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## Combination Pharmacotherapy for Treatment of Overactive Bladder (OAB)

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Overactive bladder (OAB) is defined by the International Continence Society (ICS) and International Urogynecological Association (IUGA) as urinary urgency, usually accompanied by frequency and nocturia, with or without urgency urinary incontinence, in the absence of urinary tract infection or other obvious pathology. Current treatment strategies for OAB includes behavior therapy, combination pharmacologic therapy, intravesical onabotulinumtoxin (BoNT-A) injection, peripheral tibial nerve stimulation (PTNS), sacral neuromodulation (SNS) etc.

Combination pharmacologic therapy is a reasonable alternative when monotherapy is associated with suboptimal efficacy and /or bothersome side effects. In my speech, special considerations and evidence will be emphasized on combination pharmacologic therapy for OAB.

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## Vaginal laser on the sexual function of women affected by GSM

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Vaginal laser therapy has been reported to be a safe, effective and noninvasive procedure which can restore vaginal health and improve sexual function. Currently, there are radiofrequency devices which produce tissue contraction as heat develops, CO<sub>2</sub> lasers which fractionally ablate the tissue and cause contraction with subsequent tissue remodeling, and Er:YAG lasers which produce wound contraction secondary to tissue heating. Studies have found that laser therapy is able to stimulate angiogenesis, increase fibroblast activity and induce collagen formation without any associated ablative or thermal damage to the vagina. Specifically, fractional CO<sub>2</sub> laser therapies have been shown to improve blood flow in vaginal tissues which assists in restoring elasticity and moisture of the vaginal canal. Furthermore, previous studies that have investigated the histological changes in vaginal epithelium found that post-fractional CO<sub>2</sub> laser treatments, there was increased amount of collagen deposits and elastic fibers, a thicker epithelium, and an increased submucosal vascularity. The present study evaluated the long-term efficacy of fraction CO<sub>2</sub> laser treatment in postmenopausal women with symptoms of GSM. The results presented in this study showed statistically significant improvement in the assessment of GSM symptoms and sexual function by VAS and the FSFI questionnaire. Significant improvements in GSM symptoms of dyspareunia, dysuria, vaginal itching, vaginal burning and vaginal dryness were seen at one-month follow-up after three laser treatment and these improvements were sustained up to one-year follow-up. Of the FSFI domains, only lubrication did not show a statistically significant improvement at one-month follow-up. However, at six-month follow-up, FSFI lubrication domain scores showed a statistically significant improvement when compared with baseline and this improvement was sustained at the one-year follow-up. All other FSFI domains including arousal, orgasm, pain, satisfaction and desire showed a statistically significant improvement over baseline at the one-month follow-up and was sustained up to the one-year follow-up.

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## Pessaries for management of symptomatic pelvic organ prolapse and incontinence

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Pelvic organ prolapse (POP) and stress urinary incontinence (SUI) are common problems in women. A pessary is made of silicone or plastic and it can be used to treat symptoms of POP and SUI. Therefore, the vaginal support device could be avoid the patients undergo surgery. Pessaries are used when symptoms of POP are mild or when childbearing is not complete. They can also be used in women who have other serious chronic health problems, such as heart or lung disease, that make a surgical procedure more dangerous. Pessaries are sometimes used to treat uterine prolapse or urinary incontinence in young women during pregnancy.

A variety of pessaries are available, including the inflatable, doughnut, and Gellhorn, etc. These pessaries can be classified into two categories: support and space-filling. Support pessaries are two-dimensional. Types of support pessaries include the ring (with or without a support diaphragm), the lever, the Gehrung, the Shaatz, and the incontinence ring or dish pessaries. Sexual intercourse is still possible when they are in place. Space-filling pessaries are three-dimensional. They include the Gellhorn, donut, cube, Inflatoball, and Colpexin sphere pessaries. They are often needed in women with severe (stage III or IV) POP. Incontinence pessaries are designed specifically to treat SUI. They compresses the urethra against the upper posterior portion of the symphysis pubis, causing an increase in urethral resistance. Whereas pessaries for POP are typically used all day, pessaries for SUI can be used as needed (for example, during exercise). Common complications include vaginal discharge and odor, new onset difficulty in voiding, spontaneous expulsion, and vaginal erosion. Treatment of these complications includes local administration of estrogen, regular follow-up, and appropriate fitting of the pessary.

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## Pelvic Organ Prolapse: Controversies in Surgical Treatment

Pelvic floor disorders affect the quality of life of millions of women worldwide. Many different operations exist for the treatment of pelvic organ prolapse and urinary incontinence. Even though uncommon, all surgery has complications which can cause morbidity and rarely mortality.

Patients often ask, “what is the best surgery to fix my problem?” This is a seemingly simple question that involves a clear understanding of what the actual “problem” is and what perceived risks the patient is willing to take on in return for the potential benefits to achieve their desired goals. In a field where most surgical procedures are elective, patients have high expectations for postoperative outcomes and providers aim to meet them. In striving to meet those expectations and examining the relationship between patient goals and provider perspectives, it has become apparent that often what a provider considers a success or complication may not be the case for the patient and vice versa. This lack of understanding is the root of some of the “controversies” (or debates) regarding pelvic organ prolapse surgery that currently demand attention and research. Other current controversies exist because of a lack of sufficient data to give a clear picture regarding the balance of outcomes and risks with different approaches to surgery and perioperative care. This talk discusses a few of the most prominent controversies currently confronting providers and patients when planning for surgical repair of pelvic organ prolapse (POP).

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**Stress urinary incontinence in women: Persistent/recurrent symptoms after surgical treatment**

Surgery is a common treatment modality for stress urinary incontinence (SUI), usually offered to women for whom conservative treatments have failed. The surgical standard for treating SUI has changed from the pubovaginal sling (PVS) and Burch colposuspension to the midurethral sling (MUS) because of comparable cure rates and lower surgical morbidity after the introduction of the MUS in 1996. The long-term objective and subjective cure rates for retropubic (RP) and transobturator (TO) slings were found to be 61.6% and 76.5%, and 64.4% and 81.3%, respectively. The failure rate was about 5-20%. There is no level 1 evidence for the best next step after a failed MUS. Repeat MUS, PVS, Burch colposuspension, tape shortening, and transurethral bulking agent injections can be considered as second-line surgical procedures. A newer bulking agent, polyacrylamide hydrogel, demonstrated excellent short-term success rates in patients after a failed sling. There is not yet any consensus regarding the choice of adequate second-line surgery for failed MUS. However, it is necessary to approach surgical options according to the cause of the previous failure rather than uniformly determining a single treatment option. Since transurethral bulking agent injections or tape shortening can be performed with minimal invasiveness, they may be suitable as office-based procedures, but have lower durability and efficacy than other treatment options. Repeat MUS is still being performed most frequently, and recently, PVS and colposuspension are receiving attention again because issues relating to the mesh-related complications have been highlighted.

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### Laparoscopic Pectopexy and sacrocolpopexy Procedure for Pelvic Organ Prolapse

Laparoscopic sacrocolpopexy is reported to offer good clinical results similar to those of abdominal sacrocolpopexy, with the added benefit of being minimally invasive. However, LSC is a lengthy procedure, which is the main limitation of this approach. In order to overcome this problem, modification to the original technique to improve its effectiveness is very important. Besides, sacrocolpopexy is still associated with some problems, and the most frequently reported complications include ileus, defecation disorders and stress urinary incontinence. Presacral hemorrhage is the most worrying intraoperative complication of sacrocolpopexy, and may have life-threatening consequences.

Laparoscopic pectopexy is a new type of endoscopic prolapse surgery. It uses the lateral parts of the iliopectineal ligament for a bilateral mesh fixation of the descended structures, so fewer potential long-term problems are expected. The pelvic outlet does not narrow with this procedure, as is expected with sacrocolpopexy, and, compared to the latter, laparoscopic pectopexy is not associated with a high intraoperative risk.

Further studies showed comparable outcomes in supporting the apical compartment at intermediate follow-up duration compared with laparoscopic sacrocolpopexy. Advantages of LP compared with LS are shorter operation time and lower complication rate. Therefore, Laparoscopic pectopexy is a feasible surgical method for apical prolapse, with a shorter operation time and less postoperative discomfort than LS.