Study: Mesh Effective for Anterior Vaginal Prolapse

BY ALICIA AULT

NEW ORLEANS — A polypropylene mesh was found effective for repair of anterior vaginal prolapse, a 12-month, single-arm multicenter study showed.

In initial data from the ongoing prospective trial, 96 women with stage II or greater anterior vaginal wall prolapse who underwent placement of the mesh had stage I or less prolapse at 12 months' follow-up.

During placement of the mesh, the cystocele was not reduced or repaired. If additional reconstructive or incontinence repair was needed, it was completed at that time. Women with a history of anterior wall graft or concomitant hysterectomy were excluded, Dr. R.D. Moore, a gynecologic surgeon in private practice in Alpharetta, Ga., reported at the annual meeting of the Society of Gynecologic Surgeons.

The trial was funded by American Medical Systems of Minnetonka, Minn., maker of the Perigee system with IntePro mesh used in the study. All of the surgeons already had experience with using this macroporous type I soft polypropylene mesh.

Dr. Moore presented 12-month data on 96 of the 114 patients studied. Twenty-three percent (22) had prior cystocele repair, 87% (83) were postmenopausal, and 54% (52) had a prior hysterectomy. With the Perigee only, the procedure took about 29 minutes. If there was a concomitant repair, overall operative time averaged 87 minutes. Sixty-four percent (61) had a concomitant vault suspension, 70% (67) had an incontinence procedure, and 65% (62) had a rectocele repair.

Thirty-seven patients were discharged on the same day and 33 on day 1.

Follow-up was conducted at 6 weeks, 3 months, 6 months, 12 months, and 24 months. The mean follow-up was 18 months. Eleven patients (11%) had a mesh extrusion into the vagina, a mean of 133 days after surgery. Dr. Moore said this extrusion rate was consistent with findings in the literature for this type of material. Nine (9%) of the extrusion cases required surgical intervention; two (2%) healed with conservative treatment, including trimming of exposed mesh in the office. Not a single mesh system was removed to try to resolve an extrusion, said Dr. Moore.

Five (5%) patients had postoperative pain. Almost 3% of women reported de novo urge with incontinence and dyspareunia, but those cases all resolved. One patient had a reoperation for a device system failure.

The researchers looked to see whether use of vaginal estrogen postoperatively had any protective effect, and found that it did not change the extrusion rate, said Dr. Moore.

There was a significant improvement in all the quality of life scales used. And there was a decrease in dyspareunia, from 46% (44) to 31% (29) at the 12-month mark. Sexual activity remained consistent, with 52% (50) of women reporting they were active.

Despite its limitation as a single-arm study, the trial did show consistent and good anatomic results and minimum morbidity, said Dr. Moore. He said he expected to report data soon on the 2-year follow-up.

Dr. Moore disclosed that he received honoraria, and speaking and teaching fees from American Medical Systems. He also is on some AMS advisory committees.

In discussing the paper, Dr. Charles R. Rardin of Brown University, Providence, R.I., lauded the study for its relatively large numbers, but said the lack of a comparison group hindered its conclusions. Also, he said there were no data on women who were implanted but excluded from follow-up, and he was also concerned that results for women who had concomitant apical suspension might be confounding. He questioned whether the results were generalizable, given that the procedures in the trial were conducted by experienced surgeons.

Dr. Rardin made no disclosures.

Dr. Moore replied that the results were not likely to be reproducible in the general surgeon population, and suggested it was up to the Society of Gynecologic Surgeons and other professional groups to determine whether there should be minimum qualifications for conducting mesh procedures. ■

Neuropathy Found Rare After Gynecologic Surgery

BY ALICIA AULT

NEW ORLEANS — The incidence of neuropathy after gynecologic surgery appears to be fairly low, based on a prospective cohort study of more than 600 patients.

Dr. Justin C. Bohrer, an ob.gyn. at the Cleveland Clinic Lerner College of Medicine, presented data on his study at the annual meeting of the Society of Gynecologic Surgeons.

The authors enrolled 642 patients who underwent gynecologic surgery. The most common procedures were midurethral slings (26%, 166 patients); followed by vaginal prolapse surgery (25%, 160); abdominal hysterectomy (21%, 134); and hysteroscopy (16%, 102). Twenty-one percent of the procedures were conducted laparoscopically.

Dr. Bohrer's study 'does add significantly to our understanding of the topic.'

DR. TOGLIA

Of the total 642 enrolled, 611 subjects had a preoperative physical exam and neurologic history, asking about preexisting injuries and pain. Patients also were given a post-op neurologic exam within 24 hours of the procedure. Overall, 616 received that examination. Of the 616 patients, 12 (1.9%) were found to have a preexisting lower-extremity neuropathy. There were 14 new-onset peripheral nerve injuries in 11 patients, for an incidence of 1.8%, said Dr. Bohrer. Four of the neuropathies occurred in patients in boot stirrups and seven in those who were in candy cane stirrups.

The injuries were observed in the following nerves: lateral femoral cutaneous (five injuries), femoral (five), common fibular (one), ilioinguinal/iliohypogastric (one), saphenous (one), and genitofemoral (one). Bilateral femoral neuropathy was seen in three patients. Bilateral lateral femoral cutaneous neuropathy was seen in one patient. The injuries were mostly sensory, except for one of the bilateral femoral nerve injuries, which had motor and sensory components, said Dr. Bohrer, who reported no disclosures. No sacral nerve injuries were observed.

Looking at all the baseline characteristics, which included age, body mass index, race, tobacco use, and comorbidities such as diabetes, Dr. Bohrer found no significant differences between the groups.

The study had aimed to determine risk factors for neuropathy, but it was underpowered. It also did not fully account for patients who had a neuropathy more than 24 hours after surgery, he said. And because no nerve conduction studies were performed, the results were limited to only clinically significant injuries. Dr. Bohrer concluded that neuropathies are relatively rare in patients undergoing gynecologic surgery (at 1.9%), and that there is also a low incidence of injuries (1.8%).

Dr. Marc Toglia, a urogynecologist practicing in Philadelphia, commented that the study "does add significantly to our understanding of the topic." He added that it is also "extremely timely" as Medicare is instituting new payment policies that hold hospitals and surgeons accountable for hospital-acquired injuries. ■

Better Counseling Might Reduce Repeat Pregnancies in Teens

BY DAMIAN McNAMARA

SAN ANTONIO — The number of unintended subsequent teenage pregnancies might decrease with enhanced postpartum contraceptive counseling, particularly about side effects of different birth control options, according to a study of 40 young women.

Dr. Suzanne Elizabeth Jose and Dr. Julie Jacobstein explored the effectiveness of postpartum counseling at their institution, Sinai Hospital in Baltimore, through a telephone survey of 40 women (aged 21 years and younger) who were delivered between April and September 2007.

"We see a lot of 15-year-old, 16-year-old girls coming in with their second or third babies," Dr. Jose said in an interview. "Before they leave the hospital, we counsel them about birth control options." They are allowed to choose a contraceptive option. The most common choices were the birth control pill (13 patients) and injectable contraception (10 patients).

"But they come back. So we asked ourselves: What are we doing wrong?" Dr. Jose said at her poster during the annual meeting of the North American Society for Pediatric and Adolescent Gynecology.

The survey was conducted 7 months to 1 year post partum. The investigators called the patients to determine if they were using contraception, including the type they selected during postpartum counseling. "All of them got some form of counseling, but half had discontinued [contraception]," said Dr. Jose.

"Some had no reason—they just stopped." Others cited the adverse effects of contraception. "We have to improve our counseling about side effects," Dr. Jose said. Group contraception counseling for these adolescent women is a possible future strategy.

Talking to adolescents is not the same as talking to 30-year-olds. "You have to be able to talk to them in language they understand," Dr. Jose said. Determination of the most effective, age-appropriate dialogue is planned for a future study.

The routine 6-week follow-up visit following vaginal deliveries might be a good time to reinforce contraceptive counseling, she added. Of the 40 adolescent mothers, 11 (28%) reported a subsequent pregnancy—all unintended, Dr. Jose said. There were no miscarriages or ectopic pregnancies.

Although it did not occur in this study, some adolescents choose to get pregnant again, she said. Physicians can ask about such plans during contraceptive counseling and consider the duration of different options. For example, an intrauterine device that lasts 5 years may not be a good option for a teenager.

Next, Dr. Jose and her associates plan to study the effectiveness of postpartum contraceptive counseling in a prospective study.

Dr. Jose said she had no relevant financial disclosures. ■