Please find below the results of your literature search request.

If you would like the full text of any of the abstracts included, or would like a further search completed on this topic, please let us know.

We'd appreciate feedback on your satisfaction with this literature search. Please visit http://www.hello.nhs.uk/literature_search_feedback.asp and complete the form.

Thank you

Literature search results

<table>
<thead>
<tr>
<th>Search completed for:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Search request date:</td>
<td>21/04/2011</td>
</tr>
<tr>
<td>Search completion date:</td>
<td>28/04/2011</td>
</tr>
<tr>
<td>Search completed by:</td>
<td>Ann Darling</td>
</tr>
</tbody>
</table>

Search details

Unplanned return to theatre and readmission to ward – Gynaecology.

Resources searched

Cochrane Library, NHS Evidence – Women’s Health Specialist collection, NHS Guidance, TRIP database, Medline, Embase

Database search terms: gynaecologic surgical procedures, unplanned, unscheduled, reoperation, 30 days, gynecol* surgery

Google search string: gynecol*, reoperation, unplanned or unscheduled, 30 days

Summary

Range of published research found, not all specify the period of time before reoperation.

Guidelines

None found

Evidence-based reviews

None found

Published research

1. Laparoscopic sacrocolpopexy for the treatment of vaginal vault prolapse: With or without robotic assistance

Citation: Hong Kong Medical Journal, February 2011, vol./is. 17/1(54-60), 1024-2708 (FEBRUARY 2011)

Publication Date: February 2011

Abstract: Objective: To assess perioperative and medium-term outcome after laparoscopic sacrocolpopexy with or without robotic assistance for vaginal vault prolapse in a Hong Kong tertiary centre. Design Retrospective study. Setting: An urogynaecology unit in Hong Kong. Patients: All women who underwent laparoscopic sacrocolpopexy with or without robotic assistance for vaginal vault prolapse from March 2005 to May 2010. Main outcome measures: The perioperative and medium-term outcomes. Results: A total of 36 women underwent the operation during the study period. The mean operating time was 205 minutes, mean blood loss was 144 mL. The median hospital stay was 4 days. Two women required early re-operation but recovered fully. In all, 35 women were followed up for 29 (standard deviation, 19) months. Three of them (9%) had a recurrence of stage II prolapse, but there was statistically significant improvement in the pelvic organ prolapse quantification assessment for all three compartments of the vagina, and the length of vagina was well preserved. There were no mesh exposure or erosions. The overall objective cure rate of 91% (32/35) was high, and 91% (32/35) were satisfied with the operative outcome. Stress incontinence and voiding difficulty were significantly reduced. Conclusion: Laparoscopic sacrocolpopexy for vaginal vault prolapse is safe, although complications arising from concomitant surgery should not be neglected. High rates of objective cures and patient satisfaction were achieved. There were no mesh exposure or erosions. Laparoscopic sacrocolpopexy should be considered an option for women with vaginal vault prolapse.

Source: EMBASE

2. Surgically corrected urethral diverticula: Long-term voiding dysfunction and reoperation rates

Author(s): Ingber M.S., Firoozi F., Vasavada S.P., Ching C.B., Goldman H.B., Moore C.K., Rackley R.R.

Citation: Urology, January 2011, vol./is. 77/1(65-69), 0090-4295;1527-9995 (January 2011)

Publication Date: January 2011

Abstract: Objectives: To present the largest reported cohort of women with urethral diverticula and to evaluate the surgical outcomes and long-term voiding symptoms after urethral diverticulectomy. Studies evaluating the outcomes after urethral diverticulectomy have been limited by small patient numbers and short-term follow-up. Methods: Women who had undergone diverticulectomy at our institution from 1996 to 2008 were mailed
surveys. Urinary bother was assessed using the Urogenital Distress Inventory 6-item questionnaire, and patients were asked to report subsequent urethral or vaginal surgery and the number of urinary tract infections within the previous year. To determine the rate of surgical recurrence, the charts of women not responding to the survey were reviewed. Results: A total of 122 women were identified as having undergone urethral diverticulectomy during the study period. Of these, 13 (10.7%) had an eventual recurrence that required repeat surgical excision. Patients with a proximal diverticulum, multiple diverticula, or previous pelvic or vaginal surgery (excluding previous diverticulectomy) were more likely to develop recurrence (P = .01, P = .03, and P < .001, respectively). For the 61 women (50%) responding to our survey, the mean follow-up was 50.4 months. Of these 61 women, 24 (39.3%) had had a urinary tract infection within the previous year, with 14 (23%) women having had <3 within the previous year. Also, 16 (26.2%) had persistent pain or discomfort with urination. The mean +/- SD total Urogenital Distress Inventory-6 score was 31.1 +/- 25.5 for the survey responders. Conclusions: To our knowledge, our study represents the largest study with the longest follow-up after urethral diverticulectomy. Patients with proximal or multiple diverticula and those with previous pelvic surgery should be counseled appropriately regarding the risks of recurrence and persistent voiding dysfunction. 2011 Elsevier Inc.

Source: EMBASE

3. A randomised controlled trial comparing TVT, Pelvicol and autologous fascial slings for the treatment of stress urinary incontinence in women


Citation: BJOG: An International Journal of Obstetrics and Gynaecology, November 2010, vol./is. 117/12(1493-1502), 1470-0328;1471-0528 (November 2010)

Publication Date: November 2010

Abstract: Objective To compare TVT, Pelvicol and autologous fascial slings (AFSs). Design A multicentre randomised control trial. Setting Four units in the UK. Population Women requiring primary surgery for stress urinary incontinence (SUI). Methods A total of 201 women with urodynamically proven stress incontinence were randomised into three groups and assessed at baseline, 6weeks, 6months and 1year. Main outcome measure The primary outcome was patient-reported improvement rates. Secondary outcomes included operative complications/time, intermittent self-catheterisation (ISC) and re-operation rates. The quality-of-life tools used were the Bristol Female Lower Urinary Tract Symptoms (BFLUTS) and EuroQoL. Results Fifty women had a Pelvicol sling, 79 had AFSs and 72 had TVT. At 6months the Pelvicol arm had poorer improvement rates (73%) than TVT (92%)/AFS (95%); P=0.003. At 1year only 61% of the Pelvicol slings remained as
improved, versus 93% of TVTs and 90% of AFSs (P<0.001). Pelvicol has poorer dry rates (22%) than TVT (55%)/AFS (48%) (P=0.001) at 1year; hence, the Pelvicol arm was suspended following interim analysis. There is no difference in the success rates between TVT and AFS. One in five women in the Pelvicol arm had further surgery for SUI by 1year, but none required further surgery in the other arms. AFS took longer to do (54minutes versus 35minutes for TVT/36minutes for Pelvicol) and had higher ISC rates (9.9 versus 0% Pelvicol/TVT 1.5%). Hospital stay was shortest for TVT (2days). Most BFLUTS domains showed improvement in all three arms. The improvement for women in the Pelvicol arm, however, was less than for women in the other arms in several key domains. Conclusions Pelvicol cannot be recommended for the management of SUI. TVT does not have greater efficacy than AFS, but does utilise fewer resources. RCOG 2010 BJOG An International Journal of Obstetrics and Gynaecology.

Source: EMBASE

4. The incidence of major complications after the performance of extensive upper abdominal surgical procedures during primary cytoreduction of advanced ovarian, tubal, and peritoneal carcinomas.


Citation: Gynecologic Oncology, October 2010, vol./is. 119/1(38-42), 0090-8258;1095-6859 (2010 Oct)

Publication Date: October 2010

Abstract: OBJECTIVE: To assess the morbidity and mortality associated with extensive upper abdominal surgery (EUAS) performed during primary cytoreduction for advanced ovarian carcinoma.METHODS: We identified all patients who underwent EUAS during primary cytoreduction for advanced ovarian, tubal, or peritoneal cancer at our institution from 1/01 to 12/06. Major grade 3-5 complications were those that led to invasive radiologic intervention, re-operation, unplanned ICU admission, chronic disability, or death within 30 days of surgery.RESULTS: There were 141 eligible patients, with a median age of 60 years (range, 38-82). The majority of patients had stage IIIC disease, 103 (73%); serous histology, 131 (93%); and ascites, 118 (84%). There were 229 EUAS procedures performed-diaphragm peritonectomy, 101 (72%); splenectomy, 45 (32%); full-thickness diaphragm resection, 19 (14%); partial hepatectomy, 18 (13%); distal pancreatectomy, 17 (12%); cholecystectomy, 15 (11%); and resection of porta hepatitis tumor, 14 (10%). Cytoreductive outcomes were: no gross residual, 42 (30%); residual <= 1cm, 85 (60%); and residual >1cm, 14 (10%). Grade 3-5 complications occurred in 31 (22%) patients, including 2 mortalities (1.4%). In 21/31 (68%), the complication was successfully managed with percutaneous drainage of infected or non-infected
collections. Overall median survival for all patients was 57 months.

CONCLUSIONS: Rates of major morbidity and mortality following EUAS for primary cytoreduction were 22% and 1.4%, respectively. Approximately two-thirds of complications were readily managed by percutaneous drainage of collections. With an overall median survival of 57 months in a cohort of patients with a large tumor burden, this rate of morbidity and mortality appears acceptable. Copyright Copyright 2010 Elsevier Inc. All rights reserved.

Source: MEDLINE

5. Laparoscopic sacrocolpopexy in the treatment of vaginal vault prolapse: 8 years experience.

Author(s): Granese R, Candiani M, Perino A, Romano F, Cucinella G

Citation: European Journal of Obstetrics, Gynecology, & Reproductive Biology, October 2009, vol./is. 146/2(227-31), 0301-2115;1872-7654 (2009 Oct)

Publication Date: October 2009

Abstract: OBJECTIVE: The aim of this study was to evaluate the long-term results of a laparoscopic sacrocolpopexy for the treatment of vaginal vault prolapse. STUDY DESIGN: Between January 1999 and January 2007, 165 laparoscopic sacrocolpopexy procedures, using a polypropylene mesh, were performed on women affected by vaginal vault prolapse. Intraoperative complications included: 5 bladder injuries and 3 sigmoid perforations. Postoperative complications included: 10 cases of fever, 5 cases of lumbosciatica, 15 cases of detrusor overactivity, 2 cases of vaginal haematoma, and 5 cases of minimal dispareunia. At 1, 6 and 12 months after surgery, a clinical evaluation was carried out for all patients. After this period, we contacted the women annually. RESULTS: We treated 165 women, with an average age of 67 (range 58-76 years; S.D. 19.22), average parity of 3 (range 2-5), and average body mass index of 28 (range 24-30). In many of them, more than one additional procedure was performed. At a median follow-up of 43 months (range 6-96 months), out of a total of 138 patients (27 were lost at follow-up), we obtained successful treatment in 131 women (success rate of 94.9%), with a high rate of satisfaction from the procedure. Recurrent vaginal vault prolapse was registered in seven women (5.07%): in 3, the vaginal vault collapsed after a period ranging from 7 to 20 days, caused by the use of a Vyprol mesh (hence use of same was suspended), and in a further three women the mesh detached after less than 1 month. Finally, in one case, we reported an erosion between the first and the second follow-up and the mesh was visualized in the vagina. CONCLUSIONS: Our study shows that laparoscopic sacrocolpopexy, in the hands of an expert surgeon, can be considered a safe, effective procedure for the treatment of vaginal vault prolapse, allowing long-term anatomical restoration (94.9% success rate).

**Author(s):** Bentz E.K., Imhof M., Pateisky N., Ott J., Huber J.C., Hefler L.A., Tempfer C.B.

**Citation:** Fertility & Sterility, June 2009, vol./is. 91/6(2638-42), 0015-0282;1556-5653 (2009 Jun)

**Publication Date:** June 2009

**Abstract:** OBJECTIVE: To systematically monitor the frequency and risk factors of adverse events (AEs) in a reproductive surgery endoscopy unit. DESIGN: Prospective cohort study. SETTING: Academic research institution. PATIENT(S): All consecutive surgical patients of a reproductive surgery unit from December 2005 to March 2007. INTERVENTION(S): Monitoring for predefined AEs by trained observers. MAIN OUTCOME MEASURE(S): Number of preventable and not preventable AEs, medical errors, and system problems. Univariate analysis and multivariate logistic regression were used to identify risk factors of AEs. RESULT(S): Seven hundred ninety-six women were included. We identified 60 AEs in 45 patients (risk 6%; 95% confidence interval [CI] 1%-11%). Adverse events were postoperative fever (n = 1), wound breakdown (n = 1), intraoperative or postoperative administration of packed erythrocytes (n = 6), surgical revision (n = 7), unplanned readmission (n = 5), transfer to intensive care unit (n = 1), conversion (n = 8), intraoperative organ injury (n = 9), blood loss >500 mL (n = 3), surgery canceled (n = 15), and other AEs (n = 4). Six patients (risk 0.8%; 95% CI 0-2%) had multiple AEs. One (0.01%) and 11 (1.4%) AEs were deemed due to medical errors and system problems, respectively. Twelve and 48 AEs were deemed preventable and not preventable, respectively. In a univariate and multivariate analysis, only duration of surgery (odds ratio 3.78; 95% CI 1.95-7.33) was significantly associated with having an AE. CONCLUSION(S): Clinical outcome monitoring is a useful tool for assessing the outcome quality of reproductive surgery by identifying potentially preventable AEs and associated risk factors.

Source: MEDLINE

7. Clinical outcome monitoring in a reproductive surgery unit: a prospective cohort study in 796 patients

**Author(s):** Bentz E.-K., Imhof M., Pateisky N., Ott J., Huber J.C., Hefler L.A., Tempfer C.B.

**Citation:** Fertility and Sterility, June 2009, vol./is. 91/6(2638-2642), 0015-0282 (June 2009)

**Publication Date:** June 2009

**Abstract:** Objective: To systematically monitor the frequency and risk factors of adverse events (AEs) in a reproductive surgery
endoscopy unit. Design: Prospective cohort study. Setting: Academic research institution. Patient(s): All consecutive surgical patients of a reproductive surgery unit from December 2005 to March 2007. Intervention(s): Monitoring for predefined AEs by trained observers. Main Outcome Measure(s): Number of preventable and not preventable AEs, medical errors, and system problems. Univariate analysis and multivariate logistic regression were used to identify risk factors of AEs. Result(s): Seven hundred ninety-six women were included. We identified 60 AEs in 45 patients (risk 6%; 95% confidence interval [CI] 1%-11%). Adverse events were postoperative fever (n = 1), wound breakdown (n = 1), intraoperative or postoperative administration of packed erythrocytes (n = 6), surgical revision (n = 7), unplanned readmission (n = 5), transfer to intensive care unit (n = 1), conversion (n = 8), intraoperative organ injury (n = 9), blood loss >500 mL (n = 3), surgery canceled (n = 15), and other AEs (n = 4). Six patients (risk 0.8%; 95% CI 0-2%) had multiple AEs. One (0.01%) and 11 (1.4%) AEs were deemed due to medical errors and system problems, respectively. Twelve and 48 AEs were deemed preventable and not preventable, respectively. In a univariate and multivariate analysis, only duration of surgery (odds ratio 3.78; 95% CI 1.95-7.33) was significantly associated with having an AE. Conclusion(s): Clinical outcome monitoring is a useful tool for assessing the outcome quality of reproductive surgery by identifying potentially preventable AEs and associated risk factors. 2009 American Society for Reproductive Medicine.

Source: EMBASE

8. Abdominal sacrocolpopexy - Standardized surgical technique, perioperative management and outcome in women with posthysterectomy vaginal vault prolapse

Author(s): Huebner M., Krzonkalla M., Tunn R.

Citation: Gynakologisch-geburthilfliche Rundschau, May 2009, vol./is. 49/4(308-314), 1018-8843 (May 2009)

Publication Date: May 2009

Abstract: Aims: To provide a detailed description of abdominal sacrocolpopexy and to present a retrospective evaluation of the outcomes. Methods: 78 patients underwent sacrocolpopexy between January 2004 and July 2006; 72% had concomitant procedures; 53 patients participated in the follow-up. Anatomical success was defined as any leading point of the vaginal wall remaining 1-1 cm above the hymen. Failures were split into 3 groups: (1) asymptomatic, no further treatment; (2) symptomatic, conservative treatment; (3) symptomatic, requiring repeat surgery. The key points of the surgical technique were standardized mesh shape, reasonable choice of fixation of the mesh to the anterior and posterior vaginal walls as well as to the longitudinal ligament at S2, and short operating time. Results: Standardization kept the mean operating time short (72.7+/14.5 min for sacrocolpopexy only, 86.4+/21.0 min if combined with the Burch procedure; p = 0.03). At the follow-up,
none of the 53 patients (100%) presented with a recurrent apical prolapse; 17% (n = 9) had stage II anterior wall prolapse, and 69.8% (n = 37) did not show symptoms specific to anterior wall prolapse. Regarding the posterior compartment, 38% (n = 20) had stage II and 1 stage III posterior wall prolapse; 86.8% (n = 46) did not show symptoms specific to posterior wall prolapse. Questionnaire items showed improvement of quality of life. Nine patients required reinterventions: suburethral sling (3), excision due to erosion (2), anterior (1) and posterior (1) repair, stapled transanal rectal resection (1), botulinum toxin injection (1). Every fourth woman presented with symptoms requiring further treatment. Conclusions: Sacrocolpopexy is a valid technique to treat apical and anterior vaginal wall prolapse.

Source: EMBASE

9. Can we find predictive factors for unplanned overnight admission?

Author(s): Barros F., Monteiro M., Matos M.E., Lemos P.

Citation: Ambulatory Surgery, April 2008, vol./is. 14/1, 0966-6532 (April 2008)

Publication Date: April 2008

Abstract: Aim: To identify risk factors for unplanned admission following ambulatory surgery. Methods: Case-control analysis, involving 6740 patients from our Day Surgery Unit, between 2001 and 2005. Variables investigated were: gender, age, ASA classification, type of anaesthetic, surgical speciality, duration of anaesthesia, pain, nausea/vomiting, haemorrhage, and anaesthetic consultation. Chi-square tests were first performed for each variable. Afterwards, logistic regression was carried out on those variables found significant. Results: The unplanned admission rate was 0.8%. Factors associated with admission were: gynaecological surgery, nausea/vomiting, bleeding, severe pain and duration of anaesthesia >120 minutes. Conclusion: The acknowledgement of risk factors such as these may improve the safety and efficacy of day surgery.

Source: EMBASE

10. Morbidity associated with posterior intravaginal slingplasty for uterovaginal and vault prolapse.

Author(s): Hefni M, Yousri N, El-Toukhy T, Koutromanis P, Mossa M, Davies A

Citation: Archives of Gynecology & Obstetrics, November 2007, vol./is. 276/5(499-504), 0932-0067;0932-0067 (2007 Nov)

Publication Date: November 2007

Abstract: OBJECTIVE: This study was carried out to evaluate the safety and efficacy of posterior intravaginal slingplasty (IVS) for upper genital prolapse. SETTING: Gynaecology Department,
MATERIALS AND METHODS: An observational study was conducted on 127 women, who underwent posterior IVS using the IVS Tunneller (Tyco HealthCare, USS, Norwalk, CT, USA). The indications for surgery were uterovaginal prolapse in 65% and vault prolapse in 35%. Patient follow-up was at 6 weeks, 6 months, 1 year and annually thereafter.

RESULTS: In addition to posterior IVS, hysterectomy was performed in 22 patients, anterior colporrhaphy in 63 patients and trans obturator mid-urethral tape insertion in eight patients. The mean operating time was 46 +/- 18.5 min and for posterior IVS alone was 27.4 +/- 10 min, and the mean peri-operative drop in haemoglobin level was 1.4 +/- 0.75 gm/dL. There were no rectal, vesical or ureteric injuries. After a mean follow-up of 14 months (range 2-26 months), upper genital support was maintained in 88%, cystocele formation occurred in 8% and recurrent rectocele was seen in 11%. There was a 17% risk of tape erosion (21/127) and a re-operation rate of 24% (30/127). The risk of tape erosion was related to patient age above 60 years (RR = 1.6, 95% CI 1.02-2.5) and current treatment for diabetes (RR = 4, 95% CI 1.7-9.2). Parity, body mass index, menopausal status, HRT use, hysterectomy and surgeon's experience were not found to influence tape erosion rate.

CONCLUSION: Posterior intravaginal slingplasty is a minimally invasive procedure for upper genital prolapse with an acceptable success rate. However, the operation is associated with high vaginal erosion and re-operation rates.

Source: MEDLINE

11. A prospective observational study of the safety and acceptability of vaginal hysterectomy performed in a 24-hour day case surgery setting

Author(s): Penketh R., Griffiths A., Chawathe S.

Citation: BJOG: An International Journal of Obstetrics and Gynaecology, April 2007, vol./is. 114/4(430-436), 1470-0328;1471-0528 (Apr 2007)

Publication Date: April 2007

Abstract: Objective: To assess the safety and acceptability of vaginal hysterectomy with and without simultaneous oophorectomy in a 24-hour day case surgery setting for women with nonprolapse indications for surgery. Design: Prospective observational study. Setting: A busy teaching hospital and tertiary referral centre for Obstetrics and Gynaecology. Population: Seventy-one women from one consultant's practice underwent a vaginal hysterectomy with a planned discharge within 24 hours after the procedure. All women had a body mass index less than 40 and a suitable home environment for routine day case surgery, other than that the women were from an unselected population. Method: Prospective observational study. Main outcome measures: The duration of the operation and mean blood loss were recorded. Any intraoperative complications were noted. In addition, the proportion of women discharged home within 24 hours of the operation was recorded.
together with any readmissions to hospital. Returns to theatres and any postoperative complications were also recorded. Postoperative pain scores were assessed 6 and 24 hours after procedure in selected women. Results: Seventy-one vaginal hysterectomies were performed as 24-hour day case procedures. The intraoperative complication rate was 1.4%. Sixty-five women were discharged home within 24 hours (91.5%). The readmission rate within this group was 6.2%. The duration of the procedure, mean blood loss, return to theatre rate and incidence of febrile illness were comparable with rates recorded in inpatient studies. Conclusions: Vaginal hysterectomy performed as a 24-hour day case procedure appears to be as safe as traditional inpatient management, with a high rate of early discharge and a low rate of readmission. This may have additional advantages for the woman and healthcare provider alike. RCOG 2007 BJOG An International Journal of Obstetrics and Gynaecology.

Source: EMBASE

12. Partial small bowel obstruction and ileus following gynecologic laparoscopy

Author(s): Milad M.P., Escobar J.C., Sanders W.

Citation: Journal of Minimally Invasive Gynecology, January 2007, vol./is. 14/1(64-67), 1553-4650 (Jan 2007)

Publication Date: January 2007

Abstract: Study objective: To assess the incidence and management of partial small bowel obstruction (PSBO) and ileus after gynecologic endoscopy. Design: Internet-based cross-sectional survey (Canadian Task Force classification II-3). Material and methods: An online survey was distributed to gynecologic surgeons to collect information about frequency and management of ileus and PSBO after gynecologic laparoscopy. Measurements and main results: Of the 58 physician respondents, 22 had managed at least 1 patient with PSBO or ileus after gynecologic laparoscopy. A total of 12 PSBOs and 14 patients experiencing ileus were identified for an overall incidence of 0.036%. Patients showed symptoms between 1 and 20 days postoperatively and had findings ranging from hypoactive (45%), to normal (30%), to hyperactive (25%) bowel sounds. Plain film radiographs (75%) were the most commonly used diagnostic modality followed by computed tomography (CT) scans of the abdomen. Most patients were initially managed with intestinal rest and nasogastric tube placement for 2 to 16 days. Fifty percent required a second procedure, with reported findings that included intestinal herniation (n = 7), bowel injury (n = 4), volvulus (n = 2), and urinoma (n = 1). Conclusion: Ileus and PSBO are rare findings after gynecologic laparoscopy. We identified 26 cases, most of which were initially managed conservatively. The majority of patients ultimately required a second operation. Surgeons should have a high index of suspicion when managing a patient with PSBO or ileus after gynecologic laparoscopy. Given the findings from the second
procedures, CT scans would seem to be the diagnostic procedure of choice. 2007 AAGL.

**Source:** EMBASE

13. **Bilateral bladder erosion of a transobturator tape mesh**

**Author(s):** Parekh M.H., Minassian V.A., Poplawsky D.

**Citation:** Obstetrics and Gynecology, September 2006, vol./is. 108/3 II(713-715), 0029-7844 (Sep 2006)

**Publication Date:** September 2006

**Abstract:** BACKGROUND: The transobturator tape procedure is reported to be an effective procedure with low complication rates. CASE: A 45-year-old woman underwent surgery for prolapse and incontinence. The surgery included transobturator tape. Intraoperative cystoscopy was not performed. Postoperatively, a mesh erosion into the bladder on the left side and a large cystocele were diagnosed. The patient underwent a combined transurethral and suprapubic mesh resection. Six months later, she had another mesh erosion on the contralateral side. This time, a complete vaginal resection of the mesh was performed. CONCLUSION: Intraoperative cystoscopy should be considered after a transobturator tape procedure. Bilateral mesh erosion may result from motion of a cystocele against a fixed transobturator tape. Concurrent repair of the cystocele to prevent future mesh erosions may be warranted.

2006 by The American College of Obstetricians and Gynecologists. Published by Lippincott Williams & Wilkins.

**Source:** EMBASE

14. **A double-blind randomised controlled trial of laparoscopic uterine nerve ablation for women with chronic pelvic pain.**

**Author(s):** Johnson NP, Farquhar CM, Crossley S, Yu Y, Van Peperstraten AM, Sprecher M, Suckling J

**Citation:** BJOG: An International Journal of Obstetrics & Gynaecology, September 2004, vol./is. 111/9(950-9), 1470-0328;1470-0328 (2004 Sep)

**Publication Date:** September 2004

**Abstract:** OBJECTIVE: To determine the effectiveness of laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain in women with endometriosis and women with no laparoscopic evidence of endometriosis. DESIGN: A prospective double-blind randomised controlled trial (RCT). SETTING: Single-centre, secondary-level gynaecology outpatient service and tertiary-level pelvic pain and endometriosis outpatient service in Auckland, New Zealand. POPULATION: One hundred and twenty-three women undergoing laparoscopy for investigation and management of chronic pelvic pain, 56 with no laparoscopic evidence of endometriosis and 67 with endometriosis. METHODS: Women were randomised from
the two populations, firstly those with no evidence of endometriosis and secondly those undergoing laparoscopic surgical treatment for endometriosis, to receive LUNA or no LUNA. Participant and assessor blinding was employed. Follow up for pain outcomes was undertaken at 24 hours, 3 months and 12 months.

**MAIN OUTCOME MEASURES:** Changes in non-menstrual pelvic pain, dysmenorrhoea, deep dyspareunia and dyschezia were assessed primarily by whether there was a decrease in visual analogue score for these types of pain of 50% or more from baseline and additionally whether there was a significantly different change in median visual analogue score. The numbers requiring further surgery or starting a new medical treatment for pelvic pain and complications were also measured.

**RESULTS:** There was a significant reduction in dysmenorrhoea at 12 month follow up in women with chronic pelvic pain in the absence of endometriosis who underwent LUNA (median change in visual analogue scale (VAS) from baseline -4.8 versus -0.8 (P= 0.039), 42.1% versus 14.3% experiencing a successful treatment defined as a 50% or greater reduction in visual analogue pain scale for dysmenorrhoea (P= 0.045). There was no significant difference in non-menstrual pelvic pain, deep dyspareunia or dyschezia in women with no endometriosis undergoing LUNA versus no LUNA. The addition of LUNA to laparoscopic surgical treatment of endometriosis was not associated with a significant difference in any pain outcomes.

**CONCLUSIONS:** LUNA is effective for dysmenorrhoea in the absence of endometriosis, although there is no evidence of effectiveness of LUNA for non-dysmenorrhoeic chronic pelvic pain or for any type of chronic pelvic pain related to endometriosis.

**Source:** MEDLINE

15. **The mistakes of surgeons: "gossypiboma".**

**Author(s):** Tacyildiz I, Aldemir M

**Citation:** Acta Chirurgica Belgica, February 2004, vol./is. 104/1(71-5), 0001-5458;0001-5458 (2004 Feb)

**Publication Date:** February 2004

**Abstract:** PURPOSE: A foreign body retained in the abdominal cavity following surgery is a serious and medicolegal problem. To emphasize the importance of this operative iatrogenic complication, we reviewed our experience with six patients who had retained abdominal gossypibomas. METHODS: The records of six patients with a confirmed diagnosis of gossypiboma after abdominal surgery at Dicle University Hospital, between January 1994 and December 2000, were retrospectively reviewed. RESULTS: Four of the six patients were female and two male. Previously, of the patients, three underwent elective operations and three were operated on for emergency. Types of previous operation were gynaecological in three cases, gastrointestinal in two cases and hepatobiliary in one case. The most common symptoms were mass, nausea, vomiting, abdominal distension and pain. The intestinal obstructions and pseudotumoral syndrome were determined in three and two cases,
respectively. Abdominal ultrasonography clearly demonstrated the gossypiboma in four of our patients and CT demonstrated a more precise image of forgotten surgical sponges in the other two patients. One patient died due to ventricular fibrillation, the other five patients were discharged healthfully.

CONCLUSION: Small sponges should not be used during laparotomy. Compresses should only be used intraperitoneally, one by one, mounted on a forceps. Before closing the peritoneum, the surgeon should completely explore the abdominal cavity.

**Source:** MEDLINE

16. **Unplanned return to operating room in a community hospital-based obstetrics and gynecology residency.**

**Author(s):** Connolly TP

**Citation:** Journal of the American Osteopathic Association, March 2003, vol./is. 103/3(123-5), 0098-6151;0098-6151 (2003 Mar)

**Publication Date:** March 2003

**Abstract:** The American College of Obstetricians and Gynecologists clinical indicator for unplanned return to the operating room during the same admission in an obstetrics and gynecology residency is reviewed in this article. A retrospective chart review of all gynecologic surgeries during a 3-year period was evaluated for this indicator. An incidence of 0.03% was noted, with 3 of 1,492 procedures meeting the definition of this indicator. The incidence of this clinical indicator is uncommon in a community hospital-based obstetrics and gynecology residency.

**Source:** MEDLINE

17. **Delay of hospital discharge secondary to postoperative fever--is it necessary?.**

**Author(s):** Fanning J, Brewer J

**Citation:** Journal of the American Osteopathic Association, December 2002, vol./is. 102/12(660-1), 0098-6151;0098-6151 (2002 Dec)

**Publication Date:** December 2002

**Abstract:** Although postoperative fever is common after major gynecologic surgery, the majority of patients have no identifiable infectious or pathologic etiology. Traditional management has been to delay hospital discharge until the patient is afebrile. The authors evaluate the outcome of patients discharged with postoperative fever after major gynecologic surgery. In a retrospective review of 537 women undergoing major gynecologic surgery, 211 (39%) had postoperative fever. The authors identified all patients who were discharged despite having a temperature of 38 degrees C or higher (> or = 100.4 degrees F) in the preceding 12 hours. All outpatient and inpatient records for a period of 30 days were reviewed. Thirty-eight
(18%) of 211 patients who were febrile postoperatively were discharged despite having a fever within the preceding 12 hours. One patient was lost to follow-up. Two (5%) of 37 patients had a documented infection (one urinary tract infection and one postoperative wound infection). Four (11%) were readmitted within 30 days for noninfectious causes. None of the patients discharged on oral antibiotics had an antibiotic-related complication. Eighty-four percent of patients discharged with a postoperative fever did not have a documented infectious or pathologic cause for the fever while at home.

Source: MEDLINE

18. Leicestershire surgical readmissions survey

Author(s): Sutton C.D., Marshall L., Lloyd T., Garcea G., Berry D., Kelly M.

Citation: Journal of Clinical Excellence, 2002, vol./is. 4/1(33-41), 1465-9883 (2002)

Publication Date: 2002

Abstract: Introduction: The aim of this study was to determine the pattern of surgical readmissions, and stratify the episodes as 'preventable', 'possibly preventable' and 'non-preventable', by comparing actual diagnosis extracted from casenotes and data coded by Leicestershire Health Authority. Methods: A six-month retrospective casenotes' review of consecutive surgical readmissions to the University Hospitals of Leicester and peripheral district generals was carried out by two independent clinicians. Results: 435 patient episodes involving 384 patients were analysed (representing 94% casenote retrieval). The correlation between the two observers was good (Spearman 0.994). In total, 69% of readmissions were 'real' (patients readmitted in an unplanned fashion) but, of these, only 2% were judged as 'preventable' and 14% 'possibly preventable'. Thirty-one percent of readmissions were not 'real': one-third were elective, planned readmissions and two-thirds involved a completely new pathology. Conclusions: The number of completely preventable surgical readmissions was minuscule (2%). A further 14%, possibly preventable readmissions might benefit from targeted aftercare. A total of 31% of patient episodes were incorrectly assigned as surgical readmissions, reflecting errors in data coding and transfer.

Source: EMBASE

19. Safety and efficacy of low anterior en bloc resection as part of cytoreductive surgery for patients with ovarian cancer.


Citation: Gynecologic Oncology, October 2001, vol./is. 83/1(115-20), 0090-8258;0090-8258 (2001 Oct)
Publication Date: October 2001

Abstract: OBJECTIVE: To examine the feasibility and safety of a low anterior resection of the rectosigmoid plus adjacent pelvic tumour as part of primary cytoreduction for ovarian cancer.METHODS: This study included 65 consecutive patients with primary ovarian cancer who had debulking surgery from 1996 through 2000. All patients underwent an en bloc resection of ovarian cancer and a rectosigmoid resection followed by an end-to-end anastomosis. Parameters for safety and efficacy were considered as primary statistical endpoints for the aim of this analysis.RESULTS: Postoperative residual tumour was nil, <1 cm, and >1 cm in 14, 34, and 14 patients, respectively. The median postoperative hospital stay was 11 days (range, 6 to 50 days). Intraoperative complications included an injury to the urinary bladder in one patient. Postoperative complications included wound complications \( (n = 14, 21.5\%) \), septicemia \( (n = 9, 13.8\%) \), cardiac complications \( (n = 7, 10.8\%) \), thromboembolic complications \( (n = 5, 7.7\%) \), ileus \( (n = 2, 3.1\%) \), anastomotic leak \( (n = 2, 3.1\%) \), and fistula \( (n = 1, 1.5\%) \). Reasons for a reoperation during the same admission included repair of an anastomotic leak \( (n = 1) \), postoperative hemorrhage \( (n = 1) \), and wound debridement \( (n = 1) \). Wound complications, septicemia, and anastomotic leak formation were more frequent in patients who had a serum albumin level of \(< 30\ g/L\) preoperatively. There was one surgically related mortality in a patient who died from a cerebral vascular accident 2 days postoperatively.CONCLUSIONS: An en bloc resection as part of primary cytoreductive surgery for ovarian cancer is effective and its morbidity is acceptably low. Copyright 2001 Academic Press.

Source: MEDLINE

20. Long term outcome following laparoscopic supracervical hysterectomy.

Author(s): Okaro EO, Jones KD, Sutton C

Citation: BJOG: An International Journal of Obstetrics & Gynaecology, October 2001, vol./is. 108/10(1017-20), 1470-0328;1470-0328 (2001 Oct)

Publication Date: October 2001

Abstract: OBJECTIVES: To assess the long term outcome of laparoscopic supracervical hysterectomy.DESIGN: Retrospective study.SETTING: Minimal Access Surgical Unit, Department of Gynaecology, Royal Surrey County Hospital, Surrey.METHODS: Analysis of patient case records.POPULATION: Seventy consecutive women who had a laparoscopic supracervical hysterectomy. OUTCOME MEASURES Symptoms related to the cervical stump and the need for further surgery.RESULTS: The mean time of patient follow up was 66 months (range 52-84). The mean time from initial procedure to second treatment was 14 months (range 3-53). Seventeen women (24.3%) reported symptoms related to the cervical stump, and all required further surgery. The cervical stump was
removed in 16 (22.8%). One patient had laparoscopic adhesiolysis only and two had a laparotomy and trachelectomy because the bowel was adherent to the cervical stump. Nine had a laparoscopically assisted cervical trachelectomy as the sole procedure. Five had laser treatment to endometriotic deposits, and laparoscopically assisted cervical trachelectomy. Histological analysis showed normal cervical tissue in six (35.3%). Endometriosis was detected in four cervical stumps (23.5%), residual endometrium in another four (23.5%) cases, and chronic cervicitis, mild CIN and a mucocoele in a further three patients. Of the 17 women who reported cervical stump symptoms, 14 (82.3%) had been treated for endometriosis in the past, compared with 17/53 (32%) who did not have symptoms (P < 0.0002, chi2 test). CONCLUSIONS: Symptoms related to the cervical stump requiring further surgery frequently occur following a laparoscopic supracervical hysterectomy.

Source: MEDLINE


Author(s): Lower AM, Hawthorn RJ, Ellis H, O'Brien F, Buchan S, Crowe AM

Citation: BJOG: An International Journal of Obstetrics & Gynaecology, July 2000, vol./is. 107/7(855-62), 1470-0328;1470-0328 (2000 Jul)

Publication Date: July 2000

Abstract: OBJECTIVE: To investigate the epidemiology of, and the clinical burden related to, adhesions following gynaecological surgery. POPULATION: The Scottish National Health Service Medical Record Linkage Database was used to define a cohort of 8849 women undergoing open gynaecological surgery in 1986. METHODS: All readmissions for potential adhesion related disease in the subsequent 10 years were reviewed. MAIN OUTCOME MEASURES: Readmissions and the degree of adhesion involvement gave an indication of clinical burden and workload. The rate of readmission following the initial surgery determined the relative risk of disease related to adhesions. RESULTS: Two hundred and forty-five (4.5%) of 5433 readmissions following open gynaecological surgery were directly related to adhesions. 34.5% of patients were readmitted, on average 1.9 times, for a problem potentially related to adhesions or for further intra-abdominal surgery that could be complicated by adhesions. Readmissions related to adhesions continued throughout the 10 year period of the study. The overall rate of readmission was 64.0/100 initial operations. For readmissions directly related to adhesions, the rate was 2.9/100 initial operations. Operations on the ovary had the highest rate directly related to adhesions (7.5/100 initial operations), with an overall rate of readmission of 106.4/100 initial operations. CONCLUSIONS: Despite the conservative approach taken in this study, the clinical burden, workload and
relative risk of readmissions related to adhesions following open
gynaecological surgery was considerable. Post-operative adhesions
have important consequences for patients, surgeons and the
healthcare system. These results emphasise the need for more
effective strategies to prevent adhesions.

Source: MEDLINE

22. Three methods for hysterectomy: A randomised, prospective
study of short term outcome

Author(s): Ottosen C., Lingman G., Ottosen L.

Citation: British Journal of Obstetrics and Gynaecology, 2000,
vol./is. 107/11(1380-1385), 0306-5456 (2000)

Publication Date: 2000

Abstract: Objective: To detect differences in clinical short term
outcome between total abdominal hysterectomy, vaginal
hysterectomy and laparoscopic assisted vaginal hysterectomy.
Design: Randomised controlled trial. Setting: Department of
Obstetrics and Gynaecology, Hospital of Helsingborg, Sweden.
Sample: One hundred-twenty women scheduled for hysterectomy for
various indications. Methods: Randomisation into three treatment
arms: total abdominal hysterectomy (n = 40); vaginal hysterectomy (n
= 40) and laparoscopic assisted vaginal hysterectomy (n = 40).
During traditional abdominal and vaginal surgery, laparoscopic
assistance was kept to a minimum. Substantial number of cases
needed volume-reducing manoeuvres due to uterine size. Main
outcome measures: Duration of surgery, anaesthesia, time in
hospital and recovery time. Results: Mean duration (range) of
surgery was significantly longer for laparoscopic assisted vaginal
hysterectomy compared with vaginal hysterectomy and total
abdominal hysterectomy, 102 min (50-175), 81 min (35-135) and 68
min (28-125), respectively. Mean stay in hospital and mean time to
recovery was significantly longer for total abdominal hysterectomy
compared with vaginal hysterectomy and laparoscopic assisted
vaginal hysterectomy. The difference between vaginal hysterectomy
and laparoscopic assisted vaginal hysterectomy was not significant.
It was possible to remove uteri under 600 g with all three methods.
Four laparoscopic assisted vaginal hysterectomies and one vaginal
hysterectomy were converted to open surgery. Reoperation and
blood transfusion were required after two vaginal hysterectomies and
one laparoscopic assisted vaginal hysterectomy. One woman
needed blood transfusion after total abdominal hysterectomy.
Conclusions: Traditional vaginal hysterectomy proved to be feasible
and the faster operative technique compared with vaginal
hysterectomy with laparoscopic assistance. The abdominal technique
was somewhat faster, but time spent in theatre was not significantly
shorter. Abdominal hysterectomy required on average a longer
hospital stay of one day and one additional week of convalescence
compared with traditional vaginal hysterectomy. Vaginal
hysterectomy should be a primary method for uterine removal.
1. **Unplanned** surgical reoperations in a tertiary hospital: perioperative mortality and associated risk factors
   P Rama-Maceiras, T Rey-Rilo... - European Journal of ..., 2011 - journals.lww.com
   ... Definition of **unplanned reoperation**. **Unplanned surgical reoperation** was defined as any unexpected surgical procedure performed within **30 days** after the initial surgery in response to any complication resulting directly or indirectly from the initial operation. ...

2. Predictors of hysterectomy after uterine artery embolization for leiomyoma
   Lancashire Teaching Hospitals K Gabriel-Cox, GF Jacobson, MA Armstrong... - ... and Gynecology, 2007 - Elsevier
   ... Fifty-four women (9.6%) had emergency room visits and 17 (3%) had **unplanned** readmissions...
   ... rates of technical failure as well as long-term data on the rates of **reoperation** after UAE...
   ... fibroid registry: symptom and quality-of-life status 1 year after therapy, Obstet Gynecol 106 (2005) ...

3. “**Surgical Apgar Score**" predicts postoperative complications after cytoreduction for advanced ovarian cancer
   I Zighelboim, N Kizer, NP Taylor, AS Case... - Gynecologic ..., 2010 - Elsevier
   ... fellows in training as defined by the American Board of Obstetrics and Gynecology. ...
   ... response syndrome, **unplanned** intensive care unit (ICU) admission, need for **reoperation**, anastomotic leak or fistula, vascular, ureteral or neural injuries, **unplanned** readmission < **30 days** ...

4. Risk-adjusted rates for potentially avoidable reoperations were computed from routine hospital data
   P Halfon, Y Eggli, M Matter, C Kallay... - Journal of clinical ..., 2007 - Elsevier
   ... Indeed, many **unplanned** reoperations are generally considered avoidable: for instance **reoperation** for wound infection or anastomotic leak. However, no clear operational definition of “**unplanned**” return to the operating room exists. ...