INTRODUCTION AND OBJECTIVES: We present a video of a novel transobturator approach to autologous urethral sling placement.

METHODS: A 55-year old female presented with worsening pure stress urinary incontinence. She had significant bother from her leakage and after discussion of potential management options preferred an autologous urethral sling, however did not want an intra-abdominal portion of the procedure. Thus, we utilized a transobturator approach to autologous urethral sling placement. Following hydrodissection with injectable saline a midline incision was made in the anterior vaginal wall. Dissection was carried to the obturator foramen bilaterally. A helical trocar was passed twice through each obturator foramen and the stay sutures retracted through the incision. The sling was secured proximally and distally with interrupted sutures. Careful attention was paid to tensioning the sling, which was left flush with the urethra. The stay sutures were then tied down and cut at the skin level. The anterior vaginal wall and skin incisions were then closed.

RESULTS: The patient had an uncomplicated postoperative course and was able to spontaneously empty her bladder with low postvoid residual. She was seen back 2 weeks following her procedure noting no-leakage, requiring zero pads and subjectively pleased with her outcome.

CONCLUSIONS: Given this result, a transobturator approach to urethral sling placement appears technically feasible in appropriately selected candidates. Longer follow up and larger case series will be needed to validate this finding.

Source of Funding: None

V1-03 MANAGEMENT OF OBSTETRIC FISTULAE IN SUB-SAHARAN AFRICA
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INTRODUCTION AND OBJECTIVES: Obstetric fistulae occur due to the pressure necrosis caused by prolonged labor and insufficient obstetric care. Familial and social isolation are major consequences. The management of obstetric fistulae is complicated and depends on available medical facilities and sociocultural perceptions in the individual setting. We present our experience with the management of obstetric fistulae.

METHODS: Data of 46 women treated in a fistula clinic in Niger between 2012 and 2013 were reviewed. 18 were primary cases, 28 were treated for recurrent fistula or persistent incontinence after closure. Vesicovaginal (VVF), urethrovaginal (UVF), rectovaginal (RFV), and ureterovaginal (URVF) fistula was present in 19, 10, 2, and 3 women, respectively. One patient had concomitant UrVF+UrVF. All cases were operated under spinal anesthesia due to poor general anesthesia facilities. After circumferential incision of the fistula tract, the plane between vaginal mucosa and bladder/rectum wall was dissected. In the case of trigonal involvement, circumferential incision was carried out 0.5-1 cm more exterior to the fistula tract after catheterization of ureteral orifices under direct vision from the vagina. After generous mobilization, bladder/rectum wall was closed with running 2/0 vicryl sutures. Vaginal wall was closed primarily following check for leakage with intravesical methylene blue instillation. Urethral catheteret was kept for 2-3 weeks.

RESULTS: Mean patient age was 27.5 (16-47) years. A total of 53 procedures were performed on 46 women. Fistula diameter ranged from 1 to 7 cm. in VVF and the trigon was involved in 5 of them. Two women with large VVF associated with total bladder neck and urethral loss could not be repaired. Bladder neck and mid/distal urethra was involved in 7 and 4 patients with UVF, respectively. In 5 of these women, bladder neck/urethral continuity was interrupted (circumferential fistula). Ureteroneocystostomy with a psoas hitch was required in 3 patients with URVF. Six women received vaginal flap urethroplasty due to post-operative short urethra and stress urinary incontinence. Seven received a mid-urethral sling and four received sacrocolpopexy due to advanced postoperative pelvic organ prolapse. The closure was successful in 83% of primary cases and in 61% women operated for recurrent fistula.

CONCLUSIONS: The management of obstetric fistulae is demanding. Transvaginal approach provides successful closure in most cases. However, the surgeon should be prepared to perform additional procedures for persistent/recurrent incontinence even after a successful initial closure.

Source of Funding: none
the risk of bleeding, injury of the rectum, as well as other abdominal viscera still represents a major concern. Posterior transcoccigial mesh brings the risks of the transgluteal route, mostly pudendal neurovascular bundle injury. A new procedure for colpopexy was developed in order to allow for a single incision apical transvaginal level I repair, using a small amount of synthetic material. The kit contains a macro porous polypropylene 8 x 1.2 cm tape and two polypropylene self anchoring system, attached to polypropylene threads and a disposable retractable insertion guide for placement of the anchoring system into the sacrospinous ligaments. This video highlights the technical details of the procedure.

METHODS: It is presented the surgical treatment of a patient with a vaginal apical (uterine) prolapse stage 3 according to the POP-Q system. A vertical incision is done in the anterior vaginal. Blunt dissection is performed towards the ischial spine, and coccygeous muscle and sacrospinous ligaments are identified bilaterally. Then, the retractable insertion guide is primed with the multipoint anchoring system and introduced toward the ischial spine guided by surgeon’s index finger and implanted into the sacrosinous ligament, 1.5 cm medial to ischial spine. The tissue anchoring system is delivered and the retractable insertion guide is gently retracted. Next reconstruction of the pericervical ring is performed then, both sides of the sling are attached to the polypropylene threads and knots are tied in order to elevate the cervix and the vaginal apex to DeLancey’s level one. Finally, the vaginal incision is closed in the usual manner.

RESULTS: This procedure was performed in 10 patients (mean age 65 years-old) with POP-Q stage 3 apical prolapse. No intra-operative complications or postoperative significant adverse events were observed. None presented post-operative vaginal mesh exposure. Mean follow up was 12 months (6 to 18 months). In this short term follow up, all of the patients were considered cured (POP-Q apical stage was 0 or 1).

CONCLUSIONS: Apical sling kit adds the advantages of single incision transvaginal approach, safety and level I correction of apical defect, without the mesh related complications.

Source of Funding: None.

V1-06
TRANSURETHRAL REPAIR OF VESICO – VAGINAL FISULA, A NOVEL TECHNIQUE
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INTRODUCTION AND OBJECTIVES: Our Objective is to demonstrate a new technique for Vesico Vaginal Fistula Repair, trans urethrally. This due to the difficult that implies the Access through the abdominal or vaginal approach sometimes.

METHODS: The case is from 48 year old Lady whom was diagnosed with a metastatic ovarian tumor to the Peritoneum in 2010. She was taken to surgery and a Sugarbaker procedure was performed, with development of multiple complications among enterocutaneous fistulas, and was managed with open abdominal wall. 2 months after the surgery the patient complains of Urinary Incontinence, and a Vesico Vaginal Fistula was diagnosed, which initially was managed with a urethral catheter but incontinence persisted and the Cystourethrogram confirmed the persistence of the fistula.

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CONCLUSIONS: With the use of new technics it is possible to correct trans urethrally some fistulas without the need to open bladder or perform trans abdominal surgery, achieving good results. New instruments should be developed in order to make this approach more feasible and results reproducible.

Source of Funding: none

V1-07
ABDOMINOVAGINAL TECHNIQUE FOR COMPLETE REMOVAL OF TRANSOBTURATOR SLINGS
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INTRODUCTION AND OBJECTIVES: Transobturator vaginal mesh is commonly used for the treatment of female stress urinary incontinence. Complications of transobturator mesh may include hip, groin, or leg pain that can occasionally be debilitating. Total removal of mesh may resolve or improve pain symptoms but can be a challenging or daunting procedure.

METHODS: In this movie we present complete obturator mesh removal in a 48 year old woman suffering from disabling pelvic pain, dyspareunia and groin pain. Through a transvaginal approach, bilateral oblique distal vaginal incisions are made and the vaginal epithelium is dissected away from the perurethral fascia. The mesh is isolated and anterior and posterior vaginal wall flaps are created. The mesh is transected in the midline and dissected free transvaginally. The obturator fascia is opened and the mesh dissected from the obturator internus muscle, obturator externus and obturator membrane. The cut end of the mesh is secured with a stay suture for later identification. Bilateral incisions are made over the obturator foramen 1 cm lateral to the descending rami of the pubic bone. After opening the adductor longus fascia, dissection is carried through the adductor longus and gracilis muscles. The mesh is carefully passed under finger control from the vagina to the labial incisions and dissected free from the adductor brevis muscle and obturator membrane using a coagulation knife. The mesh is freed from the peristemeum of the pubic bone and removed entirely. The urethra is reconstructed by advancing the periurethral fascia with interrupted sutures and a flap of vaginal wall is advance to cover the area of the mesh removal. An indwelling catheter is left in place postoperatively for 5 days.

RESULTS: From June 2009 to August 2013 we have performed 217 surgeries for the removal of vaginal suburethral slings. Of these, 92 have included the removal of transobturator mesh. 16 patients had more than one mesh removed at the time of surgery. Average surgery time for removal of one transobturator sling was 84 minutes. Complete removal of transobturator mesh may improve or completely resolve symptoms of pain. Dissection of the mesh in the inferior and medial portion of the obturator foramen on the inferior pubic ramus is key to avoid injury to the obturator nerve and artery. None of our patients complained of obturator nerve injury postoperatively.

CONCLUSIONS: Complete transobturator mesh sling removal is feasible using an abdomino vaginal approach. There is minimal perioperative associated morbidity associated. Long term outcome data is still forthcoming.

Source of Funding: None

V1-08
SACROCOLOPEXY WITH AUTOLOGOUS FASCIA
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INTRODUCTION AND OBJECTIVES: Abdominal sacrocolpopexy (ASC) with mesh has been regarded as the most durable operation for advanced pelvic organ prolapse (POP). However, recent reports estimate that there is a 10.5% risk of mesh erosion at 7 years, with either symptomatic or anatomic failure in 34-48% of cases. There are few alternatives noted in the literature to manage severe mesh complications. We propose a novel technique using a patient’s own rectus fascia in lieu of mesh to perform ASC, in the setting of SCP mesh removal.

METHODS: After IRB approval was obtained, a retrospective review was performed using medical records of patients referred to our tertiary care center for mesh complications following ASC from January 2012 to October 2013. All patients underwent complete ASC mesh