Pelvic Floor Digest

Il Pelvic Floor Digest ***(www.pelvicfloordigest.org)*** *è una raccolta di abstracts scelti da 200 giornali e suddivisi in dieci capitoli a loro volta ripartiti in una sezione* generale, riabilitativa, urologica, ginecologica e colorettale.
Questa rubrica contiene un ***piccolo saggio dell'edizione on-line*** *e vuole stimolare i diversi specialisti ad estendere il loro interesse agli altri settori del pavimento pelvico, sviluppando così una cultura transdisciplinare* personale.

1 – THE PELVIC FLOOR

Stimulating aspects of sacral nerve stimulation. *Staskin DR. J Urol. 2006;175:1991-2.*

Parity, mode of delivery, and pelvic floor disorders. *Lukacz ES, Lawrence JM, Contreras R, et al. Obstet Gynecol. 2006;107:1253-60.* This study aimed to assess the associations between parity, mode of delivery, and pelvic floor disorders (pop, s.u.i., overactive bladder, anal incontinence) whose prevalence was assessed in a random sample of women aged 25-84 years by using the validated Epidemiology of Prolapse and Incontinence Questionnaire. The risk of pelvic floor disorders is independently associated with vaginal delivery but not with parity alone. Cesarean delivery has a protective effect, similar to nulliparity, on the development of pelvic floor disorders when compared with vaginal delivery.

2 – FUNCTIONAL ANATOMY

Skeletal muscle heavy-chain polypeptide 3 and myosin binding protein H in the pubococcygeus muscle in patients with and without pelvic organ prolapse. *Hundley AF, Yuan L, Visco AG. Am J Obstet Gynecol. 2006;194:1404-10.* The purpose of this study is to compare gene expression of skeletal muscle heavy-chain polypeptide 3 and myosin binding protein H in the pubococcygeus muscle of patients with pelvic organ prolapse and controls. The differences between patients with advanced pelvic organ prolapse and controls may be related to differential gene expression of structural proteins related to myosin. Specifically, advanced pelvic organ prolapse may be related to down-regulation of skeletal muscle heavy-chain polypeptide 3 and myosin binding protein H.

Drugs affecting visceral sensitivity: ready for the prime time? *Delvaux MM, Gay G. Dig Dis. 2006;24:99-104.* Visceral sensitivity is a frequent pathophysiological component of functional bowel disorders. Studies in animals and humans have identified numerous neurotransmitters involved in the processing of sensations from the gut to the brain. However, up to now none of them has actually been proven to have a marked clinical efficacy and the benefit comes rather from their action of bowel disturbances. Reproducible tests are lacking to detect visceral hypersensitivity in humans and distension tests are difficult to undertake in a clinical setting. Therefore, abnormal visceral sensitivity may not be regarded as a tool to select IBS patients as candidates for a given treatment.

3 – DIAGNOSTICS

The sensitivity and specificity of a simple test to distinguish between urge and stress urinary incontinence. *Brown JS, Bradley CS, Subak LL, Richter et al. Ann Intern Med. 2006;144:715-23.* Because treatments differ, urge incontinence should be distinguished from stress incontinence, but current guidelines recommend an extensive evaluation time-consuming for primary care practice. A simple questionnaire (3IQ) to categorize type of urinary incontinence was positively evaluated for sensitivity, specificity, and likelihood ratio.

Italian Validation of the Urogenital Distress Inventory and Its Application in LUTS Patients. *Artibani W, Pesce F, Prezioso D, et al. Eur Urol. 2006 May 4;e-pub.* The Italian version of the UDI is a valid and robust instrument, which can be used reliably in daily practice and clinical research.

Value of leak point pressure study in women with incontinence. *Sinha D, Nallaswamy V, Arunkalaivanan AS. J Urol. 2006;176:186-8.* Women with stress incontinence diagnosed with urodynamics leaked more at cough leak point pressure than the Valsalva maneuver, and women with detrusor overactivity leaked less at cough leak point pressure and more with the Valsalva maneuver.

Rectal hyposensitivity. *Gladman MA, Lunniss PJ, Scott SM, Swash M. Am J Gastroenterol. 2006;101:1140-51.* Rectal hyposensitivity relates to a diminished perception of rectal distension during anorectal physiologic investigation, being most prevalent in patients with functional constipation with or without fecal incontinence. It is usually diagnosed on the basis of elevated sensory threshold volumes during balloon distension, although such a diagnosis may be susceptible to misinterpretation in the presence of altered rectal wall properties, and thus it is uncertain whether a diagnosis of RH reflects true impairment of afferent nerve function. Furthermore, the etiology of RH is unclear, although there is limited evidence to support the role of pelvic nerve injury and abnormal toilet behavior. The optimum treatment of patients with RH is yet to be established, "sensory-retraining biofeedback" appearing as the most effective treatment, at least in the short term.

4 – PROLAPSES

Clinical implications of the biology of grafts: conclusions of the 2005 IUGA Grafts Roundtable. *Davila GW, Drutz H, Deprest J. Int Urogynecol J Pelvic Floor Dysfunct. 2006;17 Suppl 7:51-5.* With few exceptions, the current expansion of graft utilization in pelvic reconstructive surgery is not a product of evidence-based medicine. Abdominal sacrocolpopexy and suburethral sling procedures are two situations under which synthetic graft utilization is indicated, based on randomized prospective trials and reported clinical outcomes. Otherwise, indications and contraindications for graft utilization are unclear. Current published data on the biology of synthetic and biologic grafts are limited and overall not very helpful to the reconstructive surgeon who is faced with the selection of a graft for use during a reconstructive procedure. This Round Table presented the opportunity for a series of basic science researchers to present their data to a group of reconstructive surgeons and provide publishable background information on the various currently available grafts. The occurrence of healing abnormalities after graft implantation is becoming increasingly recognized as a potentially serious problem, and to date, definitions and a classification system for healing abnormalities do not exist.

Surgical management of posterior vaginal wall prolapse: an evidence-based literature review. *Maher C, Baessler K. Int Urogynecol J Pelvic Floor Dysfunct. 2006;17:84-8.* A research of conference proceedings of the International Continence Society and International Urogynecological Association was performed to summarize the available literature on gynecological management of posterior vaginal wall prolapse in this review. Two randomized trials demonstrated that the transvaginal approach to rectocele is superior to the transanal repair in terms of recurrent prolapse. The traditional posterior colporrhaphy with levator ani plication was largely superceded by fascial repairs with similar anatomic success rates but favorable functional outcome. The midline fascial plication may offer a superior anatomic and functional outcome compared to the discrete site-specific fascial repair. There is currently no evidence to recommend the routine use of grafts. Complications (mesh erosion, infection, rejection) must be considered. Controlled studies are still needed to compare a sacrocolpopexy combined with posterior mesh interposition vs the transvaginal repair.

Evaluation of a unique bovine collagen matrix for soft tissue repair and reinforcement. *Connolly RJ. Int Urogynecol J Pelvic Floor Dysfunct. 2006;17 Suppl 7:44-7.* Veritas® Collagen Matrix, a product of Synovis Surgical Innovations, is derived from bovine pericardium. In a rabbit model of uterine horn it reduces the incidence of adhesions, with an infiltration of host cells into the matrix which suggests a replacement of the material with host tissue.

Tissue engineering a clinically useful extracellular matrix biomaterial. *Hiles M, Hodde J. Int Urogynecol J Pelvic Floor Dysfunct. 2006;17 Suppl 7:39-43.* Chronic pain, tissue erosion, and late infections are just a few of the serious complications that can occur with conventional,

inert implantable materials. In contrast tissue-inductive materials directing cell growth and providing structural stability can be found in naturally occuring extracellular matrices. These "soft-tissue skeletons" of Mother Nature can be harvested, processed, and provided in a medically safe and biologically active form for repairing many different tissues in the human body. The future of surgical practice may well be determined by how well these new implant materials recreate the tisues they replace.

The biology behind fascial defects and the use of implants in pelvic organ prolapse repair. *Deprest J, Zheng F, Konstantinovic M et al.Int Urogynecol J Pelvic Floor Dysfunct. 2006;17 Suppl 7:16-25.* Implant materials are increasingly being used in an effort to reduce recurrence after prolapse repair with native tissues. The lessons from "herniology" will, wherever possible, be applied to pelvic organ prolapse problems.

Vaginal evisceration. *Khunda A, Jones D.Am J Obstet Gynecol. 2006;194:1744-5*

Gore-Tex mesh pelvic occlusion and secondary colpopexy: A new surgical technique for posthysterectomy vaginal vault prolapse. *Clavero PA, Guerrero JA, Salamanca A. Eur J Obstet Gynecol Reprod Biol. 2006;126:113-5.* A new surgical abdominal technique for the treatment of posthysterectomy vaginal vault prolapse by means of a Gore-Tex mesh is described, the vaginal vault being fixed to the centre of the mesh. Sixteen patients were followed-up for 16 to 46 months. There was only one case in which the mesh had to be removed due to infection and posterior erosion of the vaginal wall.

Using Veronikis ligature carrier to simplify transvaginal sacrospinous colpopexy. *Chang WC, Huang SC, Sheu BC et a. Acta Obstet Gynecol Scand. 2006;85:721-5.* Sacrospinous colpopexy requires significant expertise, especially in placement of the suture into sacrospinous ligament. Veronikis ligature carrier is used to facilitate suture placement and retrieval under direct visualization within the confines of the pararectal space without injury to the bladder, rectum, pudendal nerve, or major pelvic vessels.

A prospective audit of early pain and patient satisfaction following out-patient band ligation of haemorrhoids. *Watson NF, Liptrott S, Maxwell-Armstrong CA. Ann R Coll Surg Engl. 2006;88:275-9.* Pain scores were highest 4 h following the procedure. At 1 week, 75% of patients were pain-free, with 9 (7%) still experiencing moderate-to-severe pain. Rectal bleeding occurred in 86 patients (65%) on the day after banding, persisting in 32 (24%) at 1 week. Vaso-vagal symptoms occurred in 41 patients (30%) and were commonest at the time of banding. Eighty patients (59%) were satisfied with their experience and would undergo the procedure again. Patients should be aware of this in order to make an informed decision as to whether to undergo the procedure.

Longitudinal multiple rubber band ligation: an alternative method to treat mucosal prolapse of the anterior rectal wall. *Kleinubing H Jr, Pinho MS, Ferreira LC. Dis Colon Rectum. 2006;49:876-8.* Double rubber band ligation was undertaken in seven patients and triple ligation in nine patients. In a median follow up of 12 months fourteen patients (87.5 percent) showed complete and persistent remission of symptoms. No complications occured in this present series except in one patient with internal rectal prolapse patient who complained of persistent pain for seven days.

5 – RETENTIONS

Incidence of primary and recurrent acute urinary retention between 1998 and 2003 in England. *Cathcart P, van der Meulen J, Armitage J, Emberton M. J Urol. 2006;176:200-4.*

Noninvasive methods of diagnosing bladder outlet obstruction in men. Part 2: noninvasive urodynamics and combination of measures. *Belal M, Abrams P. J Urol. 2006;176:29-35.* A combination of noninvasive urodynamics and ultrasound derived measures provide promising methods of diagnosing bladder outlet obstruction. However, pressure flow studies still remain the gold standard for assessing bladder outlet obstruction.

Is it Reasonable to Treat Refractory Voiding Dysfunction in Children With Botulinum-A Toxin? *Radojicic ZI, Perovic SV, Milic NM. J Urol. 2006;176:332-336.* The effect of botulinum is transitory. However, it can break the circle of detrusor-sphincter dyssynergia and the period when it is sustained can be used for retraining the patient in normal voiding. At this moment botulinum-A toxin is one of last options in refractory cases of voiding dysfunction.

Alosetron: ischemic colitis and serious complications of constipation. *Gallo-Torres H, Brinker A, Avigan M.Am J Gastroenterol. 2006 May;101(5):1080-3.* Drugs such as alosetron that modulate serotonin effects by stimulating or blocking its receptors may play an important role in the treatment of some patients with irritable bowel system. In the case of alosetron, a 5HT-3 antagonist, an analysis of data from randomized clinical trials and postmarketing experiences have demonstrated a causal relationship between this drug and ischemic colitis and serious complications of constipation. There is need to further assess risk with regard to patient susceptibility and other factors.

Colonic irrigations: a review of the historical controversy and the potential for adverse effects. *Richards DG, McMillin DL, Mein EA, Nelson CD. J Altern Complement Med. 2006;12:389-93.* Colonic irrigations are popular among alternative medicine practitioners, and are viewed with skepticism by the conventional medical community citing the lack of evidence for health benefits and emphasizing the potential for adverse effects.. Given the current popularity, it is important that a research on the method's efficacy and risk be performed.

Short-term effects of magnetic sacral dermatome stimulation for idiopathic slow transit constipation: sham-controlled, cross-over pilot study. *Lee KJ, Kim JH, Cho SW. J Gastroenterol Hepatol. 2006;21:47-53.* Sacral dermatome stimulation may offer potential for therapeutic benefit for a subset of patients with idiopathic slow transit constipation, particularly constipated patients with rectal hyposensation or hindgut dysfunction.

6 – INCONTINENCES

Posterior vaginal sling experience in elderly patients yields poor results. *Mattox TF, Moore S, Stanford EJ, Mills BB. Am J Obstet Gynecol. 2006; 194: 1462-66.* In the evaluation of the posterior vaginal sling in an elderly population with significant vaginal prolapse using the IVS Tunneller device (Tyco), primary failure was defined as a postoperative pelvic organ prolapse quantitative point C (the apex of the vagina) within 2 cm of the preoperative value, scondary failure was defined as any portion of the anterior or posterior vaginal walls protruding to or beyond the hymeneal ring (pelvic organ prolapse quantitative points Aa or Ap equal to or greater than 0). Twenty-one patients underwent the procedure, average age 70 years (range 60-78). Twelve patients had primary or secondary failures (12 of 19, 63%). There were 5 primary failures (5 of 19, 26%) and 7 secondary failures (7 of 19, 37%). The mean time to failure was 7 weeks (range 1-18). It is concluded that in our elderly population, the posterior vaginal sling has a high early failure rate.

Factors impacting self-care for urinary incontinence. *Milne JL, Moore KN. Urol Nurs. 2006;26:41-51.*

Intravaginal electrical stimulation: a randomized, double-blind study on the treatment of mixed urinary incontinence. *Amaro JL, Gameiro MO, Kawano PR, Padovani CR. Acta Obstet Gynecol Scand. 2006;85:619-22.* Significant improvement was provided by effective and sham electrostimulation, questioning the effectiveness of electrostimulation as a monotherapy.

Hysterectomy and incontinence: a study from the Swedish national register for gynecological surgery. *Engh MA, Otterlind L, Stjerndahl JH, Lofgren M. Acta Obstet Gynecol Scand. 2006;85:614-8.* Hysterectomy cannot be considered to be a risk factor for developing stress urinary incontinence.

Quality of life in relation to TVT procedure for the treatment of stress urinary incontinence. *Bakas P, Liapis A, Giner M, Creatsas G. Acta Obstet Gynecol Scand. 2006;85:748-52.* Tension-free vaginal tape procedure as anti-incontinence surgery significantly improves the quality of life in female patients with urodynamic stress incontinence.

Cellular therapy of the urethral sphincter insufficiency. *Yiou R. Prog Urol. 2005;15(6 Suppl 1):1293.*

Remeex: a possible treatment option in selected cases of sphincter incompetence. *Campos-Fernandes JL, Timsit MO, Paparel P et al. Prog Urol. 2006;16:184-91.* The results with the adjustable tension suburethral tape in patients in whom artificial sphincter was contraindicated, are satisfactory at the price of acceptable morbidity. Before defining the place of this device in the range of treatment options for sphincter incompetence, our results must be confirmed by a longer series.

Botulinum-A toxin injections into the detrusor muscle decrease nerve growth factor bladder tissue levels in patients with neurogenic detrusor overactivity. *Giannantoni A, Di Stasi SM, Nardicchi V et al. J Urol. 2006;175:2341-4.* Botulin Toxin-A intravesical treatment induces a state of Nerve Growth Factor deprivation in bladder tissue that persists at least up to 3 months, the decrease in acetylcholine release at the presynaptic level inducing a decrease in detrusor contractility.

Failure of sacral nerve stimulation due to migration of tined lead. *Deng DY, Gulati M, Rutman M et al.J Urol. 2006;175:2182-5.* Stimulation of the sacral nerves is a commonly used treatment for frequency, urgency, urge incontinence, retention and other types of voiding dysfunction. Lead migration can occur and thus sacral radiographs should be routinely used. This complication can be easily resolved without significant morbidity to the patient.

Predictors of success for first stage neuromodulation: motor versus sensory response. *Cohen BL, Tunuguntla HS, Gousse A. J Urol. 2006;175:2178-80.* We investigated whether intraoperative motor or sensory response is more predictive of successful sacral neuromodulation using the InterStim system in 35 patients with medically refractory frequency, urgency and urge incontinence. A positive quadripolar test stimulation (greater than 50% improvement in symptoms) is more likely when intraoperative lead placement results in positive motor response vs only sensory response.

Increasing costs of urinary incontinence among female medicare beneficiaries. *Anger JT, Saigal CS, Madison R, Joyce G, Litwin MS. J Urol. 2006;176:247-51.* The financial burden of urinary incontinence in the United States among women 65 years old or older nearly doubled between 1992 and 1998 in nominal dollars, from $128 million to $234 million, primarily due to increases in physician office visits and ambulatory surgery. The costs of pads or medications are not included and, therefore, the true financial burden of incontinence on the aging community is underestimated.

The daytime alarm: a useful device for the treatment of children with daytime incontinence. *Van Laecke E, Wille S, Vande Walle J et al.J Urol. 2006;176:325-7.*

Prospective study evaluating efficacy and safety of Adjustable Continence Therapy (ProACT) for post radical prostatectomy urinary incontinence. *Trigo-Rocha F, Gomes CM, Pompeo ACet al. Urology. 2006;67:965-9.* The use of ProACT represents a safe and effective treatment for post radical prostatectomy incontinence with a good degree of patient satisfaction and a low complication rate. Postoperative adjustments were necessary in most patients and were undertaken as a simple outpatient visit.

Sacral spinal nerve stimulation for fecal incontinence: A viable therapeutic option for refractory incontinence. *Janec EM, Jonnalagadda S. Gastroenterology. 2005;129:388-9*

Recent impact of anal sphincter injury on overall Caesarean section incidence. *Mahony R, O'herlihy C. Aust N Z J Obstet Gynaecol. 2006;46:202-4.* Notwithstanding recent increased awareness and documentation, anal sphincter problems represent a small influence on total Caesarean incidence.

Is an anal plug useful in the treatment of fecal incontinence in children with spina bifida or anal atresia? *Van Winckel M, Van Biervliet S, Van Laecke E, Hoebeke . J Urol. 2006;176:342-4.* We evaluated the efficacy and tolerance of the Conveen(R) anal plug in children with spina bifida or anal atresia with persistent fecal incontinence necessitating diapers despite bowel management. The anal plug is not a universal solution, but may be an adjuvant treatment option enabling a minority to stop using diapers.

Repair Techniques for Obstetric Anal Sphincter Injuries: A Randomized Controlled Trial. *Fernando RJ, Sultan AH, Kettle C et al. Obstet Gynecol. 2006;107:1261-1268.* Primary overlap repair of the external anal sphincter is associated with a significantly lower incidence of fecal incontinence, urgency, and perineal pain. When symptoms do develop, they appear to remain unchanged or deteriorate in the end-to-end group but improve in the overlap group.

Fecal Incontinence in Females Older Than Aged 40 Years: Who is at Risk? *Varma MG, Brown JS, Creasman JM et al. Dis Colon Rectum. 2006;49:841-51.* In multivariate analysis, the prevalence of fecal incontinence in the past year increased significantly [odds ratio per 5 kg/m(2) (95 percent confidence interval)] with obesity, chronic obstructive pulmonary disease, irritable bowel syndrome, urinary incontinence, and colectomy.

Delayed urethral erosion after tension-free vaginal tape. *Powers K, Lazarou G, Greston WM. Int Urogynecol J Pelvic Floor Dysfunct. 2006;17:422-5.* Urethral erosions have been reported with various sling materials as early or late complications. The diagnosis is made on cystoscopy, and trans-vaginal mesh excision with layered urethral reconstruction is usually curative.

Outcomes following erosions of the artificial urinary sphincter. *Raj GV, Peterson AC, Webster GD. J Urol. 2006;175:2186-90.* Artificial urinary sphincter urethral cuff erosion occurs in up to 5.0% of cases, presenting a complex management problem. Patients with comorbidities including hypertension, coronary artery disease, prior radiation therapy and prior AUS revisions are more likely to have erosions. Nevertheless, continence can still be salvaged using various strategies which optimize use of the remaining healthy urethral tissue.

7 – PAIN

A new classification is needed for pelvic pain syndromes--are existing terminologies of spurious diagnostic authority bad for patients? *Abrams P, Baranowski A, Berger RE et al. J Urol. 2006;175:1989-90.*

Heat/burning sensation induced by topical application of capsaicin on perineal cutaneous area: new approach in diagnosis and treatment of chronic prostatitis/chronic pelvic pain syndrome? *Turini D, Beneforti P, Spinelli M et al. Urology. 2006;67:910-3.*

Distension of painful structures in the treatment for chronic pelvic pain in women. *Heyman J, Ohrvik J, Leppert J. Acta Obstet Gynecol Scand. 2006;85(5):599-603.*

A conceptual model for the pathophysiology of vulvar vestibulitis syndrome. *Zolnoum D, Hartmann K, Lamvu G et al. Obstet Gynecol Surv. 2006;61:395-401.* Research on the pathophysiology of vestibulitis suggests abnormalities in 3 interdependent systems: vestibular mucosa, pelvic floor muscles, and central nervous system pain regulatory pathways. To date, causes and relative contributions of these abnormalities to the development and maintenance of vestibulitis remain poorly understood. Research consistently supports the conceptualization of vestibulitis as a chronic pain disorder-akin to fibromyalgia, irritable bowel disorder, and temporomandibular disorder.

Repetitive rectal painful distention induces rectal hypersensitivity in patients with irritable bowel syndrome. *Nozu T, Kudaira M, Kitamori S, Uehara A. J Gastroenterol. 2006;41:217-22.*

8 – FISTULAE

Rectovaginal fistula after Posterior Intravaginal Slingplasty and polypropylene mesh augmented rectocele repair. *Hilger WS, Cornella JL. Int Urogynecol J Pelvic Floor Dysfunct. 2006;17:89-92.* Posterior Intravaginal Slingplasty and mesh augmented rectocele repairs are pro-

cedures promoted for correction of vaginal relaxation. More data regarding complications associated with use of these procedures is needed prior to widespread use.

Management of enterovaginal fistulae in a colorectal unit. *Kavanagh DO, Neary P, Dodd JD et al. Tech Coloproctol. 2006;10:63-4.*

Robotic repair of vesicovaginal fistula: case series of five patients. *Sundaram BM, Kalidasan G, Hemal AK. Urology. 2006;67:970-3.* Patients with posthysterectomy (n = 4) or postmyomectomy (n = 1) VVF, were first treated conservatively with continuous drainage using a Foley catheter without success. After 12 weeks, they underwent a successful robotic repair through the following steps: vaginoscopy, cystoscopy, bilateral ureteral catheterization, placement of ports for robotic repair, peritoneoscopy, lysis of adhesions, incision of the bladder and cystotomy in reverse tennis racquet fashion encircling the fistula, excision and freshening of the fistulous margins after complete separation of the bladder from the vagina, closure of the vaginal opening horizontally and bladder opening vertically with interrupted Vicryl sutures, and interposition of the omentum between these suture lines.

Successful management of vesicouterine fistula by luteinizing hormone-releasing hormone analog. *Yokoyama M, Arisawa C, Ando M. Int J Urol. 2006;13:457-9.* Vesicouterine fistula is a rare complication of cesarean section. Although surgical repair was mandatory for the management of the fistula previously, a recent review showed high efficacy of hormonal manipulation (luteinizing hormone-releasing hormone analog for 6 months) by the induction of amenorrhea.

Prognostic factors of recurrence after vesicovaginal fistula repair. *Ayed M, El Atat R, Hassine LB et al. Int J Urol. 2006;13:345-9.* Successful closure of a vesicovaginal fistula requires an accurate and a timely repair using procedures that exploit basic surgical principles. Multiple fistula, size and type of the fistula, and obstetrical etiology are the recurrence risk factors. In all patients with multiple risk factors for recurrence, the interposition of flaps is recommended.

Colovesical fistula complicating diverticular disease: one-stage resection. *Carvajal Balaguera J, Camunas Segovia J, Pena Gamarra L et al. Int Surg. 2006;91:17-23.* Colovesical fistula is the most common type (65%) of fistula associated with colonic diverticular disease. Primary resection of sigmoid colon with colorectal anastomosis performed as a one-stage procedure is its definitive treatment and can be performed safely--as simple closure, using an omental flap, or through resection and closure of bladder defect--in 90% of the patients. Diverting colostomy or Hartmann intervention is not recommended because of the lack of fistula definitive resolution and the possibility of additional complications.

Autologous fibroblasts transplant after infliximab administration: a new approach in Crohn's perianal fistulas. *Ascanelli S, de Tullio D, Gregorio C et al. Int J Colorectal Dis. 2006 May 30; e-pub.*

9 – BEHAVIOUR, PSYCHOLOGY, SEXOLOGY

Female sexual dysfunction: principles of diagnosis and therapy. *Pauls RN, Kleeman SD, Karram MM. Obstet Gynecol Surv. 2005; 60:196-205.* Female sexual dysfunction is a common health problem, affecting approximately 43% of women. Female sexual dysfunction is defined as disorders of libido, arousal, orgasm, and sexual pain that lead to personal distress or interpersonal difficulties. It is frequently multifactorial in etiology, with physiological and psychologic roots. Approaching female sexual dysfunction involves an open discussion with the patient, followed by a thorough physical examination and laboratory testing. Therapy consists of patient and partner education, behavior modification, and may include individualized pharmacotherapy.

Emotional stress reactivity in irritable bowel syndrome. *Bach DR, Erdmann G, Schmidtmann M, Monnikes H. Eur J Gastroenterol Hepatol. 2006;18:629-636.* This study, measuring reactivity to an emotional stressor in IBS, provides evidence that there is a specific alteration of physical and mental stress responses, but no overall exaggerated stress response. IBS patients showed a broader and less specific response to emotional stress than healthy controls. Rectal sensitivity was unchanged in patients and controls.

Features associated with laxative abuse in individuals with eating disorders. *Tozzi F, Thornton LM, Mitchell J et al. Psychosom Med. 2006;68:470-7.* Laxative abuse is common in patients with anorexia and bulimia nervosa and has been associated with general psychopathology. The function of this abuse may differ across individuals, alternatively serving as a method of purging and a form of self-harm.

To "lump" or to "split" the functional somatic syndromes: can infectious and emotional risk factors differentiate between the onset of chronic fatigue syndrome and irritable bowel syndrome? *Moss-Morris R, Spence M. Psychosom Med. 2006;68:463-9.* A prospective study on patients with an acute episode of gastroenteritis, measuring their levels of distress using the Hospital Anxiety and Depression scale, supports the argument to distinguish between postinfectious irritable bowel syndrome and chronic fatigue syndrome.

A brief measure for assessing generalized anxiety disorder: the GAD-7. *Spitzer RL, Kroenke K, Williams JB, Lowe B. Arch Intern Med. 2006;166:1092-7.* Generalized anxiety disorder is a common mental disorders without brief clinical measures for assessing it. A 7-item anxiety scale (GAD-7) is proposed as a valid and efficient tool for screening GAD assessing its severity.

Editorial: partner dyspareunia (hispareunia). *Brubaker L. Int Urogynecol J Pelvic Floor Dysfunct. 2006;17:311.*

Linguistic validation of the "Brief Index of Sexual Functioning for Women". *Baudelot-Berrogain N, Roquejoffre S, Game X et al. Prog Urol. 2006;16:174-83.* This questionnaire comprises 22 questions in 7 dimensions investigating all aspects of female sexuality: D1 (desire), D2 (arousal), D3 (frequency of sexual activity), D4 (receptiveness), 05 (pleasure, orgasm), D6 (relational satisfaction), D7 (problems affecting sexuality), Composite Score (CS).

Prediction of postoperative sexual function after nerve sparing radical retropubic prostatectomy. *Michl UH, Friedrich MG, Graefen M et al. J Urol. 2006 Jul;176:227-31.*

Erectile dysfunction as a predictor of the metabolic syndrome in aging men: results from the Massachusetts male aging study. *Kupelian V, Shabsigh R, Araujo AB et al. J Urol. 2006;176:222-6.*

10 – MISCELLANEOUS

Easyloop knot: a simple and safe extracorporeal knot. *Pattas M, Theodorou D, Lagoudianakis E et al. Am J Surg. 2006;191:821-2.* A new extracorporeal knot designed with an emphasis on simplicity and safety is described.

The probiotic approach: an alternative treatment option in urology. *Clayman R. J Urol. 2006;175:2136.*

Female genital mutilation and obstetric outcome. *Eke N, Nkanginieme KE. Lancet. 2006;367:1799-800.*

Sphincterolysis: A Novel Approach towards Chronic Anal Fissure. *Gupta PJ. Eur Surg Res. 2006;38:122-126.* The surgical approach in chronic anal fissure is often found associated with disturbed anal continence as well as recurrence. The fragmentation of the fibers of the internal sphincter on the left lateral anal wall is safe and effective.

Long-term results of "chemical sphincterotomy" for chronic anal fissure: a prospective study. *Lysy J, Israeli E, Levy S et al. Dis Colon Rectum. 2006;49:858-64.* Topical treatment (topical isosorbide dinitrate, 2.5 mg, or nifedipine, 0.2 percent t.i.d.) is effective for patients with chronic anal fissure, at short-term and long-term periods, but for many patients it is not a definitive treatment.