posterior: 25.3±14.2 vs. 39.4±11.3 mins). Global P-QoL domain scores significantly declined in both groups 6 months after surgery (Prolift group: 385±95 vs. 110±56; $p < 0.01$; Prosima group: 315±88 vs. 89±65; $p < 0.01$). Overall severity of prolapse symptom scores significantly declined in both groups, but no statistical difference was observed between them. Mean PGI-I score was 1 [range 1–5] in both groups. PISQ-12 and PGI-S scores were significantly reduced in both groups. Wexner constipation score was reduced only in patients undergone posterior repair. Overall anatomic cure rates were 89.5% for Prolift and 81.6% for Prosima (p NS). Complication (10.5% vs. 5.3%, $p < 0.05$) and dyspareunia rates were significantly higher in the Prolift group.

Conclusions: Both devices were effective. QoL scores did not significantly differ between the two groups, but tended to be lower in the Prosima group. Complications and de novo dyspareunia were higher in the Prolift group.

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EFFICACY OF A SECOND GENERATION THERMAL BALLOON DEVICE (THERMABLATE) FOR ENDOMETRIAL ABLATION IN THE TREATMENT OF ANEMIA INDUCED BY MENO/METRORRHAGIA

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Objectives: Aim of this study was to evaluate the effects of endometrial ablation using a thermal balloon device (Thermablate).

Materials: Thermablate is a thermal ballon device for endometrial ablation, that allows a complete destruction of the endometrium in 2 minutes and 6 seconds.

Methods: 97 patients affected by menorrhagia with anemia, resistant to medical treatment, not desiring further pregnancies, and without any contraindication to EA (genital tract malignancies, unresolved endometrial atypical hyperplasia, anatomic or pathologic uterine anomalies, transmural myomectomy, genital tract or UTI, failed previous endometrial ablation)underwent treatment with Thermablate after a diagnostic hysteroscopy. Primary end-point was the percentage of patients with a ≥3 g of Hb increase 12 months after the procedure. Secondary end-points were percentage of patients with amenorrhea, hypomenorrhea/spotting, eumenorrhea, and menorrhagia; post-operative pain VAS score; dysmenorrhea VAS score; patient's satisfaction; complications. Women were evaluated up to 24 months after the procedure. Data were evaluated using chi-square test.

Results: All patients completed the follow-up. Six months after the procedure, 44% of patients showed an increase of 3 g of Hb. This percentage rose to 62% 12 months and to 71% 24 months after the procedure. The incidence of menorrhagia was 39.2% after 6 months, 6.2% after 12 months and 2.1 after 24 months. Mean post-operative pain VAS score was 2.1±1.1, mean post-operative dysmenorrhea VAS score was 1±0.3 and mean satisfaction VAS score was 9.7±3.2. We did not record any intraoperative or post-operative complications. Only two patients underwent hysterectomy for persistent menorrhagia >24 months after the procedure.

Conclusions: Thermablate seems to be an efficient and safe procedure for the treatment of meno/metrorrhagia induced anemia.

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THE PERIPARTUM HYSTERECTOMY, AS A FINAL MANAGEMENT METHOD OF SEVERE HEMORRHAGE UNRESPONSIVE TO CONSERVATIVE TREATMENT – A SIX YEAR REVIEW

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Objectives: The purpose of this study was to review cases of emergency obstetrical hysterectomy performed during the six years period, and to estimate the incidence, indications of hysterectomies, maternal and fetal outcomes.

Materials: The study setting is a tertiary level obstetric gynecology hospital and a referral center for all the country in Tirana, Albania. We included all the cases of emergency obstetric hysterectomies performed in cases of postpartum hemorrhage unresponsive to other treatments in the time period January 1st 2005 – December 31st 2010.

Methods: In this study, were estimated the incidence of hysterectomies, demographic and clinical variables and was review the literature. Among the variables analyzed were: maternal age, gestational age at delivery, mode of delivery, obstetrical history, indications for hysterectomy, type of hysterectomy, maternal complications, number of hemotransfusion units, hospital day-stay, treatments received before hysterectomy. Also were analyzed the fetal birthweight and fetal morbidity and mortality.

Results: 23,302 women gave birth at the hospital during the six years of the study period, of which 27.2% by caesarean section and 35 obstetrical hysterectomies were performed. The incidence of obstetrical hysterectomies was 1.5 per 1000 births. The major part of hysterectomies was performed after cesarean deliveries, and abnormal placentation was diagnosed in these women. Other indications for hysterectomy were uterine atony and uterine rupture. In the majority of cases the subtotal hysterectomy was performed. There was only one maternal death (2.9%) among these cases of hysterectomies.

Conclusions: Although the incidence of obstetric hysterectomy was high, there was a lower incidence in the last three years. The further decrease of this incidence will happen by optimizing the management of severe hemorrhage with conservative treatment or surgery such as including the use of uterine artery ligation, intrauterine balloon tamponade or tranexamic acid, in the postpartum hemorrhage protocol.

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CERVICAL PESSARY FOR THE PREVENTION OF PREMATURITY IN TWINS

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Objectives: The aim of this study was to estimate the effectiveness of the prophylactic use of cervical pessary in prevention of premature delivery in twin pregnancies.

Materials: Patients with twin pregnancies are usually considered to be in high risk for premature delivery. Some treatments such as bed rest, tocolytics and progesterone have resulted without significant effect in reducing the the prematurity rate in twins, based on the recent evidences from randomized studies. The pessary cerclage is a noninvasive and simple device, and seems to be a promising treatment for prevention of premature delivery in twin pregnancies.

Methods: The study setting is a tertiary level obstetric gynecology hospital. This is a prospective cohort study. For every twin pregnancy randomly selected in pessary group, at the same time were selected randomly two other twin pregnancies. In the study were included all twin pregnancies starting from the gestational age interval (20 to 27 weeks), regardless of parity, chorionicity, or cervical length. Exclusion criteria were uterine malformations, placenta previa, fetal abnormalies, twin-to-twin transfusion, or ruptured membranes.