



TURP PROCEDURES, TVT SLINGS, AND STENTS

Speaker: Cheryl Wisinski, PT, (Partner) Family Physical Therapy Services, Omaha, NE.

Cheryl has been active in the Section on Women's Health, and the NE Chapter for over 10 years, and recently finished her term as Chair of the Advisory Panel on Public Relations for the APTA. She has lectured around the country on Women's Health topics, including CSMs and Nationals, and at the local physical therapy programs, and has had research published in this area. She currently is a partner in a private practice, established over 15 years ago.

Course Description: Learn what part of the anatomy is involved in dozens of surgical procedures to male and female pelvic floors, including bladder and colorectal repairs. After a detailed description of each procedure, emphasis will be placed on possible outcomes seen and symptoms requiring physical therapy. Post-op problems following hysterectomies and childbirth will also be explored.

Objectives: Upon completion of this course, the participant will be able to:
understand surgical approaches for dozens of pelvic floor surgeries
identify possible problematic outcomes from these surgeries
discuss physical therapy approaches with these patients

Participation Level: Intermediate

Content

1) Obstetric Surgeries

A) Vaginal deliveries, episiotomies (First degree: skin of perineum only, Second degree: into muscles of perineum, Third degree: extends thru muscles and sphincter, Fourth degree: muscles, sphincter, and anterior wall of rectum)

 Pelvic floor weakness considerations and question amt of rehab they perform

B) Cesarean deliveries, consider adhesions at line of "bikini cut". These may affect genitofemoral n. supplying vulva. Adhesions can also stick to bladder affecting detrussor muscle activity. Normal tissue healing time is 7-10 days

Even though no delivery trauma to PF, trauma in last 4 mo or so from added weight on the "sling", still need PF strengthening, and abdominal strengthening.

2) Gynecological Surgeries

A) Endometriosis: scopes

B) Rectocele repairs

 Posterior repairs: plicate the levator ani muscle over rectal wall, or "hole"

C) Prolapsed uterus

 -LeFort procedure

 -Gilliam Suspension-round ligament to rectus

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 -Watkins transposition-uterus moved under bladder

 -Mersilene strap to rectus for prolapsed vagina

consider problems with not correcting this (attachments of uterus)

D) Hysterectomies : discuss indications

-complications: n. entrapment

Pudendal n. involvement

Genitofemoral n. entrapment from suprapubic adhesions (abd hyst)

Ureters cut

Freeing bladder from uterus to minimize bladder damage

Shortened vagina leading to dyspareunia

Dyspareunia also from attaching vagina too rigidly to round lig.

Increased intra-abdominal pressure directly on bladder without “trampoline” of uterus above-incontinence

Weakened ligament connection front to back and side to side, SI and LBP considerations

Abdominal incision/adhesions, need for rehab. Lack of assist to PFM causes strain here and fatigue syndrome

-versions: leaving top of vagina open vs closed (leaving vaginal cuff open with the edges secured decreases incidence of postoperative pelvic abscess)
attaching cuff to natural ligaments (broad, round, cardinal, uterosacral

sacrospinous ligament suspension: complications can include cardinal ligament damage, pudendal artery and nerve damage (results in chronic pain)

sacral colpopexy: complications can involve right ureter. Also must take care not to let the strap (pts own fascia or synthetic) cross pelvis like a “clothesline” which can strangle small bowel

abdominal vs vaginal: advantage of vaginal-lower risk of shock, intestinal and peritoneal injury, and absence of abdominal wound. Disadvantage is not being permitted to explore abdominal cavity

oophorectomy during hysterectomy or later? (most like to leave ovaries in until age 50)

3) Oncological Surgeries

A)TRAM and VRAM flaps for pelvic reconstruction following radiation or cancer surgeries: reinforcement of hard/thin tissue from radiation or replacement of areas of tumor removal

B)Radiation for Bladder cancer-complications of filling/emptying due to loss of elasticity of detrusor mm

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C)Lumpectomy: must always consider radiation of breast/axilla-burns and changes in tissue elasticity

4) Colorectal Surgeries

- A) Rectovaginal fistula repair: consider bulbocavernosus muscle to improve blood supply to irradiated tissue, and provide thicker layer of tissue
- B) Anal Fistulas: consider that often surgery not needed-only indicated if infection occurring secondary to poor blood supply

5) Urological Surgeries

- A) Cystocele and Urethrocele: consider normal mechanics around urethra
 - Burch Culposuspension (paravaginal fascia to iliopectineal ligaments)
 - Marshall Marchetti Krantz (periurethral and vaginal fascia to pubic symph. with stiches)
 - Pubovaginal Sling: TVT
 - Rectus Sling
 - TFL, or Goebell-Frangenheim Stoeckel operation
 - Kelly Plication (anterior vaginal wall repair): remove some of anterior wall (of vaginal mucosa) and pull tighter, careful not to make vagina too small, consider intercourse
- B) Urinary fistula repair: (usually occur after gynecological surgery, esp. abdominal or vaginal hysterectomy) bulbocavernosus muscle flap plasty
- C) Collagen Injections, complications
- D) Artificial Sphincters
- E) Prostate Cancer: review differences between benign vs malignant
 - Balloon urethroplasty
 - Prostatic stents
 - Transurethral hyperthermia
 - TURP and TUIP procedures
 - Radical Prostatectomy-consider complications of adhesions/hardening of tissue around surgical site (bladder, urethra, sphincter), damage to internal and external sphincters, damage to nerve plexas (impotence)

F) Common Stoma

G) Ureterosigmoidostomy

6) General Surgeries

- A) Inguinal hernia repair: can ambulate on operative day, consider hip flexor tightness

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7) Plastic Surgeries

- A) Mastectomies- Radical: Pec Minor and Pec Major cut
Modified radical saves pec major

- B) TRAM flap reconstruction
- C) Lat flat reconstruction
- D) Submuscular Implants
- E) Breast Augmentations: submuscular implants vs surface placement, also consider postural changes
- F) Breast Reductions: remember that this does not eliminate upper back pain after so many years of upper back adaptations
- G) Tummy Tucks: consider postural changes, posterior pelvic tilt
- H) Diastasis recti repair: 4 finger with split considered a surgical necessity

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