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was reported as a percentage of the entire cohort. Implants used prior to and after the FDA warning were compared. Statistical analysis included chi-square for categorical variables and linear regression to trend mesh use over time.

**Results:** 608 surgeries for POP and incontinence were performed from January 1, 2010 to December 31, 2012. 227 procedures were prior to the release of the July 2011 FDA safety communication and 281 procedures occurred after. There was no difference in age, BMI, tobacco use or comorbid illnesses across the study period. There was also no difference in total mesh use (TVM, RASC, and MUS combined) prior to and after July 2011 (86.5% vs. 81.85%, p = 0.112). However, in vaginal surgeries for POP, mesh use significantly decreased after the safety communication was released (58.72% vs. 33.45%, p < 0.0001) while RASC significantly increased (15.9% vs. 27.4%, p = 0.005). The use of MUS did not differ significantly after the FDA warning (48.93% vs. 56.5%, p = 0.039), although there was a trend towards increased use over time. Linear regression analysis depicted similar trends with no significant change in total mesh use (slope = 0.07, p = 0.134), but a significant decline in the percentage of procedures using TVM (slope = -0.47, p = 0.002) following the FDA release and an increase in mesh used in RASC (slope = 0.9, p < 0.0001). For every quarter following the release of the FDA safety communication, there was a weekly positive linear relationship in MUS mesh use (slope = -1.2, p = 0.0063).

**Conclusions:** This study demonstrates that total use of mesh across all procedures involving POP and incontinence at our institution did not change after its release. However, TVM use alone did decrease after the FDA warning. Conversely, the RASC mesh increased after its release. Mesh in the form of MUS showed a trend in increased use over the study period, but this was not statistically significant.

Disclosures: S. A. Samuel: Nothing to disclose; D. Thompson: Nothing to disclose; B. Vakil: Speaker’s Bureau, Astellas.

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**Presentation Number: Poster 162**

**UTILITY OF ROUTINE CYSTOSCOPY DURING TRANSVAGINAL CERVICO-ISTHmic CERCLAGE**

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**Objectives:** Transvaginal cervico-isthmic cerclage (TCIC) is a minimally invasive procedure offered to women who would otherwise be candidates for transabdominal cerclage. Reported rates of urinary tract injury during TCIC are less than 2%. Reported injuries include cystotomy, vesicovaginal fistula, and ureteral injury. We hypothesized that the actual rate of significant urologic findings related to TCIC was higher than reported in the literature. This study assesses whether adding routine cystoscopy to the TCIC procedure may help prevent and manage urological injuries.

**Methods:** We performed a prospective review of 144 TCIC procedures with cystoscopy during years 2008-2015. All cerclages were done by a single perinatologist assisted by a single FPMRS surgeon who performed cystoscopies in all patients, and other pelvic floor surgeries as indicated. Patient medical records were analyzed for patient characteristics, obstetric, surgical and follow-up data.

**Results:** In total, 144 TCIC procedures with cystoscopy were analyzed. Patient ages ranged 20-48 years. Procedures were performed in previable gestations, the majority between 12w-14w (60%). There were 4 twin pregnancies (3%) and the remainder were singletons. At index TCIC, 6 patients (4%) had known intraoperative complications from prior cerclages, including 3 with vesicovaginal fistula, 2 with cervical laceration, and 1 with cystotomy. In addition to prior cerclage, many patients had prior surgeries on the cervix, including 13 with REEP (9%), cervical laceration (3), hysterectomy (2), and abdominal procedures (2), as well as repair of cervical laceration and 2 with prior hysterectomy. Under cystoscopy at the beginning of index TCIC, 3 patients had incidental urologic findings: a unilateral ureteral duplication; stenosis in the bladder within millimeters of the ureteral orifices, and one with a bladder scar from the level of the ureteral orifices to the bladder. Urologic findings as a result of the TCIC: one cystotomy repaired transvaginally; a 2cm hernoma on the bladder dome from a superficial injury, which resolved with expectant management; and four patients required ureteral catheterization when efflux was delayed > 20min. All stents were removed intraproactively when efflux occurred after stenting. There were no complications of cystoscopy and to date no delayed urologic complications. There was one non-urologic operative complication, which was a rectal perforation identified and repaired intraproactively. Postoperative outcomes: 3-second trimester pregnancy losses (2%); 141 delivered viable infants (98%); and 138 term pregnancies (95%).

**Conclusions:** This study highlights the utility of routine cystoscopy during TCIC. In 144 procedures, we observed a composite 6% rate (n=9) of significant urologic findings identified by cystoscopy. The rate of urologic injuries remained low at less than 2% (n=2), consistent with similar studies. This is the largest series of TCIC patients in the literature, with more significant urologic findings than described in prior studies. This difference may be due to under-diagnosis, delayed presentation, or patients lost to follow up. Intraoperative cystoscopy during TCIC procedure provides early detection and immediate treatment of urological injuries, thus potentially decreasing risk of delayed urologic injury.

Disclosures: M. Katz: Nothing to disclose; H. Wittenberg: Proctor, Intuitive, Proctor, Coloplast, Territory Rep/Employer, Hologic; A. Zaro: Nothing to disclose.

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**Presentation Number: Poster 163**

**COMPARISON OF LAPAROSCOPIC AND VAGINAL UTEROSACRAL LIGAMENT SUSPENSION FOR TREATMENT OF VAGINAL PROLAPSE**

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**Objectives:** Previous research has demonstrated laparoscopic suprasacral ligation suspension (L-USLS) is a safe alternative to vaginal (V-USLS), but with statistically non-significant trends toward fewer urologic injuries and apical failures. Our objective was to compare complications and prolapse recurrence between L-USLS and V-USLS procedures.

**Methods:** This was a retrospective study of all USLS procedures performed from Jan 2011- Nov 2014 at a large academic center. Urodynamics, surgical data, complications and prolapse recurrence were compared between L-USLS and V-USLS. Prolapse recurrence was defined as retreatment with pessary/surgery or any POP-Q point past the hymen (≥0). Complications included vesical injury, postoperative medical complications, readmission, transfusion, ileus, bowel, hematomas/exsanguination (excluding prolapse recurrence), buttocks pain requiring treatment and infection (excluding urinary tract infection), Logistic regression identified predictors of OR time, complications, and prolapse recurrence.

**Results:** There were 54 L-USLS and 119 V-USLS procedures performed (n=173) with median follow-up of 21.5 wks (IQR 9.3-50.8 wks). 172 women had postoperative vaginal examinations with 118 documented POP-Q exams (66.2%). Women undergoing L-USLS were less likely to have medical comorbidities (23.3% vs 57.1%, p=0.004) and had less severe prolapse (POP-Q stage 2, 35.2% vs 74.6%, p<0.001) but were more likely to report prior hysterectomy (16.7% vs 5.9%, p=0.02). L-USLS had longer operative times (190.1 ±68.8 vs 172.7±43.7 min, p=0.03) despite fewer concomitant hysterectomies (77.8% vs 94.1%, p=0.001) or anterior/posterior repairs (51.9% vs 72.3%, p=0.01). L-USLS was more likely to include salpingo-oophorectomy (35.2% vs 17.0%, p=0.01), rectovaginal sling (37.6% vs 18.1%, p<0.01), and lytic adhesions (33.3% vs 5.0%, p=0.001). After correcting for concomitant procedures, OR time was not significantly different between approaches (adjusted OR 1.00, 95%CI 0.69-1.00).

Postoperative POP-Q points did not differ between groups, except for total vaginal length (TVL) which was longer after L-USLS (8.3±3.1 vs 7.8±1.2, p=0.001). 22 patients met the composite definition of prolapse recurrence, but...