第11回
日本骨盤膣器脱手術学会学術集会

アジアにおける骨盤膵器脱手術
未来のスタンダードに向けて

プログラム・抄録集

会期
2017年3月11日（土）～12日（日）

会場
東京大学伊藤国際学術研究センター
東京都文京区本郷7-3-1 Tel: 03-5841-0779

会長
岡垣 竜吾
埼玉医科大学産科婦人科学教室教授
埼玉医科大学病院女性骨盤底医学センター長

古谷 健一
防衛医科大学校産科婦人科学講座教授
防衛医科大学校病院副院長
開催概要

第11回日本骨盤臓器脱手術学会学術集会

メインテーマ：アジアにおける骨盤臓器脱手術 未来のスタンダードに向けて

会期：2017年3月11日（土）～12日（日）

会場：東京大学伊藤国際学術研究センター
〒113-0033 東京都文京区本郷7-3-1 TEL：03-5841-0779

会長：岡垣 奄吾（埼玉医科大学産科婦人科学教室教授）
会長：古谷 健一（防衛医科大学校産科婦人科学講座教授）

参加費：医師（正会員）13,000円 医師（非会員）15,000円
前期研修医 5,000円 コメディカル 3,000円
※いずれも懇親会費を含みます。学術集会は当日受付のみとさせて頂きます。

第11回日本骨盤臓器脱手術学会学術集会 主催事務局：
埼玉医科大学産科婦人科学教室
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E-mail：11jpops@academiasupport.org

関連行事：
・世話人会
日時：2017年3月10日（金）17：00～18：30
会場：東京大学伊藤国際学術研究センター B1階 ギャラリー1

・会員総会
日時：2017年3月11日（土）13：10～13：30
会場：東京大学伊藤国際学術研究センター B2階 伊藤謝恩ホール
• 懇親会
日時：2017年3月11日（土）18：10～20：00
会場：東京大学伊藤国際学術研究センター B2階 多目的スペース

• 第6回歯科メッシュ手術研修会
日時：2017年3月12日（日）8：10～10：10（受付開始 7：55）
会場：東京大学伊藤国際学術研究センター B2階 伊藤歯科ホール
参加費：5,000円
定員：250名
お申込み方法：
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がございますので、予めご了承頂きますようお願い申し上げます。

プログラム：
1．総論 古谷 健一
（防衛医科大学校産科婦人科学講座教授）
2．手術手技材料 竹村 昌彦
（大阪府立慢性期・総合医療センター 産婦人科）
3．合併症 加藤 久美子
（名古屋第一赤十字病院 女性泌尿器科）
4．全例登録 合併症報告 成本 一隆
（金沢大学附属病院 泌尿器科）
プログラム 1日目

第11回日本骨盤臓器脱手術学会学術集会 プログラム 3月11日（土）

9:00～9:10 開会の挨拶
会長： 岡垣 竜吾（琦玉医科大学 産科婦人科学教室）
古谷 健一（防衛医科大学校 産科婦人科学講座）

9:10～9:50 ビデオセッション1「手術の工夫とビットフォール1」
座長： 成島 雅博（名鉄病院 泌尿器科）
野村 昌良（亀田メディカルセンター ウロギネコロジーセンター）
V1-1 LSCを術者1人で行う工夫
成島 雅博（名鉄病院 泌尿器科）
V1-2 LSC手術における尿管の走行
本郷 祥子（近畿大学医学部附属病院 泌尿器科）
V1-3 モノボーラーを使用しないシンプルLSCの実際
野村 昌良（亀田メディカルセンター ウロギネコロジーセンター）
V1-4 「フランス式剥離法」による腹腔鏡下仙骨結合固定術の実際
黄 鼎文（亀田メディカルセンター ウロギネコロジーセンター）

9:50～10:30 ビデオセッション2「手術の工夫とビットフォール2」
座長： 古山 将康（大阪市立大学大学院 医学研究科 女性生産医学）
三輪 好生（岐阜赤十字病院 ウロギネセンター）
V2-1 LSCにおけるメッシュ関連合併症をなくすための工夫
三輪 好生（岐阜赤十字病院 ウロギネセンター）
V2-2 腹腔鏡下仙骨結合固定術における「左手逆针」を科学する
森山 真吾（亀田メディカルセンター ウロギネコロジーセンター）
V2-3 当院における子宮摘除後症例に対するLSCの工夫と変化
新井 隆司（北九州総合病院 ウロギネコロジーセンター）
V2-4 TVM術後再発症例の検討：再発様式と治療手技（症例報告）
塩島 聡（聖隷浜松病院 産婦人科）

10:40～11:20 基調講演「骨盤臓器脱治験法の歴史的変遷」
座長： 朝倉 博孝（埼玉医科大学病院 泌尿器科）
演者： 永田 一郎（埼玉医科大学 産婦人科）
11:20～11:50 特別講演1 「カダバートレーニング」
座長：加藤 久美子（名古屋第一赤十字病院 女性泌尿器科）
        松下 千枝（大阪駿術館病院 泌尿器科）
演者：藤井 美穂（カレスサッポロ時計台記念病院 女性総合診療センター）
        安倍 弘（亀田総合病院 泌尿器科）

12:00～13:00 ランチョンセミナー 「Capio™ SLIMを用いた骨盤臓器脱修復術」
共催：ボストン・サイエンティフィック ジャパン株式会社
座長：武井 実治（原田病院 泌尿器科）
演者：嘉田 康邦（四谷メディカルキューブ 泌尿器科）

13:30～14:10 要望演題1 「手術の工夫とビットフォーラム」
座長：竹山 政美（第一東和会病院 女性泌尿器科 ウロギネコロジーセンター）
        巴 ひかる（東京女子医科大学東医療センター 骨盤底機能再建診療部/泌尿器科）
Y1-1 トータルリペア腹腔鏡下双骨髄固定術の剥離とメッシュ展開の工夫
        竹山 政美（第一東和会病院 女性泌尿器科 ウロギネコロジーセンター）
Y1-2 LSC導入期における追影3D-CTの有用性
        坂本 愛子（順天堂大学医学部附属順天堂東京江東高齢者医療センター 婦人科）
Y1-3 TVM手術後の膀胱結石の1例
        巴 ひかる（東京女子医科大学東医療センター 骨盤底機能再建診療部/泌尿器科）
Y1-4 リガシュアおよびValleylelab FT10
        エネルギープラットフォームを用いたクイックLSCの実際
        野村 昌良（亀田メディカルセンター ウロギネコロジーセンター）

14:10～14:50 要望演題2 「新しい術式の試み」
座長：清水 幸子（亀田メディカルセンター ウロギネコロジーセンター）
        成本 一隆（金沢大学附属病院 泌尿器科）
Y2-1 電動デルマートームを用いた膀胱鏡下の術式
        高橋 直子（順天堂大学医学部附属順天堂医院 泌尿器科）
Y2-2 Prolift型経陰マッシュ手術の進化型TVM-A2の成績
        滝田 知子（第一東和会病院 女性泌尿器科 ウロギネコロジーセンター）
Y2-3 円帯を利用したメッシュを使わない術式の試み
        - Laparoscopy Assisted Anterior Suspension -
        河野 亮介（大牟田市立病院 産婦人科）
Y2-4 腹開、剥離を行わない超低侵襲Semi-NTRの開発
        辻 芳之（神戸アドベンチスト病院 産婦人科）
座長：江川 雅之（市立砺波総合病院 泌尿器科）
谷村 悟（富山県立中央病院 産婦人科）

Y3-1 腹腔鏡下骨盤臓器脱手術における選択的卵管・卵巣切除の課題
谷村 悟（富山県立中央病院 産婦人科）

Y3-2 骨盤臓器脱の術前検査で鼠径ヘルニアが疑われ同時手術を行った一例
秋谷 由佳（富山県立中央病院 産婦人科）

Y3-3 女性膀胱癌に対する腹腔鏡下子宮温存膀胱全摘除術
江川 雅之（市立砺波総合病院 泌尿器科）

Y3-4 卵巣悪性腫瘍に合併した骨盤臓器脱に対する
腹式Shull縫合による腫瘍上位手術を実施した2症例
竹村 昌彦（大阪府立急性期・総合医療センター 産婦人科）

座長： 古谷 健一（防衛医科大学校 産科婦人科学講座）
演者：Douglas Miyazaki（Woman Care, Novant Health Clinical Instructor, Wake Forest, University, NC, USA）

座長：Roy Ng Kwok Weng （Department of Obstetrics & Gynaecology National University Hospital of Singapore, Singapore）
古山 将康（大阪市立大学大学院 医学研究科 女性生涯医学）

コメントター：Douglas Miyazaki（Woman Care, Novant Health Clinical Instructor, Wake Forest, University, NC, USA）

Introduction Speech
“For the Future Standard of POP Surgery in Asia”
Roy Ng Kwok Weng （Department of Obstetrics & Gynaecology National University Hospital of Singapore, Singapore）

“Description the Use of Pessary in Pelvic Organ Prolapse with Bacterial Vaginosis at Dr. Soetomo General Hospital Surabaya Indonesia during the Period of 2014-2015”
Azami Denas Azinar （Department of Obstetrics and Gynaecology, Airlangga University / Dr. Soetomo General Hospital Surabaya, Indonesia）
A-2  “Budi Iman Santoso Assessment (BISA): The Novel Screening Method for Pelvic Floor Abnormality in Postpartum Women”
   Budi Iman Santoso (Department of Obstetrics and Gynaecology, Faculty of Medicine Universitas Indonesia / Dr. Cipto Mangunkusumo Hospital, Indonesia)

A-3  “Characteristics of Pelvic Floor Dysfunction in Jakarta”
   Budi Iman Santoso (Department of Obstetrics and Gynaecology, Faculty of Medicine Universitas Indonesia / Dr. Cipto Mangunkusumo Hospital, Indonesia)

A-4  “An Audit on Major Complications of Hysterectomy in a Tertiary Institution over 6 Years”
   Lim Li Min (Department of Obstetrics and Gynaecology, Resident from National University Hospital of Singapore, Singapore)

A-5  “An Audit on Trends of the Routes of Hysterectomy in a Tertiary Institution over 6 Years”
   Lim Li Min (Department of Obstetrics and Gynaecology, Resident from National University Hospital of Singapore, Singapore)

A-6  “How Does Japanese Urogynecologists Contribute to Urogynecology Society in Asia?”
   野村 昌良 (亀田メディカルセンター ウロギネコロジーセンター)

A-7  “Our Indication of POP Surgeries Based on the Concept of ‘Site Specific Repair’”
   吉村 和晃 (産業医科大学若松病院 産婦人科)

Discussion Time
Aim
To determine the prevalence and characteristics related to pelvic floor dysfunction (PFD), including pelvic organ prolapse (POP), urinary incontinence (UI), and fecal incontinence (FI) in Jakarta.

Methods
A Cross sectional study was conducted in the Cipto Mangunkusumo Hospital as the tertiary health center in Indonesia. We recruited the patients using consecutive sampling lasted from January to April 2016 at the gynecology, endocrinology and urogynecology Cipto Mangunkusumo outpatient clinic. Data were taken from the study subjects using study form and pelvic floor examination using POP-Q.

Results
A total of 197 subjects obtained in this study, the prevalence of patients with PFD found 33%. The prevalence of POP was 26.4%; UI case of 15.3% and the case of FI of 2.50. Chi-square test performed to assess the relation between individual characteristics and PFD, found women aged > 60 years and aged 40-59 years have probability 69 and 14 times respectively to developed PFD. The probability of developing PFD were 76.0 and 14.2 times in multiparity and primiparity. Woman with vaginal delivery had a change to developed PFD 1.9 times. Postmenopausal woman had a probability 18 times developing PFD. Strongest risk factor in PFD are age parity, race, mode of delivery and postmenopausal women.

Conclusion
Pelvic floor disorder affects a substantial of women and increases with age, parity and aging.

Keywords : Pelvic floor dysfunction, pelvic organ prolapse, urinary incontinence, fecal incontinence, prevalence, risk factor
Prevalence and Characteristics of Pelvic Floor Dysfunction in Jakarta

Budi I Santoso, Nur R Fauziah
Department of Obstetrics and Gynecology
Faculty of Medicine, Universitas Indonesia/
Dr. Cipto Mangunkusumo Hospital
Jakarta

Abstract

Objective: To determine the prevalence and characteristics of pelvic floor dysfunction (PFD), including pelvic organ prolapse (POP), urinary incontinence (UI), and fecal incontinence (FI) in Jakarta, Indonesia.

Methods: A cross sectional study was conducted in the Cipto Mangunkusumo Hospital as tertiary health center in Indonesia. We recruited the patients using consecutive sampling lasted from January to April 2016 at gynecology, endocrinology, and urogynecology Cipto Mangunkusumo outpatient clinic. Data were taken from the study subjects using study form and pelvic floor examination using POP-Q.

Results: A total of 197 subjects were recruited. The prevalence of patients with PFD was 33%. The prevalence of POP, UI, and FI were 26.4%, 15.3% and 2.5%; respectively. Association between individual characteristics and PFD was found on women aged > 60 and aged 40-59 years old which have 69 and 14 times higher probability to develop PFD respectively. The probability of developing PFD was 76 and 14.2 times in multiparity and primiparity. Woman with vaginal delivery had a change to develop PFD 1.9 times. Postmenopausal woman had a probability 18 times developing PFD. Strongest risk factor in PFD were age parity, race, mode of delivery, and menopausal status.

Conclusion: Pelvic floor dysfunction affects a substantial of women and increases with age, parity and aging.

Keywords: fecal incontinence, pelvic floor dysfunction, pelvic organ prolapse, urinary incontinence

Correspondence: Budi I Santoso; budiis54@gmail.com

INTRODUCTION

Pelvic floor dysfunction (PFD) affects daily activities and decreases quality of life. The increasing prevalence of PFD corresponds to the enhancement of population growth, influencing the number of elderly worldwide. Greater participation of older women in the society is an important factor for improving quality of life. Pelvic floor dysfunction contributes to material loss for the country, especially in the health care system.

According to the National Health and Nutritional Examination Survey (NHANES) in USA, the prevalence of PFD was 23.7% in 2008. Meanwhile, Wu, et al. found an increased prevalence into 25% in 2014. PFD was found higher in older population and tended to relapse. Several risk factors found related to PFD were female, age, parity, and instrumental delivery.

PFD consists of pelvic organ prolapse (POP), urinary incontinence (UI), and fecal incontinence (FI). POP is the most common condition in elder women and the incidence reached 39.8%. Several risk factors contributing to this condition include age above 70 years old, having given birth more than three times, and menopause. For the UI, the prevalence ranged from 9.9% to 45%. Multiple vaginal deliveries, multiparity, menopause, obesity, and previous history of hysterectomy increase the risk of developing UI. FI is defined as the inability to control bowel movements, making the stools to leak unexpectedly from the rectum. Advancaged age, obesity, educational background, UI, multiparity, menopause, previous history of POP surgery, previous history of hysterectomy, urgency, diarrhea, constipation increase the risk of developing FI. This study was aimed to determine the prevalence and characteristics of PFD.

METHODS

This was a cross sectional study. Data were obtained by recruiting the PFD cases directly through consecutive sampling at the Women's Health Clinic of Dr. Cipto Mangunkusumo Hospital (RSCM) including gynecology, urogynecology, and endocrinology clinic during the period from January to April 2016. Subjects were women diagnosed with PFD who went to the Women's Health Clinic. Oncologic patients were excluded from this study.

PFD is defined as the weak of pelvic floor caused by the weakening of muscle function and pelvic floor fascia. It includes POP, UI, FI. POP is defined as a condition when a pelvic organ such as bladder (cystocele), uterine (uterine prolapse), vagina (vaginal prolapse), or rectum (rectocele) drops from
its normal place to lower abdomen and pushes against the wall of vagina. PFD was diagnosed using Pelvic Organ Prolapse Quantification System (POP-Q) continued with physical examination. We classified the subjects' BMI according to the WHO classifications. The classification is as follows: underweight (BMI < 18.5 kg/m²), normal weight (BMI 18.5-24.9 kg/m²), overweight (BMI 25.29.9 kg/m²) and obese (BMI ≥ 30 kg/m²).

Categorical variables were analyzed using the Chi-Square test or Fisher’s exact test. The linearity of continuous variables were analyzed using logistic regression. All statistical analyses were performed using SPSS 21 for Windows.

RESULTS

During the period between January and April 2016, a total of 197 patients were recruited. The detailed distribution consisted of 52 cases (26.4%) diagnosed POP, 30 cases (15.3%) diagnosed with UI, and 5 cases (2.5%) diagnosed with FI. Table 1 showed the characteristics of subjects in this study. The majority of the subjects were less than 40 years old (54.3%), Javanese (35.0%), had BMI less than 24.99 kg/m² (60.4%), had previous history of vaginal delivery (45.2%), had never undergone hysterectomy (93.9%), and had reached menopause (78.2%).

Bivariate analysis of several risk factors that were considered to have impact on the occurrence of PFD are presented in Table 2. Age above 60 years old (p<0.001, OR 68.96, 95% CI 17.08-278.53) and multiparity (p<0.001, OR 76.18; 95% CI 17.42-333.21) were the two strongest risk factors that contributed to the occurrence of PFD. Logistic regression analysis suggested that age above 60 years old had the strongest impact on the occurrence of PFD (p=0.038; OR 8.30; 95% CI 1.1361.14).

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Table 1. Characteristics of the Subjects
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<td>.36</td>
<td>12</td>
</tr>
<tr>
<td>No</td>
<td>.37</td>
<td>185</td>
</tr>
<tr>
<td>Menopausal status</td>
<td></td>
<td>.38</td>
</tr>
<tr>
<td>Postmenopause</td>
<td>1.640</td>
<td>154</td>
</tr>
<tr>
<td>Premenopause</td>
<td></td>
<td>43</td>
</tr>
<tr>
<td>Weight lifting habit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>.41</td>
<td>57</td>
</tr>
<tr>
<td>No</td>
<td>.42</td>
<td>140</td>
</tr>
<tr>
<td></td>
<td>.43</td>
<td></td>
</tr>
</tbody>
</table>
### Table 2. Bivariate Analysis between the Risk Factors and the Occurrence of Pelvic Floor Dysfunction (PFD)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>PFD (+) N (%)</th>
<th>PFD (-) N (%)</th>
<th>p value</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years old)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>19 (86.4)</td>
<td>3 (13.6)</td>
<td>&lt;0.001*</td>
<td>68.96 (17.08-278.53)</td>
</tr>
<tr>
<td>40-59</td>
<td>37 (54.4)</td>
<td>31 (45.6)</td>
<td></td>
<td>13.00 (5.65-29.89)</td>
</tr>
<tr>
<td>&lt;40</td>
<td>9 (8.4)</td>
<td>98 (91.6)</td>
<td>Reference</td>
<td></td>
</tr>
<tr>
<td><strong>Tribe</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Batak</td>
<td>13 (44.8)</td>
<td>16 (55.2)</td>
<td>0.142+</td>
<td>1.81 (0.81-4.04)</td>
</tr>
<tr>
<td>Others</td>
<td>52 (31.0)</td>
<td>116 (69.0)</td>
<td>Reference</td>
<td></td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiparous</td>
<td>54 (65.9)</td>
<td>28 (34.1)</td>
<td>&lt;0.001*</td>
<td>76.18 (17.42-333.21)</td>
</tr>
<tr>
<td>Primiparous</td>
<td>9 (26.5)</td>
<td>25 (73.5)</td>
<td>14.22 (2.88-70.21)</td>
<td></td>
</tr>
<tr>
<td>Nulliparous</td>
<td>2 (2.5)</td>
<td>79 (97.5)</td>
<td>Reference</td>
<td></td>
</tr>
</tbody>
</table>

*Chi-square test, *Fischer-exact test, PFD: Pelvic floor dysfunction

### Table 3. Stepwise and Backward analysis of Pelvic Floor Dysfunction (PFD) variables

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>PFD (+) N (%)</th>
<th>PFD (-) N (%)</th>
<th>p value</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body Mass Index (BMI) (kg/m²)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;30</td>
<td>10 (43.5)</td>
<td>13 (56.5)</td>
<td>0.347+</td>
<td>1.85 (0.74-4.60)</td>
</tr>
<tr>
<td>25-29.99</td>
<td>20 (36.4)</td>
<td>35 (63.6)</td>
<td>1.37 (0.70-2.70)</td>
<td></td>
</tr>
<tr>
<td>≥24.99</td>
<td>35 (29.4)</td>
<td>84 (70.6)</td>
<td>Reference</td>
<td></td>
</tr>
<tr>
<td><strong>Mode of delivery</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal</td>
<td>55 (61.8)</td>
<td>34 (38.2)</td>
<td>0.004+</td>
<td>1.94 (0.55-6.85)</td>
</tr>
<tr>
<td>Cesarean section</td>
<td>3 (18.8)</td>
<td>13 (81.2)</td>
<td>0.23 (0.05-1.56)</td>
<td></td>
</tr>
<tr>
<td>Vaginal and cesarean section</td>
<td>5 (45.5)</td>
<td>6 (54.5)</td>
<td>Reference</td>
<td></td>
</tr>
<tr>
<td><strong>Largest birth weight</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥3325 grams</td>
<td>34 (61.8)</td>
<td>21 (38.2)</td>
<td>0.123+</td>
<td>1.79 (0.85-3.75)</td>
</tr>
<tr>
<td>&lt;3325 grams</td>
<td>29 (47.5)</td>
<td>32 (52.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hysterectomy history</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7 (58.3)</td>
<td>5 (41.7)</td>
<td>0.064*</td>
<td>3.07 (0.93-10.07)</td>
</tr>
<tr>
<td>No</td>
<td>58 (31.4)</td>
<td>127 (68.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Menopausal status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postmenopause</td>
<td>35 (81.4)</td>
<td>8 (18.6)</td>
<td>&lt;0.001+</td>
<td>18.08 (7.61-42.97)</td>
</tr>
<tr>
<td>Premenopause</td>
<td>30 (19.5)</td>
<td>124 (80.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Weight lifting habit</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>24 (42.1)</td>
<td>33 (57.9)</td>
<td>0.083+</td>
<td>1.76 (0.93-3.33)</td>
</tr>
<tr>
<td>No</td>
<td>41 (29.3)</td>
<td>99 (70.7)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DISCUSSION

In this study, the prevalence of PFD was 33%. The reported prevalence of PFD in the world varies, in United States 23.7% in 2008 and 67.5% reported in Turkey. The number of patients seeking medications for PFD is low. One possible explanation is that patients with PFD are often embarrassed, making them rarely seek treatment.

The prevalence of POP reported varied from country to country. Nygaard found that the prevalence of POP in United States was 2.9%, while the of POP in Netherlands was 12.1%. The prevalence of POP in this study was greater than other studies. Dr. Cipto Mangunkusumo Hospital is a tertiary care center, and urogynecologist are limited to tertiary hospitals. Thus, patients with POP are often referred to this hospital.

The prevalence of UI in Dr. Cipto Mangunkusumo was 15.3%. Of this prevalence, 7.1% had stress urinary incontinence (SUI), 4.6% had urge urinary incontinence (UUI), and 3.6% had mixed urinary incontinence (MUI). This result was similar to other study conducted in United States which found that the prevalence of UI was 15.7%. The highest prevalence was found in women aged 70-74 years old, which was amounted to 51.9%. This study mentioned that the number of women seeking medical help regarding UI was low despite frequent symptoms and disrupted daily activities. This might be due to lack of knowledge regarding condition suffered. They often think that UI is a normal condition that occurs as a part of aging or postpartum process. There is also a belief that no intervention could be done to cure symptom.

The prevalence of IF in this study was 2.5%. In other study, the prevalence of IF cases was between 3.5% and 9%. The low prevalence might be due to embarrassment to seek treatment and lack of knowledge regarding IF.

Previous studies revealed age, vaginal delivery, and obesity as risk factors for PFD, along with genetic predisposition contributing to the development of PFD in some women. Kepenekci, et al. reported age as a risk factor related to the incidence of PFD. Vaginal delivery and high parity were known to increase both urinary and defecation issues related to PFD.

According to multivariate analysis, the most contributing risk factor to the incidence of PFD was age, followed with parity, ethnicity, mode of delivery, and menopausal status. Gradual denervation of smooth muscles on the pelvic floor in the aging process also contributes to the weakening of smooth muscle. Muscle denervation increases with prolonged active phase in vaginal deliveries. Age also contributes to degradation of nerves in accordance with prior degradation of muscle fibers activity. There is a decrease of the components in fascia including collagen, elastin, and smooth muscle in connective tissue matrix. Ethnicity is proven as a weak risk factor contributing to incidence of PFD, as there are anatomical and functional variations of pelvic floor across ethnicities resulting in difference of risk between each ethnic group.

CONCLUSION

The prevalence of PFD in this study is 33%. Age above 60 years and multiparity are the two strongest risk factors contributing to the occurrence of PFD. Further studies with larger sample sizes are needed in order to obtain more precise results regarding the prevalence and characteristics of patients with PFD.

REFERENCES


The 11th Japanese Society of POP Surgery
Annual Scientific Meeting
“For the future standard of POP surgery in Asia”
March 11-12, 2017, Tokyo Japan

Certificate of Appreciation
Dr. Budi Iman Santoso

This is to express our sincere gratitude for your presentation, which was a great contribution to The 11th Japanese Society of POP Surgery Annual Scientific Meeting “For the future standard of POP surgery in Asia” held on March 11-12, 2017 in Tokyo, Japan.

Please accept our thanks and appreciation for your efforts to make this conference a success.

Kenichi Furuya
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President, The 11th Japanese Society of POP Surgery Annual Scientific Meeting

Ryugo Okagaki
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President, The 11th Japanese Society of POP Surgery Annual Scientific Meeting