Recently we have been using ultrasonic examination of abdominal cavity for diagnostics of prevalence of adhesive process, which gave us the best results in comparison with others non-invasive methods (reliability about 64%). In the making, in 147 patients, the previous laparotomy was a relative contraindication for laparoscopic operations. The intraoperative analysis of prevalence of adhesions has allowed to establish, that in 81 patients (55,1%) of this group the safe laparoscopic intervention was possible with use of rational endosurgery approach.

Conclusions. Thus, the majority of patients with adhesions in abdominal cavity can have endoscopic operations. The most safe endosurgery approach in this case in our opinion will be the open laparoscopy.

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TAPE RELATED COMPLICATIONS OF MID-URETHRAL SLING PROCEDURES FOR FEMALE URINARY STRESS INCONTINENCE

Introduction. The mid-urethral sling procedures (MUS), like tension free vaginal tape (TVT) or transobturator tape (TOT) procedures are recent modalities for managing female urinary stress incontinence. They have been rapidly gaining popularity worldwide but little has been published to date on the nature and symptoms of associated complication

Material and methods. From April 1998 till now, about 300 patients underwent MUS procedure in our department. During the last five years twenty patients underwent, and three refused corrective surgery for complications resulting from the MUS, another two patient are only being observed. Their records were reviewed to retrieve data on presenting symptoms and signs, diagnostic tests, surgical procedures, and outcomes

Results. One patient had tape erosion into the bladder, six had vaginal tape erosion (one with concomitant urethral obstruction), and another eighteen had an obstructed urethra. The more common presenting symptoms were persistent urethral pain, recurrent urinary tract infection, urgency, urge incontinence, and vaginal discharge. Twenty patients required partial tape removal or tape incision which was carried out transvaginally in nineteen of them. One patient underwent cystotomy and excision of the intravesical part of an eroded tape. Two patients with asymptomatic vaginal erosion are only being observed. No formal urethrolysis was performed in any case. The mean follow-up after corrective surgery in 20 patients was 14.8 months (range 6-48) during which fifteen patients remain continent and symptom free.

Conclusions. Urologists and gynecologists should be aware of the nature and symptoms of tape-related complications associated with a MUS procedure for prompt diagnosis and appropriate postoperative treatment managemen.

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MANAGEMENT OF UROLOGIC TRAUMA AFTER GYNECOLOGIC AND OBSTETRIC PROCEDURES

Introduction. The anatomical proximity of the lower urinary tract to the female reproductive organs renders it vulnerable to injury during obstetric and gynecologic procedures. Overall, the reported incidence of iatrogenic injury is between 0,5% and 2% for gynecologic and pelvic operations; however, the true incidence is difficult to ascertain from the literature because most studies are retrospective and only review patients who have become symptomatic, requiring urological intervention. Herein we retrospectively report our experience of diagnosis and treatment of iatrogenic injuries of urethra, bladder and ureters in female.

Materials and methods. Between 1987 and 2005, 125 women with a mean age of 48 years (ranged 22 – 85) were included into this study, bladder injuries – 58 patients, ureteral – 52 (4 – bilateral), and urethral – 15. Hysterectomy was the most common antecedent surgical procedure (64%).

Results. Bladder: 15 of 58 injuries were diagnosed intraoperatively and sutured, 14 – managed conservatively by urethral catheter placement only, 12 – underwent re-laparotomy and bladder tear suturing, 17 – vesico-vaginal fistula repair.

Urethra: Seven of 15 injured urethra were sutured during primary surgery (one complication – urethra-vaginal fistula formation), 1 – treated by indwelling catheter placement. 2 patients underwent urethral dilation for stricture, and 5 – urethro-vaginal fistula repair.

Ureter: Seven of 56 ureteral injuries were diagnosed and repaired during the primary operation. 45 patients required additional surgery: uretero-ureteroanastomosis – 16, release of ureter – 7, neoureterocystoanastomosis – 16, psoas hitch ureteral reimplantation – 10. The definitive corrective surgery followed percutane-

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ous nephrostomy placement in 17 cases, transurethral orifice incision – 1, ureteral catheter or stent insertion – 4. 3 patients underwent nephrectomy for longstanding non-functioning kidney. Reconstructive ureteral surgery was successful in all cases.

Conclusions. 1. The key to successful management remains a high index of suspicion with early imaging and early re-intervention.

2. Open surgical technique give far better results than minimally invasive therapies.

3.Successful repair may be achieved in the vast majority of patients.

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