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IUGA GUIDELINES

IUGA guidelines for training in female pelvic medicine and reconstructive pelvic surgery (FPM-RPS)

Updated Guidelines 2010

H. P. Drutz · IUGA Education Committee

Introduction

The first International Urogynecological Association (IUGA) Educational Guidelines were published in 2002 [Drutz HP, Riss PA, Halaska M, Hanzal E, Khullar V, Koelbl H, Vervest H: Guidelines: IUGA Guidelines for Training in Urogynecology and Reconstructive Pelvic Surgery (U-RPS). IUGA Educational Committee. Int Urogynecol J (2002) 13: 386–395].

At the 32nd IUGA Annual Meeting, in Cancun, Mexico (June 2007), the Education Committee (Chair: E. Hanzal) asked Professors Drutz and Koelbl to form a subcommittee to revise and update the original guidelines. A review of the original guidelines was done by the Division of Urogynecology (Staff and Fellows), University of Toronto, Mount Sinai Hospital, Toronto. A Special Educational Workshop was held at the 33rd IUGA meeting in Taipei, Taiwan (September 2008). Invited presentations of the current status of Educational Guidelines in their individual countries were presented by doctors H. Drutz (Canada), J. Gebhart (USA), C. Benness (Australia), P. Toozs-Hobson (UK), E. Hanzal (Austria), and H. Vervest (The Netherlands). The Special Workshop was attended by Fellowship Program Directors, members of the IUGA Educational Committee and current trainees in existing postgraduate programs. All of their suggestions have been incorporated in this version.

In the opinion of the Educational Committee, the Guidelines represent a consensus of IUGA and provide standards of knowledge and skills in Urogynecology/Reconstructive Pelvic Surgery (U-RPS) and Female Pelvic Medicine/Reconstructive Pelvic Surgery (FPM-RPS) at the three levels. It is the obligation of national societies and licensing bodies to use the guidelines and adapt them to national and regional needs. The Education Committee recognizes that the practice of healthcare in women in general, and of female pelvic health varies widely throughout the world, and is dependent on cultural, socio-economic and professional circumstances. However, the Education Committee feels that there is a need for standards for training in U-RPS/FPM-RPS at all levels of medical education in order to ensure quality assurance purposes. Finally, the Committee recognizes the need for regular review of these guidelines, which is reported here.

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Guidelines for General Medical Training Programs in FPM-RPS

Background

It is recognized that FPM-RPS is an important part of general medical training in women's health. Every student and licensed physician should be familiar with the relevant aspects of urogynecology and should acquire the necessary knowledge and skills for his or her own practice. Therefore, all accredited medical training programs should provide access to meet these teaching objectives.

The International Urogynecological Association (IUGA), as the leading organization in this field, wishes to establish guidelines that will be universally acceptable to allow governing boards and licensing bodies on national levels to establish educational objectives. IUGA is aware that there are important regional differences in

the organization and structure of medical undergraduate training (university or medical school) and postgraduate training. By publishing universal guidelines, IUGA hopes to promote a high and global standard for the care of women with pelvic floor disorders, to enhance scientific knowledge, and to encourage international dialogue among all health-care providers involved with female pelvic healthcare.

Objectives for U-RPS/FPM-RPS in General Medical Training Programs (Medical School)

The following objectives are formulated for general medical training programs:

- To improve the quality of care of women with pelvic floor disorders.
- To improve knowledge, practice, teaching and research in female pelvic health.
- To promote knowledge and clinical skills relating to female pelvic health.

Definition

A student is a person attending university or medical school. In his or her training—leading usually to a degree of MD, MBBS (in UK), etc.—the student should acquire knowledge in urogynecology and reconstructive pelvic surgery. Postgraduate training provides theoretical and practical training necessary for a general practitioner. Since these two components of general medical training vary widely in different countries, they are considered together for the purpose of these guidelines.

General Requirements

Since medical school curricula and the specifics of general training programs vary widely, the present guidelines focus on knowledge and skills every physician with a license to practice medicine should have. It is the responsibility of local academic, professional and government institutions to incorporate the aims of these guidelines in program curricula.

Training Program and Guide to Learning

Theoretical Aspects

The following knowledge should be acquired:

- The urinary tract and pelvic floor
  - Embryology
  - Anatomy
  - Physiology
  - The urinary tract in pregnancy
- Lower urinary tract dysfunction
- History and physical examination
- Simple urodynamic evaluation
  - Urinary incontinence—general considerations
  - Urodynamic stress incontinence
  - Detrusor overactivity
  - Voiding abnormalities
  - Urinary tract infections
  - Urethral disorders
  - Intraoperative injuries
  - Urinary tract fistulae
  - Neoplasia
  - Psychological impact of genitourinary disorders
- brief overview of pain disorders as they relate to pelvic health
- Genital prolapse
  - Pathophysiology
  - Diagnosis
  - Treatment
- Anal incontinence and rectal prolapse
  - Pathophysiology
  - Diagnosis (general)
  - Treatment (general)

Clinical Expertise

On the basis of the learning objectives listed above, the physician must have clinical expertise and skills in the following areas (specific skills are listed in Appendixes 1.1 and 1.2).

Diagnostic Techniques The student must understand the indications for, the technique of, and the interpretation of results of diagnostic techniques used in the differential diagnosis of urinary incontinence, pelvic floor and anorectal disorders.

Clinical Skills Objectives The student should have acquired a high degree of clinical competence and skills to be able to understand pelvic floor disorders, to counsel patients, to make basic management decisions, and appropriately refer for specialized care.

Community Care The student will understand and interact with the role of the community nurse in the detection and management of urinary and fecal incontinence and other pelvic floor disorders in the community. A knowledge of health care economics and resource availability within the community together with the provision of facilities must be obtained.

Appendix 1.1: Knowledge and Understanding

- Differential diagnosis of incontinence
- Normal and pathologic micturition
- Pelvic floor and urinary tract anatomy
- Principles of proctology
- Principles and interpretation of simple cystometry, multichannel urodynamics
- Fistulas
- Effect of pelvic tumors on the urinary tract
- Anatomy and physiology of fecal incontinence
- Operations for incontinence and pelvic floor relaxation
- Postoperative care after surgery for incontinence and prolapse

Appendix 1.2: Skills

- Detailed history
- Urinalysis
- Clinical examination including evaluation of pelvic floor function
- Understanding
  - Cystoscopy
  - Evaluation of the upper urinary tract (ultrasound, X-ray, CT scan)
  - Single channel cystometry
  - Clinical stress test
  - Fitting and management of pessaries

Guidelines for Residency Training (RT) Programs and Educational Objective for RT in U-RPS/FPM-RPS

Scope of these Guidelines

The guidelines in this paper provide standards for Ob/Gyn RT programs. However, these requirements may differ between countries, depending on national laws and regulations. Each national organization or association in U-RPS/FPM-RPS, government, or licensing body, may adjust these requirements to their national situation or law.

Objectives for U-RPS/FPM-RPS in RT Programs

The following objectives are formulated for Ob/Gyn RT in U-RPS/FPM-RPS.

- To improve the quality of care of women with pelvic floor disorders.
- To improve knowledge, practice, teaching and research in female pelvic health.
- To promote specialized expertise, special facilities and clinical material that will be of considerable benefit to patients with female pelvic disorders and hence improve the quality of their care.
- To encourage coordinated management of relevant clinical services throughout a region.

Definition

Obstetricians/gynecologists trained according to IUGA guidelines will have a detailed knowledge of the anatomy and physiology of the pelvis, the contained viscera and the pathological processes affecting their function. They will have defined skills and knowledge in the investigation and treatment of disorders of lower urinary tract function, pelvic floor disorders and other benign pelvic conditions in women. They should be in a position to perform basic examinations and to direct conservative treatment in patients with urinary incontinence and pelvic floor disorders and should know when to refer women with complicated urinary and pelvic floor problems to a FPM-RPS subspecialist.

Requirements for Trainees

In order to start education within an Ob/Gyn U-RPS/FPM-RPS RT program, the following requirements are mandatory:

- Trainees should be qualified physicians.
- The minimum requirements for entry into a RT program in obstetrics/gynecology is dependent on national laws and regulations.

Length of Training and Registration

The length and scope of specialty training is dependent on national laws and regulations. It is strongly encouraged that a formal training period is dedicated to FPM-RPS training. In order to qualify as a specialist in OB/GYN, the trainee should meet skills in FPM-RPS as outlined in these objectives.

Requirements for RT Programs

Special Requirements An accredited RT program in OB/GYN should have access to a service for the referral and transfer of patients with urogynecological problems, with close collaboration with other gynecologists, family physicians, urologists, geriatrists, colorectal surgeons, or other primary care providers, within and outside the center; and

have access to a urodynamic laboratory including cystometry, urethral function tests, uroflowmetry, ambulatory equipment, cystourethroscopy, ultrasound, and video-urodynamics.

General Requirements In addition to these special requirements, the following general requirements must be met:

- have established close collaboration with other obstetricians and gynecologists within and outside the center, including major regional roles in continuing education and training, research advice and coordination, and audit;
- have a program director who will coordinate the training program, accept the main responsibility for its supervision and be actively involved in it; when more than one center provides the program, there must be a supervisor at each center, with one having overall responsibility as director; have adequate medical staff to enable the trainee to be engaged in his/her field on a full-time basis (or in the case of a part-time trainee, during all of his/her normal working hours); participation in emergency and on-call work outside normal working hours is not excluded; and
- have adequate library, laboratory and other resources to support training.

Training Program and Guide to Learning: Theoretical Aspects

The following knowledge should be acquired:

- The urinary tract and pelvic floor
  - Embryology
  - Anatomy
  - Physiology
  - The urinary tract in pregnancy
- Lower urinary tract dysfunction
  - History and physical examination
  - Urodynamic evaluation
  - Urinary incontinence—general considerations
  - Urodynamic stress incontinence
  - Detrusor overactivity
  - Voiding abnormalities
  - Urinary tract infections
  - Urethral disorders
  - Intraoperative injuries
  - Urinary tract fistulae
  - Neoplasia
  - Psychological impact of genitourinary disorders
- Pelvic pain disorders (IC/PBS)
- Genital prolapse
  - Pathophysiology
  - Diagnosis
  - Treatment
- Anal incontinence and rectal prolapse
  - Pathophysiology
  - Diagnosis
  - Treatment

Clinical Expertise

On the basis of the learning objectives listed above the resident must develop clinical expertise and skills in the following areas (specific skills are listed in Appendixes 2.1 and 2.2):

Diagnostic Techniques The trainee must understand the indications for, the technique of, and the interpretation of results the items listed in Appendix 2.2.

Clinical Skills Objectives The trainee should have acquired a high degree of clinical competence and skills to be able to make a clinical diagnosis, plan appropriate management and treat women with the clinical problems listed above.

Medical Therapy and Surgical Skills The trainee must be fully conversant with the indications for, techniques of and complications surrounding the items listed in Appendix 2.2.

Community Care The obstetrician/gynecologist will understand and interact with the role of the community nurse, community advisor and general practitioner in the detection and management of urinary and fecal incontinence and other pelvic floor disorders. A knowledge of health care economics and resource availability within the community, together with the provision of facilities such as caregivers' bedside commodes, enuresis alarms, and laundry services, must be understood.

It is to be recognized that specific skills necessary for the practice of urogynecology will vary in different parts of the world. The Education Committee of IUGA acknowledges these regional differences and encourages regional boards to develop detailed guidelines tailored to the needs of the population served.

Appendix 2.1: Knowledge and Understanding

- Principles and interpretation of multichannel urodynamics

- Differential diagnosis of incontinence
- Normal and pathologic micturition
- Fistulas
- Effect of pelvic tumors on the urinary tract
- Pelvic floor and urinary tract anatomy
- Anatomy and physiology of anal incontinence and rectal prolapse
- Operations for incontinence and pelvic floor relaxation
- Postoperative care after surgery for incontinence and prolapse
- Evaluation and management of anorectal disorders

Appendix 2.2: Skills

Mandatory

- Detailed history
- Urinalysis
- Clinical examination including evaluation of pelvic floor function
- Clinical stress test
- Fitting of pessaries
- Management of pessaries

Encouraged

- Cystoscopy
- Evaluation of the upper urinary tract (ultrasound, X-ray, CT scan)
- Basic urodynamics

Guidelines for Postgraduate Training Programs and Educational Objectives for Subspecialty Training in FPM-RPS

Background

In order to improve the care given to women with disorders of the pelvic floor, to enhance medical knowledge and to enhance scientific research, several Boards and Colleges around the world have established guidelines for subspecialization in Urogynecology/ FPM-RPS.

Guidelines for subspecialization in Urogynecology and Reconstructive Pelvic Surgery of the following Boards and Colleges were used in this paper: Royal College of Obstetricians and Gynaecologists (RCOG), German Society of Urogynecology, Society of Obstetricians and Gynaecologists of Canada (SOGC), American Board of Obstetrics and Gynecology (ABOG), Royal Australian College of Obstetricians and Gynaecologists (RANZCOG), European Urogynecological Association (EUGA)

The joint proposal for General and Special Requirements for the new subspecialty of Female Pelvic Medicine and Reconstructive Pelvic Surgery from the American Board of Obstetrics and Gynecology and American Board of Urology have also been incorporated.

Scope of These Requirements

The requirements in this document provide optimal standards for subspecialization. However, these requirements may differ between countries, depending on national laws and regulations. Each national organization or association in U-RPS and/ or FPM-RPS, government or licensing body, may adjust these requirements to their national situation or law.

These guidelines will be updated or revised on a regular basis.

Objectives for Subspecialization

The following objectives are formulated for subspecialization in U-RPS/ FPM-RPS.

- To improve the quality of care of women with pelvic floor disorders.
- To improve knowledge, practice, teaching and research in female pelvic health.
- To promote the concentration of specialized expertise, special facilities and clinical material that will be of considerable benefit to patients with female pelvic disorders and hence improve the quality of their care.
- To establish a close understanding and working relationship with other disciplines involved in the field of U-RPS/FPM-RPS.
- To encourage coordinated management of relevant clinical services throughout a region.
- To accept a major regional responsibility for higher training, research and audit in the subspecialty fields.
- Fellowship recognized programs should be expected to promote evidence-based medicine prior to the widespread clinical application of industry-driven new technology.

These objectives may vary from country to country.

Definition

Subspecialists in U-RPS/FPM-RPS are defined as surgical clinicians, either obstetricians/gynecologists or urologists, who, by virtue of education and training, are prepared to provide consultation and comprehensive management of women with complex benign pelvic

conditions, lower urinary tract disorders, and pelvic floor dysfunction*.

Comprehensive management includes those diagnostic and therapeutic procedures necessary for the total care of the patient with these conditions and complications resulting from them.

Subspecialists in U-RPS/FPM-RPS will have a detailed knowledge of the anatomy and physiology of the pelvis, the contained viscera and the pathological processes affecting their function. They will have clinical competence in the investigation and treatment of the disorders of function of the lower urinary tract in women, pelvic floor and anorectal function. They should be in a position to establish and maintain a U-RPS/FPM-RPS unit and should provide a referral service for women with complicated urinary and pelvic floor problems. They should be active in research and teaching and concerned with the management of women with intractable urinary and/or fecal incontinence, and persistent pelvic floor dysfunction.

Requirements for Trainees

In order to start subspecialization in U-RPS/FPM-RPS the following requirements are mandatory:

- Trainees should be qualified physicians, certified by their national Board as having successfully completed general residency training in obstetrics and gynecology or urology.
- The minimum requirements for entry into the clinical subspecialty of U-RPS/FPM-RPS are dependent on national laws and regulations.
- The minimal requirement may vary from country to country.
- The minimum requirements for recognition as a subspecialist in U-RPS/FPM-RPS are dependent on national laws and regulations, which may include board examination and certification.
- In order to register as a subspecialist in U-RPS/FPM-RPS, the trainee should be able to demonstrate his or her skills by means of a list of performed diagnostic and therapeutic procedures, scientific publications and have the approval of the director of the training program to be recognized as subspecialist.

Length of Training and Registration as Subspecialist in U-RPS/FPM-RPS

The length of subspecialist training is dependent on national laws and regulations. It is encouraged that this period include at least 2 years of clinical training and should include scientific research leading to peer-reviewed publication.

Requirements for Training Centers in U-RPS/FPM-RPS

To be eligible for providing subspecialty training in U-RPS/FPM-RPS a center must adhere to the following special and general requirements.

Special Requirements

- provide a service for the referral and transfer of patients with urogynecological problems, with close collaboration with other gynecologists, family physicians, urologists, geriatrists, colorectal surgeons, physiotherapists or other primary care providers, within and outside the center;
- have an sufficient clinical workload. The center should see a wide range of urogynecological problems;
- have a well equipped urodynamic laboratory which included cystometry, urethral function tests, and cystourethroscopy;
- there must be easy access to neurophysiological testing equipment, ultrasound, video-urodynamics and anorectal function studies;
- have close collaboration, including cross-referral of patients, with a consultant urologist, a consultant for medicine of the elderly, a colorectal surgeon, a neurologist, a continence nurse advisor, and an appropriately trained physiotherapist, all with definite commitments to the management of urogynecological, pelvic floor, sexual problems and pelvic pain, and
- have an active clinical research program in urogynecology for the trainee to access.

General Requirements In addition to these special requirements, the following general requirements must be met:

- have established close collaboration with other obstetricians and gynecologists within and outside the center, including major regional roles in continuing postgraduate education and training, research advice and coordination, and audit;
- have a program director who will coordinate the training program, accept the main responsibility for its supervision and be actively involved in it; when more than one center participates the program, there must be a supervisor at each center, with one having overall responsibility as director. Directors and supervisors will be consultants with special experience in U-RPS/FPM-RPS, and with the eventual development of subspecialization the directors and supervisors will themselves be trained and accredited subspecialists;
- have adequate medical staffing to enable the trainee to be engaged in his/her subspecialty field on a full-

*In the UK, you can only be a subspecialist if (a) you have undertaken a subspecialty training program and (b) you spend >50% of your working week in this area. Subspecialty trained refers to someone who has undergone a subspecialty training program.

time basis (or in the case of a part-time trainee, during all of his/her normal working hours); participation in emergency and on-call work outside normal working hours is not excluded, subject to approval by the National Subspecialty Committee (applications for approval of training program should include an outline of the on-call commitments etc., but all trainees must have suitable experience of emergency and on-call work relevant to their subspecialty; and
- have adequate library, laboratory and other resources to support subspecialty work, training and research.

Certification

Certification of training centers in U-RPS/FPM-RPS is carried out by the national government or the national licensing body, dependant of the national regulations or law. It is encouraged that approved programs be reviewed periodically, but not less frequently than every 5 years.

Training Program and Guide to Learning

Theoretical Aspects The following advanced knowledge and skills should be acquired:

- Anatomy and embryology
  - the bony pelvis
  - all pelvic viscera
  - the pelvic floor and endopelvic fascia
  - the development of the urogenital system including congenital malformations
- Physiology
  - A detailed knowledge of the physiology of the urinary tract, lower gastrointestinal tract, pelvic floor and genital viscera.
- Pharmacology
  - the principles of pharmacology
  - the pharmacology of chemical substances which act upon the pelvic organs
- Pathophysiology
  - The effects of pregnancy, parturition, menopause and ageing upon the pelvis and its organs. The effects of disease, both mental and physical upon the pelvic organs. The effects of surgery, trauma, and radiotherapy upon the pelvic organs.

Clinical Expertise

Diagnostic Techniques The trainee must understand the indications for, the technique of, and the interpretation of results the items listed in Appendix 3.1.

Clinical Skills Objectives The trainee should have acquired a high degree of clinical competence and skills to be able to make a clinical diagnosis, plan appropriate management and treat women with the clinical problems listed in Appendix 3.2.

Medical Therapy and Surgical Skills The trainee must be fully conversant with the indications for, techniques of and complications surrounding the items listed in Appendix 3.3. In order to obtain these skills a modular attachment to other departments, including colorectal surgery and care of the elderly, in the same or another hospital are to be encouraged. A modular attachment to Urology must occur. The details of these modular attachments will vary depending upon national or local circumstances.

Community Care The U-PRS/FPM-RPS subspecialist will understand and interact with the role of the community nurse, community advisor and general practitioner in the detection and management of urinary and fecal incontinence and other pelvic floor disorders in the community. A knowledge of health care economics and resource availability within the community, together with the provision of facilities such as caregivers' bedsite commodes, enuresis alarms, and laundry services, must be understood.

Other Related Skills and Expertise

Epidemiology and Research The trainee should be familiar with the basics of epidemiology and statistics in order to interpret scientific literature and in order to design research trials that will encourage evidence based medicine.

Scientific Meetings The trainee should have the opportunity to attend and present their own research at appropriate scientific meetings of the training center and at national and international meetings. Trainees should be encouraged to attend, with attendance faciliated, the annual meetings of the IUGA, the International Continence Society, and other relevant societies.

Teaching The trainees should gain experience in teaching which will include:

- some responsibility for teaching medical students, interns, core residents, junior staff, general practitioners, nursing staff and midwives in their subspecialty area;

- full participation in the unit's postgraduate program with some administrative responsibility for organization of teaching in their subspecialty, to include scheduled teaching rounds and journal clubs;
- participation in the undergraduate teaching program; and
- gain experience of appraisal and assessment techniques.

Ethical and Legal Aspects The trainee should be able to discuss the ethical and legal aspects of the clinical practice of this subspecialty within the scope of their national law and regulations.

Administration The trainee should be given some administrative experience and responsibility which will allow the development of skills relevant to the future provision and organization of clinical services. Types of relevant knowledge and experience are listed below:

- attendance at a management course;
- an understanding of health service organization and administrative and advisory structures;
- an understanding of the mechanisms of health care purchasing, provision of care, resource allocation and contractual issues relevant to the clinical service;
- be cognizant of the need for regional referral systems and role of tertiary service in health care provision;
- the system for managing hospital complaints; and
- know how to review a service and formulate a business plan.

Training Assessment It is recommended that trainees keep record of their training in a Training Assessment Record Book. It is furthermore recommended that periodically (i.e. every 6 months) the training is being evaluated by the supervisor or the program director.

Certification Designation and certification of the training program is carried out by the national government or the national licensing body, dependant of the national regulations or law. These international guidelines are designed to assist the individual national groups (or bodies).

Appendix 3.1: Diagnostic Techniques

- Subjective assessment including detailed history and quality of life (QoL) measurement(s).
- Clinical assessment of the patient including the pelvic organs, a prolapse grading system, pelvic floor tone and strength, an appropriate neurological examination, and a mobility—mental state assessment.
- Determination of residual urine
- Urinalysis and cytology of urine and the microbiology of the urogenital tract.
- Frequency—volume charts.
- Quantification of urine loss by pad or ambulatory studies.
- Uroflowmetry (simple and pressure/flow/EMG)
- Cystometry—filling and voiding phases (simple and subtracted)
- Ambulatory cystometry
- Urethral function tests including urethral pressure profilometry, electrical conductance test, Q tip, and leak point pressures
- Perineometry
- Anal sensation and manometry.
- Imaging techniques ultrasound (transabdominal including upper tracts, transvaginal, perineal, introital, endoanal, intraurethral and 3D intraurethral) radiological (micturating cystogram, IVU, video cystourethroscopy, pelvic barium studies (defecography), image intensification, urethrogram, MRI, CT)
- nuclear medicine—isotope bowel transit studies
- Cystourethroscopy including biopsy
- Electrophysiological studies
- Electromyography including Pudendal Terminal Motor Nerve Latency (PTMNL) testing.
- Nerve conductance studies

Appendix 3.2: Clinical Knowledge Objectives

- Urinary incontinence due to stress incontinence, detrusor overactivity (neurogenic and idiopathic), mixed incontinence, trauma and congenital abnormalities
- Voiding disorders and urinary retention
- Urinary frequency and urgency
- Pelvic pain
- Vulvar disorders
- Lower urinary tract and lower gastrointestinal tract fistulas
- Genital tract prolapse, both primary and recurrent
- Chronic inflammatory conditions of the lower urinary tract
- Sensory disorders of the lower urinary tract
- Urethral lesions, e.g., diverticula
- Effects of pelvic surgery and irradiation on the lower bowel, urinary tract and pelvic floor
- Urinary disorders in pregnancy
- Evaluation and care of pelvic floor problems in the elderly
- Lesions of the central nervous system affecting urinary, fecal control and pelvic floor

- Defecation disorders
- Disorders of lower gastrointestinal tract function including incontinence and motility
- Urinary disorders in childhood
- Pelvic floor problems in the physically or mentally handicapped
- Sexually transmitted diseases
- Emotional and behavioral disorders' effects on pelvic floor problems
- Hormone deficiency states
- Urinary problems secondary to medical disorders and drugs
- Sexual problems related to U-RPS/FPM-RPS

Appendix 3.3: Medical Therapy and Surgical Skills

The trainee should receive experience in the theory, practice, and performance of procedures listed below. Trainees are not expected to gain expertise in all these techniques, but should achieve proficiency in commonly used procedures.

Management options

- Catheterization (urethral, suprapubic and clean intermittent self catheterization)
- Devices (mechanical and electronic)
- Aids, appliances, pants and pads

Nonsurgical treatment

- Urinary and GI tract disorders including incontinence
- Physiotherapeutic techniques and aids including biofeedback
- Electrical stimulation/ modulation therapy
- Behavioral therapy including bladder and bowel retraining and acupuncture
- Role of pharmacologic agents to treat pelvic floor disorders
- Role of hormonal therapy
- Role of bulking agents (for urinary and fecal incontinence)
- Role of intravesical botulinum toxin.
- Role of stem cells.

Pessary fitting and management

Surgical Procedures

- Urethral dilatation
- Urethrotomy
- Suprapubic cystotomy
- Bladder neck buttress and plication
- Minimally invasive slings
- Vaginal repair of genital tract prolapse including anterior colporrhaphy, posterior colpoperineorrhaphy, vaginal hysterectomy and repair, enterocele repair, Manchester repair, sacrospinous fixation, iliococcygeous fixation, uterosacral fixation, paravaginal repairs
- Mesh use in repairs, use of various graft materials
- Le Fort procedure/colpocleisis
- Abdominal repair of primary and recurrent prolapse including sacrocolpopexy, rectopexy, uterosacral ligament plication, sacrohysteropexy, Moscowitz and Halban procedure, colposuspension, and similar suprapubic suspension operations (both open and through minimal invasive techniques)
- Laparoscopically assisted vaginal hysterectomy (LAVH) and supracervical hysterectomy (LSH)
- Total and subtotal laparoscopic hysterectomy (TLH, sTLH)
- Sling procedures—retropubic, pubo-vaginal, mid-urethral and transobturator
- Para- and transurethral injection procedures
- Vaginal plastic surgery
- Implantation of artificial urinary sphincter
- Repair of vesico-vaginal, uretero-vaginal, urethrovaginal, and recto-vaginal fistulas
- Martius graft technique and gracilis muscle technique
- Augmentation cystoplasty
- Urinary diversion and undiversion
- Urethral diverticulectomy and excision of paraurethral cysts
- Urethral reconstruction
- Urethral closure techniques
- Rectal mucosal prolapse surgery (abdominal Ripstein procedure, and rectal approach)
- Anal sphincter repair—primary and secondary
- Artificial anal sphincter
- Sacral nerve stimulation and implantation
- Dynamic graciloplasty
- Recognition and treatment of intraoperative bladder and bowel injuries.
- Robotic surgery
- Operative urethrocystoscopy (removal of mesh/sutures)

The Final Draft of these Guideline Proposals was distributed to international and national societies, organizations, and governing boards in Obstetrics and Gynecology and other related specialties for their input and suggestions within a specified timeframe.

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