EUGA

European Urogynaecological Association

Newsletter

Volume 1, Issue 1, 2020

SCIENTIFIC CORNER

CLINICAL OPINIONS

ARTICLE OF THE MONTH

NEWS

TABLE OF CONTENTS

MESSAGES

CLINICAL OPINIONS

ARTICLE OF THE MONTH

NEWS

EUGA COMMITTEES

MESSAGE FROM THE PRESIDENT

STAVROS ATHANASIOU
Assistant Professor of Urogynecology, University of Athens

Dear Friends and Colleagues,
In the recent emergency period due to the COVID pandemic, the EUGA Committees and the EUGA Office have been actively engaged in the achievement of important objectives for the association that I'm pleased to share thanks to this newsletter.

EUGA recently signed an agreement with the Female Pelvic Medicine & Reconstructive Surgery Journal (FMPRS) in order to provide all EUGA active members with free access to the publications of the prestigious FPMRS Journal. The access is granted through the members' area of our website and I hope you all will benefit from this new collaboration.

A great deal of work has been done to review the members database and reserved area of our website.
New articles, clinical opinions and video presentations selected from past EUGA conferences will be published monthly, exclusively for EUGA members. I wish to thank Ilias Giarenis, Chair of the Publication Committee, for putting together this newsletter as well as all the other committee members who provided researches and commentaries which you will soon see online.

One of the most important objectives of this EUGA Executive Committee is the professional accreditation in urogynaecology. For this reason, I'm proud to announce the recent constitution of the EUGA-EBCOG Joint Committee for individual accreditation,whose purpose is to provide a central system for professional accreditation based on a certified evaluation process with final examination recognized at European level.

The Committee recently met to discuss the main aspects necessary for the creation of the Logbook and set the next EUGA 2021 Annual Congress as the first deadline and examination session.
The EUGA-EBCOG Committee members are Ioannis Messinis, Karen Rose and Sam Mukhopadhyay for EBCOG and Stavros Athanasiou, Stefano Salvatore, Barry O 'Reilly and Kamil Svabik for EUGA.
As a member-driven organization, I hope we'll soon be able to return to networking in person.
Looking forward to meeting you soon
Kind Regards

Stavros Athanasiou

MESSAGE FROM THE PUBLICATION COMMITTEE

ILIAS GIARENIS
Chair of EUGA Publication Committee
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The COVID-19 pandemic has changed our lives and our medical practice. I am sure that most of you have been asked to take on additional tasks outside your usual clinical practice. Continuation of patient care, mainly from a distance, has become challenging over the last few months. During these unprecedented times people around the world have shown us their appreciation for our ongoing hard work. Having passed the peak of the pandemic we have been currently trying to get to grips with the next steps in recovering and restarting safely our “new normal” clinical practice.

In a world that is changing daily, EUGA is still growing and trying to meet your membership needs. With most of the conferences cancelled or postponed there has been increasing demand for educational material. Under the guidance of the executive board, the members of the publication committee have been working very hard to generate high quality and up-to date educational sources. The redesign of the EUGA website is in progress and we should be able to launch within the next few months a user-friendly platform that meets your educational needs.

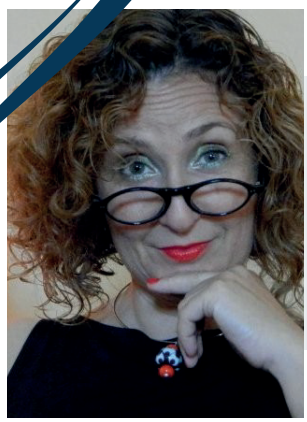
We are very proud to present our first newsletter and we are looking forward to receiving your feedback.

We are aiming to publish four EUGA newsletters per year. Our committee would be grateful for your contribution of educational material for the website and the newsletters. We would like to receive video-presentations, video-demonstrations of surgical procedures, short clinical reviews, expert opinions, interesting case reports and commentaries on important published papers. Please forward your material to the EUGA office.

In this issue you will find two interesting up-to-date papers about the challenges in the management of vaginal pessaries in a COVID environment and the effects of the Covid-19 pandemic on Genito-Pelvic Pain Penetration Disorders (GPPPD). You can also find a commentary on the published randomised controlled trial of TVT vs Bulkamid (J Urol. 2020 Feb;203(2):372-378).

Enjoy reading the newsletter and keep safe!

Ilias Giarenis



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Effects of the Covid-19 Pandemic on Genito-Pelvic Pain Penetration Disorders (GPPPD)

Home confinement social distancing and quarantine may have a significant impact on women with genito-pelvic pain penetration disorders (GPPPD), both on a psychological and on a practical level. Studies on the effects of quarantine in the general population have shown high prevalence of depression, low mood, acute stress disorder and posttraumatic stress symptoms. Pre-existing psychiatric conditions, younger age and female gender have been shown to be associated with worse psychological impact [1]. This information may imply that women suffering from GPPPD, typically presenting in young adulthood and associated with depression and anxiety, may be at risk for worsening of their mood disorder [2]. Obsessive-compulsive symptoms, found to be prevalent in women with GPPPD, [3] may become all-pervasive and emotionally disruptive, as recommendations on hygienic measure for contamination prevention become ubiquitous. Women who experienced more severe and frequent pain during intercourse report increased loneliness; the current social isolation measures may potentiate such feelings and further increase distress. Post-traumatic stress disorder (PTSD), especially following sexual abuse, has been documented as a common antecedent to GPPPD. The effect of pandemic and quarantine on pre-existing PTSD has not been studied yet, nevertheless conditions involving fear of infirmity or death and disruption of one's sense of safety, have been shown to provoke PTSD reactivation [4]. As for the effect on couple dynamics, home confinement may amplify the complex interpersonal responses which maintain and worsen GPPPD. On the other hand, motivated couples without major relationship conflict may benefit from the time spent at home during lockdown and better comply with home exercises such as sensate focus.

The cornerstone of therapy for GPPPD includes various psychotherapy and sexual therapy approaches, which under social isolation measures cannot be continued through traditional face to face appointments. Nevertheless, current technology allows psychotherapists and clients to continue therapy through internet-based platforms; evidence has shown that the latter are no less effective than the classical in person approach [5]. CBT therapy for GPPPD involves home exercises, such as the use of vaginal accommodators. During confinement, when both partners and often additional family members are at home all of the time, negotiating personal privacy can be a challenging and interruption of the exercises may occur. Physiotherapy and other follow-up appointment for non-emergencies are postponed during lockdown and women may find themselves lacking important sources of emotional support. The client-caregiver relationship is an integral part of the social context of someone suffering from a chronic illness, halting this relationship can negatively affect treatment compliance and health outcomes of women with GPPPD. A last important factor to consider during quarantine is financial loss, with people having to interrupt their professional activities with no advanced planning and becoming unable to pay for therapy [1].

In conclusion, the Covid-19 pandemic may have significant implications regarding the coping

ability of GPPPD patients. Increased emotional distress, mood disorder, PTSD exacerbations and amplification of couple dynamics may be expected. Treatment plan interruption and regression of symptoms may occur. Even so, in the context of a good couple relationship and healthy sexual communication, this novel situation may provide an occasion for increased intimacy and progress in sexual function.

References

1. Brooks SK, Webster RK, Smith LE, et al (2020) The psychological impact of quarantine and how to reduce it: rapid review of the evidence. Lancet 395:912–920.
2. Pukall CF, Goldstein AT, Bergeron S, et al (2016) Vulvodynia: Definition, Prevalence, Impact, and Pathophysiological Factors. The Journal of Sexual Medicine 13:291–304.
3. van Lankveld JJDM, Granot M, Weijmar Schultz WCM, et al (2010) Women's sexual pain disorders. J Sex Med 7:615–631.
4. Kinzie JD, Boehnlein JK, Riley C, Sparr L (2002) The effects of September 11 on traumatized refugees: reactivation of posttraumatic stress disorder. J Nerv Ment Dis 190:437–441.
5. Christensen H, Batterham P, Calear A (2014) Online interventions for anxiety disorders. Curr Opin Psychiatry 27:7–13.

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Challenges in the management of vaginal pessaries in a COVID environment

According to Smith et al (2010) it is estimated that 50% of women who have had children will develop a pelvic organ prolapse (POP) over time [1]. Traditionally, treatment options for POP include pelvic floor muscle training (PFMT), vaginal pessaries and surgical management. Vaginal pessaries are devices that are placed into the vagina to support the vaginal walls and pelvic organs to manage the symptoms of a prolapse. In the pre-COVID climate with pauses on the surgical repair of POP with synthetic meshes and negative media coverage related to surgical complications, an increasing number of women were choosing to adopt a more conservative method of management. In the National Health Service in the UK for 2018/2019, 97781 pessary procedures were performed on an outpatient basis.
According to Dwyer & Kearney (2017) approximately 73% of pessary users will experience a complication, however, most continue to have a pessary as they are satisfied with the improved quality of life that it provides [2]. Complications are more likely when follow up care of the fitted pessary is not maintained or is forgotten, but can occur relatively quickly following fitting, even with good follow up [3]. Common complications include vaginal bleeding, pain or excessive vaginal discharge, an offensive odour, erosion or ulceration of the vaginal tissue. In cases of neglected pessaries, complications including urosepsis, vesicovaginal and rectovaginal fistulae have also been reported [4].
There is no evidence to guide safe and effective pessary follow up care. Follow up reviews (for women not self-managing their pessary) may be offered every 3 – 6 months and should include a speculum examination to ensure the health of the vaginal tissue. However, across Europe and the world with the current COVID 19 pandemic, access to health care services is severely restricted and many women will be shielding at home and unable to travel to health care settings for reviews. This represents a significant challenge for pessary services and a potential increase in risks for women.
To try to provide guidance for clinicians, National Societies eg. British Society of Urogynaecology have developed recommendations for the use and management of pessaries in the COVID pandemic [5]. These documents can guide how and when these women are reviewed and provide advice regarding the different types of pessary (eg shelfs and gelhorns) that are more dangerous if left in for prolonged periods and much harder to self manage.
For services, measures such as sending information letters to patients to educate them regarding symptoms and signs of potential complications and how to seek help may be useful. Especially, as a drop in accessing health care for all other emergency conditions has been observed in the community and hospital settings. Clinicians may need to consider how services restart and the need for alternative ways of working for example outreach clinics in the community or home visits for particularly vulnerable women. If this is not possible, pessary training for those already working in the community setting may be an alternative option. Consideration when rebooking these women into clinics for review will also be needed, as trying to review a large number of women in a short space of time will only result in additional strains on the service in 4-6 months time when their next follow up is scheduled.

An alternative that can be offered when suitable for patients is to learn to self-manage their pessary. Traditionally, self management is taught in person with the clinician, however, some women may choose to discuss this virtually with the aid of on-line videos (which are available on you tube) and try this at home. For women who are concerned about having the pessary for longer than normal but not wishing to self manage, they can be advised on how to remove it themselves and just manage their prolapse symptoms until an appointment can be arranged.

Ultimately, many services will have to consider alternative clinical pathways and service provision for an unknown period of time. The focus should be patient safety, education and increasing their understanding of complications, when / how to seek help and where possible empowering self management.

References

1 Smith, F.J., Holman, C.A.J., Moorin, R.E. and Tsokos, N., 2010. Lifetime risk of undergoing surgery for pelvic organ prolapse. Obstetrics & Gynecology, 116(5), pp.1096-1100.

2 Dwyer, L. and Kearney, R., 2018. Conservative management of pelvic organ prolapse. Obstetrics, Gynaecology & Reproductive Medicine, 28(1), pp.15-21.

3 O'Dell, K. and Atnip, S., 2012. Pessary care: Follow up and management of complications. Urol Nurs, 32(3), pp.126-36.

4 Arias, B.E., Ridgeway, B. and Barber, M.D., 2008. Complications of neglected vaginal pessaries: case presentation and literature review. International Urogynecology Journal, 19(8), pp.1173-1178.

5 https://bsug.org.uk/news-details/bsug-guidance-on-management-of -urogynaecological-conditions-and-vaginal-pessary-use-during-the-covid-19-pandemic/90/0/0

Clinical opinions, Articles of the month and EUGA Meeting proceedings are also available in the private area of the EUGA Website as member-only contents.

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Commentary on "Tension-Free Vaginal Tape Surgery versus Polyacrylamide Hydrogel Injection for Primary Stress Urinary Incontinence: A Randomized Clinical Trial", Itkonen Freitas AM, Mentula M, Rahkola-Soisalo P, Tulokas S, Mikkola TS. J Urol. 2020 Feb;203(2):372-378.

This randomised controlled trial (RCT) compared tension-free vaginal tape (TVT) vs polyacrylamide hydrogel (Bulkamid) injection for treatment of primary stress urinary incontinence (SUI) in women. Considering the ongoing controversy regarding the use of mesh in SUI surgery, the results of this study were highly anticipated. The authors evaluated Bulkamid as first-line treatment and not as a salvage procedure. They also compared to a gold standard procedure (TVT) rather than another bulking agent, making the results more relevant in clinical practice. They randomised 224 women and they reported the findings at 1-year follow-up.

The design was a non-inferiority RCT with patient satisfaction as the primary outcome. The authors used a non-validated visual analogue scale (VAS) of 0 to 100 with an arbitrary cut-off of 80 for measurement of patient satisfaction. This was an interesting choice compared with the usual practice of choosing validated patient reported outcome measures or objective tests as primary outcomes. However, a cough stress test and a pad test were included in the secondary outcomes.

Bulkamid did not meet the non-inferiority criteria, with 59.8% of women reporting a satisfaction score of 80 or greater (VAS 0-100) at 1 year compared to 95.0% for women randomised to TVT. The objective cure rate **was** 54.2% for the Bulkamid arm versus 91.1% for the TVT arm. The subjective cure was reported by 23.4% of women in the Bulkamid group and 83.2% for the TVT group. The respective improvement rates were 68.2% and 16.8%. As the statistical analyses was performed on an intent to treat basis, it is worth pointing out that 43% of women in the Bulkamid arm had another injection at 3 months and 15% underwent TVT surgery at 3 months or after 2 Bulkamid treatments.

Most perioperative complications (18.8% vs 2.8%) and all reoperations due to complications were associated with the TVT. In the hands of the experienced surgeons at Helsinki University Hospital, 5% of patients with TVT reported pain at 1-year follow-up and 5% were diagnosed with vaginal tape exposure by 1 year. There were also 6 reoperations in the TVT arm for urinary retention, tape erosion or haematoma. The occurrence of these complications should be evaluated with extreme caution in the current environment of SUI surgery.

While TVT provides higher satisfaction and cure rates, it is also associated with more complications. As the majority of women were satisfied and subjectively improved or cured with Bulkamid, this bulking agent can be offered as alternative therapy to women with primary SUI who want to avoid the implantation of synthetic mesh. This study supports the increasing role of Bulkamid in the SUI surgery armamentarium. As there are limited long-term data on urethral buking agents, I am looking forward to the publication of the 5-year results of this RCT.

FPMRS JOURNAL

The European Urogynaecological Association is proud to announce the selection of Female Pelvic Medicine & Reconstructive Surgery (FPMRS) as EUGA official journal.
This agreement will give to all EUGA regular members free access to electronic copies of the journal directly from the EUGA member area.

Click here to know more

EUGA

CALL FOR TRAINEES

EUGA is currently evaluating applications for the EUGA Trainee Committee submitted by the deadline of 6th July 2020.

Click here to know more

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Scientific Corner

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