many urologists.

Treatment of rectovaginal fistula: A 5-year review.
Casadesus D, Villasana L, Sanchez IM, Diaz H, Chavez M, Diaz A
Aust N Z J Obstet Gynaecol. 2006 Feb;46(1):49-51.
This paper presents a chart review of 17 patients who had been treated for rectovaginal fistula (RVF) from 1996 to 2000. In most cases (13; 76.5%), the fistula was the result of post-surgical complications. Following vaginal mucosa advancement flap repair or repair after conversion to a fourth-degree perineal laceration, 16 (94%) of the rectovaginal fistulae (during the first attempted repair or after failed treatment) were successfully treated. In all patients but one, faecal diversion was avoided. In two patients, fistulography was both a diagnostic procedure and the method of treatment.

Efficacy of Anal Fistula Plug vs. Fibrin Glue in Closure of Anorectal Fistulas.
Johnson EK, Gaw JU, Armstrong DN

Dis Colon Rectum. 2006 Jan 20;.
Closure of the primary opening of a fistula tract using a suturable biologic anal fistula plug is an effective method of treating anorectal fistulas. The method seems to be more reliable than fibrin glue closure. The greater efficacy of the fistula plug may be the result of the ability to suture the plug in the primary opening, therefore, closing the primary opening more effectively. Further prospective, long-term studies are warranted.

The Use of Fibrin Glue in the Treatment of Fistula-In-Ano: A Prospective Study.
Maralcan G, Baskonus I, Aybasti N, Gokalp A
Surg Today. 2006 Feb;36(2):166-170.
Fibrin glue application was thus found to be an easy, safe, effective, and useful alternative treatment in the management of fistulas-in-ano. However, our findings need substantiation by increasing the number of patients and prolonging the follow-up duration, as well as carrying out comparative studies.

9 – BEHAVIOUR 2006 01

9 Psychology 2006 01

JAMA patient page. Depression.
Torpy JM, Burke AE, Glass RM
JAMA. 2006 Jan 18;295(3):348.

9 Sexology 2006 01

Erectile dysfunction.
Burnett AL
J Urol. 2006 Mar;175(3 Suppl):S25-31.

Female sexual dysfunction following vaginal surgery: a review.
Tunuguntla HS, Gousse AE
J Urol. 2006 Feb;175(2):439-46.
PURPOSE: Depending on age it has been estimated that up to 40% of women have complaints of sexual problems, including decreased libido, vaginal dryness, pain with intercourse, decreased genital sensation and difficulty or inability to achieve orgasm. In this review we address the etiologies and incidence, evaluation and treatment of female sexual dysfunction following vaginal surgery for indications such as stress urinary incontinence and pelvic organ prolapse; anterior/posterior colporrhaphy, perineoplasty and vaginal vault prolapse. MATERIALS AND METHODS: Literature on the mechanisms by which vaginal surgery affects female sexual function are discussed along with related pathophysiology to potential causes. The anatomy, neurovascular supply of the clitoris and introitus, and intrapelvic nerve supply are discussed as related to vaginal surgery. Techniques to avoid neurovascular damage during pelvic floor surgery were corroborated by supporting literature. Literature regarding female sexual dysfunction following other procedures, such as vaginal hysterectomy, Martius flap interposition, and vesicovaginal and rectovaginal fistula repair were also discussed. RESULTS: Current literature does not support an association between vaginal length following vaginal surgery and sexual function. The proportion of women who are sexually active does not appear to be affected by vaginal surgery. Sling surgery for urinary incontinence does not appear to adversely affect overall sexual function, although individual parameters of sexual function scores may vary, eg a significant percent of women report pain during intercourse. Some patients experience improved overall sexual function due to complete relief from coital incontinence CONCLUSIONS: Symptomatic vaginal narrowing is rare even in women undergoing simultaneous posterior repair. Overall sexual satisfaction appears to be independent of therapy for urinary incontinence or prolapse. Data indicate that defect specific posterior colporrhaphy with the avoidance of levator ani plication may improve sexual function. The possible etiological factors for sexual dysfunction following vaginal surgery deserve further investigations.

Re: Sexual function in women with pelvic organ prolapse compared to women without pelvic organ prolapse.
But I
J Urol. 2006 Jan;175(1):393.

Relationship between sexual dysfunction and psychiatric status in premenopausal women with fibromyalgia.
Aydin G, Basar MM, Keles I, Ergun G, Orkun S, Batislam E
Urology. 2006 Jan;67(1):156-61.

Depression is one of the emotional disorders commonly encountered in women with fibromyalgia, most possibly leading to sexual dysfunction. Thus, sexual dysfunction related to impaired psychiatric status should be considered a common problem in premenopausal women with fibromyalgia.

Progress in female sexual dysfunction.
Verit FF, Yeni E, Kafali H
Urol Int. 2006;76(1):1-10.
Due to the fact that there has been little research and attention on FSD, our knowledge in this field is quite limited and there is still no approved therapy. Future advances in evaluation and treatment of female sexual problems are forthcoming.

Practice patterns of physician members of the American Urogynecologic Society regarding female sexual dysfunction: results of a national survey.
Pauls RN, Kleeman SD, Segal JL, Silva WA, Goldenhar LM, Karram MM
Int Urogynecol J Pelvic Floor Dysfunct. 2005 Nov-Dec;16(6):460-7.

Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies.
Feder GS, Hutson M, Ramsay J, Taket AR
Arch Intern Med. 2006 Jan 9;166(1):22-37.
BACKGROUND: The appropriate response of health care professionals to intimate partner violence is still a matter of debate. This article reports a meta-analysis of qualitative studies that answers 2 questions: (1) How do women with histories of intimate partner violence perceive the responses of health care professionals? and (2) How do women with histories of intimate partner violence want their health care providers to respond to disclosures of abuse? METHODS: Multiple databases were searched from their start to July 1, 2004. Searches were complemented with citation tracking and contact with researchers. Inclusion criteria included a qualitative design, women 15 years or older with experience of intimate partner violence, and English language. Two reviewers independently applied criteria and extracted data. Findings from the primary studies were combined using a qualitative meta-analysis. RESULTS: Twenty-nine articles reporting 25 studies (847 participants) were included. The emerging constructs were largely consistent across studies and did not vary by study quality. We ordered constructs by the temporal structure of consultations with health care professionals: before the abuse is discussed, at disclosure, and the immediate and further responses of the health care professional. Key constructs included a wish from women for responses from health care professionals that were nonjudgmental, nondirective, and individually tailored, with an appreciation of the complexity of partner violence. Repeated inquiry about partner violence was seen as appropriate by women who were at later stages of an abusive relationship. CONCLUSION: Women's perceptions of appropriate and inappropriate responses partly depended on the context of the consultation, their own readiness to address the issue, and the nature of the relationship between the woman and the health care professional.

The efficacy of a nerve stimulator (Cavermap) to enhance autonomic nerve identification and confirm nerve preservation during total mesorectal excision.
da Silva GM, Zmora O, Borjesson L, Mizhari N, Daniel N, Khandwala F, Efron J, Weiss EG, Nogueras JJ, Vernava AM, Wexner SD
Dis Colon Rectum. 2005 Dec;48(12):2354-61.
PURPOSE: Sexual dysfunction after total mesorectal excision may be caused by injury to the autonomic nerves. During surgery, nerve identification is not always achieved, and, to date, there has been no method to objectively confirm nerve preservation. The aim of this study was to assess the efficacy of a nerve-stimulating device (CaverMap) to assist in the intraoperative identification of the autonomic nerves during total mesorectal excision, and objectively confirm nerve preservation after proctectomy is completed. PATIENTS AND METHODS: Sexually active consecutive male patients undergoing total mesorectal excision were prospectively enrolled in this study. During pelvic dissection, the surgeon attempted to localize the hypogastric and cavernous nerves. CaverMap was used to confirm these findings and to facilitate the identification in cases of uncertainty. At the completion of proctectomy, the nerves were restimulated to ensure preservation. Factors that could affect the surgeon's ability to localize the nerves and CaverMap to confirm this were evaluated. RESULTS: Twenty-nine male patients with a median age of 58 years were enrolled in this study. An attempt to visualize the hypogastric nerves during dissection was made in 26 patients; the surgeon was able to identify the nerves in 19 (73 percent) patients. CaverMap successfully identified the nerves in six of the seven remaining patients, and failed to identify them in only one case. An attempt to localize the cavernous nerves during dissection was made in 13 patients, of which localization

was successful in 8 (61.5 percent) patients. CaverMap improved the identification rate in four of the remaining five patients. After proctectomy, CaverMap successfully confirmed the preservation of both hypogastric and cavernous nerves in 27 of 29 (93 percent) patients. A history of previous surgery statistically correlated with failure to identify the hypogastric nerves by the surgeon (P = 0.005). There were no adverse events related to use of the device. CONCLUSION: CaverMap may be a useful tool to facilitate identification of the pelvic autonomic nerves during total mesorectal excision and to objectively confirm nerve preservation.

[Transsexuals' life satisfaction after gender transformation operations.]
Zimmermann A, Zimmer R, Kovacs L, Einodshofer S, Herschbach P, Henrich G, Tunner W, Biemer E, Papadopulos NA
Chirurg. 2006 Jan 26;.

10 – MISCELLANEOUS 2006 01
Pelvic organ myiasis.
Shaunik A
Obstet Gynecol. 2006 Feb;107(2):501-3.
BACKGROUND: Myiasis is infestation with dipterous larvae, which feed on the host's dead or living tissue, liquid body substances, or ingested food. CASE: A 76-year-old, multiparous woman presented at a tertiary care hospital in India with vaginal discharge and itching for 3 weeks. The patient had a health care attendant who apparently failed to notice the problems she was experiencing. Pelvic examination revealed grade 2 uterine prolapse. Vaginal discharge was purulent, foul smelling, and contained several 8-10-mm white maggots of Musca domestica (housefly). Turpentine oil was instilled locally, and maggots were removed manually. The patient was treated with broad spectrum antibiotics. Maggot removal was repeated weekly for 3 weeks until no further maggots were present. Hysteroscopy was normal. The prolapsed uterus was replaced in its anatomic position with vaginal pessary. CONCLUSION: Decreased physical and mental capabilities due to old age and poor care by health providers can lead to maggot infestation of prolapsed pelvic organs.

Total pelvic exenteration: The Albert Einstein College of Medicine/Montefiore Medical Center Experience (1987 to 2003).
Goldberg GL, Sukumvanich P, Einstein MH, Smith HO, Anderson PS, Fields AL
Gynecol Oncol. 2006 Jan 17;.
OBJECTIVE.: To review the trends, modifications and results of 103 consecutive total pelvic exenterations (TPE) performed at the Montefiore Medical Center and Albert Einstein College of Medicine from 1987 to 2003. METHODS.: All patients who underwent TPE from January 1987 to December 2003 were included. The medical record, complications, follow-up, clinical status and demographic information were entered in a database. The procedure performed, the method of urinary diversion, colonic diversion, pelvic floor support and vaginal reconstruction were documented. Surviving patients were surveyed regarding their satisfaction with the urinary diversion, the vaginal reconstruction and their sexual function since the surgery. RESULTS.: 103 pts were identified. Indications for TPE were recurrent cancers of the cervix (95), endometrium (2), colon and rectum (5), vulva (1). Overall 5-year survival was 47%. 5-year survival for pts with recurrent cervix cancer was 48%. Six pts (6%) recurred >5 years after the TPE. 14 pts (14%) had ureteral anastomotic leaks (no difference between ileal conduit 9/65 (14%) versus 5/38 (13%) continent conduit (P = 0.92). 34 pts (89%) with continent conduits were "continent." 14 pts (17%) had wound complications. 4 pts (4%) had parastomal hernias. 5/11 (46%) pts who had a low rectal reanastomosis developed recurrence in the pelvis. 21/39 (54%) of pts with continent conduits would choose an ileal conduit if they had the option again. Long-term renal function was similar in pts with ileal and continent conduits. Mesh of any type for pelvic floor reconstruction is associated with infection and bowel/urinary fistulas. VRAM flaps for neovagina fill the pelvic dead space, reduce the risk of fistulas and 20/36 pts (55%) are sexually active. CONCLUSIONS.: Our overall 5-year survival is encouraging, and modifications in surgical technique have improved the reconstructive phase. Low rectal anastomoses at TPE adversely affects survival. Many of our pts with continent urinary diversions would not choose this method again. Mesh of any type is associated with sepsis and bowel/urinary fistulas. VRAM for neovagina reduces fistula rate and are functional in >55% of pts. TPE remains a potentially curative option for these pts.

The tongue as an alternative donor site for graft urethroplasty: a pilot study.
Simonato A, Gregori A, Lissiani A, Galli S, Ottaviani F, Rossi R, Zappone A, Carmignani G
J Urol. 2006 Feb;175(2):589-92.

Prostatic Infarction Involving the Urinary Sphincter, an Association with Pyoderma Gangrenosum.
van de Riet JE, Benton EC, McNeill SA
Eur Urol. 2006 Jan 13;.

Chemoprevention of human prostate cancer by oral administration of green tea catechins in volunteers with high-grade prostate intraepithelial neoplasia: a preliminary report from a one-year proof-of-principle study.
Bettuzzi S, Brausi M, Rizzi F, Castagnetti G, Peracchia G, Corti A
Cancer Res. 2006 Jan 15;66(2):1234-40.

Long-Term Effect of Preoperative Radiation Therapy on Anorectal Function.
Pollack J, Holm T, Cedermark B, Holmstrom B, Mellgren A
Dis Colon Rectum. 2006 Jan 31;.
PURPOSE: Preoperative radiotherapy improves local control in rectal cancer treatment, but there are few reports on the influence of radiotherapy on anorectal function. The aim of the present study was to assess late effects of short-course, high-dose radiotherapy on anorectal function after low anterior resection for rectal cancer. METHODS: Sixty-four patients, randomized within the Stockholm Radiotherapy Trials and operated on with low anterior resection with or without preoperative radiotherapy (mean, 14 years), previously were followed up with quality-of-life questionnaires, clinical examination, anorectal manometry, and endoanal ultrasound. Twenty-one patients had received preoperative radiotherapy of the rectum and 43 patients had been treated with surgery alone. RESULTS: Impaired anorectal function was common after low anterior resection for rectal cancer and the risk was increased after radiotherapy. Irradiated patients had significantly more symptoms of fecal incontinence (57 vs. 26 percent, P = 0.01), soiling (38 vs. 16 percent, P = 0.04), and significantly more bowel movements per week (20 vs. 10, P = 0.02). At anorectal manometry, irradiated patients had significantly lower resting (35 mmHg vs. 62 mmHg, P < 0,001) and squeeze pressures (104 mmHg vs. 143 mmHg, P = 0.05). At endoanal ultrasound, irradiated patients had significantly more scarring of the anal sphincters (33 vs. 13 percent, P = 0.03). There were no significant differences in quality-of-life scores between irradiated and nonirradiated patients; however, patients with anal incontinence had significantly lower quality-of-life scores compared to continent patients. CONCLUSIONS: Short-course radiotherapy, including the anal sphincters, impairs anorectal function and increases gastrointestinal symptoms permanently when the anal sphincters are irradiated.

Treatment of anastomotic leakage after rectal resection with transrectal vacuum-assisted drainage (VAC) A method for rapid control of pelvic sepsis and healing.
Nagell CF, Holte K
Int J Colorectal Dis. 2006 Jan 31;:1-4.