MIGS 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

Surgical Tutorial 414

Evidence-Based Decision-Making and Surgical Strategies for Apical Prolapse Repair: Improving Outcomes Through Technique, Judgment, and Standardization

HONORARY CHAIR
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SCIENTIFIC PROGRAM CHAIR
Nash S. Moawad, MD

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Surgical Tutorial 414 - Evidence-Based Decision-Making and Surgical Strategies for Apical Prolapse Repair: Improving Outcomes Through Technique, Judgment, and Standardization

Chair: Sara Karbage
Faculty: Sara Karbage, Andreisa Paiva Monteiro Bilhar, Sara Karbage, Luiz Gustavo Oliveira Brito

Course Description

Apical prolapse represents a critical determinant of long-term pelvic floor outcomes, directly impacting symptom recurrence, quality of life, and the success of reconstructive pelvic surgery. Despite advances in minimally invasive approaches, significant variability persists in patient selection, surgical planning, and intraoperative decision-making, contributing to heterogeneous outcomes. This Surgical Tutorial is designed to move beyond procedural demonstration and focus on evidence-based judgment, decision-making, and surgical strategy in the management of apical prolapse. Through structured discussions and real-world surgical scenarios, faculty will address patient-centered evaluation, selection of surgical approach, and technique standardization aimed at optimizing functional outcomes and reducing recurrence and complications. The course integrates current evidence, anatomical principles, and practical surgical insights to improve timely access to high-quality, minimally invasive care for women with pelvic organ prolapse, aligning surgical excellence with outcomes-driven practice.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Apply evidence-based criteria to select appropriate candidates for surgical correction of apical prolapse, emphasizing patient-centered outcomes; 2) Compare minimally invasive surgical approaches for apical prolapse repair based on anatomical findings, comorbidities, and functional goals; and 3) Implement standardized surgical strategies to reduce variability, minimize complications, and improve long-term prolapse outcomes; and 4)Integrate outcome-focused metrics into clinical practice to improve quality of care and patient autonomy.

Course Outline

10:30 am	Welcome, Introduction and Course Overview	S. Karbage
10:35 am	Framework for Decision-Making In Apical Prolapse	S. Karbage
10:50 am	Minimally Invasive Surgical Techniques and Standardization	A. Paiva Monteiro Bilhar
11:05 am	Managing Complexity and Optimizing Outcomes	L. Oliveira Brito
11:20 am	Discussion Questions & Answers	All faculty
11:30 am	Adjourn	

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Disclosure of Relevant Financial Relationships

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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

Sara Karbage, MD*

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).

Sara Karbage, MD*
Luiz Gustavo Oliveira Brito, MD, PhD*
Andreisa Paiva Monteiro Bilhar, MD, PhD – Speakers Bureau: Zambon

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.

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

Session Title 414:
Evidence-Based Decision-Making and Surgical Strategies for Apical Prolapse Repair: Improving Outcomes Through Technique, Judgment, and Standardization

Sara Arcanjo Lino Karbage, MD · Instituto Salvata de Educação

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

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1. Framework for Decision-Making In Apical Prolapse
2. Minimally Invasive Surgical Techniques and Standardization
3. Managing Complexity and Optimizing Outcomes

Sara Arcanjo Lino Karbage, MD · Instituto Salvata de Educação

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

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Disclosure

- *I have no financial relationships to disclose."*

3

Objectives

- *Evaluate* and select appropriate candidates for surgical correction of apical prolapse, emphasizing patient-centered outcomes.

4

Framework for Decision-Making in Apical Prolapse

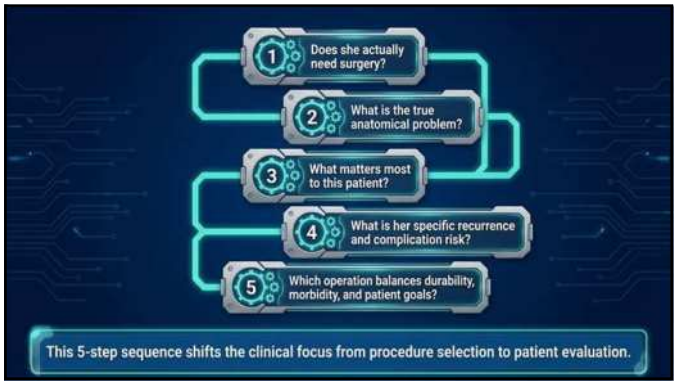
Not which operation is best – but which operation is best for this patient.

- Anatomy defines the problem.
- Evidence defines the options.
- The patient defines priorities.
- The surgeon defines what is safely achievable.

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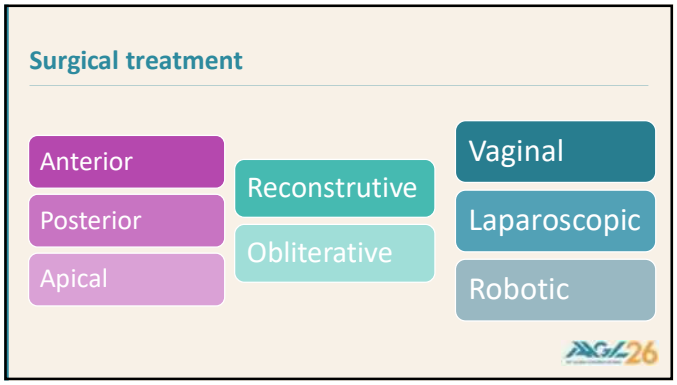
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1 Does she actually need surgery?
2 What is the true anatomical problem?
3 What matters most to this patient?
4 What is her specific recurrence and complication risk?
5 Which operation balances durability, morbidity, and patient goals?
This 5-step sequence shifts the clinical focus from procedure selection to patient evaluation.

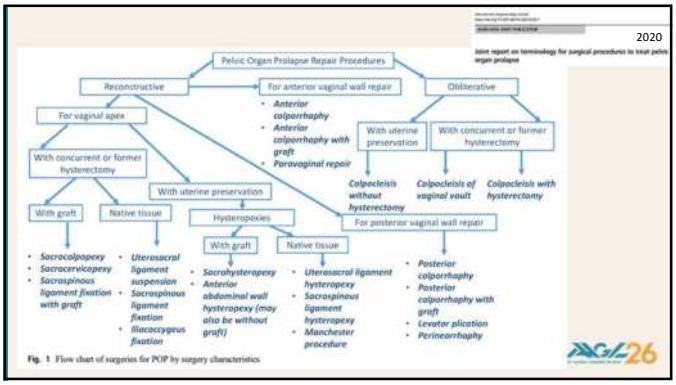
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Conservative treatment

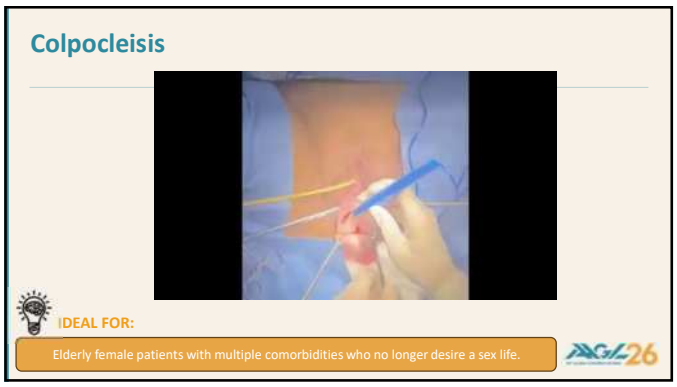
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Surgical treatment
Anterior
Posterior
Apical
Reconstrutive
Obliterative
Vaginal
Laparoscopic
Robotic

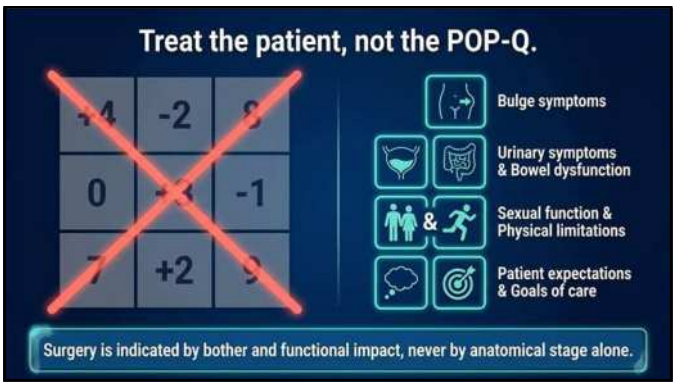
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2020
Pelvic Organ Prolapse Repair Procedures
Reconstructive
Obliterative
For anterior vaginal wall repair
For vaginal apex
Anterior colporrhaphy
Anterior colporrhaphy with graft
Paravaginal repair
With uterine preservation
With concurrent or former hysterectomy
Colpocleisis without hysterectomy
Colpocleisis of vaginal vault
Colpocleisis with hysterectomy
With graft
Native tissue
Hysteropexies
For posterior vaginal wall repair
Sacrocolpopexy
Sacrocervicopexy
Sacrospinous ligament fixation with graft
Uterosacral ligament suspension
Sacrospinous ligament fixation
Iliococcygeus fixation
Sacrohysteropexy
Anterior abdominal wall hysteropexy (may also be without graft)
Uterosacral ligament hysteropexy
Sacrospinous ligament hysteropexy
Manchester procedure
Posterior colporrhaphy
Posterior colporrhaphy with graft
Levator plication
Perineorrhaphy
Fig. 1 Flow chart of surgeries for POP by surgery characteristics

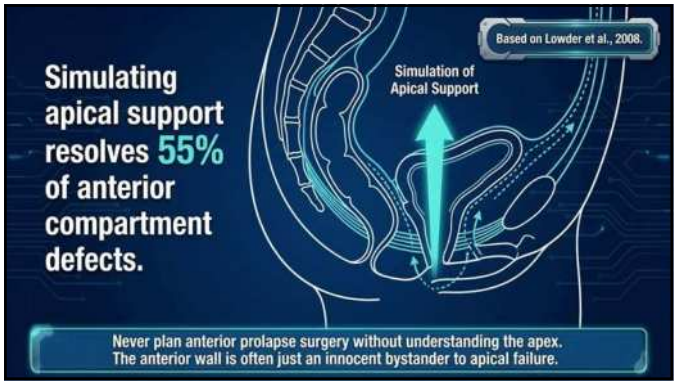
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Colpocleisis
IDEAL FOR:
Elderly female patients with multiple comorbidities who no longer desire a sex life.

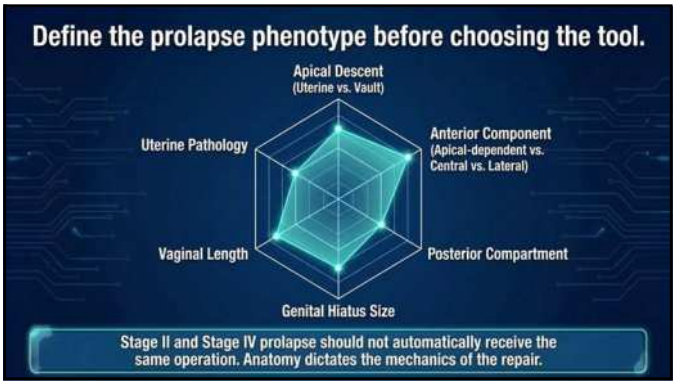
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Treat the patient, not the POP-Q.
-2
0
-1
+2
Bulge symptoms
Urinary symptoms & Bowel dysfunction
Sexual function & Physical limitations
Patient expectations & Goals of care
Surgery is indicated by bother and functional impact, never by anatomical stage alone.

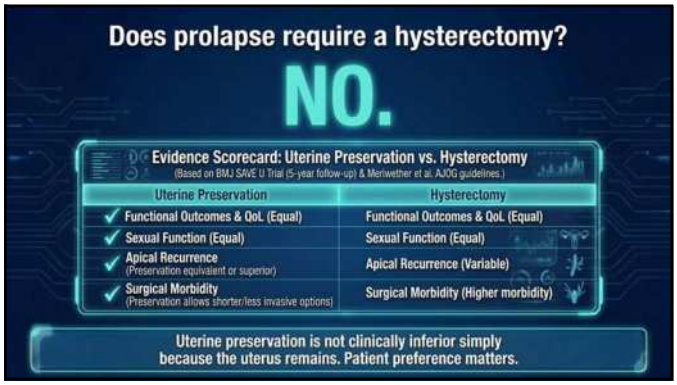
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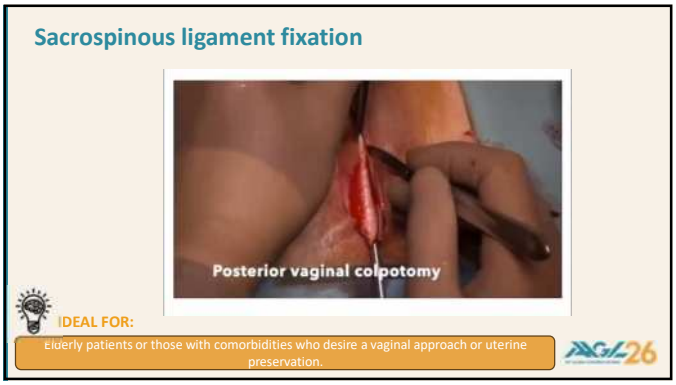
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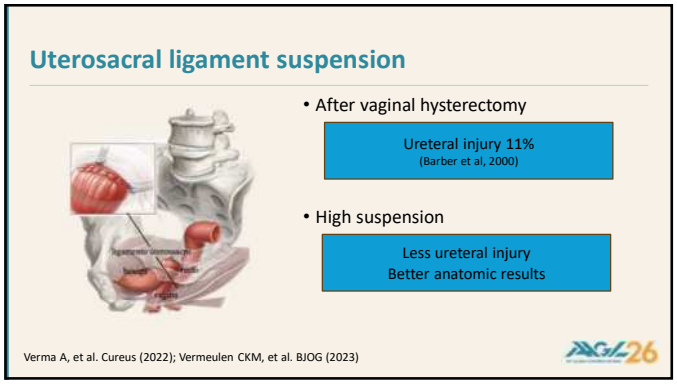
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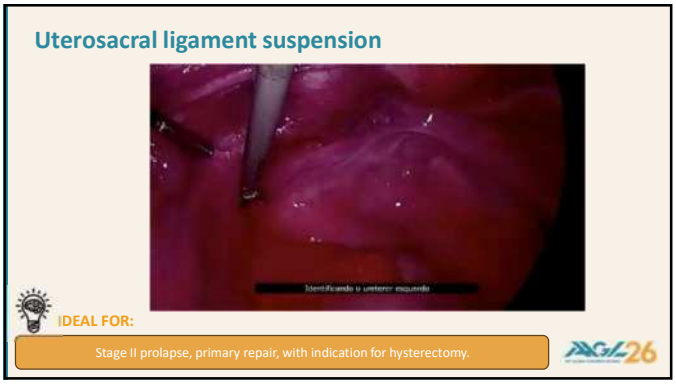
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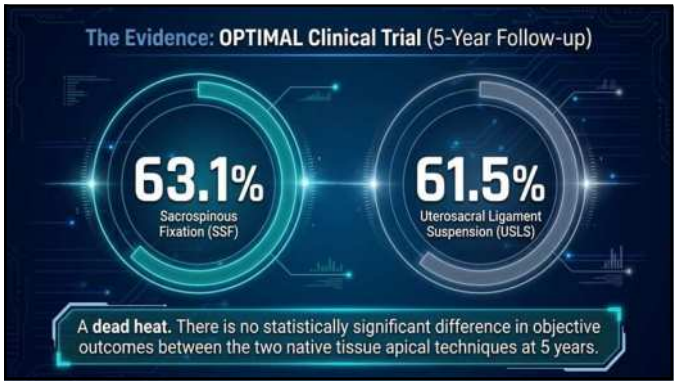
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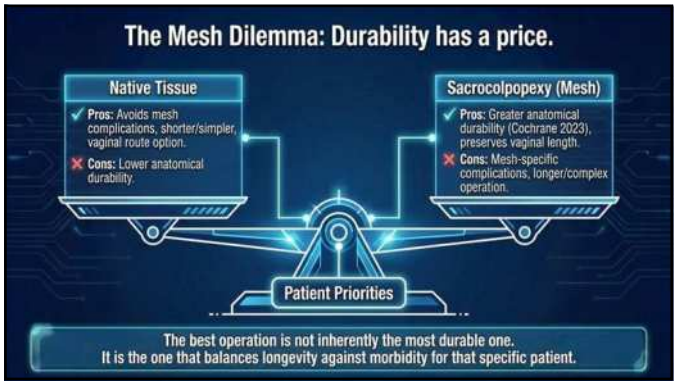
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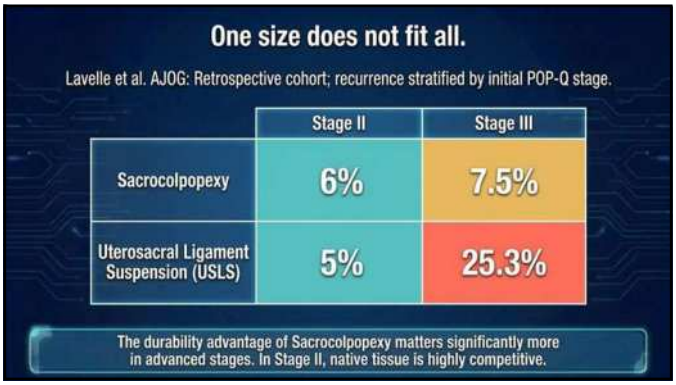
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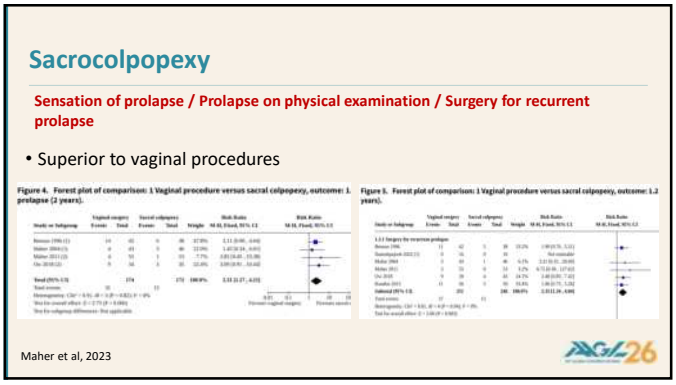
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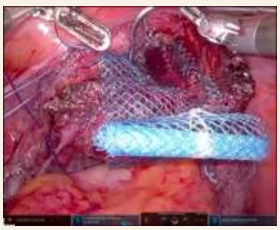


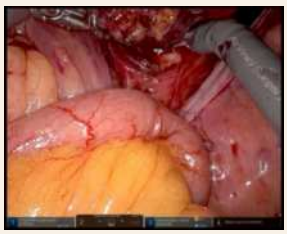
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Sacrocolpopexy

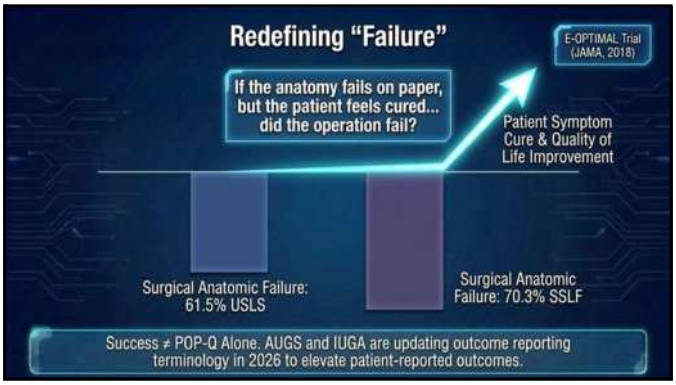




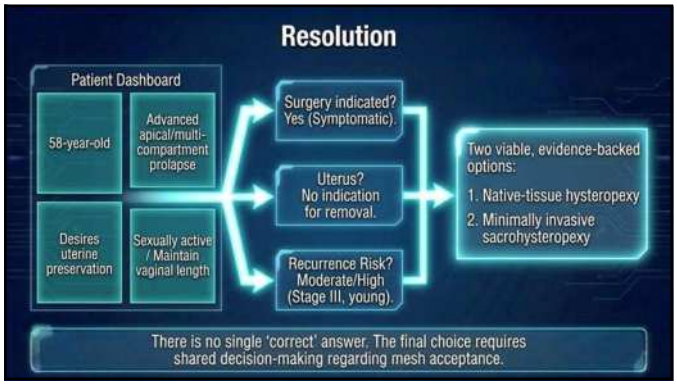
IDEAL FOR:

Sexually active patients under 70 years of age with no contraindications to laparoscopic/robotic surgery.

25



26



27



28

References

- Maher C, et al. Surgery for women with apical vaginal prolapse. Cochrane Database Syst Rev. 2023;7:CD012376.
  Provavelmente sua referência-base para comparação das abordagens.
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  SAVE U — essencial para preservação uterina.
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  Excelente para o conceito anatômico apex/anterior wall.
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- Siddiqui NY, Grimes CL, Casiano ER, et al. Mesh sacrocolpopexy compared with native tissue reapir: a systematic review and meta-analysis. Obstet and Gynecol. 2015.
- Guo L, Li X, Li H, et al. Comparative outcomes of laparoscopic lateral suspension, sacrocolpopexy, and transvaginal mesh for advanced apical prolapse: A retrospective cohort study. PloS One. 2025. 7.
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MINIMALLY INVASIVE SURGICAL TECHNIQUES AND STANDARDIZATION

Andreisa Bilhar, MD, PhD · Federal University of Ceará · Brazil

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosure

Speakers Bureau - Zambon

2

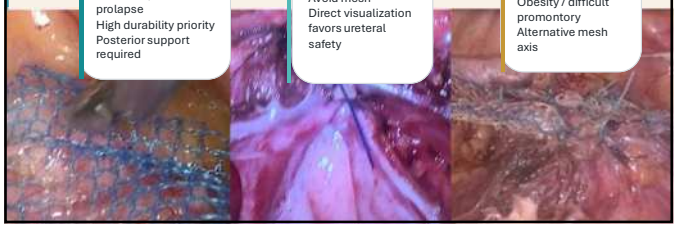
The minimally invasive toolbox

APICAL PROLAPSE

SACROCOLPOPEXY
Advanced / multicompartment prolapse
High durability priority
Posterior support required

USLS
Native-tissue option
Avoid mesh
Direct visualization favors ureteral safety

PECTOPEXY
Avoid presacral dissection
Obesity / difficult promontory
Alternative mesh axis



3

START WITH THE BENCHMARK: SACRAL COLPOPEXY

Surgery for women with apical vaginal prolapse (Review)

Cochrane Library

Maher C, Yeung E, Haya N, Christmann-Schmid C, Mowat A, Chen Z, Baessler K 2023

- 59 RCTs, 6,705 women

Vaginal procedures versus abdominal sacrocolpopexy (6 months to 4 years)

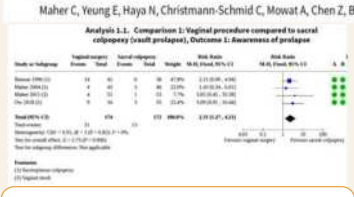
1. Abdominal sacrocolpopexy (open, laparoscopic, or robotic)
2. Vaginal procedures (e.g., sacrospinous fixation, uterosacral ligament suspension)

4

Surgery for women with apical vaginal prolapse (Review)

Cochrane Library

Maher C, Yeung E, Haya N, Christmann-Schmid C, Mowat A, Chen Z, Baessler K 2023



VAGINAL SURGERY

- Awareness of prolapse
- RR 2.31 (95% CI 1.27–4.21)
- Repeat surgery for prolapse
- RR 2.33 (95% CI 1.34–4.04)
- Recurrence on examination (POP-Q)
- RR 1.87 (95% CI 1.32–2.65)
- SUI
- RR 1.86 (95% CI 1.17–2.94)

Sacrocolpopexy provides greater anatomic and symptomatic durability than vaginal procedures, at the cost of a longer operative time

= Dyspareunia
↓ Operative time

5

Sacrocolpopexy Established Gold Standard

- Mesh Y leve
- Fixação ao promontório e vagina
- Correção anatômica apical + anterior/posterior



Maher et al, 2004; Maher et al, 2011; Maher et al, 2016; Maher et al, 2023

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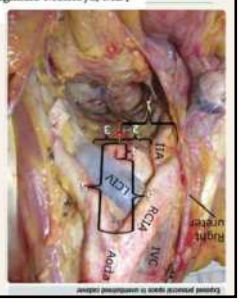
Vascular and ureteral anatomy relative to the midsacral promontory

American Journal of Obstetrics & Gynecology

Meadow M. Good, DO; Travis A. Abele, MD; Sunil Balgobin, MD; T. Ignacio Montoya, MD; Donald McIntire, PhD; Marlene M. Corton, MD

2013

1. stance from the right ureter to the midpoint of the sacral promontory
   2.7 cm (1.6–3.8 cm) in cadavers
2. e right internal iliac artery is the closest vessel to the right of the promontory
   2.5 cm (1.4–3.9 cm) in cadavers
4. The left common iliac vein is the closest vessel cephalad to the promontory
   2.7 cm (0.95–4.75 cm) in cadavers
5. Distance from the promontory to the aortic bifurcation
   5.3 cm (2.8–9.7 cm) in cadavers



7

WHY STANDARDIZATION MATTERS

The problem is not a lack of procedures, it is variability

Sacrocolpopexy is highly effective, yet the literature often compares procedures that are not technically identical.

DISSECTION
Anterior and posterior vaginal dissection endpoints vary substantially across trials.

FIXATION
Suture material, number of sutures, sacral fixation and mesh configuration are inconsistent.

REPORTING
Many RCTs do not fully describe key operative steps, limiting reproducibility and interpretation.

Does sacrocolpopexy present heterogeneity in its surgical technique? A systematic review

Rafael M. Moroni[1] | Cassia R. T. Juliato[2] | Michel Cosson[3] | Geraldine Giraudet[3] | Luiz G. O. Brito[1]

Neurourology Urodynamics ICS

2018

22 RCTs included

Depth of vaginal dissection
Number and type of sutures
Mesh type and configuration

Sacral fixation
Surgeon experience

Moroni RM et al. Neurourol Urodyn. 2018; Nassar DT et al. JSLS. 2024.

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Does sacrocolpopexy present heterogeneity in its surgical technique? A systematic review

Rafael M. Moroni[1] | Cassia R. T. Juliato[2] | Michel Cosson[3] | Geraldine Giraudet[3] | Luiz G. O. Brito[1]

Neurourology Urodynamics ICS

2018

Anterior compartment
16 studies
Only 5 studies – complete dissection to the bladder neck
Some dissect only the vaginal apex
Others dissect to 1/3 or 2/3 of the vaginal length

Posterior compartment
Hi…
5 s…
pe…
2 s…
6 s…

Number of vaginal sutures
Most used 4–6 sutures

Suture type (vaginal wall)
14 studies
50% used absorbable sutures (PDS, PGA)
50% used nonabsorbable sutures (PTFE, polyester, polypropylene)

3 left the choice to the surgeon

SCP is highly non-standardized in the literature
Surgical technique varies widely across the RCTs analyzed
These differences may compromise the comparative validity of the studies

9



10

Does Omitting Posterior Fixation Compromise Efficacy?

Posterior mesh fixation versus non-fixation in sacrocolpopexy: A randomized clinical trial

Jasmine Di Biasi[a,c], Stefania Ruggieri[b], Chiara Taccaliti[c], Michela Ciocca[d], Christian Di Florio[c], Guglielmo Stabile[e], Paola Catana[b], Matteo Bruno[a,c], Maurizio Guido[b,c]

2025

Similar anatomic and subjective success in both groups
- Failure: 8.3% in both groups, all in the anterior compartment (point Ba)

Persistent constipation
3% WITHOUT FIXATION vs. 13% WITH FIXATION (p=0.04)

Persistent urinary incontinence
0% WITHOUT FIXATION vs. 7% WITH FIXATION (p=0.04)

Pelvic pain: 3.3% in both groups

11

MESH FIXATION

May increase the risk of:
- **Defecatory dysfunction**
- **Persistent SUI**
- **Rectal injury**
- **Chronic pelvic pain**

NO FIXATION

- Less tension on the posterior vaginal wall
- Lower incidence of constipation and SUI
- Similar anatomic outcomes

3D ultrasound showed that mesh position remained stable over 12 months in both groups

Omission of posterior mesh fixation is noninferior to fixation in laparoscopic sacrocolpopexy
It may be considered safe and effective, with a potential benefit in reducing constipation and persistent stress urinary incontinence at 12 months
Larger studies with longer follow-up and assessment of patient satisfaction are needed

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Difficult Sacral Promontory Access

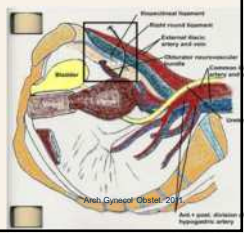
Laparoscopic pectopexy: a new technique of prolapse surgery for obese patients

Carolin Banerjee · Karl Günter Noé

Tension-Free Technique for Apical Prolapse

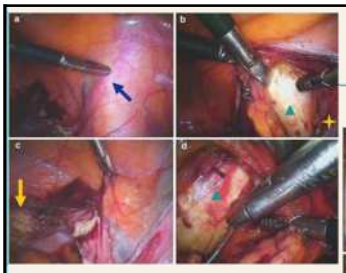
Obesity

Difficulty Accessing the Sacral Promontory

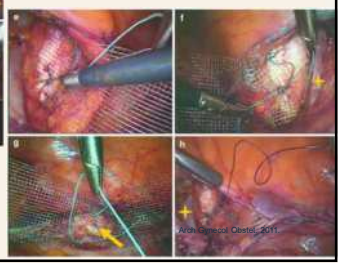


Arch Gynecol Obstet. 2011

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Peritoneal Opening
Landmarks: round ligament, iliac vessels, obturator nerve
Identification of Cooper's Ligament



Dissection to the Cervix/Vaginal Vault
Mesh Fixation with Sutures
Peritoneal Closure

Arch Gynecol Obstet. 2011

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PECTOPEXY

Pectopexy: a lateral alternative when the promontory is the problem

ANATOMY
Bilateral fixation to the iliopectineal (Cooper's) ligaments avoids presacral dissection.

META-ANALYSIS 2025
11 studies · 1,043 patients · 4 RCTs. Comparable recurrence, mesh complications, urinary, bowel and sexual outcomes vs SCP.

EFFICIENCY
Shorter operative time and less blood loss; shorter hospital stay in pooled analysis.

Best framed as an evidence-supported alternative, not a replacement for sacrocolpopexy

Parsaei M et al. J Minim Invasive Gynecol. 2025;32:1-22

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PECTOPEXY · PATIENT SELECTION

Where pectopexy may add value

Difficult presacral access
Obesity, adhesions or vascular/anatomic variation may make promontory dissection less attractive.

Need to avoid sacral danger zone
Pectopexy shifts fixation laterally to visible external iliac / pectineal anatomy.

Efficiency matters
Pooled operative time: 112.7 vs 147.4 min; blood loss: 46.6 vs 60.0 mL in the 2025 meta-analysis.

Evidence boundary
Most comparative follow-up is ≤12 months; long-term durability remains less established than SCP.

Parsaei M et al. J Minim Invasive Gynecol. 2025;32:1-22

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Uterosacral Ligament Suspension



- Uterosacral Ligament: 3 Segments
  - Distal (near the cervix)
  - Intermediate
  - Proximal
  - First described by Shull in 1994 using the vaginal approach
- Technique modifications

Panico et al. Int Urogynecol J. 2018.

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UTEROSACRAL LIGAMENT SUSPENSION

Laparoscopic USLS: native tissue with direct visualization

Systematic review: 13 studies · 933 patients
mean follow-up ≈ 22 months

EFFECTIVENESS
Pooled anatomic success ≈ 90%. Apical recurrence ≈ 10%.

SAFETY
Overall complications ≈ 8%; Clavien–Dindo III ≈ 0.6% in the review.

URETER
No ureteral obstruction/damage reported in the included LUSLS series; laparoscopy allows direct ureter identification.

Strength: mesh-free apical suspension. Limitation: evidence is predominantly nonrandomized and follow-up is modest.

Vermeulen CKM et al. BJOG. 2023;130:1568–1578. Ronsini C et al. Front Surg. 2023;10:1150607

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USLS · TECHNIQUE

Standardize USLS around anatomy

1	IDENTIFY	Trace the pelvic ureter before suturing.
2	TARGET	Use the upper uterosacral ligament with clear visualization.
3	BILATERALITY	Create symmetric apical support when anatomy allows.
4	TENSION	Elevate without medial ureteral kinking.
5	VERIFY	Reassess ureteral course and apical axis before closure.

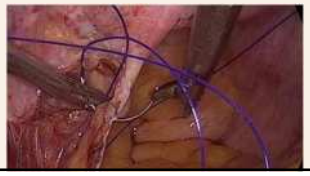
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Technique

Identification of the Uterosacral Ligaments

Retroperitoneal Opening Lateral to the Ligament with Ureterolysis





Hysterectomy / Hysteropexy

Continuous Suture Along the Ligament

Panico et al. Int Urogynecol J. 2023

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Laparoscopic uterosacral ligament suspension: a systematic review and meta-analysis of safety and durability

Carlo Ronsini[1*], Francesca Pasanisi[1*], Stefano Cianci[2], Maria Giovanna Vastarella[1], Marika Perruacchio[1*], Marco Torella[3], Alfredo Ercoli[1] and Nicola Colacurci[1**]

9 Studies
543 WOMEN
V-USLS vs L-USLS

RECURRENCE RATE

REOPERATION RATE



Front Surg. 2023

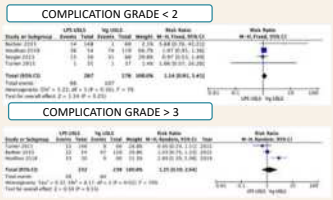
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Laparoscopic uterosacral ligament suspension: a systematic review and meta-analysis of safety and durability

Carlo Ronsini[1*], Francesca Pasanisi[1*], Stefano Cianci[2], Maria Giovanna Vastarella[1], Marika Perruacchio[1*], Marco Torella[3], Alfredo Ercoli[1] and Nicola Colacurci[1**]

COMPLICATION GRADE < 2

COMPLICATION GRADE > 3



L-USLS demonstrated low complication and recurrence rates
Comparison of the two techniques showed no inferiority of one approach over the other

Front Surg. 2023

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The effectiveness and safety of laparoscopic uterosacral ligament suspension: A systematic review and meta-analysis

Carolien K. M. Vermeulen[1,2] | Britt Schuurman[1] | Anne-Lotte W. M. Coolen[2,3] | Puck R. Meijs-Hermanns[1,4] | Sanne A. L. van Leijsen[1] | Joggem Veen[1] | Marlies Y. Bongers[1,2]

Laparoscopic uterosacral ligament suspension (with or without uterine preservation) appears to be an effective and safe treatment for women with apical POP.

Objective cure: 90%
Subjective cure: 72–100%
Anatomical success: L-USLS with hysterectomy 96.6%; uterus-preserving L-USLS 83.4%
Major complication rate: 1%.

BJOG. 2023

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DECISION + STANDARDIZATION

A practical minimally invasive algorithm

What is the dominant defect?

ADVANCED / MULTICOMPARTMENT
Favor SCP when durability and broad compartment support dominate.

MESH AVOIDANCE
Consider laparoscopic USLS; standardize ureter visualization and suture construct.

PROMONTORY UNFAVORABLE
Consider pectopexy; consider LLS for anterior–apical dominant disease.

Maher C et al. Cochrane 2023; Vermeulen CKM et al. BJOG 2023; Parsaei M et al. JMIG 2025; Plotti F et al. J Clin

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TAKE-HOME MESSAGES

1. Sacrocolpopexy remains the durability benchmark for vault and advanced multicompartment prolapse.
2. Minimally invasive alternatives are not interchangeable: choose the vector of support that matches the defect and risk profile.
3. Standardization means defining anatomy, dissection endpoints, fixation, tension and outcome metrics, not merely naming the procedure.
4. **The best operation is the one that is evidence-based, anatomically coherent, reproducible, and aligned with the patient's goals.**

Thank you

Key sources: Maher 2023 · Moroni 2018 · Vermeulen 2023 · Nassar 2024 · Parsaei 2025 · Plotti 2025 · Di Bella 2025

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Managing Complexity and Optimizing Outcomes

Luiz Gustavo Oliveira Brito, MD, PhD
Ribeirão Preto Medical School, University of São Paulo, Brazil

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosure

"I have no financial relationships to disclose."

2

Objectives

At the end of this session, participants will be able to:

- **Identify** the patient and anatomic factors that define a complex apical prolapse case and predict recurrence
- **Compare** long-term evidence on apical repair durability, uterine preservation, mesh, and concomitant continence surgery
- **Apply** evidence-based strategies that optimize outcomes, and recognize adjuncts that do not

3

Who is the complex apical prolapse patient?

1. **Recurrent prolapse**
   Failed native tissue or prior apical repair
2. **Prior mesh**
   Exposure, pain or failure after mesh
3. **High anatomic risk**
   Stage III–IV, levator avulsion, wide genital hiatus
4. **Uterine preservation**
   Patient wish, no uterine pathology
5. **Host factors**
   Elderly, frail, obese, multiple comorbidities
6. **Multicompartment**
   Coexisting SUI, posterior defect, rectal prolapse

4

Recurrence risk is identifiable before surgery

Consistent predictors

- Preoperative stage III–IV
- Levator ani avulsion
- Family history of prolapse
- Large genital hiatus

What it changes in practice

- Image the levator when it will change the plan
- Set realistic expectations up front
- Favor a more durable apical option
- Plan longer follow-up

Vergeldt TF et al. Int Urogynecol J 2015

5

Optimizing starts with defining success

19% → **97%**

Same patients, same operation: "success" ranged from 19% to 97% depending only on the definition used.

Absence of bulge symptoms correlated best with the patient's own assessment of outcome.

Composite success today

- No prolapse beyond the hymen
- No bothersome bulge symptoms
- No retreatment (surgery or pessary)

Barber MD et al. Obstet Gynecol 2009 (CARE cohort)

6

Every apical repair erodes with time

OPTIMAL · NATIVE TISSUE

Sacrospinous vs uterosacral

Failure rose steadily in both arms through 5 years, with no significant difference between them.

CARE · SACROCOLPOPEXY

Abdominal mesh, 7 years

Anatomic failure kept rising, and mesh exposure reached about 10% by 7 years.

Implication: counsel on long-term durability, and follow patients beyond 1–2 years.

Barber MD et al. JAMA 2014 · Jelovsek JE et al. JAMA 2018 · Nygaard I et al. JAMA 2013

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Hysteropexy is a legitimate first-line option

SUPER · 183 WOMEN

Mesh hysteropexy vs vaginal hysterectomy + USLS

Lower composite failure with hysteropexy through 5 years; shorter operating time; mesh exposure about 8%.

SAVE U · NATIVE TISSUE

Sacrospinous hysteropexy vs vaginal hysterectomy + USLS

Non-inferior for apical failure; at 5 years, apical failure 1% vs 8%.

Select: no uterine pathology, normal bleeding pattern, informed patient preference.

Nager CW et al. JAMA 2019; AJOG 2021 · Detollenaere RJ et al. BMJ 2015 · Schulten SFM et al. BMJ 2019

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Mesh: selected cases, the right route

Setting	Evidence	Practical point
Transvaginal mesh, primary repair	PROSPECT: no benefit over native tissue; mesh complications in about 1 in 8	Avoid as a routine primary option
Sacrocolpopexy	CARE: mesh exposure about 10% at 7 years	Reserve for recurrence and high-risk anatomy
Concomitant hysterectomy	Total hysterectomy: 23% erosion vs 5% (aOR 5.7)	Prefer supracervical hysterectomy or hysteropexy
Prior mesh complication	Expert, multidisciplinary management	Refer to centers with mesh-removal experience

Glazener CMA et al. Lancet 2017 · Nygaard I et al. JAMA 2013 · Tan-Kim J et al. Int Urogynecol J 2011

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Prolapse repair can unmask SUI

OPUS · VAGINAL REPAIR

27% vs 43%

Urinary incontinence at 12 months, with vs without a prophylactic sling. More bladder perforation, UTI and voiding dysfunction.

CARE · SACROCOLPOPEXY

24% vs 44%

Stress incontinence at 3 months, with vs without Burch, in women continent before surgery.

Individualize: prolapse-reduced stress test plus shared decision on combined vs staged surgery.

Wei JT et al. N Engl J Med 2012 · Brubaker L et al. N Engl J Med 2006

10

Popular adjuncts that failed in RCTs

NO BENEFIT

Perioperative pelvic floor muscle training

OPTIMAL: no improvement in urinary symptoms or prolapse outcomes at 2 or 5 years.

Barber 2014 · Jelovsek 2018

NO BENEFIT

Perioperative vaginal estrogen

IMPROVE: 12-month failure 19% vs 9% with placebo; no reduction in recurrence after native tissue repair.

Rahn 2023

Still use estrogen for atrophy symptoms — just not to "prepare the tissue".

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Optimizing outcomes is a system, not a stitch

1 **Patient goals first**

Goal setting, shared decision-making, frailty and sexual function assessed

2 **Standardized technique**

Surgeon volume, structured training, a reproducible operative protocol

3 **Enhanced recovery**

ERAS pathway, opioid sparing, early voiding trial, same-day discharge

4 **Measure what matters**

Composite success, validated PROMs, registries, long follow-up

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Take-home messages

1. Identify complexity before surgery: stage, avulsion, prior repair.
2. No apical repair is permanent; counsel on long-term durability.
3. Uterus, mesh and continence: decide with the patient, on evidence.
4. Outcomes improve through systems: standardization, ERAS, measurement.

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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/