Speaker Questions and Answers

May 11, 2023 - Video 1

Sarah Boyd, MD - Evaluation and Management of Pelvic Organ Prolapse

Q1: Do you use a pop q stick or estimate visually?

*Our office uses the popstix measuring tool.*

Q2: What’s the best way to manage a pt that can’t use estrogen with pessary that end up with erosions or granulation tissue?

*Unfortunately, this is tough. I would verify the contraindication as there are little to no absolute contraindications to vaginal estradiol, even in breast cancer patients. Sometimes if this is the contraindication given, I will ask to contact the patient’s oncologist to review their recommendations and insights. If there is still a contraindication, the only way is to ensure adequate use of vaginal moisturizers (water-based or silicone based) daily and trying to decrease number of removals and reinsertions as we know from Dr. Propst’s study, those that remove and replace more often have more epithelial erosions.*

Q3: Patient morbidly obese cardiology contraindications for surgery using donut and gelhorn and Estring …. 1 year any other recommendation?

*Obesity involved. I'm not sure the question here. Is the patient not doing well with the pessaries? If failed pessaries and medically complex, may warrant a discussion on safe surgical practices like vaginal surgery under regional anesthesia. Obesity is a risk factor for failure so emphasizing good nutrition and exercise is important.*

May 11, 2023 - Video 2

Kalle Propst, MD - Surgical Interventions and Relevant Anatomy: What Are the Surgeries?

Q1: Is there a reason you would choose a sacrospinous over uterosacral suspension?

*This depends on several factors: especially the patient's anatomy, surgical history, and surgeon expertise influence this decision.*

Q2: Do the apical procedures also treat anterior prolapse? can you choose that procedure over anterior colpohrraphy for tx of anterior prolapse?

*Treatment of apical prolapse can improve anterior compartment prolapse but, re-supporting the apex is not a replacement for anterior colporrhaphy. Choosing to do an anterior colporrhaphy depends on the patient's anatomy- the severity of prolapse, length of the anterior vaginal wall, and if a midurethral sling is planned.*
Q3: I've had multiple patients with rUTIs after prolapse repair, why is that and any recommendations for treatment beyond the typical for rUTIs?

I think that the reason for this probably varies from one patient to the next. One important thing to evaluate is whether the patient is emptying her bladder completely, if there is any component of urinary retention, this can lead to UTIs.

Natalie Weigand, APNP & Cecile Ferrando, MD - Becoming A Skilled Surgical Assistant: Tips and Tricks

Q1: What surgical first assist course did you attend?

I attended Lakeland Community College's RNFA course here in the Cleveland area.

May 11, 2023 - Video 4

Lisa Hickman, MD - Developing Your Prolapse and Incontinence “Spiel”: How to Efficiently and Effectively Perform Patient-Centered Counselling

Q1: Do you have a different list of bladder irritants for your IC patients vs. OAB?

I basically have 1 bladder irritants handout that I give to my overactive bladder patients. I was always taught to recommend a low oxalate diet for IC; however I think there is significant overlap between the bladder irritants and low oxalate diets.

Natalie Weigand, APNP & Cecile Ferrando, MD - Care of the Transgender Patient Undergoing Feminizing Surgery

Q1: Why 12-15 cm? [regarding length of neovagina]

The neovagina is a graft and often contracts, this gives us wiggle room to end up with a total vaginal length of 9-12cm months after surgery, which is anatomic and in line with vaginal length in all women.

Q2: Since the prostate stays, do they need to worry about LUTS from BPH in the future and also checking PSA for prostate ca?

BPH and prostate cancer are always possible in this patient population. Estrogen is protective, so patients on longstanding therapy are less at risk. However, we do know that patients are screened later for prostate cancer when they have symptoms and when they do have it, it is more aggressive – probably because they avoid screening or we are more dismissive of symptoms because we think the estrogen is protecting them. Trans women over age 50 should be asked annually about any symptoms that could raise
concern for prostate cancer and they should have an annual exam – vaginal if they have had vaginoplasty, or rectal if they have not.

Q3: I have successfully managed neovagial prolapse with a Gelhorn pessary for 2 years without any complications of erosion or bleeding. Cannot find anything in literature on this. Anyone else have experience doing this?

“Prolapse” is unusual in these patients. But pessary use is completely fine and appropriate for most patients.

Q4: Do you typically ask for approval from the patient’s gyn onc to start them on vaginal estrogen?

Our practice is to message their oncologist as we participate in shared decision-making. We have literature that shows that recurrence is rare in patients who use estrogen post cancer treatment – these data are from our own center and based on a large cohort of patients.

May 12, 2023 – Video 1

Cameron Pikula, DPT - Overview of Pelvic Floor Physical Therapy

Q1: What approach would you recommend when talking about pelvic floor physical therapy with elderly, obese and physically challenged patients?

I address these patients in a similar way, knowing that making modifications to my assessment and home program are very common. Meeting the patient where they are capable, making adaptations to my home program for simplicity and to increase compliance. This patient may need more frequent visits for education and may progress slower but definitely possible to improve their symptoms with PFPT.

Q2: What kind of exam are you doing for fecal incontinence?

For fecal incontinence, with consent I do a rectal assessment. I am looking at pelvic floor strength, endurance, dynamics and coordination. Also, finding out exactly what type of fecal incontinence the patient is struggling with isn’t always a weakness problem! Sometimes these patients need to evacuate better to decrease the incontinence after a BM so working on pelvic floor coordination and lengthening is important.

May 13, 2023 – Video 1

Sarah Boyd, MD - Vulvar Dermatoses: Evaluation and Management

Q1: I have a current patient with biopsy confirmed lichen sclerosus. Started her on clobetasol this week. Her clitoris is 100% buried. Is there a way to save the clitoris?

Yes. Surprisingly, diligent steroid use can recover the clitoris over time. However, in refractory cases, they may warrant surgical exploration and revision.
Q1: How long do they sit on the commode to get accurate assessment of rectal prolapse?

I ask the patient to sit in the commode and I look (using a mirror) to see if there is prolapse initially (just at rest). Then, I ask patient to “push” and I watch to see if/what prolapses. Then I ask the patient to “relax” to see if prolapse retracts. Then I may ask the patient to “push” 1-2 more times depending on what I see or don’t see. Then I ask the patient to “squeeze in” to see if a prolapse can be voluntarily reduced. That’s it! So the entire commode exam takes about 2-4 min.

Q2: I deal with a lot of post op constipation, what would be your approach for prevention?

Patients who are prone to constipation - start 1-2 capfuls of Miralax daily starting 10 days prior to surgery and then resume daily starting POD# 1. Patients who are not prone to constipation at baseline - start 1 capful of Miralax daily on POD#1. In both scenarios, I continue daily Miralax while patient is on narcotics, less active, and/or eating less (10-30 days). Some patients I encourage to take Miralax daily for life! If patient becomes constipated post op despite taking Miralax, then I have them increase the daily dose of Miralax and take MOM 1 tbsp every 8 hrs until defecation (and then stop MOM but continue Miralax). I recommend patients stay off fiber supplement for 1-2 wks post op.