Minutes of the Southern Pelvic Floor Society

Evening 22/01/2014 Harbour Heights Hotel, Poole

Present:

Andrew Clarke (AC) (Today's Chair) Poole
Chris Vickery (CV) Taunton
Chris Oppong (CO) Plymouth
Patricia Boorman (PB) Exeter
Deborah Clarke (DC) Poole (Physio)
Jonathan Randall (JR) BRI (trainee)
Ahmed Mukhtar (AM) Poole
Jan Hicks (JH) (ODP specialist) Southampton
John Camilleri-Brennan (J C-B) Visiting External speaker and surgeon
Michael Lamparelli (ML) (Minutes) Dorchester
David Tarver (DT) Poole (Radiologist)
Steve Perring (SP) Poole (Physiologist)
Sally Sheppard (SS) Poole (Physio)
Paul Durdey (PD) BRI
Sophie Pilkington (SP) Southampton

Apologies:

Tony Dixon (on call)
Karen Nugent
Paula Hughes

Kindly sponsored by THD

Commenced with an update of Poole Patient Pathway (SS & AC) with discussions of the current set up and its improvements in patient flows, waits and costs.
ML discussed the Telephone assessment Clinic Pathway in Dorchester.
Such less expensive pathways and their potential adoption by commissioners caused a lively debate

Discussed AC's role on NPFS for training and ideas of accreditation of current units, new units and surgeons - current consultations and trainees.

Discussed proposed three tiers of Pelvic floor units
1 has everything - probably a teaching hospital
2 has access to everything with trained surgeon and local MDT (most of us)
3 the occasional dabbler in external prolapse

It was made clear to AC that the message from those present to the NPFS is that we would strongly recommend that we remain under the umbrella of ACP at this stage until we are much better established. AC to report back after NPFS executive meeting.

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Cases

1 PB Exeter
48 yr old lady completed her family, This is a second opinion from plymouth, previously seen at St Mark's.
Joint Hypermobility Disorder
SRUS symptoms, chronic fissure in past, currently irrigating lady expecting a LAP VMR chronic pain, colpo-suspension,
3 x VD (1 forceps and 1 Ventouse)
?sexual abuse
Proctogram RRI Rectocoele, deep enterocoele, lax pelvic floor but empties OK
ARP - low normal pressures - intact sphincters

Proctogram's reviewed.
Recommended continue with Irrigation or could offer LAP VMR, but only if conservative treatment fails to be efficacious.

2 AC Poole
Perineal Injury in male in his 40's
fall off bike at 70mph causing right sided pelvic bony and soft tissue injuries (amongst others) currently has a stoma and considering closure. Proctogram demonstrates some contraction of pelvic floor. Has evidence of improvement of sphincter function on ARP. He wants stoma closed...?
Advised to trial a closure of his stoma. Could consider a porridge enema first to allow him to judge what he can control.
If this leaves troublesome incontinence, consider SNS. No role for Fennix. Worried about reconstruction as this may worsen her function.

3 AC/ DT Poole
Lady in her 40's, imperforate anus, colostomy to perineum as infant (no sphincters on scanning). Worsening control, what to do?
CO has a similar patient in Plymouth, who had a successful SNS in this situation, and has got back to work.
Could consider a Fennix but CV warned of high risk of erosion.
Recommended SNS in first place

4 CV Taunton
Male Rear Admiral in his 70's, retired down from London
Chronic sepsis in perineum, ? duplication cyst - left a drain in the external opening track (inter-sphincteric opening extending up posteriorly) without resolution. Reviewed MRI's (DT) this extends above levators and may require a defunctioning stoma.
Planning to jointly operate with PD from below on this.

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5 CO Plymouth
60s Prolapse ops 1 Altemeiers, 2 Lap VMR -Now developed mesh erosion noted at recent colonoscopy and removal of polyp - this in lower neo-rectum. - Seen also by Gynecologists and have found evidence of sepsis with erosion into Cervix - Awaiting histology to exclude Cancer
Findings are of 3 cm hole in neo-rectum although relatively asymptomatic

He is planning operation with removal of mesh, and closure of defect.
PD - discussed a similar case with mesh erosion into rectum which resolved with removal of the mesh alone and antibiotics.
Recommended that this is the first approach, reserving a stoma or resection, if this fails.

JC-B

Gave lecture on injectables (copy of slides enclosed)
Discussed Gatekeeper for passive faecal incontinence where conservative measures have failed
12 cases in last 2 and a half years
all better at this stage (median of 12 month follow up)

three cases for Gatekeeper also presented by AC, AM and ML.

Retired to Dinner. (2200)