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MP-02.01
Preliminary Results of Mitomycin on Recurrent Bladder Neck Contracture After Radical Prostatectomy

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Introduction and Objective: One of the most frequent complications after radical prostatectomy (RP) is bladder neck contracture (BNC) that occurs in up to 32% of patients. Several treatment options for BNC have been proposed, but none reached a consensus and success rates are disappointing. Mitomycin, by inhibiting fibroblast proliferation, decreases scar formation. It was already used as an anti-scarring agent treating successfully glaucoma, tracheal and oesophageal strictures. In urology, 0,1 mg of Mitomycin had been used after laser incision to treat anterior urethral stricture. The objective of this study is to assess the safety and efficacy of Mitomycin in recurrent BNC.

Methods: This study was approved by our Institutional Review Board committee. Recurrent BNC was defined as the inability to pass a 16 French cystoscope through the stricture after at least one previous treatment. The initial workup included history, physical examination, urodynamic studies, urinalysis and urine culture. After informed consent, 0.1 mg of Mitomycin diluted in 2 mL of normal saline was injected submucosally at 3, 6 and 9 o'clock positions and the BNC was then dilated with «S shape» dilatators up to 18-20 Fr under sedation. A 16 Fr urinary catheter was left in place for 3 days. Follow-ups at 2, 6 and 12 months were scheduled (urinalysis, urine culture and cystoscopy). If a recurrence occurred, patients were offered another treatment option.

Results: From March to July 2009, ten patients had recurrent BNC after RP diagnosed in the workup of urinary incontinence. Nine patients had retropubic and 1 had laparoscopic RP. The mean age was 67 years old [59-75]. The mean time between RP and diagnosis of BNC was 39 ± 7 months [2-180]. Patients had an average of 2 treatments for their BNC before Mitomycine [1-9]. All patients had dilatation, 2 had laser incision and 2 had cold knife incision. Eight patients showed no recurrence of BNC at 2 months follow-up cystoscopy. Of those recurrences, one had 9 and the other had 4 previous treatments. Five patients completed 6 months of follow-up and they were still stricture free. No adverse event was reported.

Conclusions: Preliminary results of this case series showed an 80% success rate at 2 months post Mitomycin injection and dilatation for recurrent BNC after RP. It seems promising and there is no associated adverse event. However, longer follow-up and further studies are needed to access its use and long term efficacy in BNC following RP.

MP-02.02
Excision and Replacement of Failed Male Bulbourethral Sling for Treatment of Post-Prostatectomy Incontinence

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Introduction and Objective: Postprostatectomy incontinence (PPI) is a significant morbidity associated with prostate cancer surgery. Placement of a trans-obturator bulbourethral male sling (TOMS) (Advance Male Sling, American Medical Systems, Minnetonka, MN) has shown excellent results with minimal morbidity. One issue has been management of sling failure. We address the method and results of sling excision and replacement following initial failure.

Methods: A retrospective chart review of patients undergoing excision and replacement of an TOMS at our institution was performed. A standardized surgical method similar to the described original placement method was used. The centre portion of sling material was dissected off the corpus spongiosum and excised prior to replacement of the sling. Several factors including time to treatment of incontinence, time to initial failure, potential reasons for failure and end outcomes were identified.

Results: Replacements were identified, with an average age of 66.1 yrs (47-84). The average time between treatment of the malignancy and first incontinence procedure was 21.2 months (12-40). The mean time to sling replacement was 205.6 days (3-600). Six of the twelve patients identified a period of postoperative strenuous activity associated with recurrence of incontinence. Persistent incontinence in one was recognized as inappropriate anatomical positioning. Four patients were completely dry at last follow up with no other intervention. Another patient was dry with subsequent Coaptite injection. Seven patients were socially continent (</=1pad per day). Two other patients had subsequent artificial urinary sphincter placement. No mesh erosions, hemmorhage or mesh infections were identified after repeat TOMS.

Conclusions: While placement of a TOMS to treat PPI is effective, failures do occur. Nonetheless, repeat placement of TOMS after excision of the previous mesh is a viable option for patients with persistent or recurrent bothersome incontinence.

5-STAR
MP-02.03
"Doc, Can I get my Prostate Back?": A Review of Radical Prostatectomy Specimens in Patients Requiring Surgical Correction of Post-Prostatectomy Complications

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Introduction and Objective: Radical prostatectomy remains a common treatment for locally confined prostate cancer; however, complications of erectile dysfunction, incontinence and bladder neck contracture (BNC) persist. While active surveillance with delayed intervention is a treatment option, many patients still choose invasive therapies. When a patient suffers a significant complication that requires surgery, such as an artificial urinary sphincter (AUS) or a penile prosthesis, they often wonder if they could have selected a less invasive therapy or even observation. This review of radical prostatectomy specimens was initiated to investigate the relationship between pathology and complications. Additionally, we retrospectively consider how many patients may have been candidates for active surveillance based on their pathologic review.

Methods: All patients who required AUS, male slings, penile prosthesis or complex management of bladder neck contractures including open repair were identified. All patients had undergone a radical prostatectomy prior to their complication at sites throughout North America. Pathology was available from the Calgary Prostate Database from 2000 to 2010 to allow for analysis. Those patients who had suffered their complication as a result of external beam radiotherapy, cryotherapy, brachytherapy or HIFU were excluded.

Results: We identified 80 patients who had required surgical management of post-prostatectomy complications. Pathologic review was then undertaken and identified 35 patients who had pathologic specimens from both TRUS biopsy and radical prostatectomy. Of these patients, 16 had an AUS, 16 had a male sling and a remaining 3 had complex management of their bladder neck contracture or refractory overactive bladder. Of the 35 patients, 20% had bladder neck contractures requiring at

least a dilation and 20% of patients had required radiation in addition to radical prostatectomy. Review of pathology identified an average preoperative PSA of 6.32 and gland volume of 49.6 grams. Postoperative pathologic review showed that 40% were Gleason 6, 54% were Gleason 7 and 6% were either Gleason 8 or 9. Average tumour volume was 12.4% of prostate volume. In this population, 37% had positive surgical margins and 8.6% had positive seminal vesicles. Twenty-three percent of patients may have been candidates for active surveillance.
Conclusions: Active surveillance must be considered as a treatment option in patients with low grade prostate cancer. In a population of men who have suffered a significant complication from radical prostatectomy, pathologic review identifies a large number of patients who have low grade disease and even clinically insignificant cancers.

MP-02.04

Voiding Pattern after 'U-Method' TVT-Secur: Is it Obstructive?

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Introduction and Objective: The last generation of midurethral slings, the tension-free vaginal tape system (TVT-Secur™, Gynecare, Ethicon, NJ, USA) was introduced in 2005 in an attempt to lower the complication rates. There are two surgical techniques currently used either the 'hammock' or the 'U-method' technique. With the latter, the sling is tightened as to create a 'pillowing effect' on the urethra until obtaining a negative stress test. Short term current results of this surgical option seem promising, however, no study ever reported on the voiding function after its implantation. This is a retrospective, clinical study in which the main objective is to evaluate if this method creates an obstructive pattern on pressure-flow study 12 months after the surgery.
Methods: These are preliminaries data on a population which consisted of 34 women operated between October 2007 and April 2009. The implantation of the TVT-Secur™ system was done under local anesthesia by a single surgeon, using the 'U-Method' technique. Patients were evaluated before and 12 months after the surgery with regard to different urodynamic findings including uroflowmetry (UFM), postvoiding residual volume (PVR), filling cystometry (CMG), pressure-flow studies and valsalva leak point pressures (VLPP).
Results: To date, 20 out of 33 patients have completed their 12-month urodynamic evaluation. The mean (± standard deviation [SD]) age of the population was 63 (± 9) years old, 21.2 % (7/33) complained of genuine SUI and 18.2 % (6/33) had undergone a previous anti-incontinence surgery. At 12 months postoperative, median satisfaction rate was 98% (range 95-100), the subjective cure rate was 82% (22/27) and 11% (3/27) of the patients reported a significant improvement. The objective cure rate (defined as no leakage at all during the VLPP) was 55% (11/20) while 40% (8/20) of the subjects were objectively improved (defined as leakage which occurred at a higher volume than preoperative VLPP). UFM and PVR were not affected by the surgery. The pressure-flow studies were not obstructed in all evaluated subjects (16/16). No patients developed de novo urge incontinence at 12 months.
Conclusions: Midurethral TVT-Secur™ slings represent an appropriate option for patients suffering from SUI. They are not associated with any significant bladder obstruction nor long term urinary retention while having very similar cure rate as the other midurethral slings. To our knowledge, this is the first study comparing preoperative and postoperative urodynamic findings in patients with 'U-method' TVT-Secur™ midurethral sling.

MP-02.05

National Trends in the Usage and Success of Sacral Nerve Stimulation in the American Medicare and Privately Insured Population

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Introduction and Objective: There have been over 40,000 sacral neuromodulation (SNM) systems implanted worldwide. Published reports to date have been limited to case series or randomized controlled trials with a few hundred patients at most, but with very high success rates. Our aim was to report patterns of use and outcomes of SNM in the general community.
Methods: A 5% random sample of United States Medicare beneficiaries from 1997 to 2007 and the entire Ingenix from 2002 to 2007 were the data source. CPT codes were used to identify all procedures, and ICD-9 diagnosis codes were used to identify the indication. Successful test stimulation was defined as a percutaneous or surgical lead placement followed by a battery implant at a later date.
Results: In the Medicare population there were 358 patients who received percutaneous tests and 1132 a 2-stage (permanent) lead placement; 91.3% of patients were white and 73.6% were female. Of all percutaneous tests, 45.8% were considered to be successful. Of those with a 2-stage (permanent) test lead 62.7% failed and were not implanted with a battery. In the multivariate analysis there were greater odds of success in females compared to males overall (OR 1.86, 95% CI 1.38-2.51). When comparing those aged 65-75 to those over 75 there were inferior results in the younger group in the perc test (OR 0.11, 95% CI 0.054-0.22), but the opposite in the two staged (OR 2.04, 95% CI 1.49-2.79) and the overall odds ratio was not significant when combining both samples. There were no differences in success by race or by diagnosis except those with "dry" OAB overall fared worse compared to "wet" OAB (OR 0.73, 95% CI 0.55-0.97). In the privately insured there were 266 percutaneous and 794 two-staged procedures. The sample was 81.3% female, 82.2% were under the age of 65 and 62.7% were Caucasian. Percutaneous procedures were only successful in 24.1% of cases, whereas 50.9% of all two stage procedures resulted in a battery implant ($p < 0.0001$). On multivariate analysis women were 1.99 times more likely to be successful overall (95% CI 1.4-2.8) and those with a diagnosis of neurogenic bladder were 0.38 times less likely that OAB wet to succeed (95% CI 0.20-0.73).
Conclusions: SMN is far less successful than quoted in published literature. Females have better success than males. These findings suggest the need to counsel patients realistically about their chances of success with such a procedure.

MP-02.06

Contemporary Use of Pubovaginal Sling for Female Stress Urinary Incontinence

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Introduction and Objective: Until the advent of mid-urethral synthetic slings, autologous fascia pubovaginal slings (PVS) were regarded as the treatment of choice for primary and secondary surgical management of female stress urinary incontinence (SUI). The management of failed synthetic slings or recurrent SUI following erosion or fistulae associated with synthetic slings is problematic. This retrospective analysis is a review of current experience with management of complex SUI with PVS.
Methods: A retrospective chart review of patients undergoing PVS was used to assess patient characteristics, indication for the sling, and preoperative urodynamic features, and continence outcomes.
Results: This study comprises of 34 females, with an average age of 57 (33-77) years who underwent a rectus fascial PVS. Seven patients had concomitant surgery for cystocele, rectocele or urethral/vesical fistula repair. Preoperative mean pad usage was 6 pads/day. There were 31/34 patients who were selected for a PVS due to severe injury to the urethral sphincter: eroded midurethral sling (10), failed midurethral sling (6), operative or traumatic urethral injury (6), previous failed pubovaginal sling (4), urethral diverticulectomy (3), obstetrical urethral trauma (1), and previous pelvic radiation (1). An average of 2 (0-4) surgical incontinence procedures had been carried out before the PVS was performed. Preoperative urodynamics were completed for 29 of the patients. Capacity was <250 mL in 3 patients, and detrusor overactivity was demonstrated in 8 patients. Valsalva leak point pressures were <60 cmH2O for 5 patients, 60-90 cmH2O for 11 patients, and >90 cm H20 for 13 patients. Mean urodynamic peak flow was 20 (2-44) mL/sec. After a

mean follow-up of 15 months, 72% of the patients were using ≤2 pads per day. Intermittent catheterization was required for 4 patients temporarily, and 4 patients continue on intermittent catheterization. Mean peak flow was 11 (3-20) mL/sec. In follow-up, 50% had urinary frequency of <1.5hrs, 32% had mild urgency, and 42% had bothersome urgency.
Conclusions: The PVS is now rarely used as first line therapy for SUI. It is primarily used as a salvage procedure for patients with previous urethral surgery, failed mid-urethral sling(s), and complex and severe SUI. Outcomes in this population are reasonable considering the severity of the underlying problems.

MP-02.07
Urinary Frequency in Women: Are There Multiple Factors at Play?

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Introduction and Objective: Urinary frequency is an extremely troublesome symptom for many women and its causation is relatively poorly understood. This study attempts to identify urodynamic indices that may play a role in patient-reported frequency severity. In this study, we investigated the relationship between patient-reported urinary frequency versus maximum cystometric capacity (MCC), first sensation of bladder filling (FSBF) and detrusor overactivity observed on cystometrogram in women. The relationship between patient reported frequency and nocturia was also investigated.
Methods: We have electronic charts on all patients who have undergone Conventional Urodynamic Studies from 1996-2007 at our institution contained in an urodynamic (UD) database. Using this database, MCC, volume at FSBF, detrusor overactivity and patient reported nocturia were cross-referenced with the degree of frequency reported by women. Frequency was divided into normal, 2-3 hrs, 1 hr and <1hr. Mean and standard deviation for MCC, FSBF and nocturia were then determined for each level of frequency. A one-way ANOVA ($p < 0.05$) was applied to determine statistical significance. Bladder overactivity for each group was described as a total number and as a percentage.
Results: There were 2532 consecutive patients identified in the UD database. The numbers of patients for each frequency group (normal, 2-3 hrs, 1 hr, and <1 hr) were 346, 875, 852, and 459 patients, respectively. MCC, volume at FSBF and patient reported nocturia all significantly correlated with increasing severity of patient reported frequency ($p < 0.0001$). In addition, bladder overactivity increased with increasing severity of frequency.
Conclusions: This is the first large study to demonstrate that multiple factors may play a role in patient-reported frequency. Increasing severity of frequency is associated with decreased bladder capacity, earlier first sensation of bladder filling and increased prevalence of detrusor overactivity. Not surprisingly, these same factors are likely to play a role at night resulting in increased nocturia in the patient with frequency. Understanding that multiple variables are involved and interrelated may allow us to more thoroughly treat our patients

MP-02.08
Evaluation, Management and Outcomes of Female Urethral and Periurethral Masses

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Introduction and Objective: The presentation of female periurethral mass is rare in urological practice, with few series reported. We herein share our experience with their diagnosis and management.
Methods: A prospective case series was maintained from clinical diagnosis to complete follow-up by a single surgeon (KVC). All cystic and solid masses were included. Simple condylomata, caruncles and urethral prolapse were excluded.
Results: Forty-one women were evaluated over a seven-year period (2002-2009), and complete follow-up is available on 36 (88%). Mean age was 41 with a mean follow-up time of 9 months. No masses were discovered incidentally. Most patients (92%) presented with a bothersome introital mass, 45% each with dyspareunia and urethral discharge, 29% with obstructive voiding and 22% with dysuria. A history of urinary infections was elicited in 24% of women, and stress incontinence (SUI) in 22%. Symptoms did not correlate with final diagnosis. All women underwent clinical history, physical exam and flexible cystourethroscopy. Clinical evaluation was accurate in the majority of cases (89%). There

Table 1. MP-02.08. Findings, management and outcomes in women presenting with urethral mass

Type of mass at final diagnosis	Clinical diagnosis	Final diagnosis	Management	Outcome
Cystic (30)	Skene's gland abscess (11)	Skene's gland abscess (11)	Simple excision	Success (10) Recurrence (1)
	Skene's gland diverticulum (2)	Skene's gland diverticulum (2)	Simple excision	No recurrences Urethral stenosis (1)
	Urethral diverticulum (9)	Urethral diverticulum (9) [8 with inflammatory change, 1 with ulceration, 1 with nephrogenic adenoma, 2 were recurrent lesions]	Excision with layered closure only (5) Martius flap interposition (4) Pubovaginal sling (2)	No recurrences Latent SUI (1)
	Periurethral cyst NOS (4)	Simple cyst (3)	Simple excision (8)	No recurrences Latent SUI (1)
		Diverticulum (1)		
	Gartner's duct cyst (4)	Gartner's duct cyst (3)		
		Diverticulum (1)		
Solid (6)	Urethral diverticulum	Leiomyoma	Excision +/- layered closure	No recurrences No complications
	Soft tissue mass (3)	Leiomyoma (2)		
		Fibroepithelial polyp (1)		
	Condylomata	Urethral epitheliod squamous hyperplasia		
	Urethral carcinoma	Giant condyloma		

SUI = stress urinary incontinence.

were 19 patients (46%) who underwent MRI, which includes all but 2 patients with a suspected or potential diverticulum or solid mass proximal to the meatus. MRI diagnosis correlated with final diagnosis in 15 cases (79%), added to the preoperative diagnosis in 2 (11%), and was considered useful overall for diagnosis or surgical planning in 10 (53%). Thirty patients (83%) had cystic and 6 (17%) solid masses at final diagnosis. To date, no malignancies have been encountered. One Skene's gland abscess has recurred, 1 patient following excision of Skene's gland diverticulum has developed stenosis requiring dilatation, and two cases of latent SUI have required further surgery. No other recurrences or complications have been observed.

Conclusion: After appropriate history, physical exam and cystourethroscopy most women can undergo successful surgical management of periurethral masses. Preoperative imaging should be used selectively: It is considered useful for surgical planning but should not be relied upon for definitive diagnosis. Our bias is toward surgical removal given the diagnostic uncertainty in some cases and the small but potential risk of malignancy reported by other authors. Careful dissection is critical to discern diverticula, and complete excision mandatory to avoid recurrence. Complications of surgery are minor and uncommon.

MP-02.09

Assessment of Central Nervous System (CNS) Comorbidity in Patients with Overactive Bladder (OAB)

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Introduction and Objectives: To determine proportion of OAB patients potentially at risk for adverse CNS events by assessing pre-existing CNS comorbidities.

Methods: This retrospective cohort study used the GE Centricity EMR database. OAB patients were identified by ICD-9 codes or a prescription between 01/01/1996 to 03/30/2007 for an OAB antimuscarinic agent. OAB patients with 13 months of continuous eligibility pre and post index date formed the OAB cohort. Based on the presence of a pharmacy claim for an OAB antimuscarinic agent, the OAB cohort was stratified as treated or untreated. A random sample of age and gender matched patients with no diagnosis of OAB, urinary bladder dysfunction, or pharmacy claim for an OAB antimuscarinic agent formed a non-OAB control cohort. During 6 months before OAB diagnosis/treatment, CNS co-morbidity as measured by biologic measures, CNS diagnoses, and use of concomitant drugs with CNS effect and antimuscarinic effect (i.e. drugs other than those used for OAB treatment) were assessed across the cohorts using t-tests or chi-square where appropriate. Results: OAB patients (N:41,440; 83.6% women; median age 65 years), as compared to non-OAB patients (N:77,272; 83.2% women; median age 64 years), were more likely to have CNS comorbidities (45.4% vs. 29.0%; $p < 0.001$) such as neurotic disorders, personality disorders, and other nonpsychotic mental disorders (35.3% vs. 22.5%, $p < 0.001$), use medications with CNS effects (33.3% vs. 20.0%; $p < 0.001$) and antimuscarinic effects (39.6% vs. 25.4%; $p < 0.001$). In treated vs. untreated OAB patients, use of medications with CNS effects (35.3% vs. 24.8%; $p < 0.001$) and antimuscarinic effects (41.5% vs. 31.8%; $p < 0.001$) was higher for treated OAB patients.

Conclusions: Pre-existing CNS comorbidities were more prevalent in OAB patients than in non-OAB patients. Use of medications with CNS and antimuscarinic effects was more prevalent in those who received antimuscarinic treatment than in patients not receiving treatment.

MP-02.10

Surgical Intervention Following Interstim® Sacral Neuromodulation Implant for the Management of Lower Urinary Tract Symptoms: 14-Year Experience of One Centre

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Introduction and Objective: Re-operation rate of the sacral neuromodulation (SNM) remains a concern. There are very few reports addressing this issue. We are reporting a 14-year experience with SNM from our centre.

Methods: Retrospective review of the patients' data was performed to assess incidence and cause of surgical re-intervention after SNM implant between 1994 and 2008 in our centre.

Results: There were 96 SNM devices implanted in 88 women (91.7%) and 8 men (8.3%). Mean age at implantation was 45 years (SD ± 12.5). The indications for implantation were painful bladder syndrome/ interstitial cystitis (PBS/IC) (47.9%), urge urinary incontinence (UUI) (35.4%) and idiopathic urinary retention (IUR) (16.7%). The explantation rate was 20.8% and the median time to removal was 18.5 months (SD ± 31.7). The PBS/IC had the shortest time to explantation with mean of 15 months ($p = 0.02$). The reasons for the explantation were poor result in 12 patients (12.5%), painful stimulation in 6 patients (6.25%) and radiation of the stimulation to the leg in 2 patients (2%). The median long-term follow-up was 50.7 months (SD ± 38.1). The long term success rate was 87.5%, 84.8% and 73 % in the IUR, UUI and PBS/IC respectively ($p = 0.6$). In all, 39% of the patient needed revision of the SNM implant. The revision rate was highest in IUR (56%), while in UUI it was the lowest (32%). The main reason for revision was loss of stimulation in 24 procedures (58.5%). Other reasons includes pain from the pulse generator in 7 procedures (17%), painful stimulation in 5 procedures (12.2%) and radiation of the stimulation to the leg in 5 procedures (12.2%). There was drop in the rate of revision with the introduction of the tined lead technique from 50% (lead model 3092) to 31% (lead model 3893); however, this difference was not statistically significant ($p = 0.1$). The battery was changed in 8 patients and the mean battery life was 101.8 months (SD ± 23.4).

Conclusions: The SNM is a minimal invasive procedure with a very good long-term outcome. Re-operation rate reduced with improvement in surgical technique and equipment.

MP-02.11

Long-Term Tolerability and Efficacy of Pentosan Polysulphate Sodium in the Treatment of Painful Bladder Syndrome/Interstitial Cystitis (PBS/IC)

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Introduction and Objectives: To evaluate the long-term efficacy and tolerability of Pentosan Polysulphate Sodium (PPS) in the treatment of PBS/IC.

Methods: This is a single institution, retrospective study to evaluate the clinical efficacy of PPS as treatment for the cases of PBS/IC for the period of 1994 till 2008. We have included all patients with bladder pain symptoms and either frequency, urgency or nocturia in the absence of urinary tract infection and any other pathology as per ICS definition. All patients had glomerulation with cystoscopic hydrodistention under general anesthesia. The primary end point of this study is the overall improvement on the global response assessment scale (GRA).

Results: Based on the inclusion criteria, 271 patients were eligible for the study. Most of the patients were female (90%), and the mean age at presentation was 45.5 year (SD ± 13.9). The average duration of symptoms was 28.5 month (SD ± 25.4).The average maximum cystometric capacity was 251.3 ml (SD ± 134.4), while the average maximum cystoscopic bladder capacity under general anesthesia was 659.1 ml (SD ± 147.4). The cough leak test was positive in 30 patients (11.1%). Detrusor overactivity on filling cystometry study was found in 39 patients (14.4%). With a mean follow up of 22 month (SD± 28), 147 patients (54.2%) reported over 50% improvements in there bothered symptoms on the

GRA scale. There was mild improvement in additional 55 patients (20.2 %). Ninety-three patients (34.3%) decided to stop taking the medication for various reasons. The most common reason to stop the medication was poor response in 45 patients (16.6%). Others include drug side effect in 30 patients (11.1%), resolution of the PBS/IC symptoms in 11 patients (4.1%) and financial reason in 6 patients (2.2%). The side effects include stomach upset in 23 patients (8.5%), headache in 6 patients (2.2%), hair loss in 3 patients (1.1%), hypersensitivity in 3 patients (1.1%), and increase in liver enzyme in 2 patients (0.7%). Patients with history of detrusor overactivity or positive cough leak test during the urodynamic study were predictor of poor outcome of the PPS in the management of PBS/IC with p values of 0.037 and 0.035 respectively.

Conclusion: The Pentosan Polysulphate Sodium is an effective oral therapy to control the symptoms of the PBS/IC with good long term efficacy and tolerability. More than 65% of the patients continued to take the medication with mean follow up of 22 months.

MP-02.12

Transvaginal Repair of Vesicovaginal Fistula is Superior to Transabdominal Repair

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Introduction and Objective: Vesicovaginal fistulas (VVFs) may be managed by a transabdominal (TA) or transvaginal (TV) approach. With increasing urologic training in transvaginal surgery, there has been a movement towards transvaginal repairs whenever possible. The objective of this study was to evaluate our experience with VVFs over a 7 year period following the arrival of a fellowship-trained female urologist.

Methods: We performed a retrospective chart review of VVFs presenting between April 1, 2002 and Dec 31, 2009. All final TV closures were performed by a single surgeon (KC) while the TA repairs were spread amongst a broader group of surgeons.

Results: 31 cases were identified. Average age at surgery was 50.5 years (range 27-84 years). Follow-up ranged from 3-222 weeks (median 8). The etiology of 26 (84%) was hysterectomy [19 abdominal (73%), 7 vaginal (27%)]. The remaining 5 fistulas were caused by radiation (1), birth trauma in a developing country (1), uterine rupture and caesarean section (1), and bowel surgery (2). 6 VVFs occurred after hysterectomy complicated by intraoperative cystotomy repaired by the operating gynecologist. At the time of referral to urology 6 patients (19%) had prior failed repairs: 4 patients with 1, 1 patient with 2, and 1 patient with 4 prior repairs. Ultimately, 20 fistulas (65%) were repaired transabdominally and 11 (35%) transvaginally. The time to surgical repair ranged from 2 weeks to 30 years. Compared to TA repairs, TV repairs were associated with shorter hospital stay (p = 0.005), and there was a trend toward shorter operative time (p = 0.09) and blood loss (p = 0.07). Suprapubic catheters (SPC) were placed at the time of 13 TA repairs (65%) versus 1 TV repair (9%). One patient (9%) following TV repair developed postoperative pelvic pain syndrome, while 8 patients (40%) undergoing TA repairs experienced complications [small bowel obstruction, bladder infection, prolonged postoperative pain, incisional hernia, enterotomy, prolonged ileus, prolonged pain secondary to SPC (2)]. No patients remain with fistula at the time of reporting.

Conclusions: The majority of VVFs can be managed via a TV approach employing tissue interposition. These repairs are associated with reduced hospital stay and lower morbidity, and a trend toward lesser blood loss and operating time when compared to TA repairs. Suprapubic catheters can add morbidity, and are not necessary for successful outcome in uncomplicated repairs.