

a distance about 3 cm distal to the vesicovaginal fistula site. The bladder was then further mobilized in order to ensure good distance away from the vaginal opening as well. The vagina was then closed. The bladder was closed watertight in two layers. Attention was turned to the rectus flap harvesting. The robot was undocked and the robot boom was rotated so that we were operating towards the patient's right side. The fourth arm port became the camera port. Two additional robot ports were placed, one in the left lower quadrant and another one in the left upper quadrant as our working arms for dissection of the rectus flap. Rectus flap dissection was carried out under the guidance of a plastic surgeon (AR) using an intraperitoneal anterior sheath sparing technique. The right rectus muscle was mobilized to its lateral border in order to obtain maximum mobility, making sure to leave the inferior blood supply intact. It was transected superiorly near the right costal margin. The flap reached the pelvis easily and under no tension. The robot was undocked, rotated again and docked back into the pelvic configuration. The Flap was then interposed between the closed vagina and bladder, securing in with interrupted absorbable sutures. A 15 Fr Blake drain was left in place and a 20 Fr Foley catheter was left in place for 2 weeks

CONCLUSIONS: Robotic harvest and interposition of a rectus abdominus flap is a technically feasible and effective technique with minimal morbidity, and could prove quite useful for a variety of needs in pelvic reconstructive surgery. In the case described here, the patient had a successful outcome done in a minimally invasive approach.

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GENDER-AFFIRMING VAGINECTOMY AND COLPOCLEISIS

Helen Hougen, Kamran Sajadi, Portland, VA*

INTRODUCTION AND OBJECTIVES: In the United States, surgeons are performing increasing numbers of gender-affirming procedures for transgender patients. At our institution, trans men undergo multiple procedures doing their gender-affirming bottom surgery—vaginectomy and colpocleisis, urethral lengthening, scrotoplasty, and free-flap phalloplasty or metoidioplasty. We demonstrate the gender-affirming vaginectomy and colpocleisis in this video and its key differences from the procedure for pelvic organ prolapse.

METHODS: We present a 23-year-old transgender male undergoing gender-affirming phalloplasty, scrotoplasty, and urethral lengthening. Vaginectomy and colpocleisis are routinely performed as part of this operation. The patient has had previous hysterectomy and bilateral mastectomy. We begin the procedure excising the vaginal mucosa from the underlying muscularis and rectum posteriorly, the pelvic floor laterally, the pubocervical fascia anteriorly, and the vaginal cuff proximally. We preserve the labia minora and the anterior vaginal wall with a "U" incision for later urethral lengthening. Colpocleisis incorporates the prerectal fascia, pelvic floor, and pubocervical fascia from proximal to distal. Distally, the levators and bulbocavernosus muscles are incorporated to close the genital hiatus.

RESULTS: Due to the chronic testosterone exposure, we excise a thicker layer of vaginal mucosa since it tears easily. These patients are often younger and bleed more from testosterone exposure. The combination of testosterone and lack of prolapse makes the pelvic floor musculature more robust and prominent than in a colpocleisis for prolapse.

CONCLUSIONS: As transgender surgery becomes more common, surgeons with Female Pelvic Medicine and Reconstructive Surgery background may perform vaginectomy and colpocleisis in a younger population as part of their transgender surgery. Vaginectomy decreases the likelihood of retained mucocoele and may be safer than blind fulguration of the vagina, which is another common practice. This video demonstrates the key steps in this procedure as well as differences from a prolapse colpocleisis.

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THE NOVEL HYBRID TECHNIQUE OF PELVIC ORGAN PROLAPSE TREATMENT BASED ON APICAL SLING: 2 YEARS' FOLLOW-UP

Dmitry Shkarupa, Nikita Kubin, Ekaterina Shapovalova, Olga Staroseltseva, Anastasia Zaytseva, Saint-Petersburg, Russian Federation*

INTRODUCTION AND OBJECTIVES: The majority of patients with expressed anterior vaginal wall prolapse have associated defect in apical compartment, that predisposes simultaneous correction of the defects. A leading role of the apical support in the pathogenesis of pelvic organ prolapse point at the need of its durable restoration. Whereas a high rate of mesh-associated complications dictates the reducing of synthetic materials in pelvic reconstructive surgery. The objective of this study was to evaluate a mid-term effectiveness of the hybrid technique: bilateral sacrospinous fixation by monofilament polypropylene apical sling (UroSling-1, Lintex) in combination with the original technique of subfascial colporrhaphy (Holsted suture laid on the internal surface of vaginal fascia) in surgical treatment of POP with associated defects of the apical support and pubocervical fascia.

METHODS: This prospective study involved 148 women suffering from a combination of the apical prolapse with a prolapse of the anterior vaginal wall. Patients underwent hybrid reconstruction of the pelvic floor in accordance with the proposed method. To evaluate the results of surgical treatment, data of a vaginal examination (POP-Q), uroflowmetry, bladder ultrasound were used, determined before the surgery and at control examinations (1,6, 12, 24 months). Changes in quality of life were evaluated by comparing the scores according to PFDI-20, PFIQ-7, PISQ-12, ICIQ-SF questionnaires.

RESULTS: Of the 148 women operated, 126 remained at 24-months. Mean operation time was 32 11 minutes. There were no cases of intraoperative damage of the bladder or rectum, as well as clinically significant bleeding. The recurrence rate was 2.2% at 12 months (cystocele II-III stage in 3 patients), at 24 months two more cases were identified: 1-cystocele (II stage), 1-apical prolapse (II stage). The effectiveness of the surgery was 96.0% at 24 months. There were no statistically significant changes of Qmax or PVR in comparison to 12-month data. After 6 months of follow-up stress urinary incontinence de novo was noted in 4.7%, to a two-year follow-up, this number didn't increase. There were no cases of mesh erosions during 24 months of follow-up. Most of the patients reported a significant improvement in the quality of life after treatment.

CONCLUSIONS: The hybrid technique showed high mid-term results in treating patients with a combination of the apical prolapse with a prolapse of the anterior vaginal wall. It provides high functional results and improves quality of life.

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TOTAL AUTOLOGOUS FASCIA LATA ROBOTIC SACROCOLPOPEXY: A NEW TECHNIQUE

Christian Twiss, Frank Lin, Joel Funk, Tucson, AZ*

INTRODUCTION AND OBJECTIVES: The reclassification of vaginal mesh to a high risk device for treatment of pelvic organ prolapse has prompted many patients to desire only native tissue repairs. This poses a problem for robotic sacrocolpopexy which has historically utilized a synthetic or biologic foreign graft. Our objective was to develop a technique for robotic sacrocolpopexy using autologous fascia lata graft for patients desiring pelvic organ prolapse repair with only their own tissue.

METHODS: The video demonstrates our technique for Total Autologous Fascia Lata Robotic Sacrocolpopexy. Autologous fascia lata of suitable size (4 X 16 cm up to 5 X 18 cm) is harvested through a minimally invasive, 4 cm, lateral upper thigh incision. The graft is cut into