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correction of uterovaginal malformations. This classification consist seven classes, and 23 basic groups of: 1. Vaginal aplasia: utero-vaginal aplasia (MRKH syndrome), complete cervico-vaginal aplasia and partial vaginal aplasia. 2. Unicornuate uterus: with functional uterine horn, nonfunctional uterine horn, without horn. 3. Uterus duplex: symmetric form with duplication of vagina, asymmetric with aplasia of hemivagina. 4. Bicornuate uterus: complete, incomplete and arcuate forms. 5. Septate uterus: complete septum with vaginal duplication, incomplete septum. 6. Fallopian tubes anomaly: absence of tube/adnexa, additional fimbria. 7. Complex and genitourinary anomalies: renal aplasia, renal and ureteral duplication, nephroptosis. Correct classification of utero-vaginal malformations necessary for adequate treatment, allows us to perform optimal surgical correction and improves reproductive results.

"DESIGNER VAGINA": FOR FEMALE SEXUAL EXPRESSION AND ENJOYMENT OR IS IT AN EXPLOITATIVE PROCEDURE?

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Background: "Designer Vagina", "Laser Vaginal Rejuvenation[®]", "Designer Laser Vaginoplasty[®]", and "G-spot Amplification[®]" terms became popular and responsible for very controversial viewpoints about the cosmetic-plastic gynecology field around the globe.

Objectives: To identify deceptive and unethical terms in cosmetic-plastic gynecology.

Methods: Electronic and manual searches of the scientific, congresses proceedings and marketing literatures of cosmetic-plastic gynecology were conducted and analyzed.

Results: In early 2000, the phrases "Laser Vaginal Rejuvenation™ (LVR)" and "Designer Laser Vaginoplasty™" (DLV) had been marketed. In 2004, the "Designer Vagina" term was introduced. In September 2007, the American College of Obstetricians and Gynecologists determined that "Laser Vaginal Rejuvenation[®]" and "Designer Laser Vaginoplasty[®]" are deceptive, unethical, and nonmedical terms without description of surgical procedures, even though they are still being practiced, taught, and marketed. In April 2011, the true surgical and medical nature of "Laser Vaginal Rejuvenation[®]" and "Designer Laser Vaginoplasty[®]" were disclosed and documented that they were traditional gynecologic procedures. New surgical cosmetic-plastic gynecologic interventions have been developed without adaption from traditional gynecology.

Conclusion: "Designer Vagina", "Laser Vaginal Rejuvenation[®]", and "Designer Laser Vaginoplasty[®]":

- This terminology cannot and does not represent the modern cosmetic-plastic gynecologic field because these terms are deceptive, unethical, meaningless, exploitative, and nonmedical marketing phrases.
- The advents of new and honest cosmetic gynecologic surgical interventions based upon well-designed and well-executed clinical-scientific studies have replaced these deceptive and unethical procedures.
- These cannot be practiced, taught, and marketed as modern cosmetic-plastic gynecologic procedures as modern cosmetic-plastic gynecologic procedures and must be abandoned.

Keywords: Vaginal rejuvenation; Cosmetic gynecology; G-Spotplasty Wide vagina; Smooth vagina; Labioplasty; Clitoral Hoodoplasty.

Introduction: A woman's expression of her individuality includes, among other things, changing her physical appearance to meet her body image perception. In the U.S.A., the Patient's Bill of Rights provided the opportunity to make choices about individual medical decision-making which includes the transformation of female external genitalia for body image and aesthetic purposes.¹ The desire of improving a woman's overall look cannot be restricted to a particular social-economic class or race, or to a particular part of her body. All women enjoy being sexually irresistible which may require application of cosmetic-plastic gynecology to fulfill their desires. Historically, the social standard of acceptable sexuality has changed at a very slow pace. The condom was developed over three thousand years ago in ancient Egypt and formally came "out of closet" in the 1960s; oral birth control pills also became available in the 1960s and caused social unrest including street protests; female anatomy was censored for centuries until artists started expressing the form. Therefore, we do not expect that the cosmetic-plastic gynecologic field will receive different treatment. Nevertheless, today, the situation is different due to the electronic-information age with faster communications. Contentious disputes can reach a much larger segment of the population-at-large and the results of the studies can be shared with clinicians and women in much greater numbers, almost instantaneously. These factors are the reasons that cosmetic-plastic gynecology is on the rise and scientific data are paving the road for justifiable growth of the field.

The objective of this presentation was to examine the relevant scientific, congressional proceedings, and marketing literatures related to "Designer Vagina": for female sexual expression and enjoyment or is it an exploitative procedure?

REDUCING MASSIVE ADENOMYOMA WHILE CONSERVING THE UTERUS: IS IT FEASIBLE? TECHNIQUES AND PITFALLS

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Introduction: Severe case of adenomyosis is not only a cause of infertility, but may include severe dysmenorrhea, thus may interfere with a woman's well-being. Routine conservative surgery for adenomyosis involves a wedge resection of the involved uterine tissue, followed by approximating the remaining myometrium and serosa. However, this method may retain unexcised affected tissue, and thus result in an unsatisfactory post-surgical prognosis such as being incapable of sustaining a normal pregnancy. Our proposed treatment for severe cases of adenomyosis involves wide complete excision of affected tissues to reduce post-surgical dysmenorrhea, followed by a triple-flap reconstruction of the uterine wall to prevent ruptures in subsequent pregnancies.

Methods: 1. Resection and removal of all adenomyosis-affected myometrium: The affected tissue is vertically incised, to split the area to be excised in two, the incision is extended to the uterine cavity. The tissue to be excised is grasped and placed under tension with Martin forceps. The tissue is adequately dissected free with scissors, with care taken to retain a serosal flap with a layer of myometrium, as well as a medial flap containing both endometrium and myometrium. The tissue flaps, both medial and distal must be more than 5 mm in thickness to assure adequate material for the reconstruction of the uterine wall. It is essential to introduce an index finger into the uterine cavity to assure maintenance of an adequate medial flap thickness. Special care must be taken to prevent damage to the Fallopian tubes.

2. Reconstruction of the uterine cavity: Care must be taken to retain sufficient endometrium to allow reconstruction of an adequate uterine cavity. In cases of an overabundance of endometrial tissue, excess amount must be removed to secure a more physiological uterine cavity.

3. Reconstruction of the uterine wall: Reconstruction of the middle portion of the uterine wall involves approximation of the myometrial musculature to ablate the space created by the excision of diseased tissue. The serosa including adequate myometrium is dissected free with a scalpel to form the third flap. The serosal or distal and third flap is then approximated to finish the reconstruction.

4. Hemostasis and application of hemostatic barriers for prevention of adhesion: The last step of this method is to apply TachoComb®, a Fibrin adhesive in sheet form, to the uterine surface for the control of oozing. The applied TachoComb® is firmly anchored and works as physical barriers, thus contributing to the reduction of post-surgical adhesions.

Results: Clinical post-surgical evaluation was performed using the Visual Analog Scale (VAS) to assess dysmenorrheal and hypermenorrhea at 3, 6, 12, 24 months after surgery. We performed the procedures on 104 patients during the period between June 1998 and August 2008. Of the 26 women desired to conceive, 16 (61.5%) subsequently conceived. Of these, 4 women conceived spontaneously and 12 women conceived by in vitro fertilization and embryo transfer (IVF-ET). Two women who had IVF-ET experienced a spontaneous abortion; 14 went to term and all were delivered by elective Caesarean section. There were no cases of uterine complications to the pregnancies. The triple-flap reconstruction of the uterine wall following wide adequate excision of adenomyosis tissue in women with hypermenorrhea and/or dysmenorrhea resulted in a dramatic reduction in both menstrual cramping and menstrual flow volume post surgically and gave women chances to become pregnant.

Conclusion: The triple-flap method offers the following advantages: First, it permits the excision of the affected tissues more widely and thoroughly than the conventional wedge resection. As a result, it is extremely effective for the management of dysmenorrhea and hypermenorrhea. Secondly, the massive tissue defects created by the wide excision of the lesion can be reconstructed into a uterine wall of adequate thickness by the three-fold myometrial musculature, thereby the reconstructed uterus will be capable of sustaining a normal pregnancy without the risk of uterine rupture. Thirdly, we have not encountered any severe post-surgical complications. Although recurrence of the condition may occur because adenomyosis is a progressive disorder, we have experienced only 4 cases of recurrence. Even if recurrence does occur, the method will at least temporarily alleviate patient's clinical symptoms, including severe menorrhagia, and give her a chance to become pregnant. On these grounds, we believe this method to be of great benefit to women suffering from severe adenomyosis.

rationale for clinically evaluating V γ 9V δ 2 T-cell adoptive immunotherapy with intra-peritoneal carcinomatosis pre-sensitization by zoledronate in EOC patients.

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CAN WE TRUST EPIDEMIOLOGICAL DATA?

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Current surveillance systems for many reportable genital infections are defective in many respects due to lack of information of the number of persons approached who did and did not accept to participate. This is of importance in calculations of prevalence figures. Likewise, it is needed to know if the surveillance system is reporting cases found at screening or not. Information that one has to include if it concerns antibiotic-treated cases, and if so if mixed with non-treated cases. Furthermore, if the cases reported are found by contract tracing or not. If the prevalence is not known of the infectious diseases under study in the health care units catchment area one may run into low positive predictive value (PPV) problems, which may question the result of laboratory tests. These circumstances may all question the value of many of currently published epidemiological data for a number of sexually transmitted diseases. The diagnosis of PID is often wrong if based on clinical observation and patient close laboratory tests. Furthermore, patients may be negative for etiological tests from the lower genital tract, but anyway be carriers of pathogens from the upper genital tract. This questions the value of many studies performed on tubal factor infertility and other reproductive events proposed to be related to genital infections.

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MENOPAUSE HORMONE REPLACEMENT THERAPY AND METABOLIC SYNDROME

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Introduction: We conducted a case-control study to calculate the odds ratio (OR) for the influence of Hormone Replacement Therapy (HRT) on the incidence of postmenopausal SM. We analyzed medical records and made an oral questionnaire to post-menopausal women of General Gynecology consultation. Results: It was obtained 123 questionnaires, 21 were excluded. Forty nine women had the diagnosis of MS after the age of menopause. Of these 11 receive HRT for at least 2 years. At the group with no diagnosis of the MS, 24 women were treated with HRT. The calculated odds ratio was 0.350 (95%CI: 0.148 to 0.8281). Discussion: Prevalence of MS and treatment with HRT in the study sample are higher than the general population, justified by the of sample selection method. Other limitation of this study relate to the small sample size. Conclusion: In this study the OR demonstrate a statistically significant decrease in estimated risc of MS in women who took HRT for 2 or more years.

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SEXUAL AND FUNCTIONAL RESULTS AFTER NONSURGICAL OR SURGICAL CREATION OF A NEOVAGINA IN WOMEN WITH MAYER-ROKITANSKY-KÜSTER-HAUSER SYNDROME: A COMPARATIVE STUDY

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The Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome is characterized by congenital utero-vaginal aplasia. Treatment consisting of creating a neovagina may be either nonsurgical or surgical. Although perioperative complications and anatomic results are important, the most important outcome is the functional result. The aim of the current study was to evaluate the sexual satisfaction of patients with MRKH syndrome after neovagina procedures. Method: Women were recruited via a national patient association. Functional results were assessed by the Female Sexual Function Index (FSFI) questionnaire. The control group consisted of healthy women, published in the literature. Results: Of 80 members of the patient association, 37 (46%) returned the questionnaire. The different reported procedures were Frank's method, sigmoid vaginoplasty, and Davydov technique. No statistically significant difference was found between the different methods in the population characteristics. The FSFI scores of the whole population, regardless of the procedure used, were compared with the scores of the control group. The patients' scores were significantly lower

except the satisfaction domain score. The subgroup analysis based on the procedure used to create a neovagina found a significantly lower FSFI score in comparison to the control group. No significant difference in FSFI scores was found between the three methods. Conclusion- Our results showed that sexuality outcome after neovagina procedure was lower than in healthy women. Analysis of FSFI scores after the surgical or nonsurgical creation of a neovagina failed to focus on a particular technique. As FSFI scores seem lower in the studied group, further technical improvements are needed.

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VAGINAL REJUVENATION BY MEANS OF OSTRZENSKI'S VAGINAL RUGATION REJUVENATION (O-VRR)

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BACKGROUND: Recently, Ostrzenski's published "Vaginal Rugation Rejuvenation" a new surgical technique (Gynecol Obstet Invest 2011). This operation has revitalized the use of the medical term "Vaginal Rejuvenation". Previously, a "Laser Vaginal Rejuvenation®" slogan was popularized; however, this term was without a specific surgical procedure and the operation was adapted from a traditional gynecologic operation of colpoperineorrhaphy. A colpoperineorrhaphy term was change to "Laser Vaginal Rejuvenation®" in order to use it as the market tool. "Laser Vaginal Rejuvenation®" was considered by the American College of Obstetricians and Gynecologists in the U.S. as deceptive and unethical practice. OBJECTIVE: To determine the novelty of the "Ostrzenski's Vaginal Rugation Rejuvenation" surgical technique and to present my experience. METHODS: Electronic and manual searches were conducted. Medical Subject Headings (MeSH) were selected and used in a search on MEDLINE (1980– May 2007), ACOG online database (1990 – May 2007), HealthSTAR (1990 – May 2007), Cochrane Library database (1995 – May 2007), OviDisc database. RESULTS: The study indicated that "Ostrzenski's Vaginal Rugation Rejuvenation" is a new surgical technique. The review of scientific and marketing literatures failed to show any scientific or marketing description of a "Laser Vaginal Rejuvenation®" surgical technique. CONCLUSION: The Ostrzenski's Vaginal Rugation Rejuvenation surgical technique is as a new operation in the cosmetic-plastic gynecologic field. This procedure is the truly new cosmetic method and no traditional gynecologic procedures was adopted or modified for developing this new technique.

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VAGINAL REJUVENATION BY: OSTRZENSKI'S URETHROVAGINAL SPINDCTER MUSCLE RECONSTRUCTION (O-UVSMR)

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BACKGROUND: O-UVSMR for vaginal rejuvenation is a new surgical procedure for the acquired sensation of wide/smooth vagina treatment. OBJECTIVES: To describe the specific and gross-functional anatomy of the urethrovaginal sphincter muscle and its role in an acquired sensation of wide/smooth vagina; to present step-by-step O-UVSMR and to examine the novelty of this operation. METHODS: A review of the existing literatures related to the newest anatomic discoveries and their confirmation by MRI dynamic studies on the subject matter. A functional anatomy of the urethrovaginal sphincter muscle, complex make-ups, its topography, and relationship with the adjacent anatomic structures will be detailed. The incision is made in the midline of the perineal raphe skin. The inferior bulbocavernosus muscle was sharply separated from the superior aspect of the urethrovaginal sphincter muscle. The site-specific defect(s) of the urethrovaginal sphincter muscle was identified; scarification of the damaged edges was performed with surgical scalpel. The freshly prepared edges were approximated with 0-4 PDS absorbable suture. A single type suturing technique was applied. The inferior bulbocavernosus and superior surface of the urethrovaginal sphincter muscles were approximated and the perineal wound was closed. RESULTS: Electronic and manual searches failed to show any operation for the urethrovaginal sphincter muscle reconstruction. The surgical procedure is simple operation and easy to learn. CONCLUSIONS: O-UVSMR is a new and original method for the acquired sensation of wide/smooth vagina treatment (vaginal rejuvenation).