REPORT ON INTERNATIONAL UROGYNECOLOGICAL ASSOCIATION OBSERVERSHIP

Name: Sharon Ayore

Dates of observership: 22nd April to 20th May 2025

Host Site: Monash Health, Melbourne, Australia

Host Name: Professor Anna Rosamilia

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Introduction

Urogynecology is a budding sub-speciality in Kenya with only few specialists who are mostly concentrated in the capital city. Having worked as a gynecologist in the rural set up and faced with challenges in management of patients with pelvic floor disorders, the International Urogynecological Association (IUGA) Linda Cardozo observership grant afforded me a great learning opportunity.

Observership educational experience and skill acquisition

My aim during the observership was to gain knowledge on the current practices in management of urogynecological conditions including pelvic organ prolapse, urinary incontinence, and other areas like chronic bladder pain, and to get a glimpse of the new developments and research areas. I also aimed to gain practical surgical tips that I could apply back at home.

I had the opportunity to do my observership at Monash Health, Australia under my host, Professor Anna Rosamilia, who allowed me to additionally accompany her to the Cabrini Hospital, Malvern and Waverly Private Hospital in Melbourne, and to join the other unit members, Dr. Wong, Dr. Lin Li Ow, Dr. Fay, Dr. Narthania, Dr. Nisha and Dr. Mugdha. I interacted with Dr. Sascha and the fellows, Dr. Sally and Dr. Shakespeare who were very resourceful.

This is a summary of my weekly schedule during the 4 week period:

- Monday: Cabrini Hospital Malvern, theatre
- Tuesday: Morning Clinic at Monash Moorabin, Urogynecology Unit meeting to discuss the theatre list for the week, followed by an afternoon theatre session
- Wednesday: Cabrini Hospital, Malvern theatre / Monash Health Moorabin urodynamic clinic/transperineal ultrasound clinic
- Thursday: Waverly Private Hospital theatre/ Monash Health, Moorabin
- Friday: Monash Health, Dandenong Clinic and theatre

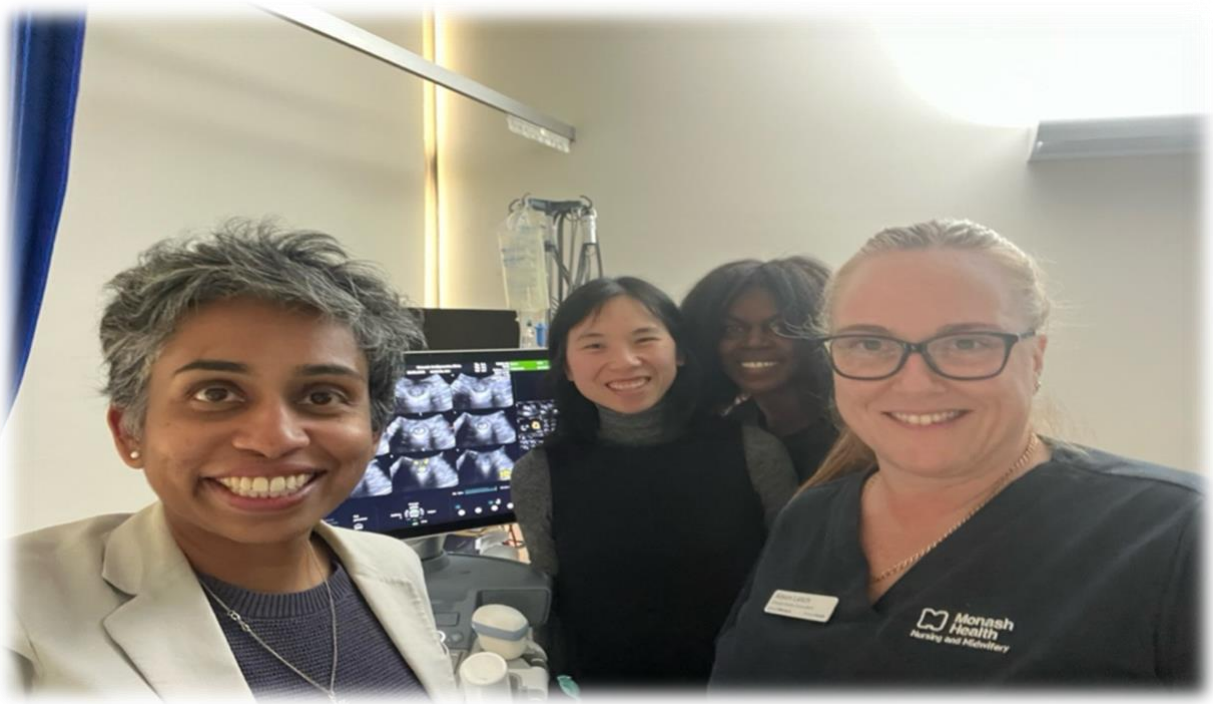
Professor Anna Rosamilia (left); Dr Ayore (centre); Dr. Sascha(right) after robotic surgery performed at Cabrini Hospital, Malvern.

I appreciated the use of standardized patient symptom assessment tools for pelvic floor dysfunction. I learnt a lot from the specialist nurses, Alison and Christine at Monash, especially during the urodynamics sessions. These sessions, typically lasting about 30 minutes per patient, comprised free uroflowmetry, filling cystometry and pressure flow studies, and provided an objective assessment of urinary incontinence.

Dr. Nisha demonstrated a standardised reproducible protocol for performing dynamic transperineal ultrasound in the assessment of the three pelvic floor compartments. I appreciated the objective assessment of pelvic organ prolapse, levator ani integrity, anal sphincter integrity and the evaluation of mid urethral slings. Women who had suffered perineal tears were evaluated objectively sonographically to assess degree of anal sphincter injury to guide mode of subsequent delivery and further management.

Depending on the management plans, patients who qualified for surgery were given IUGA leaflets with detailed description of the surgical options which spelt out the details of the

procedure, success rates , pros and cons of each, possible complications and preparations needed before surgery and the recovery process.



Dr. Nisha (left), Dr. Sally(second left) , Dr. Ayore (second, right), specialist nurse Alison (right) after a urodynamic and transperineal ultrasound clinic session at Monash Moorabin

I learnt the various algorithims used in management of pelvic floor disorders. For urge incontinence,I appreciated conservative management (medical i.e anticholinergics, adrenergic agonists like mirabegron; lifestyle modifications which included limiting intake of bladder irritants, and bladder training), botox detrusor injections , and tibial nerve stimulation which was performed as an outpatient procedure by specialist nurse, Alison. This was done weekly over a 12 week period before re-assessment for symptom improvement. It was a well tolerated procedure lasting about 30 minutes per patient.

For stress urinary incontinence, I appreciated conservative management (using pelvic floor exercises and pessaries) and invasive methods like urethral bulking agents cystoscopically, and surgical methods like Burch colposuspension, autologous fascial sling procedures and allografts for patients who desired non-synthetic methods. Synthetic slings(Tension free Vaginal Tape- Retropubic) which are less invasive, as involved no fascial harvesting with an easier recovery process, were also used. The principle of tension free urethral support to avoid over correction and subsequent voiding dysfunction could not be overemphasized. I

learnt that the obturator approach ceased being used due to groin pain and that the mesh used artificially is different from that which is used in general surgery as they are lightweight polypropylene to improve tissue integration, with some being titanium-coated (Ti- mesh) to improve biocompatibility. I learnt that burch colposuspension, despite being less effective than sling procedures, avoided the use of mesh slings in patients who did not desire this. I got to learn principles of revision surgery including the two-week window period.

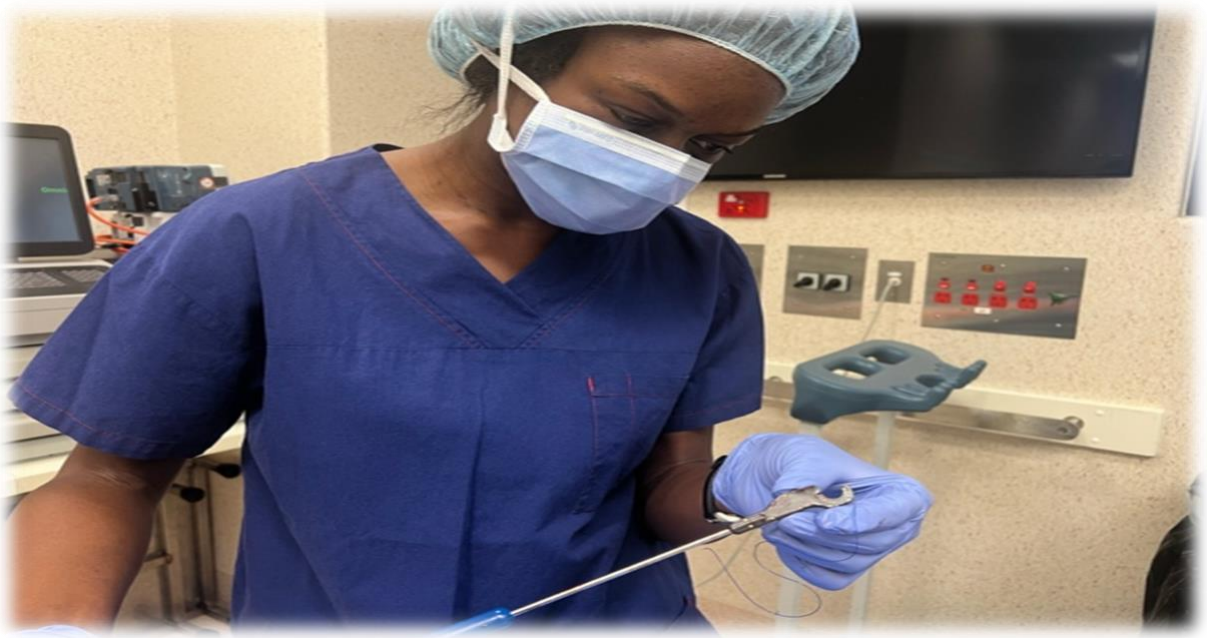
I got an insight into the management strategies for recurrent urinary tract infections and bladder pain syndrome. This included bladder irrigation procedure using clorpactin solution and detrusor botox injections cystoscopically. I appreciated medical prevention of urinary tract infections using Hiprex (methenamine hippurate) and ovestin (Estriol).

I also appreciated various management options for pelvic organ prolapse(POP). These included conservative management by physiotherapy and vaginal pessaries: gellhorn pessaries for more severe degrees of prolapse, and ring pessaries for less severe degrees. I witnessed both patient centered and physician aided pessary care, especially for the gellhorn pessary, which would be scheduled every 3 to 6 months. I appreciated that a patient may require trial of different sizings to get the best type and fit for a pessary and the importance of concomitant use of vaginal estrogen cream to reduce risk of atrophy and ulceration during the pessary use.

Surgical options for POP that I observed include the manchester procedure, sacrohysteropexy(both laparascopic and robotic), vaginal sacrospinous ligament fixation and high uterosacral ligament suspension, with anterior and posterior repair (colporrhaphy) when necessary. Observing the same procedures performed robotically at the Cabrini Hospital made me appreciate the improved 3D view and ease of surgical dexterity with the robot. We discussed the posterior approach of sacrospinous ligament fixation being more feasible in a set up without cystoscopy availability, compared to the anterior approach in which ureteric compromise was possible. I was challenged to look into the feasibility of incorporating high uterosacral ligament suspension into practice compared to the common practice of McCall's culdoplasty, which was of limited value in severe prolapse. I also had the opportunity to observe a modified technique, which was still under research, of performing the laparascopic mesh sacrocolpopexy by Dr. Yik Lim from the Mercy Hospital in Melbourne, which involved a vaginal component to the vesicovaginal space dissection. Multidisciplinary management of patients in a single set up was a smooth practice and I got to observe mesh sacrohysteropexy and rectopexy performed during one session with a colorectal surgeon present. I appreciated the importance of mesh non-exposure during this surgery. For all procedures, cystoscopy to ensure urethral integrity was performed and I learnt a few tricks like the use of aramine to hasten the ureteric jet.

I also observed non- uterine sparing management with vaginal hysterectomy in combination with high uterosacral ligament suspension or sacrospinous ligament fixation. I learnt how to

use the capio suture capturing device and discussed alternative more sustainable methods in resource limited settings, like the use of the cheaper aneurysm needle.



Ayore practising how to use the Capio suture capturing device after a sacrospinous ligament fixation procedure

I also observed vaginal hysterectomy and vaginal natural orifice transluminal endoscopic surgery (vNOTES) and appreciated the better visualization of the surgical field during salpingo-oophorectomy and uterosacral ligament suspension with vNOTES.

Areas of research

I had the opportunity to get insight into the ongoing research at Monash health including comparison of vaginal uterosacral suspension and laparascopic uterosacral suspension (on going VULU study); laser study for pelvic floor dysfunction, studies on fascia lata and rectus fascia used in native tissue surgery among many others. I also got a glimpse of the controversies around the use of vaginal meshes and ceasation of their use in this setting.

Career impact

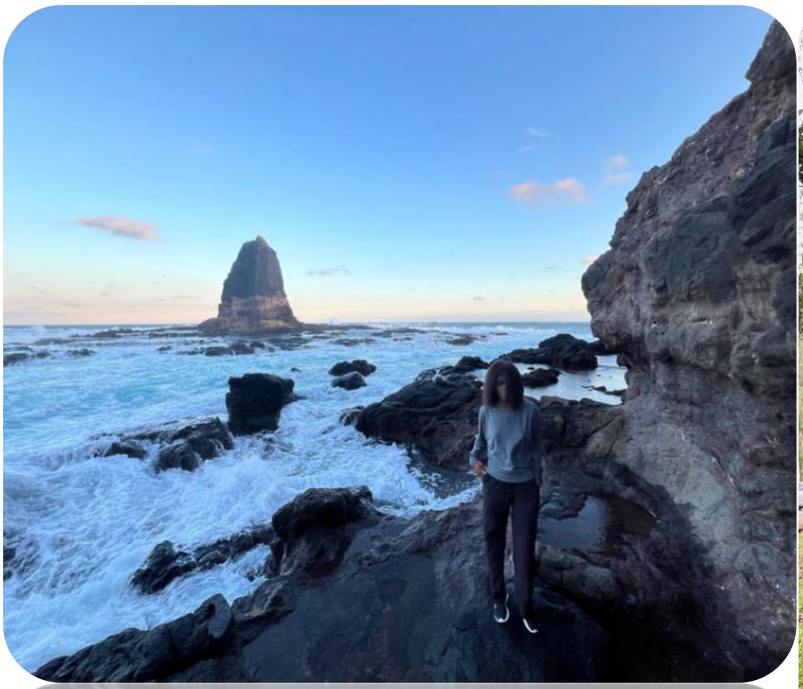
I am now more eager to explore the field of urogynecology and put the experience into practice. The experience opened my eyes to the large scope of practice in urogynecology and areas of controversy. I also borrowed a couple of surgical tips for my practice. It has helped me to identify possible limitations I would likely face back at home and brainstorm on ways to circumvent them.

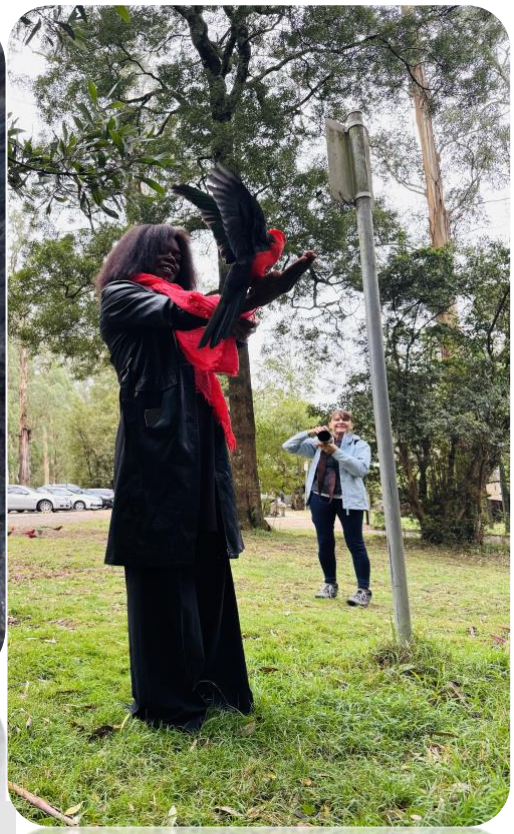
The experience also afforded me the opportunity to network. I was lucky enough to get donation of urogynecological equpment from Dr. Sascha and Endotherapeutics company, a supplier of surgical equipment, for demostration purposes back at home.

Dr. Ayore receiving donation of vaginal retractor for demonstration from Jessica Patara of Endotherapeutics company after a brief talk from the company representatives given at Monash Moorabin.

Cultural experience

My experience was made even more exciting by the opportunity to explore the multi-cultural Melbourne with a rich city life, rich cuisines, top of the world shopping centres, beach experience and beautiful nature and wildlife.





Above and left: Exploring the nature in Australia

Conclusion

I am grateful to IUGA for affording me this memorable and career-defining opportunity, Monash Health administration for allowing me to observe at their facilities, professor Rosamilia for hosting me, and the Monash Health team for going out of their way to make me have a worthwhile learning experience. This is a great initiative to foster knowledge dissemination and global networking in a bid to improve women's health.