O-GYN-008
A RANDOMIZED TRIAL OF LAMINARIA VERSUS VAGINAL MISOPROSTOL FOR CERVICAL DILATION PRIOR TO SURGICAL TERMINATION
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Objectives: To compare laminaria tents with misoprostol for cervical ripening prior to first trimester surgical termination.

Methods: In a prospective, open-label, randomised trial, 70 women were assigned to have an intracervical laminaria tent or vaginal misoprostol 200µg the day prior to suction D&C. Cervical dilation and operating time were measured by the surgeon performing the D&C. Ease of surgery was rated subjectively by the surgeon. Study subjects were interviewed just prior to the D&C with regard to pain, vaginal bleeding and dilator preference.

Results: Laminaria produced significantly (p<0.001) greater dilation of the cervix (34.9 Pratt, SD=6.2) than did misoprostol (28.4 Pratt, SD=5.8). There was no demonstrable difference in ease of surgery or operating time. Laminaria patients reported significantly more pain on insertion than did misoprostol patients (p<0.001). On the other hand, misoprostol patients reported more vaginal bleeding (p<0.01). Pain following insertion was similar in the two groups. One patient aborted completely after misoprostol alone. Overall, the stated patient preference for cervical dilator was more likely to be misoprostol (p<0.01).

Conclusions: Laminaria are more effective cervical dilators than vaginal misoprostol inserted the day prior to suction D&C. Misoprostol insertion is likely to be more comfortable for the patient although it is associated with more vaginal bleeding and may abort the pregnancy. Vaginal misoprostol is a viable alternative for cervical preparation prior to suction D&C.

O-GYN-010
OPERATING ROOM TIME QUALITY ASSURANCE AUDIT
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Objectives: The aims of this study were to evaluate the efficiency of booked operating room time and reasons for delays.

Methods: Prospective recording of times for anesthesia, preparation, surgery and cleanup were undertaken from May 17 to October 11, 2000(1) and from May 1 to July 30, 2003(2). Reasons for delays were recorded. Where appropriate, times were compared and delays evaluated as controllable or uncontrollable.

Results: In time period (1), 64 of 71 (90%) cases were completed on 28 booked days. Seven (25%) had delayed starts, seven (25%) had delayed endings. Eight (29%) days ended early. In time period (2), 31 of 35 (89%) cases were completed on 12 booked days. Two (16%) were delayed starts; three (25%) ended late and seven (58%) ended early. In time period (1), time (in minutes) was distributed as: anesthetist 1643 (13%), preparation 1042 (9%), surgery 7436 (61%), and cleanup 185 (1.5%). Total time used/booked was 10306/12570 (84%). In time period (2), time (in minutes) was distributed as: anesthesic 570 (13%), preparation 389 (9%), surgery 1759 (41%), and cleanup 90 (2.1%). Total time used/booked was 2088/4260 (66%). Controller reasons for delays included: poor communication, poor assessment of surgical time required, inadequate staffing and personal reasons. Uncontrollable reasons for delays included: icy road conditions, unexpected severe intraoperative hemorrhage, failed anesthetic procedures and the “bumping process”.

Conclusions: Booked operating room time is inefficiently used for multifactorial reasons. Controllable delays need to be eliminated to improve efficiency, potentially reducing wait times and improve public image.

O-GYN-JM-009
BEST OF FOUR PAPERS
A PREVALENCE STUDY OF SUBJECTIVE AND OBJECTIVE URINARY INCONTINENCE AND PELVIC ORGAN PROLAPSE IN NORTH AMERICAN FIRST NATIONS WOMEN
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Objectives: To determine the cross-sectional prevalence of stress urinary incontinence (SUI) and pelvic organ prolapse (prolapse) in First Nations (Cree) women.

Methods: All First Nations (Cree) women (15 - 50 years old) reporting for routine gynaecologic assessment in Moose Factory, Ontario, were offered participation. Women with prior surgery for SUI or prolapse were excluded. Participants completed standardized questionnaires and physical examinations. Outcomes included subjective SUI (urine loss with physical activity, coughing or sneezing), objective SUI (positive paper towel test preceding a void (150mL), and prolapse (Pelvic Organ Prolapse): Quantification Stage (2). Risk factors for SUI and prolapse were evaluated using logistic regression analysis.

Results: 51 women were recruited to participate. Mean age was 33 years (95% CI [30.2 - 35.9]). Eighty percent were parous (mode = 3). The average largest birth weight was 4033. The average body mass index was 32.5 kg/m² with 60% of women defined as obese. Subjective and objective SUI and significant prolapse were reported in 63%, 59% and 58% of women, respectively. Parity predicted subjective SUI (OR=2.3, 95% CI [1.36-3.97] for each delivery). Age predicted objective SUI (OR=2.12, 95% CI [1.02-4.26] for every ten years). Age (OR=1.09, 95% CI [0.99-1.20] for every ten years), parity (OR=1.38, 95% CI [0.81-2.37] for every delivery) and presence of abdominal wall striae (OR=14.77, 95% CI [1.77-122.49]) predicted prolapse (age and parity had a collinear relationship).

Conclusions: In our study population, significant prolapse was strikingly prevalent, as well as both subjective and objective SUI. We speculate that this may be due to an underlying genetic predisposition for the development of pelvic floor dysfunction in the First Nations women. To test this hypothesis, further work is planned to compare these findings to prevalence rates in matched White female controls.

O-GYN-JM-016
BEST OF FOUR PAPERS
ALIMENTATION PRÉCOCE VS TARDIVE APRÈS CHIRURGIE GYNECOLOGIQUE MAJEURE : ÉTUDE RANDONNÉE
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Objectifs : Comparer l'alimentation précoce versus tardive chez des femmes ayant subi une chirurgie gynécologique majeure en regard de la durée d'hospitalisation et de la satisfaction générale des patientes.

Méthodes : Étude randomisée contrôlée incluant des femmes ayant subi une chirurgie gynécologique majeure. Les patientes ont été randomisées en deux groupes: l'alimentation précoce qui offrait une diète de liquides clairs dans les 6 premières heures postopératoires, suivie d'un diète solide selon tolérance versus l'alimentation tardive où seulement de la glace était permise pour les 12-24 premières heures, suivie des liquides clairs le 1er jour postopératoire et de la nourriture solide le 2ème et 3ème jours postopératoires.

Résultats : 119 femmes ont été randomisées, 61 femmes ont été assignées au groupe d'alimentation précoce et 58 au groupe d'alimentation tardive. Les caractéristiques démographiques étaient comparables dans les deux groupes incluant l'âge, le poids et le tabagisme. La durée d'hospitalisation était comparable (précoce 86.4 ±21.0 heures versus tardive 85.6 ±26.2 heures). Un nombre comparable de patientes ont souffert de nausées dans les deux groupes. La satisfaction générale s'est révélée être comparable dans les deux groupes.

Conclusions : L'introduction d'une alimentation précoce chez des femmes ayant subi une chirurgie gynécologique majeure semble bien tolérée. La satisfaction générale et la durée d'hospitalisation sont comparables dans les deux groupes.

O-GYN-JM-012
BEST OF FOUR PAPERS
OFFICE BASED GLOBAL ENDOMETRIAL ABLATION: FEASIBILITY AND OUTCOME FOR 3 MODALITIES
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Objectives: To evaluate the safety, feasibility and efficacy of office based global endometrial ablation techniques under local anaesthesia.

Methods: Office based global endometrial ablation techniques were evaluated prospectively since 1998 employing a local anaesthesia regimen. 259 patients have been treated for intractable menorrhagia. Pre-procedural evaluation included sonohysterography to ensure normal cavity geometry, endometrial biopsy. Patients received a prep oral
Results: The association of genital prolapse and stress incontinence is very high regardless of patient's symptoms. Many pelvic surgeons thus during surgical correction of genital prolapse would plan a concomitant anti-incontinence procedure based on urodynamical findings with reduction of prolapse. Sacropinous ligament suspension, a vaginal approach technique for surgical correction of pelvic organ prolapse, has a reported success rate of >90% TVT, a minimally invasive technique for SUI, similarly has shown excellent immediate and long-term success rate. A combined surgical approach utilizing these two techniques will thus eliminate the need of abdominal incision and morbidity associated with this. To evaluate combined technique of sacropinous ligament suspension and tension free vaginal tape in surgical correction of pelvic organ prolapse with associated urinary stress incontinence.

Methods: From September 2002 to January 2004, a total of 70 patients with genitourinary stress incontinence underwent acrococcygeal suture. The mean age was 59 years (range 34-76), parity 3.35 (range 1-10), 31 patients (44%) had simultaneous vaginal hysterectomy, 15 (21%) were prone to incontinence surgery. A full gynecological and multichannel urodynamic assessment was carried out on all patients. Postoperatively all patients had gynecological examination, urethra by voiding and post void residual of urinary tract infections. Patient satisfaction was assessed on a visual analogue scale.

Results: Surgery was successfully carried out on all patients. Febrile morbidity was recorded in four patients (7.5%) and urinary tract infections in 13 (18%). All patients were cured from apical support defects. Postoperative cystoscopy were done in 2 patients (2.9%) with one requiring a repeat surgical correction. Persistent voiding dysfunction was seen in three patients (4.3%). Two patients (2.9%) had postoperative urinary hematomas, both drained spontaneously. One patient had vaginal erosion of TVT mesh. Three patients (4.3%) required incision of TVT mesh and two developed recurrent incontinence. Surgical correction of incontinence was achieved in 66 patients (94.3%).

Conclusions: A combined vaginal approach of pelvic reconstructive surgery for prolapse and incontinence is safe and effective. The vaginal approach with sacropinous ligament suspension and TVT is justified for surgical correction of prolapse and associated incontinence.