AAGL 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

PGSIG-857

Urogynecology Call 101: Surviving—and Succeeding—on Urogyn Call

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PGSIG-857: Urogynecology Call 101: Surviving—and Succeeding—on Urogyn Call

Chair: Katherine Woodburn
Co-Chair: Katie Propst
Faculty: Shirley Dong, Katie Propst, Andrew Sokol, Katherine Woodburn

Course Description

Urogynecology Call 101 is a practical, case-based postgraduate course designed for early-career gynecologic surgeons who are cross-covering urogynecology calls or managing urogynecology-related urgent and emergency presentations. As minimally invasive gynecologic surgeons increasingly provide shared or backup call coverage, confidence in recognizing, triaging, and safely managing common urogynecologic issues is essential for patient safety and outcomes-driven care. This course will focus on what matters on call, not comprehensive subspecialty training. Through real-world scenarios, participants will learn how to evaluate common postoperative concerns, urinary retention and obstruction, mesh- and sling-related complaints, pelvic pain and bleeding, and other high-anxiety presentations encountered in the emergency department or after hours. Emphasis will be placed on initial assessment, red-flag recognition, appropriate workup, and knowing when to observe, intervene, or escalate care.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Identify concerning postoperative symptoms and red-flag findings following stress urinary incontinence procedures that require urgent evaluation, management or escalation of care; 2) Differentiate expected postoperative findings from complications following vaginal and laparoscopic prolapse repairs when managing after-hours presentations; and 3) Manage common office-based urogynecology call issues, including post-onabotulinumtoxinA urinary retention, pessary-related concerns, medication management, etc.

Course Outline

2:15 pm	Welcome, Introduction and Course Overview	K. Woodburn
2:20 pm	Problems from the URPS Office	K. Woodburn
2:45 pm	Stress Incontinence Surgery Complications	K. Propst
3:10 pm	Laparoscopic Prolapse Repair Complications	S. Dong
3:45 pm	Vaginal Surgery Complications: What a Pain!	A. Sokol
4:10 pm	Discussion Questions & Answers	All faculty
4:15 pm	Adjourn	

ADA Statement: In accordance with the Americans with Disabilities Act (ADA), please contact CMEsupport@aagl.org should you require any special assistance.

Disclosure of Relevant Financial Relationships

As an ACCME-accredited provider, AAGL is responsible for ensuring that accredited education is fair, balanced, free of commercial bias, and supports safe, effective patient care. AAGL maintains control over all aspects of educational planning, content, faculty selection, delivery, and evaluation.

All individuals in a position to control educational content are required to disclose financial relationships with ACCME-defined ineligible companies within the past 24 months. AAGL identifies and mitigates all relevant financial relationships before individuals assume their respective roles. Educational content is also subject to independent peer review by individuals without relevant financial relationships.

Disclosure information and acknowledgment of any commercial support are provided to learners before the activity to promote transparency and maintain the independence and integrity of the education.

Asterisk (*) denotes no financial relationships with ACCME-defined ineligible companies to disclose.

PLANNER DISCLOSURES

The following members of AAGL have been involved in the educational planning and/or review of this course (listed in alphabetical order by last name).

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COURSE CHAIR DISCLOSURE

Katherine Woodburn, MD*

COURSE CO-CHAIR DISCLOSURE

Katie Propst, MD – Contracted Research: Axena Health

FACULTY DISCLOSURES

The following faculty have agreed to support their presentations and clinical recommendations with the best available evidence from the medical literature (in alphabetical order by last name).

Shirley Dong, MD*
Katie Propst, MD – Contracted Research: Axena Health
Andrew Sokol, MD*
Katherine Woodburn, MD*

MITIGATION OF RELEVANT FINANCIAL RELATIONSHIPS

All relevant financial relationships have been mitigated.

Drs. Lee, Lemos, Mikhail, and Chaudhari's planning decisions, as part of the Scientific Program Committee (SPC), were peer reviewed by other planners on the SPC who had disclosed no financial relationships with ineligible companies, and found to be fair, balanced, and free of commercial bias. Dr. Moawad's financial relationships ended 12/2024, thus mitigating them. For most of his AAGL Professional Education Committee service, Dr. Mourad had no financial relationships to disclose. He recently disclosed a new relationship as a Proctor for Intuitive Surgical. Since then, he has not participated in activities involving control or influence over accredited educational content; therefore, no additional mitigation was necessary.

Dr. Lee's role as Course Co-Chair was limited primarily to course oversight and moderation, rather than development of educational content. Any planning decisions or content under her influence were subject to independent peer review by individuals without relevant financial relationships.

The presentation content for course faculty, Dr. Propst, has been peer reviewed and found to be fair, balanced, and free from commercial bias.

URPS Potpourri

Kate Woodburn, MD FACOG FACS
Atrium Health Wake Forest Baptist

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1

Disclosure

"I have no financial relationships to disclose."

2

Case #1

68-year-old woman, post-op day 5 after TVH, USLS, PR
She failed her voiding trial and went home doing clean intermittent self-catheterization (CISC) four times a day.

At 9 pm she calls: cloudy, smelly urine and mild suprapubic ache. Temperature 37.1 C, no flank pain, no vomiting

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Case #1- What to Ask

- Fever, chills, flank pain, vomiting?
- Are the urinary symptoms new, or is this her baseline since surgery?
- Gross blood or clots?
- How many catheterizations a day, and what volumes?
- Is the catheter passing easily? Is she leaking between catheterizations?

5

Next Steps

A- Call in an antibiotic

B- Tell her to go to urgent care in the morning for a culture

C- Reassure her and tell her to increase fluid intake

6

Catheters

- Indwelling 16-18 Fr
- Clean intermittent catheterizations 10-14 Fr

- Urinalysis NOT indicated with catheterizations
- Urine culture only for true UTI symptoms

- Bladder spasm
- Leakage around the catheter

7

Case #2

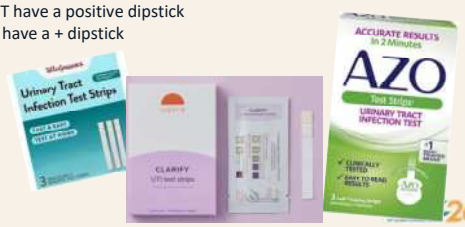
66-year-old woman, breast cancer four years ago on an aromatase inhibitor. She has had three "UTIs" in eight months, each treated by phone or urgent care, with no cultures she can recall.

Today: dysuria and urgency, no fever, no flank pain.
She wants another antibiotic

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"I did a home test and I have a UTI"

- Urine dipstick: sensitivity of 75% and specificity of 82% in patients with ≥100,000 CFU/mL
- UTI? 25% will NOT have a positive dipstick
- No UTI? 18% will have a + dipstick



9

What to do tonight?

A- Empiric Nitrofurantoin

B- Empiric Ciprofloxacin

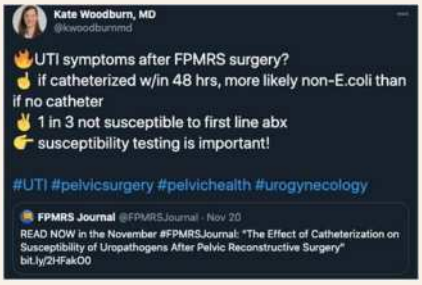
C- hydration, pyridium, Tylenol

D- recommend urgent care in the morning for evaluation and culture

10

UTIs in URPS Surgery

POP surgery? 1/3 of patients with symptomatic UTI within 8 weeks



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AUA Recurrent UTI Guidelines

- Localized vs systemic
- Acute bacterial cystitis = acute-onset symptoms, pyuria of at least 5 WBC/HPF, and a bacterial uropathogen
- Recurrent UTI
  - 2 culture proven UTIs within 6 months OR 3 in 1 year

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UTI Prevention Strategies

- Vaginal estrogen: *clinicians **should** recommend local low-dose vaginal estrogen to reduce future UTIs in patients with GSM (moderate recommendation, grade B)*

- Methenamine Hippurate
- Water: over 1.5 L a day in premenopausal patients
- Cranberry: now with stronger evidence, caution in IC patients
- D-mannose alone: not recommended
- Probiotics?

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How to choose an antibiotic

- Culture!
- Prior cultures
- Local antibiogram

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Medication choices

- Phenazopyridine: turns urine orange, time limited?, avoid in significant kidney impairment
- Uribel/ UroMP

- TMP-SMX interacts with warfarin (INR rises) and with ACE inhibitors or ARBs (potassium).
- Fluoroquinolones: almost never
- Pyelo concerns? Not macrobid

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Surviving Urogyn Call Midurethral Slings

Katie Propst, MD · University of South Florida

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosure

Research funding from Axena Health

2

Objectives

- Explain common postoperative concerns following midurethral sling placement
- Apply management principles of common postoperative concerns following midurethral sling placement
- Recommend when urgent evaluation is indicated following midurethral sling placement

3

My disclaimer…

- This is not an exhaustive list
- These are the most important things to understand and address

4

Typical Course: midurethral sling

- 20-30 minute outpatient procedure
- EBL 25-50 mL
- Pain control: primarily NSAIDS, minimal narcotics
- Suprapubic or groin incision sites often have bruising
- A few days off work
- Most do not call the office with concerns

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Case 1

- A 42-year-old patient underwent a retropubic midurethral sling placement 6 days ago. She calls reporting **painful, small voids, occasional urine leakage, and urinary urgency** throughout the day today.

- Chart review:
  - Retropubic midurethral sling placement 6 days ago, uncomplicated procedure
  - Failed postoperative active void trial, discharged with a foley catheter on DOS
  - Passed repeat void trial on postoperative day 5

6

Possible Diagnoses

- Postoperative urinary retention
- Urinary tract infection
- Urethral or bladder foreign body

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Postoperative Urinary Retention (POUR)

Impaired voiding after a procedure despite a full bladder resulting in an elevated postvoid residual.

Etiology Relevant to MUS
- Mechanical urethral obstruction (sling, swelling)
- Functional urethral obstruction (pelvic floor tone)
- Decreased sensation of bladder filling (anesthesia/narcotics)

Risk factors (general population)
- Age over 50 years
- History of preexisting urinary retention
- Concurrent neurologic disease
- Administration of >750 mL IVF
- Surgery duration > 2 hours
- Intraoperative anticholinergic medications
- Use of regional anesthesia
- History of prior pelvic surgery
- Incontinence surgery or radical pelvic surgery
- Joint arthroplasty surgery

8

POUR

- Secondary analysis of the participants of the Urinary Incontinence Treatment Network Trial of Midurethral Sling (TOMUS) Study
- TOMUS trial: randomized 597 women to retropubic versus transobturator midurethral sling to compare objective and subjective cure rates.
- Active void trial: backfill to 300 mL or to bladder capacity; to be "self-voiding" the PVR had to be ≤100 mL or less than 1/3 of the bladder volume.

76% self-voiding on discharge	24% required a repeat voiding trial

- Rates of urinary retention after a successful void trial are lower but less-well reported in literature, less than 5%, however, this is still possible.

Ferrante KL et al. Neurourol Urodyn. 2014

9

POUR

- Prolonged POUR → bladder distention injury
- Low threshold for evaluation
- If suspected → need urgent evaluation

Symptoms
- **Urinary urgency**
- **Small, frequent voids**
- **Inability to void**
- **Bladder pressure, pain**
- **Urinary leakage**
- **Lower abdominal distention**

10

Possible Diagnoses

- Postoperative urinary retention
- Urinary tract infection
- Urethral or bladder foreign body

11

UTI

- TOMUS trial: in the first 6 postoperative weeks:
  - 12% following retropubic MUS
  - 7% following transobturator MUS
- Retrospective study of 556 patients:10.4% at up to 8 weeks postop

We all know the symptoms!
- Small, frequent voids
- Painful voids
- Blood in the urine
- Feeling of incomplete emptying
- Urinary incontinence

Richter HE, et al. N Engl J Med. 2010
Doganay M, et al. Eur J Obstet Gynecol Reprod Biol. 2017

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UTI

- Low threshold for evaluation
- Culture +/- UA
- Treat empirically only after culture collected

13

Possible Diagnoses

- Postoperative urinary retention
- Urinary tract infection
- Urethral or bladder foreign body

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Urethral or Bladder Foreign Body

- Mesh perforation into the urethra or bladder during the procedure
- Retrospective review: 5.7% (97/1702, all but one were RP)
- TOMUS:
  - No TO perforations
  - RP: 0.3% urethral perforation, 5.0% bladder perforation
- Rate of unrecognized injury?





Richter HE, et al. N Engl J Med. 2010
Gurbuz E, et al. Int Urogynecol J. 2025

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Case 1: irritative voiding symptoms with recent catheter removal following an initially failed voiding trial

UTI	Urinary Retention (recurrent)	Foreign body
Irritative voiding symptoms ~10% Low threshold for evaluation with culture +/- UA	Irritative voiding symptoms Following procedure ~25% Following passed TOV <5% Low threshold for evaluation to avoid bladder distention injury	Irritative voiding symptoms +/- hematuria Recognized: 5% Unrecognized: unknown but low

Possible given recent instrumentation and catheterization

Possible, low risk but risky if it occurs

Unlikely

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Case 1: irritative voiding symptoms with recent catheter removal following an initially failed voiding trial

UTI	Urinary Retention (recurrent)	Foreign body
Irritative voiding symptoms ~10% Low threshold for evaluation with culture +/- UA	Irritative voiding symptoms Following procedure ~25% Following passed TOV <5% Low threshold for evaluation to avoid bladder distention injury	Irritative voiding symptoms +/- hematuria Recognized: 5% Unrecognized: unknown but low

Possible given recent instrumentation and catheterization

Possible, low risk but risky if it occurs

Unlikely

Plan:
- **Urine culture**
- **Trial of void**
- **+/- empiric UTI treatment**

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Case 2

- A 52-year-old patient calls reporting **increasing pelvic pain, bladder pressure, and fullness in the pelvis**. She underwent retropubic midurethral sling yesterday. She has a catheter in place because she failed the void trial in the PACU. The catheter is draining clear, yellow urine. She also reports occasional feeling of **dizziness and bruising over her lower abdomen.**

- Chart review:
  - Retropubic midurethral sling placement yesterday, uncomplicated procedure
  - Failed postoperative active void trial, discharged with a foley catheter

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Possible Diagnoses

- Urinary tract infection
- Catheter obstruction
- Retropubic hematoma

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Catheter Obstruction

- Catheter obstruction → lack of bladder drainage → pelvic pain, bladder pressure and fullness
- Catheter tubing kinking
- Obstruction by stone or encrustation: 50% of long-term indwelling catheters

Shepherd AJ, et al. Cochrane Database Syst Rev. 2017

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Retropubic Hematoma

- Rates are not well established, difficult to define this complication:
  - Hemorrhage during periurethral dissection can be self-limited and easily contained
  - Insignificant hematomas are common and found in up to 25% (<100 mL)
  - **Significant bleeding:**
    - **RP MUS: 0.7-8.0%**
    - **TO MUS: 0.2-2.0%**

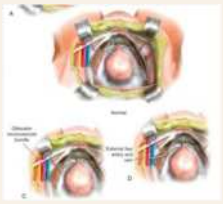
Symptoms:
Pelvic pressure and pain
Urinary retention
Lower abdominal distention, bruising
Hemodynamic changes

Gomes CM, et al. Int Braz J Urol. 2017

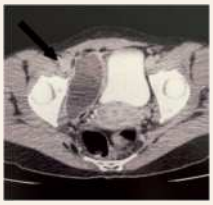
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Retropubic Hematoma

Plan:
Urgent evaluation



Obturator Neurovascular Bundle
External Iliac Artery and Vein



W&K Urogynecology and Reconstructive Pelvic Surgery, 4th Ed.
Gomes CM, et al. Int Braz J Urol. 2017

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Case 2: pelvic pain, bladder pressure, pelvic fullness, abdominal bruising, and dizziness

UTI	Catheter Obstruction	Retropubic Hematoma
Irritative voiding/bladder symptoms ~10% Low threshold for evaluation with culture +/- UA	Bladder pressure/fullness Bladder fullness and pain Unlikely in recently-placed catheter	Pelvic pain and fullness, abdominal bruising, hemodynamic symptoms Uncommon but life-threatening

Possible given recent instrumentation and catheterization, not most concerning

Unlikely

Most likely given presentation

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Case 2: pelvic pain, bladder pressure, pelvic fullness, abdominal bruising, and dizziness

UTI	Catheter Obstruction	Retropubic Hematoma
Irritative voiding/bladder symptoms ~10% Low threshold for evaluation with culture +/- UA	Bladder pressure/fullness Bladder fullness and pain Unlikely in recently-placed catheter	Pelvic pain and fullness, abdominal bruising, hemodynamic symptoms Uncommon but life-threatening

Plan:
Urgently to ED for exam, labs, and imaging

Possible given recent instrumentation and catheterization, not most concerning

Unlikely

Most likely given presentation

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Case 3

- A 66-year-old patient calls reporting **blood in her catheter bag and increased vaginal bleeding**. She underwent a transobturator midurethral sling four days ago. She has a catheter in place because she failed the void trial in the PACU. On further discussion, she reports walking 2 miles today because she woke up feeling great.
- Chart review:
  - Transobturator midurethral sling placement four days ago, uncomplicated procedure
  - Failed postoperative active void trial, discharged with a foley catheter

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Possible Diagnoses

- Urinary tract infection
- Bladder foreign body
- Bladder and vaginal irritation

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Catheter and Vaginal Irritation

- From my experience:
  - Increased activity after surgery can lead to vaginal bleeding and blood in the catheter bag
  - As long as bleeding is not heavy, okay to observe

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A few other things…

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Surgical Site Infection

- Rare (0.3% in TOMUS)
- Superficial soft tissue infection or abscess
- Sx: pain, tenderness, swelling at sling exit sites
- Begins within a week of surgery
- Necrotizing fasciitis has been described



Gomes CM, et al. Int Braz J Urol. 2017
Richter HE, et al. N Engl J Med. 2010

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Postoperative Pain

- Usually well-controlled with NSAIDS and minimal narcotics
- Common
- Most commonly resolves within first 2 weeks
- May persist more than 4 weeks in 1.0-2.7%
- Worsening pain: consider evaluating for infection
- Rarely needs urgent evaluation

Gomes CM, et al. Int Braz J Urol. 2017

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UTI	Urinary Retention	Foreign body	Catheter Obstruction	Retropubic Hematoma	Surgical site infection
Irritative voiding symptoms ~10% Low threshold for evaluation with culture +/- UA	Irritative voiding symptoms Following procedure ~25% Following a passed TOV <5% Low threshold for evaluation to avoid bladder distention injury	Irritative voiding symptoms +/- hematuria Recognized: 5% Unrecognized: unknown but low	Bladder pressure and fullness, urinary urgency Unlikely in recently-placed catheter	Pelvic pain and fullness, abdominal bruising, hemodynamic symptoms Uncommon but life-threatening	Pain at sling exit sites Usually within the first week postop

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References

1. Doganay M, Cavkaytar S, Kokanali MK, Ozer I, Aksakal OS, Erkaya S. Risk factors for postoperative urinary tract infection following midurethral sling procedures. Eur J Obstet Gynecol Reprod Biol. 2017 Apr;211:74-77. doi: 10.1016/j.ejogrb.2017.02.006.
2. Ferrante KL, Kim HY, Brubaker L, Wai CY, Norton PA, Kraus SR, Shepherd J, Sirls LT, Nager CW; Urinary Incontinence Treatment Network. Repeat post-op voiding trials: an inconvenient correlate with success. Neurourol Urodyn. 2014 Nov;33(8):1225-8.
3. Gomes CM, Carvalho FL, Bellucci CHS, Hemerly TS, Baracat F, de Bessa J Jr, Srougi M, Bruschini H. Update on complications of synthetic suburethral slings. Int Braz J Urol. 2017 Sep-Oct;43(5):822-834. doi: 10.1590/S1677-5538.IBJU.2016
4. Gurbuz E, Cevik EC, Telek SB, Harmanli O. Postoperative Management of Bladder Perforation During Mid-Urethral Sling Procedures. Int Urogynecol J. 2025 Aug;36(8):1679-1683.
5. Richter HE, Albo ME, Zyczynski HM, Kenton K, Norton PA, Sirls LT, Kraus SR, Chai TC, Lemack GE, Dandreo KJ, Varner RE, Menefee S, Ghetti C, Brubaker L, Nygaard I, Khandwala S, Rozanski TA, Johnson H, Schaffer J, Stoddard AM, Holley RL, Nager CW, Moalli P, Mueller E, Arisco AM, Corton M, Tennstedt S, Chang TD, Gormley EA, Litman HJ; Urinary Incontinence Treatment Network. Retropubic versus transobturator midurethral slings for stress incontinence. N Engl J Med. 2010 Jun 3;362(22):2066-76.
6. Shepherd AJ, Mackay WG, Hagen S. Washout policies in long-term indwelling urinary catheterisation in adults. Cochrane Database Syst Rev. 2017 Mar 6;3(3):CD004012.

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Urogynecologic Office Complications

Shirley Dong, MD · Ohio State University Medical Center

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosure

I have no financial relationships to disclose.

2

Objectives

- Identify common complications from in-office urogynecologic procedures.
- Formulate appropriate management and follow-up plans to assess patients after in-office procedures.

3

Case 1

- 50 year old patient presents overnight stating that she is having hematuria with clots following in office bladder botox injections. This was the first time she had this procedure

4

Intradetrusor OnabotulinumtoxinA (BTX-A)

- Indication: overactive bladder/urge incontinence, neurogenic bladder or interstitial cystitis/painful bladder syndrome
- Performed via cystoscopy with injections across the bladder dome and posterior base
- Patients typically have a urine dip performed pre-procedure and may receive antibiotics after the procedure



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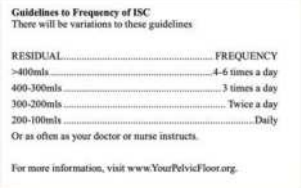
Bladder BTX-A Complications

- Gross Hematuria
  - Assessing voiding function including measured void and post-void residual
  - Evaluate urine
    - Color
    - Clot burden
  - Consider labwork if concerns for considerable blood loss or vital signs are unstable
  - Management
    - Continuous bladder irrigation (CBI)
    - Consider indwelling foley upon discharge if presents in clot retention
    - If persistent gross hematuria, may require OR for cauterization

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Bladder BTX-A Complications

- Incomplete Emptying
  - Rates of retention range widely in literature up to 43%
  - Typically presents 1-2 weeks AFTER injection
  - Assess voiding function
    - May consider indwelling catheter if there was distention injury
  - Management: teach patient intermittent self catheterization (ISC)
  - Have outpatient team follow up with patient to review volumes


Guidelines to Frequency of ISC
There will be variations to these guidelines

RESIDUAL	FREQUENCY
>400mls	4-6 times a day
400-300mls	3 times a day
300-200mls	Twice a day
200-100mls	Daily

Or as often as your doctor or nurse instructs.

For more information, visit www.YourPelvicFloor.org.

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Case 2

- 65 year old patient pages you overnight noted that she is having significant pain following pessary fitting in the office earlier today. She is also having worsening abdominal pain after pessary placement.

8

Pessaries for Stress Incontinence or Prolapse

- Pessaries may be placed for either stress urinary incontinence or pelvic organ prolapse
- Pessaries are typically silicone or plastic and come in a variety of shapes, some of which may need to be removed by a provider
  - Most common pessaries used include ring with support (with or without knob) and Gellhorn



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Pessary Maintenance

- If patients are able, pessaries should be removed weekly for cleaning
- In office cleaning and exam may be performed at 3 month intervals (may be longer pending provider)
- Counsel patients that increased discharge may occur if pessaries remain in place longer without cleaning

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Pessary Complications

- Incorrect Fit
  - Pessary may fall out with Valsalva/using the bathroom
  - Pain may indicate that the pessary is too large
    - Assess patients ability to void (if patient has been unable to void, either remove pessary versus present to ER setting)
- Bleeding
  - Differential may include incorrect fit leading to erosion or irritation
  - Consider performing an exam
  - Pessary rest and/or vaginal estrogen
- Rare complications include fistula formation or bilateral hydronephrosis

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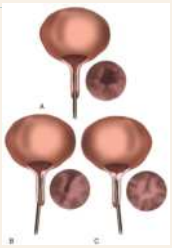
Case 3

- 35 year old calls 2 days following in office urethral bulking procedure. She reports increased frequency, urgency and dysuria but denies hematuria.

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Urethral Bulking

- Bulking material (most commonly Bulkamid currently) transurethrally in the proximal urethra
- Practice patterns vary across the country, with some physicians performing the procedure in the office. There is also variation in assessment of voiding function and peri-procedure antibiotics



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Urethral Bulking Complications

- Infection
  - Urinary tract infection rates vary in the literature from 10-25%
  - Dysuria may be present for the first 48 hours after the procedure (patients may note changes in urinary stream)
  - If persistent or worsening dysuria/UTI symptoms, consider antibiotics with culture collection
  - Consider complicated course of antibiotics for UTI given recent endoscopic procedure

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Urethral Bulking Complications

- Voiding Dysfunction
  - Variation present regarding immediate evaluation of voiding function
  - Retention is often short-lived
  - Recommend either ISC versus indwelling catheter
    - Theoretical risk of indwelling catheter, should use <12 Fr catheter for drainage
- Rare complications
  - Abscess (has not been described with Bulkamid) (can consider pelvic MRI to further evaluate vs cystoscopy)

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Case 4

- 45 year old who presents to an urgent care 5 days after having percutaneous nerve evaluation in the office with worsening redness around the procedure site.

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Percutaneous Nerve Evaluation (PNE)

- Indication: overactive bladder/urge urinary incontinence, fecal incontinence, incomplete bladder emptying
- Procedure places 2 temporary leads in the S3 foramen which are connected to a temporary device introducing current into the leads.
- Some providers may elect to have patients take prophylactic oral antibiotics while temporary leads are in place

17

PNE Complications

- Lead migration
  - Patients may note that leads may get displaced after their procedure
- Pain
  - If shock-like pain in the bicycle seat area, likely due to high amplitude for current
  - Have patient reach out to their device representative
- Infection
  - Recommend starting oral antibiotics
  - Consider evaluation as soon as able in the office setting to evaluate if lead removal is needed

18

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- Barber MD, Bradley C, eds. *Walters & Karram Urogynecology and Reconstructive Pelvic Surgery*. 6th ed. Elsevier; 2026

19

Vaginal Surgery Complications: What a Pain!

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NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosure

- I have no financial relationships to disclose

2

Objectives

- Evaluate and manage transient positioning neuropathy vs injury requiring escalation
- Recognize red flags for pudendal nerve entrapment after sacrospinous fixation
- Apply a stepwise observe, intervene, or escalate approach to delayed ureteral injury and pelvic abscess

3

Positioning Neuropathy: The Call

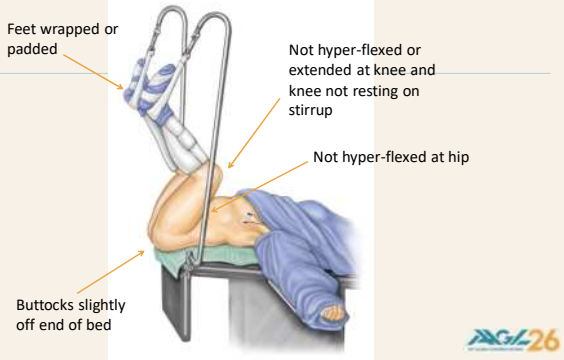
CASE

POD#0, TVH/BS, USLS, APR, sling, cysto in high lithotomy in an obese patient

Recovery room: weak knee extension, numbness over the anterior thigh, trouble standing from a chair

Observe as transient compression, or escalate for neuropathy workup?

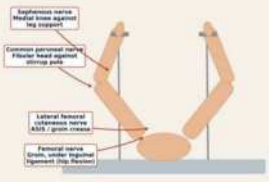
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5

Positioning Neuropathy: Mechanism & Risk

- Occurs in ~1.8% of gynecologic surgeries in lithotomy position[3]
- Most common: lateral femoral cutaneous and femoral nerves[3]
- 91% resolve completely, median recovery 31.5 days[3]



Femoral	Obturator	Sciatic
Hip hyperflexion	Hip external rotation	Knee hyperextension

[3]Bohrer JC, et al. Am J Obstet Gynecol. 2009;201(5):531.e1–531.e7. [4]Chan JK, Manetta A. Am J Obstet Gynecol. 2002;186(1):1–7. [5]Litwiller SP, et al. Clin Anat. 2004;17(1):45–49.

6

Positioning Neuropathy: Symptoms by Nerve

Femoral Sensory: anterior thigh Motor: weak knee extension	**Obturator** Sensory: medial thigh Motor: weak hip adduction	**Sciatic** Sensory: posterior leg / foot Motor: hamstring + foot weakness
Lat. femoral cutaneous Sensory: anterolateral thigh Motor: none (sensory only)	**Common peroneal** Sensory: lateral leg / dorsum foot Motor: foot drop	**Saphenous** Sensory: medial leg / ankle Motor: none (sensory only)

Standard peripheral nerve exam findings; not drawn from a single peer-reviewed source.

7

Positioning Neuropathy: Evaluation & Management

- Focused neuro exam: document motor vs sensory findings and laterality
- Persistent beyond ~3 weeks: electrodiagnostic testing localizes injury, severity[11]
- Most recover fully in 1–3 months with physical therapy[11]
- **ESCALATE:** motor weakness, foot drop, bilateral, or rapid progression
- **OBSERVE:** sensory only, unilateral, expect gradual improvement
- **MEDICATION**
- Gabapentin may help persistent neuropathic pain[13]

[11]Kuo LJ, et al. J Chin Med Assoc. 2004;67(12):644–646. [13]Gordh TE, et al. Pain. 2008;138(2):255–266.

8

Pudendal Nerve Entrapment: The Call

CASE

POD#2 after sacrospinous ligament fixation, calling the on-call line

Severe left buttock and perineal pain, much worse sitting than standing

Expected post-op soreness, or pudendal nerve entrapment?

9

Sacrospinous Fixation: Anatomy & Typical Course

- Pudendal nerve, S3 root, gluteal vessels: within mm of sacrospinous ligament[1]
  - Pudendal nerve closest to ischial spine (median 0 mm, range 0–9 mm)[1]
- Most gluteal pain after fixation self-limited, improves over days–weeks
  - Typically unilateral, worse sitting, distinct from true nerve entrapment
  - May be related to muscle spasm rather than nerve involvement

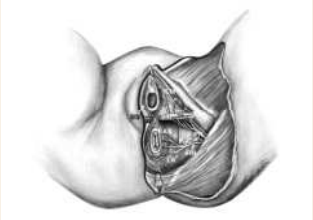


[1]Florian-Rodriguez ME, et al. Am J Obstet Gynecol. 2016;215(5):646.e1–646.e6.

10

Pudendal Nerve Entrapment: Presenting Symptoms

- Severe burning pain, worse with sitting
  - Radiates to perineum, vulva, or rectum
- New bowel or bladder dysfunction
- Distinct from ordinary post-op buttock soreness



11

Pudendal Nerve Entrapment: Evaluation & Management

- First line: early removal of sacrospinous fixation suture[2]
  - Can be done at bedside
  - Relieves pain in 95%, complete relief in 57%[2]
- Gabapentin 300 mg TID, titrate as tolerated, for pain control[14]
- Amitriptyline 10 mg nightly, titrate: reasonable alternative[14]
- Refer for nerve decompression if suture removal and medications fail[2]

[2]Vodegel EV, et al. BJOG. 2022. doi:10.1111/1471-0528.17145. [14]Leslie SW, et al. Pudendal Neuralgia. StatPearls. Updated 2024.

12

Ureteral Injury: The Call

CASE

POD#4 after TVH/BS, USLS, APR presenting to the ED

New left flank pain, temperature 38.4°C

Pyelonephritis, or a missed ureteral injury?

13

Ureteral Injury: Anatomy & Intraoperative Prevention

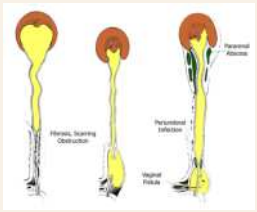
- Ureter: close to uterosacral ligament, en route to bladder trigone[5]
- Injury usually suture entrapment/kinking, not transection; rates ~0.6–10.9%[6]
  - Modern series: 0.8% injury rate, all identified and repaired intraoperatively[4]
- Cystoscopy with IV indigo carmine: bilateral efflux confirmed at every apical suspension

[5]Buller JL, et al. Obstet Gynecol. 2001;97(6):873–879. [4]Sewell J, et al. Gynecol Pelvic Med. 2020.

14

Delayed Ureteral Injury: Presenting Symptoms

- Flank pain, unexplained fever, persistent ileus, rising creatinine, failure to improve
  - Cr may stay within normal range (rise >0.2–0.3 mg/dL)[7]
- New vaginal fluid leakage suggests fistula

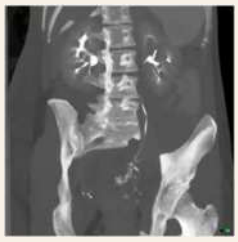


[7]Walter AJ, et al. Am J Obstet Gynecol. 2002;186(6):1315–1319.

15

Delayed Ureteral Injury: Diagnostic Imaging

- CT urogram with delayed (excretory) phase: first-line if stable[12]
  - Looks for contrast extravasation, urinoma, delayed pyelogram, hydronephrosis[12]
- Renal ultrasound
  - Quick bedside hydronephrosis screen; may miss injury
- Postoperative/delayed: retrograde pyelogram with attempted stent[12]



[12]Morey AF, et al. Urotrauma: AUA guideline. J Urol. 2014;192(2):327–335.

16

Delayed Ureteral Injury: Management Pathway

- Obtain urology consult once obstruction confirmed[12]

RETROGRADE STENT
First-line, attempted initially for incomplete injury

PERCUTANEOUS NEPHROSTOMY
If stent fails, unsuccessful, or patient unstable

[12]Morey AF, et al. Urotrauma: AUA guideline. J Urol. 2014;192(2):327–335.

17

Pelvic Abscess: The Call

CASE

POD#6 after TVH/BS, USLS, APR, cysto calling with ongoing pain

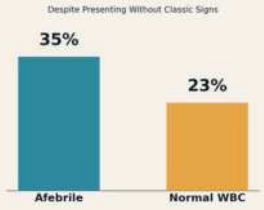
Persistent pelvic pain, low-grade fever, new vaginal discharge; abdomen soft, no rebound

Normal post-op course, or a developing pelvic abscess?

18

Pelvic Abscess: Presenting Symptoms

- Classic triad (fever, leukocytosis, pelvic mass) often absent[8]
- Persistent pelvic pain not improving as expected
- New vaginal bleeding or discharge
- Unexplained ileus after surgery

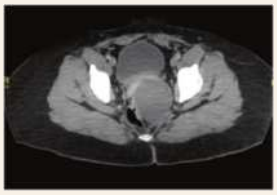


[8]Khaliq K, et al. StatPearls. 2023.

19

Pelvic Abscess: Evaluation & Management

- CT abd/pelvis with contrast (consider delayed excretory phase if unclear if ureteral involvement)
- <8 cm, patient stable, no sepsis
  - Start IV antibiotics, reassess in 48–72 hours[8]
- ≥8 cm or no improvement in 2–3 days
  - Percutaneous drainage, 80–90% success[8]
- After sacrocolpopexy: small abscess may resolve with antibiotics alone
  - Mesh removal not always required[9]



[8]Khaliq K, et al. StatPearls. 2023. [9]Kwon SY, et al. Int Urogynecol J. 2016;28(6):875–879.

20

Pelvic Abscess: Empiric Antibiotic Therapy

- Empiric (broad)
  - Ceftriaxone 1–2 g IV daily + metronidazole 500 mg IV q8h[15]
  - Piperacillin-tazobactam 3.375 g IV q6h if healthcare-associated/critically ill[15]
- Narrow once culture/sensitivity results return
- Limit IV to 3-4 days after adequate source control[15]
  - STOP-IT trial: 4-day course noninferior to 8-day for recurrent infection/death[16]

[15]Mazuski JE, et al. Surg Infect (Larchmt). 2017;18(1):1–76. [16]Sawyer RG, et al. N Engl J Med. 2015;372(21):1996–2005.

21

Pelvic Abscess: Oral Step-Down & Re-Imaging

- Switch to oral once afebrile, tolerating PO (24–48 h)
  - Ciprofloxacin 500 mg PO BID + metronidazole 500 mg PO TID, or amoxicillin-clavulanate[15]
- Re-imaging not routine if fever, pain, white count improving[15]
  - Reserve CT for suspected failure (~48–72 h) to assess for undrained collection[15]

[15]Mazuski JE, et al. Surg Infect (Larchmt). 2017;18(1):1–76.

22

Take-Home: What Not to Miss on Call

- Motor weakness or bilateral symptoms → escalate; sensory-only, unilateral usually resolves; gabapentin for persistent pain
- Worsening gluteal pain after SSLF → suspect pudendal entrapment; remove suture early, consider gabapentin or amitriptyline
- Rising creatinine or flank pain after apical suspension → CT urogram if stable, retrograde pyelogram with stent if delayed
- Fever not required for pelvic abscess, trust exam and imaging

23

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24

CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

The California Medical Association (CMA) outlines standards for Cultural Linguistic Competency and Implicit Bias in CME. The goal of the standards is to support the role of accredited CME in advancing diversity, health equity, and inclusion in healthcare. These standards are relevant to ACCME-accredited, CMA-accredited, and jointly accredited providers located in California. AAGL is ACCME-accredited and headquartered in California.

CMA developed the standards in response to California legislation (Business and Professions (B&P) Code Section 2190.1), which directs CMA to draft a set of standards for the inclusion of cultural and linguistic competency (CLC) and implicit bias (IB) in accredited CME.

The standards are intended to support CME providers in meeting the expectations of the legislation. CME provider organizations physically located in California and accredited by CMA CME or ACCME, as well as jointly accredited providers whose target audience includes physicians, are expected to meet these expectations which began on January 1, 2022. AAGL has been proactively adopting processes that meet and often exceed the required expectations of the legislation.

CMA CME offers a variety of resources and tools to help providers meet the standards and successfully incorporate CLC & IB into their CME activities, including FAQ, definitions, a planning worksheet, and best practices. These resources are available on the CLC and IB standards page on the CMA website.

Important Definitions:

Cultural and Linguistic Competency (CLC) – The ability and readiness of health care providers and organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities and behaviors, in order to meet social, cultural and linguistic needs as they relate to patient health.

Implicit Bias (IB) – The attitudes, stereotypes and feelings, either positive or negative, that affect our understanding, actions and decisions without conscious knowledge or control. Implicit bias is a universal phenomenon. When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics.

Diversity – Having many different forms, types or ideas; showing variety. Demographic diversity can mean a group composed of people of different genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences, ages, etc.

Direct links to AB1195 (CLC), AB241 (IB), and the B&P Code 2190.1:

Bill Text – AB-1195 Continuing education: cultural and linguistic competency.
Bill Text – AB-241 Implicit bias: continuing education: requirements.
Business and Professions (B&P) Code Section 2190.1

CLC & IB Online Resources:

Diversity-Wheel-as-used-at-Johns-Hopkins-University-12.png (850×839) (researchgate.net)
Implicit Bias, Microaggressions, and Stereotypes Resources | NEA
Act, Communicating, Implicit Bias (racialequitytools.org)
https://www.contemporaryobgyn.net/view/overcoming-racism-and-unconscious-bias-in-ob-gyn
https://pubmed.ncbi.nlm.nih.gov/34016820/
https://hr.ucdavis.edu/departments/learning/certificate/implicit-bias
https://pmc.ncbi.nlm.nih.gov/articles/PMC7011228/