Pune Ob-Gyn Society
Estd. 1953

Pune Obstetric & Gynecological Society

SPECULUM

News Letter

"Nuances of Pelvi-Perineology "

MARCH 2025

Pune Obstetric & Gynecological Society
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PUNE OB-GYN SOCIETY ESTD. 1953

SHE IS SPECIAL

SPECULUM
NEWSLETTER

MARCH 2025

PRESIDENT'S ADDRESS

Dr. Arati Nimkar
President, POGS (2024-25)

Respected Seniors, Past Presidents, Esteemed Members, and Dear Friends,

Namaste!

It is with immense gratitude and pride that I stand before you today as we reflect on an extraordinary year for POGS 2024-25. Our collective vision, relentless dedication, and unwavering teamwork have propelled us to new heights in advancing Women's Holistic Health. True to our theme, "She is SPECIAL"—Sensitive, Passionate, Energetic, Caring, Intelligent, Alert, and Lively—we have worked tirelessly to make a lasting impact.A Year of Milestones & Achievements

* Safe Motherhood Initiatives – Raising awareness through six impactful social programs, beginning with Save Our Mothers on April 10.

* Academic & Scientific Excellence – Landmark conferences like ENDOART 24, Breast Health & Lactation Summit, Zero preterm Birth,Annual conference EndoART and FOGSI ICOG UP2 Date in OBGYN showcased cutting-edge advancements.

* Grand Celebrations – A dazzling POGS Awards Night, breathtaking cultural performances, and an overwhelming response to our events.

* Leadership at the Forefront – Witnessing Dr. Sunita Tandulwadkar as FOGSI President 2025 and Dr. Parag Biniwale as ICOG Chairman made this year historic for POGS.

* Unparalleled Recognition – POGS honored with AMOGS Best Society (A Category) Award and Dr. M.V. Chitale Prize for excellence in activities.You Know Bioluminescence is the production and emission of light by living organisms. It's nature's glow-in-the-dark magic! But here is a magic of high dreams, Desire to work, Discipline & Dedication to achieve. Each glow serves a distinct role, Here's how we light up the society and association : The Road Ahead

* As we step into another promising year, let us continue our commitment to education, innovation, and women's health advocacy. POGS is not just an organization—it is a movement, a family, and a force for change.I urge each of you to register for the 40th Installation CME – "CODE RED" on April 19-20, 2025, at Sheraton Grand, Pune. Let's come together once again to make it a grand success! in a leadership of our next President Dr. Manish Machave along with Hon. Gen. Secretary Dr Nilesh Balkawade.

We appeal non-members to join POGS and be part of this thriving community!

With heartfelt gratitude and best wishes, Adieu! Sayonara! Onward & Upward!

- Dr. Arati Nimkar
President POGS

I N D E X

SECRETARY'S ADDRESS

Dr. Meenakshi Deshpande
Secretary, POGS (2024-25)

Respected Seniors , Past Presidents,

Dear friends and colleagues,

Namaskars and thank you all from the bottom of my heart for your best wishes, and words of appreciation and encouragement as Gen. Secretary !

This is my last communication with you all as Gen.Secretary POGS ! With all your blessings flowing, this year we have been successful with our plans and endeavours to enhance and promote Women's Holistic Health so as to improve all over wellbeing of a woman and make true our theme logo " She is SPECIAL(SENSITIVE, PASSIONATE, ENERGETIC,CARING, INTELLIGENT, ALERT, LIVELY). TEAM WORK MAKES DREAMS WORK!

Just to put it all in a small nutshell , we started with Safe Motherhood Day (10th April)Public Awareness of Red Flags of Pregnancy "Save Our Mothers " a social programme conducted with AMOGS PAC at Symbiosis Nursing College with Obgyn.dept of Women's Medical C, which was tremendously successfull (& we conducted such six social awareness programmes at different venues).Other Highlights of this year 2024-25 :

1) 39 th Installation of POGS President Dr Aarti Nimkar at Hotel Hyatt ista , with three preconference workshops and one post conference workshop on colposcopy , theme of Saving Mothers, Giving Life , SAFOG Certified Emergency Obstetrics Symposium (Dr.Shyam Desai , Dr.Pritikumar), Late Prof.Dr Anjanellu Oration by esteemed Dr.V.P.Pailly , GOH FOGSI President Dr Jaydeep Tank & FOGSI president elect Dr Sunita Tandulwadkar, Dr.Raman Gangakhedkar as Chief Guest , POGS Zankar Dance Competition and Navras performance by our own members in Cultural Evening all were highly appreciated and thoroughly enjoyed !

2) Dr A.V Umranikar Oration by esteemed Dr Mrutyunjay Bellad sir.

3) POGS Annual Conference with 6 th International conference on pearls and pitfalls in ART : "ENDOART 24" was a big hit at a different venue in Sheraton Grand and six very much interactive workshops and two halls of academic extravaganza manicured by Dr Meenu Agarwal , Dr Amol Lunkad and an excellent cultural programme. A grand POGS AWARDS nite with dazzling orchestra

4) Two Great Conferences adorned and hosted by POGS : FOGSI Vice-president Conference by Dr.Girija Wagh in October end on a truly different Towards Zero Preterm Births and FOGSI ICOG Conference with theme U2 Date in obgyn. by Dr.Parag Biniwale in March ,both were excellently organized and attended.

5) POGS Breast Health and Lactation Summit Conference held at Hyatt Regency on 10 11 August with Rishte Reshimgathi for staff , by Dr Charu Bapaye and Dr Mangala Wani was star studded event ,and further crowned by celebration of IPP Dr Meenu Agarwal winning FOGSI VP elections by more than 6980 votes.

6) Several extra-ordinary and our of box programmes planned by Dr Meenakshi Deshpande and supported by Dr Aarti Nimkar, which were very much appreciated : A) Starting the POGS Yuva WhatsApp group (idea by Dr Vaishali korde Nayak) ,B) Starting monthly newsletter SPECULUM ,edited beautifully by editorial team ,which could be posted to all members addresses C) Exchange Conference at ANANDWAN , with Chandrapur & Amravati Obgyn society, D) OGS Tour and Overseas CME in Busan ,South Korea ,E) Garba Festival programme with POS , F) Detox with Yoga by Dr Shirish Patwardhan : Religious Wari walk to spread positive messages :AMOGS wari lek ladki theme.

7) Our diamonds : like Rotating Trophy competition spearheaded by Dr Charuchandra Joshi, POGS rounds of Dr Usha Krishna Quiz and UG Quiz by Dr.Nilesh Balkawade, and Dr Sunita from AFMC, wonderful Outreach CME programmes crafted by Dr Amol Lunkad and Dr. Samidha Dalvi , monthly PG Masterclasses designed by Dr.Uma Wankhede and Dr Vaishali KN, Students online Quiz by Dr Kanchan Durugkar and Dr Manasi Sharma , Cutting Edge Webinars by Dr Vaishali Chavan ,our candidate for FOGSI VP elections, Our POGS Journal which has given us one more feather in our cap by becoming an indexed Journal kudos to Dr Parag Biniwale, Dr Vaishali KN , and All our CMEs, Conferences and academic , cultural programmes have

been going extremely well and very well attended .

8) In our tenure we were fortunate to have witnessed Dr Sunita Tandulwadkar installed as FOGSI President 2025, and Dr Parag Biniwale as ICOG Chairman , both Past Presidents of POGS and Dr Ashwini Kale as Joint secretary Fogsi.

9) This year POGS is a crowning glory with these two POGS celebrities and with AMOGS President Dr Kiran Kurtkoti , POGS is shining and shimmering everywhere .

10) WE ARE PROUD TO SHARE THAT POGS HAS BEEN AWARDED AMOGS BEST SOCIETY A CATEGORY AWARD, HAS RECEIVED DR M.V.CHITALE PRIZE for all the activities in 2024-25 at Annual Conference of AMOGS at Chandrapur on 14,15,16 February .A sincere thanks to all members and office bearers who have contributed immensely .

11) Let us promise ourselves to continue with enthusiastic participation in all POGS activities and academics .

And now , all of you after enjoying the exuberance of Year 2024-25 , MUST register and attend 40 th Installation CME of POGS "CODE RED" in our own City of Pune at Sheraton Grand ,on 19,20 April 2025.

ENCOURAGE ALL NONMEMBERS TO BECOME POGS members!Welcome to All ! Adieu ! Sayonara !

- Dr. Meenakshi Deshpande
Hon. Secretary POGS, Organizing Secretary ENDOART 2024 Conference

EDITORIAL TEAM

Dr. Amol Lunkad
Clinical Secretary

Dr. Vaijayanti Patwardhan
Treasurer

Dr. Laxmikant Behele
Managing Committee Member POGS

EDITORIAL

Namaskar to all POGS members and readers ..

Happy Holi ..

Happy Gudhi Padwa ...

Editorial team of Speculum this month has highlighted few interesting topics related to "Pelvi-Perineology". As we know it is a field focusing on the pelvic floor and its disorders, including muscles, ligaments, connective tissues, and nerves supporting the bladder, rectum, and pelvic organs. It is a very important part of our OBGY practice. Pelvic floor, is crucial for maintaining overall health and well-being because it supports pelvic organs, stabilizes the pelvis and spine, assists with sexual function, and helps maintain bowel and bladder control.

This issue we highlight various important topics related to Uterine Prolapse, Stress Urinary Incontinence, OASI, & Vault Prolapse.

This is last issue of Speculum by Team POGS 2024-25 .. but off course Speculum would continue for POGS members in a new form by the new Team.. as it is said, “Every new beginning comes from some other beginning’s end.”

Happy reading to all of you..!! Stay healthy ..!!

Long Live POGS...

- Dr. Amol Lunkad, Clinical Secretary

POGS February - March 2024 Programmes Report, By Dr. Meenakshi Deshpande (General Secretary)

1) 2 February: First POGS Green Array CME on Genetics testing in Women's Health : Practical Applications from prescription to interpretation) Infertility was held from 9 AM to 4 PM, Had 2 MMC credit points ; MMC observer was Dr Nandkishore Mantri and was attended by more than 58 delegates

2) 4 February : World Cancer Awareness Day : We had a grand Launch of FOGSI "Do tike zindagi ke " by POGS at Hotel Crowne Plaza , Pune an unique flagship programme under President Dr Sunita Tandulwadkar.

The wonderful programme started with the Launch of the Do Tike Zindagi ke concept explained by FOGSI President Dr Sunita Tandulwadkar. This was followed by a Talk on HPV vaccination by Dr Parag Biniwale.

Then followed a Panel discussion on myths and misconceptions in HPV moderated by Dr. Meenakshi Deshpande, and the

Panellists were - Dr Aarti Nimkar, Dr. Nilesh Balkawade, Dr. Ashish Kale, Dr Chaitanya Ganapule, Dr Vaijayanti Patwardhan. All the delegates also joined in this interactive discussion and it was a thoroughly enjoyable academic event

3) POGS Cutting-edge webinars: there were two cutting-edge Webinars in February

A) 20th February 2025: with Thrissur Obstetric & Gynaecological Society & Palakkad OBGY

B) 27th February 2025: With Ahmednagar OBGY

4) The AMOGS State Conference was at Chandrapur on 14,15,16 February: POGS RECEIVED THE AMOGS DR CHITALE BEST SOCIETY AWARD (Category A) for activities done in 2024-25.Thanks to Dr Kiran Kurtkoti, President AMOGS and Dr Nilesh Secretary and all office bearers and members of Team POGS 24-25 who have contributed immensely.

5) 16 February.: Second Green Array POGS CME was held, with different delegates and 2 MMC points.

6) 23 February : Progenesis CME with AMOGS and POGS was held at Hotel President from 9 AM to 2 pm. About 55 delegates attended.

7) 1,2 March 25 : The Indian College of Obstetricians and Gynaecologists (ICOG) , the academic wing of The Federation of Obstetric and Gynecological Societies of India (FOGSI) along with The Pune Obstetric and Gynecological Society(POGS) organised the 10th FOGSI- ICOG Annual Conference in Pune on Saturday and Sunday with the theme 'Updates in OBYGN- Fundamentals to advanced'.

Prof.Dr.Suresh Gosavi VC Savitribai Phule Pune University graced the occasion as the Chief Guest. Dr.Sunita Tandulwadkar, President FOGSI, Dr Parag Biniwale, Chairman ICOG 2025, Dr.Aarti Nimkar President, POGS, Dr.Kiran Kurtkoti, organising co-chairman Dr Sarita Bhalerao, organising secretary, Dr Chaitanya Ganpule were present on the occasion.

Various publications including ICOG book on research methodology, FOGSI book on women and thyroid, POGS books on thyroid and women, PCOS, POGS index journal, workshop manual on PCOS, midlife blogs initiatives were released on the occasion.

The two-day conference included various scientific sessions and workshops on advancement in obstetrics, orations, keynotes and paper presentations. Mid level and senior doctors from the field of OBYGN were handed the certificates of fellowship for completing various advanced courses in a special convocation ceremony with a special ceremonial procession. Young doctors from all over India presented more than 100 papers and posters on various subjects.

Prof. Dr. Suresh Gosavi VC Savitribai Phule Pune University gave information about the ongoing

research work on Nano materials in technology, drug development and drug delivery systems. He said that the two communities including academia and medical can come together to develop appropriate technologies to serve the society.

Dr. Sunita Tandulwadkar, President FOGSI said that the response to the conference reflects the popularity of ICOG Talking about academic activities she added that with 286 societies we will have one CME in each society.ICOG ramps up academic activities for advancement in knowledge.

Dr Parag Biniwale, Chairman- ICOG said that ICOG was started in 1984 as an academic wing of FOGSI to promote education, training and research in the field of Obstetrics, Gynaecology and family welfare. This conference, the first of the Annual ICOG Conference in Pune saw more than 300 delegates. The ICOG will reach out to smaller societies of FOGSI with an 'academics and perspectives' program. A new program called Harmoni for post graduate students with online classes for gynaecology and endocrinology will be started this month. Apart from this masterclass for teaching faculty will be started this month focusing on competency-based postgraduate teaching. The academic activities will continue through various workshops, collaborations with the Royal College of UK, Royal Australia and New Zealand College, European Board College and Srilankan College.

Dr.Aarti Nimkar, President POGS said that it is a matter of pride that the sitting chairpersons of POGS, FOGSI, AMOGS and ICOG are members of POGS.

Dr. Sarita Bhalerao Secretary ICOG provided a glimpse into the ICOG activities.

Dr Chaitanya Ganpule proposed the vote of thanks.

8) 4 March: CLUSTER 5 POGS FOGSI MSD programme on HPV vaccination Awareness and Training was held at Hotel Parcel executive, Vimannagar. Dr Lakshmikant Behele and Dr Aarti Yewale were coordinators. Speakers were Dr Aarti Nimkar and Dr Girija Wagh .More than 40 Obgyn delegates attended it.




9) 9 th March : POGS was associated with Chellaram Institute for the special Obgyn session of Symposium on Endocrinology, Diabetes and Women Health, in 9 th International Diabetes Summit , held at J.W Mariott. It was attended by more than 100 Obgyn and was was well appreciated and academically enriching. Program after 15th March

11) 29th March 2025: CME Program on IFS WMC Installation CME on the 29th of March 2025 at Hotel Sheraton Grand Pune from 4pm to 10 pm

	29th Mar 25	Scientific Program :	Saturday
	4.00 - 4.- 20 pm	Hi Tea & registrations	
	4.20 - 4.30 pm	Welcome	
	4.30 - 5.30 pm	**Session 1 :**	
	Chairpersons	*Anand Shinde, Amol Lunkad*	
	4.30 - 4.50 pm	Practical tips & tricks for follicular monitoring in IUI & IVF	Manjiri Valsangkar
	4.50 - 5.10 pm	Obesity and IVF	Mamta Dighe
	5.10 – 5.30 pm	Duostim & Bistim in IVF	Shweta Mittal
	5.30 – 6.00 pm	**Session 2 : IFS President's Oration 2025**	
	Chairpersons	*Meenakshi Deshpande, Vaijayanti Patwardhan*	
		Artificial intelligence for Gynecologists	Pankaj Talwar
	6.00 – 6.30 pm	**Inauguration & Installation Ceremony**	
		..Chief Guest	Pankaj Talwar
		..Guests of Honor	Aarti Nimkar
			Kiran Kurtkoti
	6.30 - 8.00 pm	**Session 3 : Panel discussions**	
	6.30 – 7.15 pm	ART Bills & its implications	
		Expert	Dilip Walke
		Moderators	Meenu Agarwal
			Nalini Bagul
		Panelists	Vrushali Chavan
			Vaishali Choudhary
			Arpita Gandhi
			Tejas Gundewar
			Sandhya Meshram
			Manjiri Valsangkar
			Vaishali Chavan
			Sagar Bumb
			Veena Todkar
	7.15 – 8.00 pm	PCOS	
		Expert	Shirin Venkat
		Moderators	Bharati Dhorepatil
			Neha Lad
		Panelists	Ranjana Shintre
			Akhileshwar Singh
			Poonam Patil
			Suryakumar Khandare
			Prasad Halkarnikar
			Anagha Pairaiturkar
			Charulata Bapaye
			Amit Shah
			Reshma Rajbhoi
	8.00 – 8.15 pm	Felicitations of new members	
	8.15 - 9.15 pm	Dinner	
	9.15 - 10.30	Session 4 :: Interactive session with Experts	
	10.30 - 11.00 pm	Valedictory ceremony	Anuradha Shewale

10) 23rd March 2025: SAMPOORNA CME at Hotel Sheraton Grand, Pune from 10:30 am to 1: 00 pm

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Obstetric anal sphincter trauma (OASI)

- Dr. Kameshwari

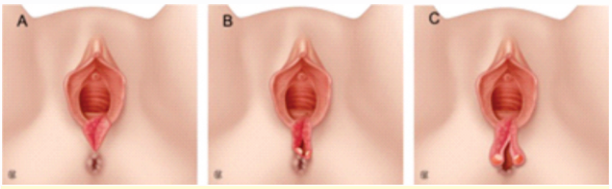
Mrs X , a 28 yr old primigravida had an uneventful antenatal period in a planned pregnancy. She wrote her birth plan as wanting a normal vaginal birth with no interventions. She set into labour at term, she was so much looking forward to a seam less delivery. All went well till full dilatation but unfortunately she had to have a forceps delivery for a fetal bradycardia in 2nd stage. An episiotomy was given which got extended into a 4th degree tear and the baby weighed 3.5 kg. She had to have the tear repaired in theater under spinal anaesthesia.A traumatic period followed with fecal urgency and flatal incontinence. She was very disappointed that all her dreams were shattered and felt let down…both Mrs X and her obstetrician were not happy…..... does this sound familiar? We all face these situations but how do we handle them appropriately? Can we prevent OASI from happening? Let's learn more about OASI.

Every obstetrician dreams of achieving a spontaneous vaginal birth for their patients which mother nature intended with an intact perineum or at least only a 1st or 2nd degree tear. Then the sense of satisfaction can bring joy. However, in reality this is not always possible. We do encounter severe degree perineal tears which encompass 3rd and 4th degree perineal tears in a small proportion of women despite our best intentions and these can cause significant morbidity to the women with consequences leading to anal incontinence or rectovaginal fistula or pain and dyspareunia. It is important to identify severe perineal trauma so that an adequate primary repair can be done to reduce the morbidity.

Obstetric anal sphincter injuries include 3rd degree tears which involve the external and internal anal sphincters muscles and 4th degree tears which extend up to the anal mucosa. Incidence varies between 1- 9% in literature. It was initially thought that a third of these sphincter injuries were occult, but it is now realized that most of them were either missed 3rd/4th degree tears or wrongly classified and not always occult. It is recommended to do a systematic examination of perineum, vagina and rectum following vaginal birth so the extent of trauma can be correctly identified and classified so that an appropriate repair can be performed. It is useful to follow the standardized classification for perineal trauma by WHO and RCOG for uniformity.

WHO/RCOG classification of perineal tears

	Childbirth Related Perineal Trauma Classification	
	First degree tear	Injury to perineal skin and/or vaginal epithelium
	Second degree tear	Injury to perineum involving perineal muscles but not involving the anal sphincter complex
OASIS encompass both third and fourth degree tears	Third degree tears:	
	3A tear	Less than 50% of the external anal sphincter (EAS) torn
	3B tear	More than 50% of the EAS torn
	3C tear	Both EAS and internal anal sphincter (IAS) torn
	Fourth degree tear	Injury to the perineum involving the anal sphincter complex (EAS & IAS) and anal epithelium

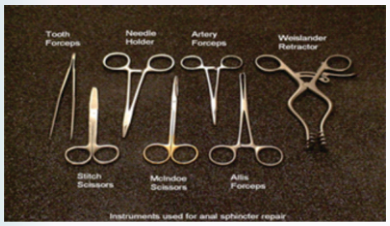


Representation of different grades of surgery 3a/3b/4th
Ref - Journal of Visceral Surgery 158 (2021) 231—241

Risk factors leading to occurrence of OASI include instrumental deliveries (higher with forceps than ventouse), occipitoposterior position, prolonged 2nd stage, nulliparity, epidural anaesthesia, shoulder dystocia with big baby and previous OASI. None of these risk factors are avoidable and we have to focus on prompt recognition. Prevention of OASI can be attempted by educating the woman not to push actively in second stage at crowning to avoid sudden explosive expulsion of fetal head which can lead to OASI and also by perineal support with various manoeuvres e.g. Finnish manouvre. Support with controlled head delivery help reduce OASI as the force is evenly distributed on the perineum. There is some evidence that antenatal perineal massage from 36 weeks onwards and using warm perineal compression during second stage can reduce OASI. Role of episiotomy is controversial but evidence does not support its protective role. Hence it must be a restricted episiotomy policy and if given must be at 60 degree angle away from midline.

Accurate diagnosis by thorough examination of vagina, rectum and perineum under good analgesia helps to identify sphincter trauma and enables correct classification. Once OASI is recognized repair must be done by an experienced obstetrician who had formal training as adequate primary repair is more likely to reduce long term consequences of anal incontinence. Detailed counseling of the patient and family about the degree of trauma and need for repair in theatre must be done after explaining the risks and long term sequelae.

In the operating theater repair must be done under regional anaesthesia so the sphincter

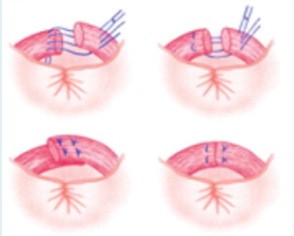


Instruments used for anal sphincter repair

muscle can relax, and ends can be retrieved without tension for repair. A perineal repair pack must be used with all the necessary equipment and repair must be done in layers as recommended in the table. There is no role for chromic catgut in repair of OASI and no role for figure of 8 sutures. Sutures must be approximated layer to layer with no tension.

Repair of OASI

Anatomical layer	Recommended Suture material	Type of suture
Anal mucosa	3-0 Vicryl	Continuous or interrupted with knots in anal lumen
IAS	2-0 Vicryl or 3-0 PDS	Interrupted mattress sutures
EAS	2-0 Vicryl or 3-0 PDS	End to end or overlap
Superficial perineal muscles	2-0 Vicryl rapide	Continuous or interrupted if deep in 2 layers
Vaginal mucosa	2-0 Vicryl rapide	Continuous
Skin	2-0 Vicryl rapide	Subcuticular


End to end or overlap techniques

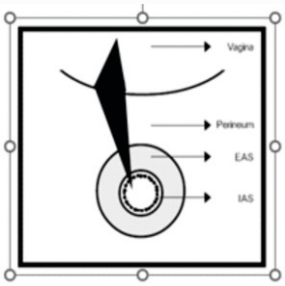
Post repair rectovaginal examination must be done to ensure no sutures are felt rectally. All swabs, instruments and tampons must be accounted for and documented. Estimated blood loss must be calculated and entered in the proforma.

There is evidence that antibiotic cover decreases wound infection and breakdown. It is recommended to administer Injection Cefuroxime 1.5 gm IV and Inj Metronidazole 500 mg stat doses intraoperatively followed by oral course for 5 -7 days. After the procedure detailed documentation about the nature and severity of injury using the RCOG classification is mandatory. Institutional proformas with structured checklist and picture depiction is recommended for clear understanding of the extent of trauma. Foley's catheter should be inserted for 24 hours to avoid retention due to pain. Laxatives must be prescribed for a less painful and earlier motion and discharge.

Postoperative medication advice

Antibiotics (oral)	CEFUROXIME 500 mg 12 hourly	METRONIDAZOLE 400 mg 8 hourly
Laxatives (oral)	Lactulose syrup 15 ml twice daily	Fybogel if required
Analgesia	Tab PARACETAMOL 1 GM 8 hrly and IBUPROFEN 400 MG 8 - 12 hrly	Diclofenac 100 PR for 3 rd degree tears (not for 4 th degree tears)
Probiotic	Becelac PB once daily	

Detailed counseling of the woman and her family about the extent and nature of trauma along with repair details and post operative instructions must be done and documented in her notes. Wound hygiene and need for sitz baths must also be explained. Dietitian and physiotherapist reviews can be arranged. It is important to avoid constipation and necessary diet changes with increased fiber and fluids must be advised. Kegel's exercises must be explained and can be commenced once they are pain free. Discharge must be done after atleast one controlled bowel motion. An information leaflet of perineal tears with all instructions must be given at discharge.



Picture to draw the trauma

Follow up must be arranged in a dedicated perineal clinic run by a gynaecologist with special interest and supported by physiotherapist at 6 weeks, 3 and 6 months. Structured questionnaires have to be used in follow up visits to assess for their pain, bowel, bladder and sexual symptoms and appropriate advise given. Endoanal scan and manometry are reserved for symptomatic women with access to a colorectal surgeon for significant defects.

Mode of delivery in subsequent pregnancy has to be decided based on symptoms and endoanal scan findings. If symptomatic with defect on scan elective cesarean can be offered. Some women may want vaginal birth and are willing to accept the risk of worsening symptoms. In asymptomatic women with no significant defect on endoanal scan, vaginal birth can be offered but recurrence risk of OASI of 4-5 % has to be explained. Some women may find the experience of OASI traumatic and may request elective cesarean. Involving the woman and respecting her choice is essential.

Secondary repair is reserved for women with missed complete perineal tears who have significant anal incontinence and elective cesarean section is recommended in subsequent deliveries after secondary repair.

OASI continues to be a serious complication of childbirth and we must endeavor to see that no OASI must be missed. Prompt recognition and adequate primary repair can reduce the morbidity. All obstetricians must be trained in identification and repair techniques by attending formal training courses to follow evidence based safe practice guidelines. Controlled head delivery with perineal support, antenatal perineal massages and intrapartum warm compresses have been shown to reduce the occurrence of OASI, hence all care givers must be trained in these interventions. Efforts should be directed to studies looking at the interventions to prevent the occurrence of OASI in future so as to make vaginal birth safer.

PELVIC ORGAN PROLAPSE – DON'T FORGET THE APEX

- Dr. Pankaj Sarode

Pelvic organ prolapse (POP) affects millions of women. 11 to 19 percent women would have to undergo surgery for POP or incontinence by the age of 80 years. One third of them may need repeat surgery for recurrence after such surgeries.

Apical prolapse refers to the downwards displacement of the vaginal apex, cervix with uterus or vault in case of previously hysterectomized woman. Support of the apex is primarily derived from uterosacral - cardinal ligament complex, endopelvic fascia and intact levator ani- anatomically as well as neuromuscularly. The etiology of prolapse is related to defects in these supports. The risk of apical prolapse increases 5 fold with history of vaginal delivery, 8 fold with history of prior surgery for incontinence and 13 folds with history of surgery for POP. Hence importance of apical prolapse prevention at hysterectomy and treatment at earlier stages of the prolapse could not be stressed more.

Traditionally, hysterectomy and vaginal wall repairs, if necessary, is the rule for the cases of POP. But review of literature makes it is clear that this traditional approach may not be sufficient. Addition of surgery for prevention of apical prolapse is necessary. Also we are using hysterectomy as a primary modality to treat POP along with vaginal wall repairs. The time has come when we need to question the necessity of hysterectomy for treating POP. Because prolapsed uterus is the effect and not the cause of POP. Pathology is not with the uterus and adnexa but with the supports of these structures. Also, there is no sufficient data to support routine use of hysterectomy with POP repair surgery. In that case, can we do uterus sparing surgeries for POP? With increasing emphasis on women centered decision making it becomes more important. In two studies totaling over 300 women that assessed opinions on uterine preservation versus hysterectomy at POP repair,36 to 60 % women preferred uterine preservation in case of equal outcome of surgery. In case of superior outcome with hysterectomy ,21 % women still preferred to conserve the uterus. Obviously, women with uterine pathology and with high risk for development of malignancy in later life are not candidates for uterus sparing surgery for POP.

With multiple surgical approaches available for treating POP and despite multiple statistical analyses, it is difficult to compare the outcome of different surgeries modalities. But uterus preserving surgeries appear to have similar success rates. They have shorter surgical time and lesser surgical complications.

Mesh repairs were promising options before being banned by US FDA for use in POP surgeries for the reason of mesh erosions. The principal of mesh use in case of mesh surgeries is most appropriate. POP is similar to hernia where there is protrusion of abdominal organs through an opening due to weakness of the native tissue. Native tissue repair has inherent fallacy where one uses same weakened tissue to reinforce the repair. It is bound to fail. Hence use of synthetic material is justified. Meshes failed as same meshes used for abdominal hernia repair were used enthusiastically for vaginal repair not taking into consideration special properties of vaginal tissue. Research is on for inventing a material for vaginal mesh which will have less erosion. Till then no mesh should be used for POP repair. The surgical options for prevention and treatment of apical prolapse are –

Sacro-hysteropexy - abdominal, laparoscopic or robotic.

Vaginal Sacro-spinous ligament suspension (SSLS) of the uterus or of the cervix.

Vaginal / Laparoscopic / robotic high utero-sacral ligament (USL) suspension of vaginal vault or of the cervix.

Choice of surgery depends upon the age of the patient, her desire to conserve the uterus, her goals of surgical outcome, her ability to tolerate the surgery (co morbidities) , concern for recurrence , complication profile of each surgery, her concerns regarding sexual function, degree of prolapse , availability of the resources (laparoscopy/robotics) and surgeon's expertise. Key issues to take into consideration are route of surgery, need for repair of other pelvic defects and presence of urinary incontinence. Urinary incontinence is commonly associated with women with prolapse. Most of the times it is occult and revealed only after surgical correction. Hence evaluation for the urinary incontinence before each POP surgery is necessary. A simple cough test after correction of prolapse can be of great help to diagnose a significant number of cases of incontinence. A surgical correction of it needs to be added with POP surgery. It can be either Burch colposuspension or mid urethral sling.

Choice between abdominal versus vaginal route for apical prolapse repair-

Data suggest that abdominal surgery, typically with abdominal sacrocolpopexy, provides better objective anatomic outcome than native tissue vaginal apical support procedures for most women. However, vaginal procedures are a reasonable alternative because of similar rates of postoperative prolapse sysptoms, reoperation and adverse events compared with ASC. The uterus or Fallopian tubes can be removed by either route. While the majority of studies on ASC outcomes used an open technique, laparoscopic and robotic approaches appear to offer improved vaginal support associated with open procedures and shorter recovery of vaginal procedures.

A 2016 metaanalysis of 30 trials concluded that open sacrocolpopexy had superior outcomes compared with a variety of vaginal procedures but resulted in longer operating time and greater delay in resumption of acivity. It can be mitigated by use of laparoscopy or robotic-assisted surgery. Therefore, ASC may be more appropriate for women with risk factors for recurrence including young age, stage three or four POP, prone to high-impact activities or heavy lifting and previous failed POP repair. Other reasons to choose abdominal route include insufficient vaginal length for transvaginal repair or other indications for abdominal surgery. Transvaginal repairs can be an appropriate option for women for whom abdominal surgery can be high risk or for whom recovery from abdominal surgery can be difficult. Retrospective data from Medicare study suggests women more than 65 years of age had better recovery with vaginal route with lesser GI complications as compared to abdominal route. Concomitant repair of vaginal defects can be a reasonable indication for choosing vaginal route. But a study has demonstrated that apical suspension itself can be effective in repairing anterior and posterior wall defects in a significant number of women. One third of women with anterior vaginal wall defects and half of women with posterior vaginal wall defects experienced improvement with apical suspension.

In conclusion, POP surgery is incomplete without consideration for apical support. Out of all the available options, one needs to choose one which best suits the patient's expectations from the surgery.

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POGS IN NEWS

१०वी आयसीओजी वार्षिक परिषद पुण्यात संपन्न

१० वी आयसीओजी वार्षिक परिषद पुण्यात संपन्न

'आयसीओजी'ची वार्षिक परिषद

पुणे : पुढारी वृत्तसेवा

द फेडरेशन ऑफ ऑब्स्टेट्रिक अँड गायनेकोलॉजिकल सोसायटीज ऑफ इंडिया (फॉग्सी) चा शैक्षणिक विभाग असलेल्या द इंडियन कॉलेज ऑफ ऑब्स्टेट्रिक्स न्ड गायनेकोलॉजिस्ट (आयसीओजी) ने पुणे स्त्रीआरोग्य व प्रसूतीशास्त्र (पीओजीएस) संघटनेच्या सहकार्याने १० वी फॉग्सी - आयसीओजी वार्षिक परिषदेचे आयोजन पुण्यात करण्यात आले होते. या परिषदेची संकल्पना अप २ डेट - फंडामेंटल टू अँडव्हान्सड अशी होती

या कार्यक्रमाला सावित्रीबाई फुले पुणे विद्यापीठाचे कुलगुरू प्रा.डॉ.सुरेश गोसावी प्रमुख पाहुणे म्हणून उपस्थित होते. याप्रसंगी फॉग्सीच्या अध्यक्षा डॉ. सुनिता तांदुळवाडकर, आयसीओजीचे अध्यक्ष डॉ. पराग बिनीवाले, पीओजीएसच्या अध्यक्षा डॉ.आरती निमकर, परिषदेचे सहअध्यक्ष डॉ. किरण कुर्तकोटी, आयोजन समितीच्या सचिव डॉ. सरिता भालेराव, डॉ. चैतन्य गणपुले आदी उपस्थित होते.

आयसीओजी वार्षिक परिषद पुण्यात संपन्न

- समाजासाठी उपयुक्त वैद्यकीय तंत्रज्ञान विकसित करण्यासाठी शैक्षणिक आणि वैद्यकीय क्षेत्राने एकत्र यावे -प्रा.डॉ.सुरेश गोसावी
- तरुण स्त्रीरोग तज्ज्ञांसाठी आयसीओजी तर्फे शैक्षणिक उपक्रमांचा विस्तार

• पुणे •

द फेडरेशन ऑफ ऑब्स्टेट्रिक अँड गायनेकोलॉजिकल सोसायटीज ऑफ इंडिया (फॉग्सी) चा शैक्षणिक विभाग असलेल्या द इंडियन कॉलेज ऑफ ऑब्स्टेट्रिक्स अँड गायनेकोलॉजिस्ट (आयसीओजी) ने पुणे स्त्रीआरोग्य व प्रसूतीशास्त्र (पीओजीएस) संघटनेच्या सहकार्याने १० वी फॉग्सी - आयसीओजी वार्षिक परिषदेचे आयोजन पुण्यात करण्यात आले होते. या परिषदेची संकल्पना अप २ डेट - फंडामेंटल टू अँडव्हान्सड अशी होती

या कार्यक्रमाला सावित्रीबाई फुले पुणे विद्यापीठाचे कुलगुरू प्रा.डॉ.सुरेश गोसावी प्रमुख पाहुणे म्हणून उपस्थित होते. याप्रसंगी फॉग्सीच्या अध्यक्षा डॉ.सुनिता तांदुळवाडकर, आयसीओजीचे अध्यक्ष डॉ.पराग बिनीवाले, पीओजीएसच्या अध्यक्षा डॉ.आरती निमकर,परिषदेचे सहअध्यक्ष डॉ.किरण कुर्तकोटी,आयोजन समितीच्या सचिव डॉ.सरिता भालेराव,डॉ.चैतन्य गणपुले व इतर मान्यवर उपस्थित होते. उदघाटन सोहळ्यात आयसीओजी, फॉग्सी व पीओजीएसची संशोधन पध्दती,मायग्रेईड, पीसीओएस, मिडलाईफ या सारख्या अनेक विषयांवर लिहिलेली पुस्तके आणि पीओजीएसची नियतकालिका (पीओजीएस इंडक्स जर्नल) यांचे मान्यवरांच्या हस्ते प्रकाशन करण्यात आले. या दोन दिवसीय परिषदेमध्ये स्त्रीरोग व प्रसूती शास्त्रातील विविध वैद्यकीय सत्रे,कार्यशाळा व व्याख्याने यांचा समावेश होता. एका विशेष दीक्षांत समारंभात स्त्रीरोग चिकित्सा क्षेत्रातील डॉक्टरांना प्रगत अभ्यासक्रम पूर्ण केल्याबद्दल फेलोशिप प्रमाणपत्र देण्यात आले. संपूर्ण भारतभरातील तरुण डॉक्टरांनी विविध विषयावर 100 हून अधिक शोधनिबंध व पोस्टर्सचे सादरीकरण केले. सावित्रीबाई फुले पुणे विद्यापीठाचे कुलगुरू प्रा.डॉ.सुरेश गोसावी यांनी विद्यापीठात नेमो मटेरियलसह वैद्यकीय तंत्रज्ञानाबाबत चालत असलेल्या संशोधनाबाबत माहिती दिली. ते म्हणाले की, समाजाला उपयुक्त ठरेल असे वैद्यकीय तंत्रज्ञान विकसित करण्यासाठी शिक्षण व वैद्यकीय क्षेत्राने एकत्र येणे गरजेचे आहे.

फॉग्सीच्या अध्यक्षा डॉ.सुनिता तांदुळवाडकर म्हणाल्या की, या परिषदेला मिळालेला प्रतिसाद आयसीओजीची लोकप्रियता दर्शविते.

आयसीओजीचे अध्यक्ष डॉ.पराग बिनीवाले म्हणाले की,आयसीओजीची स्थापना 1984 साली फॉग्सीचा एक शैक्षणिक विभाग म्हणून झाली होती. स्त्रीरोग व प्रसूती तंत्रशास्त्र क्षेत्रात शिक्षण,प्रशिक्षण व संशोधनाला प्रोत्साहन देणे हे या संस्थेचे उद्दिष्ट आहे. पुण्यात प्रथमच आयसीओजीची वार्षिक परिषद पार पडली असून यामध्ये 300 हून अधिक डॉक्टरांनी सहभाग घेतला. नजिकच्या काळात आयसीओजी तर्फे ॲकेडेमिक्स अँन्ड परमेक्टिक्स या शैक्षणिक उपक्रमाद्वारे फॉग्सीच्या छोट्या शाखांपर्यंत पोहचण्याचा प्रयत्न आम्ही करू. पदव्युत्तर विद्यार्थ्यांसाठी हार्मनी या नवीन उपक्रमाद्वारे स्त्रीरोग व ऐडोकिनोलॉजी यासाठी ऑनलाईन क्लासेस या महिन्यात सुरू होतील.यासिवाय क्षमता आधारित पदव्युत्तर अभ्यासनावर लक्ष केंद्रित करत शिक्षकांसाठी मास्टर क्लासेस सुरू केले जातील. रॉयल कॉलेज ऑफ सुर्जन्स,रॉयल कॉलेज ऑफ ऑब्स्ट्रेशा अँन्ड गायनॉलॉजी, यूरोपियन बोर्ड कॉलेज आणि श्रीलंकेतील कॉलेज यांच्या सहकार्याने शैक्षणिक कार्यक्रम सुरू राहतील.

पीओजीएसच्या अध्यक्षा डॉ.आरती निमकर म्हणाल्या की,पीओजीएस,फॉग्सी,एमओजीएस व आयसीओजी या सर्व संस्थांचे सध्याचे अध्यक्ष हे पीओजीएसचे सदस्य असून ही एक अभिमानास्पद बाब आहे.

आयसीओजीच्या सचिव डॉ.सरिता भालेराव यांनी आयसीओजीच्या विविध उपक्रमांबाबत माहिती दिली. डॉ.चैतन्य गणपुले यांनी आभार प्रदर्शन केले.

PUNE OB-GYN SOCIETY ESTD. 1953
SHE IS SPECIAL
SPECULUM
NEWSLETTER
MARCH 2025

Vaginal Pelvic Floor Surgeon

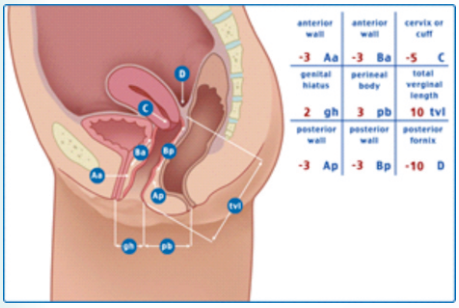
- Dr. J. P. RATH, MD

Man has always been deeply obsessed by "Length"!
So also woman, but never by "Depth"!!

Genital prolapse is unique to women, and especially those that have had childbirth, or poor support due to advancing age or poor muscles and collagen support. Post hysterectomy the problem is pronounced. Every Pelvic surgeon should be sensitive to the need of giving vagina a depth while contemplating a repair of vault; and whilst doing hysterectomy, to prevent a vault prolapse. All repairs may not be permanent, but at least they should be long lasting, and offer a reasonable depth to the vagina.

Vault prolapse, occurs when the apex of the vagina weakens following the removal of uterus, causing it to collapse into the vaginal canal. In more serious cases of vaginal prolapse, the top of the vagina may bulge outside the vaginal opening. Vaginal vault prolapse has been defined by the **International Continence Society** as descent of the vaginal cuff below a point that is 2 cm less than the total vaginal length above the plane of the hymen. Coexistent pelvic floor defects which may be a cystocoele, rectocoele or enterocoele are present in 72% of patients with vault prolapse (1).

Prolapse of the vaginal vault after hysterectomy may occur when the structures that support the top of the vagina and uterus are not reattached at the time of the initial procedure or due to weakening of these supports over time. The reported incidence is reported from 0.2% to 40 %. (2).The scope of discussion of preventive surgery is out of this article. However, McCall Culdoplasty, Sacro-spinous fixation should be considered while doing a vaginal Hysterectomy for prevention, and a robust vault lift during abdominal or laparoscopic procedure, keeping the integrity of the ligaments. Although prolapse is usually multi-compartmental and isolated defects are rare, ***the apical compartment deserves special attention because apical support is integral to durable prolapse repair (3).*** For brevity, precise procedures of repair techniques are going to be a part of the discussion.



POP-Q standard classification has been followed, in assessing descent as well as the repair. Fig.1

The main issue is to actually quantify the descent, and address the associated symptoms, which could vary from dryness, discharge, pain, and incontinence of urine and or any colorectal anal distress. If multiple symptoms exist the repair should be meticulous and involve a Urogynecologist, and perhaps Proctologist. Ultimate aim of repair should address her symptoms, sexual function and Quality of Life.

A serious evaluation of associated prolapse of Anterior Compartment (Cystocele), Posterior Compartment (Enterocele, Rectocele, and Pelvic outlet relaxation), and Paravaginal prolapse should be done; to determine the choice of surgery.

There are multiple methods of doing a vault repair. They could be done by vaginal route, by Laparoscopy or routine Laparotomy. Meta-analysis done for the type of surgery did not show much difference in the result, but the satisfaction rate was less in vaginal mesh group than Laparoscopic or vaginal and also the incidence of mesh erosion. (3)

VAGINAL

1. Sacro-spinous fixation
2. Creation of new apex using native tissue
3. High Uterosacral ligament suspension (HUSLS)
4. Colpocleisis

ABDOMINAL

1. Open Abdominal Sacrocolpopexy (ASC) using mesh or tape
2. Burch's Coloposuspension (if associated Stress Urinary Incontinence)

LAPAROSCOPIC / ROBOTIC

1. Sacrocolpopexy (LSC) using Tape
2. Burch's Coloposuspension (if associated Stress Urinary Incontinence)
3. High Uterosacral ligament suspension (HUSLS) High Risk for ureteric injuries

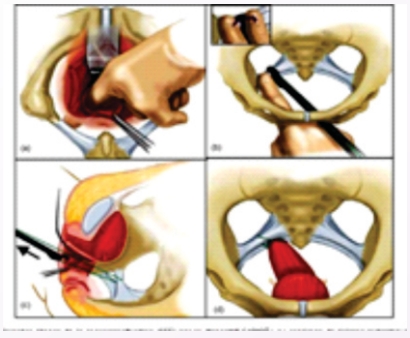


Fig 2 a

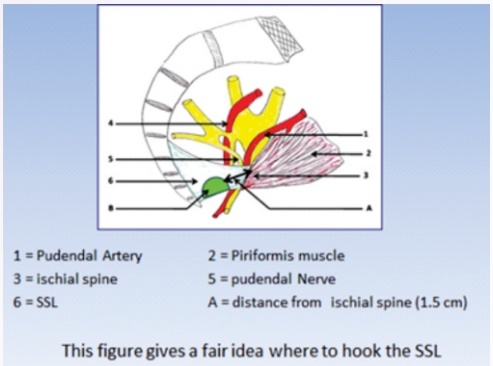
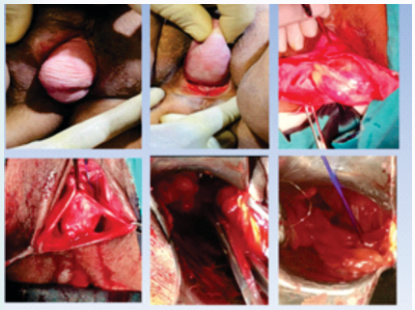


fig 2 b..... (7)



SACROSPINOUS LIGAMENT (SSL) FIXATION - Principle: This is done purely by the vaginal route. After correcting the associated compartment defects, newly created apex is fixed to the SSL on either or both sides. Surgery is easy to perform. (Fig 2a and 2b).

Procedure: After identifying the sulcus with puckering on the prolapsed vault, the Cystocele repair is completed first, and then a cut is taken on the lateral wall of vagina or the fourchette. The pararectal space opened, and reached upto the SSL (I prefer right side), and the connective tissue cleared by blunt gauze dissection. After the ligament is clean Miya's hook or Mixter or directly the needle of the suture is passed through the SSL, 1.5 cm medial to the ischial spine, to prevent damage to the Pudendal vessels and nerves. Care should also be taken not to go medially to prevent entrapment of the Sciatic nerve and its branches. Use of Polygalactin, Polypropelene (Prolene) or PDS no-1 is as per choice of the surgeon (4).

Problems : Recurrence is known and can manifest within the first year as failure of surgery. Over the years the laxity of vaginal tissue with age can manifest with weakness necessitating another procedure. Bleeding is not common as this is a celomic space, but can be encountered, seldom torrential which can be managed with packing. Buttock pain on the ipsilateral side is also known and usually passes of with time. The depth achieved is never over 5-6 cm (point C). It does have a low satisfaction index from those sexually active, often complain of dyspareunia. Recurrence is as high as 17-30 %

Advantage : can be done concomitant with procedentia as prevention, for long term results.

CREATION OF NEW APEX USING NATIVE TISSUE

Principle: It is similar to McCall Culdoplasty. The uterosacral ligaments are harnessed after reduction of the prolapse tissue and brought to the center, and if accessible, the white line (Arcus tendineus) may be held and approximated in the center to form a new apex

Procedure: Saline infiltration done below the vaginal mucosa, after holding the vault ends. The flaps opened, and the respective Cystocele and Enterocele is pushed up high, without opening the peritoneum. The Utero-sacral ligaments identified and held as high as possible (note: very high will cause ureteric damage). If one is conversant with deeper anatomy, the white line may be held and brought to the center. Material can be Polypropelene or PDS, to give it a longer life. Then the anterior defect is closed using the periosteum of the ischio pubic rami. The posterior defect closed by approximating the Levator ani muscles on either side to the center. For this the pararectal space is accessed. Here again use of PDS is done. Finally wound closed (Fig.4).

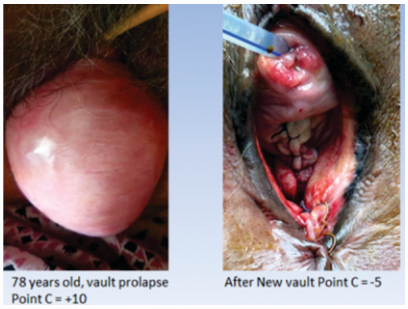


Fig 4

Problem: The surgeon should be conversant with perineum and pelvic floor anatomy. Bleeding is rare, unless para rectal venous plexus is injured and can be effectively dealt with pressure. It has long standing results, with apex (point C) being a length of 6-8.

Advantage: It's very easy to perform. It has a high satisfaction index (3). The surgery can be done under low spinal or saddle. Lesser operative time.

HIGH UTEROSACRAL LIGAMENT SUSPENSION (HUSLS)

Principle: High uterosacral ligament suspension is an intraperitoneal procedure that traditionally uses a permanent suture to suspend

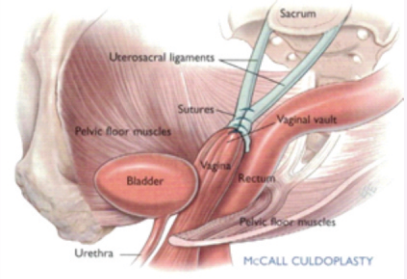


Fig 5

the vaginal apex to the remnant of the intermediate portion of the uterosacral ligament at the level of the ischial spine and cephalad with the incorporation of fibromuscular walls of the anterior and posterior part of vagina. This is quite much similar to the above procedure, but takes longer time to perform. (Fig. 5).

Procedure: Long moistened gauge was packed to keep the bowels away from the operative field, and appropriate retractors were used to expose the uterosacral ligament on each side. The ligament is pulled at its tied end to make it prominent and is caught by Allis forceps as close to the ischial spine as possible after palpating it digitally as well. One to two sutures are taken through the substance of the ligament rather than encircling it, avoiding ureteral involvement. The sutures are left long, and the same procedure was repeated on the opposite side. These sutures are tied to the endovaginal fascia and vaginal skin after the completion of colporrhaphy in the usual manner. A cystoscopy is always done after every HUSLS before the closure of the vault. Sutures: delayed absorbable sutures, either number-1 polydioxanone (PDS II) or polygalactin-910 (Vicryl-0).

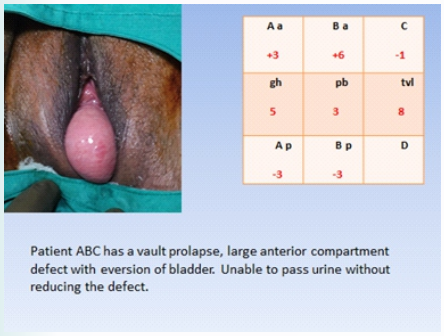


Fig 6 a

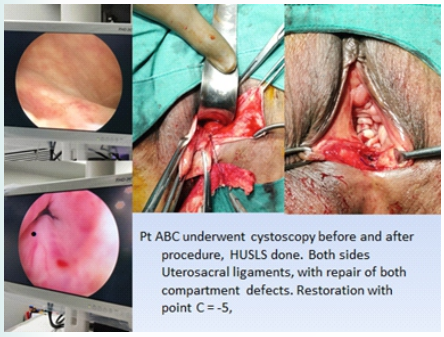


Fig 6 b

Problem: Many studies support that HUSLS repairs all vaginal defects, the vaginal vault is well supported, and the vaginal axis is restored, which prevents further recurrence of prolapse. There are reported incidents of hematoma and gluteal pain. If this procedure is done vaginally, the chances of ureteral injury have been reported up to 11%. Thus, it is essential to perform a cystoscopy after each vaginal procedure to check the ureteral patency. (5) Advantage: Can be performed vaginally or laparoscopically Fig (6a-6b) and can give a vaginal depth of 6-8 cm (point C), so better sexual function (6)

COLPOCLEISIS

Principle: The vagina is obliterated to reduce the vaginal prolapse, keeping the urethral opening for passing urine. Done, in cases who are very old or unfit for surgery and anaesthesia

Procedure: The common procedure is Le Fort Colpocleisis. After a good preparation of the mucosa by oestrogen based gels and cream for a week, the patient is taken up preferably under Low spinal or saddle block. Often patients are unfit and it's done under local anesthesia. After injection of diluted saline, a rectangular slice of vaginal mucosa is removed from the anterior and posterior wall about 1 cm above the protruding vault upto 1.5 cm below the urethral opening. Three or four step sutures are taken from the anterior to the posterior denuded area and held long. Serially they are tied from below upwards, till the entire vault is reduced, keeping the lateral area slightly open. It's a short procedure and delayed absorbable sutures are used.

Problem: once fused, difficult to open, hence used as a final procedure where the coital functions are not needed. May form hematoma or non-healing may occur.

Advantage: Colpocleisis remains a viable option for POP, without compromising QOL, body image, or sexuality, but diligent patient selection is needed. Particular concern should be given to bladder and bowel symptoms since these are the main reasons for dissatisfaction after colpocleisis. Recent series have shown close 100% success rate (8)

It gives us great pleasure to inform you that our son **DR. ISHAAN PADORE** received a GOLD MEDAL for being TOPPER with DISTINCTION in MS(OBGY) exam in BJ govt medical college & SGH Pune held in 2023 (summer). ISHAAN was among the youngest to pass his MS exam.

Ishaan is son of Dr Sachin and Archana Padore who are POGS members.

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Surgical Management of Stress Urinary Incontinence: A Review

- DR. AJAY RANE
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Introduction - Stress urinary incontinence (SUI) remains a prevalent condition affecting almost a third of women in their lifetime. (1-3). It is the bothersome involuntary leakage of urine when there is increased abdominal pressure such as with sneezing or coughing. (4)

The underlying pathophysiology often involves weakened pelvic floor musculature and compromised urethral sphincter function, leading to insufficient support of the urethra. The De Lancey hammock theory postulates that anterior vaginal wall and the overlying connective tissue provide the urethra with support. When there is increased pressure in the bladder or abdomen, the urethra is compressed, and the lumen closes. This support is weakened over time with factors such as pregnancy, childbirth, obesity, constipation, repetitive heavy lifting and menopause. (3,5).

Bladder storage is via the sympathetic nerves which stimulate the beta adrenergic receptors of the bladder wall relaxing the smooth muscles of the bladder wall. The alpha adrenergic receptors of the urethra increase the pressure of urethra through contraction. The pudendal nerve also innervates the urethra so neuropathy with pregnancy, childbirth and ageing can also contribute to the pathophysiology of urinary incontinence.

Preoperative Workup - The diagnosis of SUI is through detailed history taking, urinary stress testing and consideration of urodynamics for a select population. Often pelvic organ prolapse or mixed urinary incontinence will co-exist so it is important to screen for this as it will change the surgical decision making process. Factors such as age, parity, medical history, pelvic organ prolapse, and previous pelvic surgeries need to be considered to ensure optimal patient selection for surgical intervention.

Most practices will have a questionnaire that patients are required to fill out. Symptoms that patient present with typically include leaking of urine during physical exertion, coughing or sneezing. If the patient reports symptoms which are inconsistent with leaking during increased intra-abdominal pressure or if there are mixed symptoms of stress and urge incontinence, urodynamics testing is recommended.

A thorough medical history is always recommended to rule local or systemic conditions which may be contributing or worsening the patient symptoms e.g., medications such as tricyclic antidepressants or calcium channel blockers.

A pelvic exam and utilising the pelvic organ quantification (POP-Q) system should be performed. This can help exclude a pelvic or urethral mass such a urethral diverticulum contributing to the patient symptoms. During the examination, ensure there is no palpable mesh erosion in those with previous pelvic surgeries. Pooling of urine in the vagina is a red flag and the possibility of urinary tract fistula needs to be excluded if found on examination.

An office urinary stress test can also easily be performed during examination, whereby a patient is asked to cough, and urine is visualised coming through the urethra. This is commonly known as the cough stress test. Immediate leakage is indicative of SUI. The valsalva manoeuvre should also be performed to assess for pelvic organ prolapse.

Urethral hypermobility is present in most women who have SUI. This can be shown through the Q-tip test, where a cotton swab is inserted into the urethra. However, this is no longer routinely performed due to patient discomfort, furthermore a positive finding is unlikely to change management. An alternative option for assessing urethral hypermobility includes performing a transperineal ultrasound. (6)

A postvoid residual volume (PVR) should also be considered via pelvic ultrasound or bladder catheterisation. Large volumes (greater than 200cc after voiding) imply voiding dysfunction or detrusor weakness. A urine dipstick to rule out a urine infection should also be performed routinely as an infection is easily treated. (7-9)

Urodynamics testing should be performed in women with complicated stress urinary incontinence or mixed urinary incontinence. Complicated SUI are those women who have had previous continence surgery, radiation therapy, leakage without exertion or persistently elevated PVRs. Whilst urodynamics does not improve treatment outcomes in those with SUI, it does help predict a woman's risk of developing adverse events including urge incontinence post surgery. (10)

Non-Surgical Management Options - Before considering surgical intervention, patients with SUI should be offered conservative management options including the no treatment option. (4,11)

1.Do Nothing - May consider this if the patients' symptoms are mild

- May choose to treat with continence aids instead

2.Non surgical Treatments

A) Lifestyle Changes - Depending on the patients risk factors recommend weight loss, avoiding heavy lifting, treating constipation and or smoking cessation

B) Behavioural Modification **-** Strategies such as bladder training, scheduled voiding, and fluid management can help patients regain control over their bladder function and reduce episodes of urinary leakage.

- Avoidance of bladder irritants such as caffeine and alcohol may also be recommended to alleviate symptoms.

C) Pelvic Floor Muscle Training (PFMT): - This is aimed at strengthening the pelvic floor muscles to improve urethral support and reduce urinary leakage.

-Patients should receive instruction and guidance from a trained pelvic floor physiotherapist to ensure proper technique and adherence to the exercise regimen. This should be targeted at 16 weeks. If there is no improvement after this timeframe, the patient should be referred for surgical consideration.

D) Continence Pessary **-** In patients with concomitant pelvic organ prolapse or mixed urinary incontinence, vaginal pessaries can provide support to the pelvic organs and improve continence.

- Pessaries come in various shapes and sizes and should be fitted by a gynaecologist or urogynaecologist to ensure optimal comfort and efficacy.

E) Medical Therapy **-** Topical vaginal estrogen should be recommend if vaginal atrophy is present, as this is often associated with genitourinary syndrome of menopause (GSM) which can cause stress or urge incontinence.

-There is no other pharmacological therapy approved by the therapeutic goods association to treat SUI.

Current Surgical Options - If non-surgical treatments do not work, and or the patient is still reporting symptoms, surgical options should be discussed. The patient then should choose if they would like a repair using their own tissues, a biological graft, synthetic mesh or a urethral bulking agent. The main options for surgical treatment are a mid-urethral sling, pubovaginal sling, colposus pension or urethral bulking agents. (4,11)

1.Midurethral Sling (MUS) Procedures (11-15) : - Tension-free vaginal tape (TVT) and transobturator tape (TOT) represent the gold standard in midurethral sling procedures.

- TVT involves the insertion of a synthetic mesh tape via a retropubic approach, while TOT utilises a transobturator route for sling placement.

- The TVT can be used for hypermobility and intrinsic sphincter deficiency (ISD), whereas the TOT should only be used for hypermobility alone, as it has poor results with ISD.

-The TOT can result in persistent groin and pelvic pain which may require removal of mesh, in about 5% of patients

- In comparison, the TVT has a higher rate of visceral injury, approximately 6%

- Complete mesh removal is usually achievable with a combined vaginal, laparoscopic & or open procedures for TVT slings, however complete removal of the TOT is far more difficult and often incomplete, with ongoing pain despite removal (11)

- As such the TVT is the preferred approach, unless the patient has higher risk factor for visceral injury e.g. extensive abdominal surgery.

- This minimally invasive technique provides dynamic support to the midurethra, preventing urinary leak during physical activity.

-The procedure has decreased operating time and is usually performed as a day procedure with low rates of post-operative complications, especially when compared to a native tissue repair (4)

2. Pubovaginal Slings (17) - This procedure uses a similar technique as the midutheral sling procedure, but instead of mesh, it uses the patients own fascial tissue, routinely from the patients abdominal rectus sheath.

-Due to the complex nature of the surgery, only some specialised surgeons perform this procedure.

- It has similar success rates compared to MUS but involves a longer procedure, with a post-operative stay of 2-3 days, and a longer recovery period.

-It has a lower rate of bladder perforation compared to MUS, but a higher voiding dysfunction rate.

-The pubovaginal sling should be recommended to women who are wanting to avoid mesh related complications.

- It has 85% long term success rate

3. Bulking Agent (17) : Injectable bulking agents offer a less invasive option for patients unwilling or unable to undergo sling procedures, for example due to multiple co-morbidities or those wanting to avoid mesh related complications .

-It is a useful option for patient with recurrent SUI but with a well-supported urethra

-Substances such as polyacrylamide hydrogel or polydimethylsiloxane are injected periurethrally to increase urethral resistance and improve continence.

-It is a relative minor procedure and patients can go home the same day

- Recovery time is short, and the complication rate is low

4. Laparoscopy or Open Colposuspension (17) - Although less commonly performed in the era of sling procedures, colposuspension remains a viable option, particularly in the context of concomitant pelvic organ prolapse repair.

-These procedures involve the surgical suspension of the bladder neck to restore urethral support and continence.

-It works well in those with ISD

-It has a longer operating time, with the laparoscopic approach having less morbidity, but an overall similar success rate as an open procedure

- There are lower rates of success, with higher rates of retreatment, compared with a pubovaginal repair

- It has a long-term success rate of at least 70%

5. Alternative options - For those who have intractable incontinence and are poor surgical candidates due to co-morbidities or requiring palliation, urinary diversion via a supra-pubic catheter should always be considered.

Conclusion - The surgical management of stress urinary incontinence continues to evolve, driven by advancements in technology, surgical techniques, and our understanding of pelvic floor anatomy and function. Urogynecology specialists must remain at the forefront of these developments to offer patients the most effective and tailored treatment options. By embracing evidence-based practices and emerging innovations, we can uphold our commitment to improving the quality of life for individuals affected by SUI.

The IVF Diet : Eating for Fertility Success

ROHIT SHELATKAR
Vice- President and
Director of Meyer Vitabiotics

When embarking on the journey of in vitro fertilization (IVF), maintaining optimal health through diet is crucial. The right nutrition can significantly influence the success of fertility treatments. One key component of a fertility-boosting diet is the inclusion of essential micronutrients. These vitamins and minerals play a vital role in reproductive health, supporting various processes from hormone regulation to egg and sperm quality.

Folate, a B vitamin, is fundamental for DNA synthesis and repair, processes that are critical during the early stages of pregnancy. Vitamin D is another crucial nutrient, playing a role in hormone regulation and ovulatory function. Low levels of vitamin D have been linked to infertility and poor IVF outcomes. Antioxidants such as vitamins C and E protect reproductive cells from oxidative stress, which can damage eggs and sperm. Including a variety of colourful fruits and vegetables in the diet helps ensure adequate antioxidant intake. Nutrients such as iron, zinc, and omega-3 fatty acids are also important for reproductive health.

Creating a fertility-friendly diet involves incorporating a variety of nutrient-dense foods to ensure the body receives all essential micronutrients. This includes plenty of fresh fruits and vegetables, whole grains, lean proteins, and healthy fats. Reducing the intake of processed foods, trans fats, and sugars is also important, as these can negatively impact hormonal balance and overall health. Hydration is another key factor. Drinking plenty of water helps maintain optimal bodily functions and supports the transport of nutrients throughout the body.

Eating for fertility success is a proactive step towards achieving the dream of parenthood.

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