Pelvic physiotherapy is one of the mainstays of prevention and treatment of high prevalence pelvic floor dysfunction (PFD), such as urinary incontinence (UI), overactive bladder (OAB), pelvic organ prolapse (POP), fecal incontinence and sexual disorders. It is widely known that the weakness of the pelvic floor muscles (PFMs) plays an important role in the pathogenesis of PFD, leading to role, social, and physical limitations, which affect personal relationships, emotions, energy and sleep. Therefore, prevention and treatment programs of PFD focus on behavioral and physical activities for increasing pelvic function, well-being, and fitness.

Research programs on prevention, such as the recently developed “motherfit program” (see www.motherfit.nl), aim to identify peri-and post partum risk factors for PFD and to evaluate cost-effectiveness of antenatal and postnatal pelvic physiotherapy. Pelvic physiotherapy is often considered as first-choice treatment of PFD since it is non-invasive, it has good subjective and objective outcomes, it is safe with no complications/side effects, and it is usually a less expensive option. The lack of motivation, adherence and perseverance of patients and therapists, as well as the time required for physiotherapy, represent the most important limitations which affect the treatment outcomes. In the last two decades, high quality research has been performed on the diagnostic assessment of PFD, education and information and treatment modalities. For stress UI, PFM training in particular has largely been proven to be effective. For OAB, pelvic physiotherapy electrotherapy has been shown to reduce or eliminate involuntary detrusor contractions during the bladder filling phase through reflex inhibition.

In the treatment of pelvic organ prolapse (POP), there is growing evidence that peri-operative pelvic physiotherapy improves surgical outcomes and reduces postoperative PFD.

It is encouraging to see that IUGA has also recently demonstrated increased interest and recognition of evidence-based pelvic physiotherapy by creating an IUGA Special Task Force in the area of ‘Pelvic Floor Rehabilitation.’

Bary Berghmans PhD MSc RPT
Chairman IUGA Special Task Force:
‘Pelvic Floor Rehabilitation’
Pelvic care Center Maastricht
Maastricht University Medical Center
The Netherlands

See next issue:

Does pilates work for pelvic floor dysfunction?
Letter from the new President

Dear Fellow Members,

IUGA has become a strong organization in the last years, and we have seen a tremendous growth in not only members, but also in scientific and educational activities. IUGA has become a well-respected international organization in the field of Urogynecology.

This is the result of many members’ working hard in all IUGA committees. In the past, we changed positions at the Annual Meeting and we were able to thank the leaving committee members for their contributions in person. Now we change positions at the end of the year and in a slightly anonymous way.

As the new President I would like to start with recognizing the important contributions of all members who are leaving IUGA committees, while at the same moment welcoming all new committee members. In particular, I would like to thank Peter Sand for not only serving as IUGA president, but also for his important role as Secretary-Treasurer for 18 years. However, it is also the time to acknowledge the tremendous work of another Secretary-Treasurer, Willy Davila, who established IUGA as an internationally recognized professional organization. He is leaving as Secretary-Treasurer, but will continue his work as the newly elected Vice-President. Finally, I would like to welcome Soren Brostrom from Denmark as our new Secretary-Treasurer.

I want to express my appreciation to the membership for the opportunity to serve you as President for the coming two years. Please feel free to contact me for questions or ideas to continue IUGA being the premier organization in Urogynecology.

Harry AM Vervest
President, IUGA
The Netherlands

IUGA eXchange, November 2010
Astana, Kazakhstan

In 2009 IUGA approved an eXchange program in order to reach out and interact with Kazakh urogynecologists and physiotherapists. The eXchange program was held in Astana, the capital city of Kazakhstan.

The Republic of Kazakhstan is a transcontinental country located in Central Asia and Eastern Europe. A former Soviet Republic, today Kazakhstan is an independent state ranked as the ninth largest country in the world as well as the world’s largest landlocked country.

Although the language barrier was significant, considering that Russian is the principal language, the enthusiasm and combined efforts of the local organizers and IUGA faculty contributed to an interesting program that was highly appreciated by the participants.

We are extremely grateful to IUGA and in particular to the Elena Lushchayeva, Dana Kassenova, Sylvia Botros, Soren Brostrom, Sanjay Sinha, and Wolfgang Umek for their contributions.

This program contributed to the implementation and spread of internationally recognized guidelines in urogynecology in Kazakhstan.

Wolfgang Umek, MD, Associate Professor
Division of General Gynecology and Gynecologic Oncology, Dept. of Ob/Gyn, Medical University Vienna

National Research Center of Mother and Child Health, Astana
ASTANA, KAZAKHSTAN: 2010 eXchange program in pictures

Preview 2011
IUGA eXchange
Beijing, China
September 24-25
Note from the new Editor

Dear IUGA Members,

As incoming Chair of the Publications Committee, first of all I would like to acknowledge the contribution of Ash Monga, the immediate past chairman, for his excellent job over the last three years. I would also like to take the opportunity to update all of you about the Committee duties and how we would like to accomplish this in the future.

The main task of the Committee will be to look after the Newsletter. However, as happens in every "new cycle", some changes I think are needed as well as expected.

The Committee is slowly expanding, and new members from different countries have agreed to help and to contribute in this new venture. Each committee member has a specific role and responsibility.

The Newsletter has regular sections (or corners) such as “The Cover Story Corner”, “The Historic Corner”, “The Research Fellow Corner”, “The Urogynecology Wine Corner”, “The Urogynecology Article Review Corner”, “The Patient Perspective Corner” and “The News Corner”. The latter includes news from the International Urogynecology Journal, news from Affiliate Societies and news from the new Fistula Initiative.

For the future, this newsletter will evolve into a “VOX populi”, a sexy and exciting medium for discussion about the hottest topics in urogynecology. This will be covered in “Controversies in Urogynecology,” which will open every new issue with a pros and cons debate between faculty. This will provide further material for the Discussion Forum section already available at www.iuga.org.

Starting from 2011, the Newsletters will come out every 3 months at the end of March, June, September and December. The word count limit for each article will increase from 300 up to 500 words. In every issue there will be a literature review on specific topics in different urogynecological fields to allow the members to be updated on the most recent published data.

Senegal

The IOFWG/ISOFS (International Obstetric Fistula Working Group/International Society of Fistula Surgeons) held their 3rd meeting in Dakar, Senegal. IUGA was very well received at the meeting. The fact that Dr. Sand came to the meeting as the sitting President of IUGA made quite an impression.

ISOFS liaison As a result of Dr. Sand’s physical presence at the ISOFS meeting, IUGA’s stature among the leadership of ISOFS was greatly enhanced. Their President, Dr. Kees Waaldijk expressed gratitude and a strong desire to form a liaison with IUGA. This liaison should help IUGA fulfill one of its goals to reach African gynecologists/urologists who work at fistula centers. IUGA has been asked to participate and Dr. Sand has committed IUGA to being a key player at the ISOFS meeting in Bangladesh in early 2012.

Collaboration with African fistula center We have identified interested sites in Nigeria, Kenya, and Malawi. IUGA needs to visit a few centers and follow up with a contractual relationship with a dedicated center. I would like to see a site chosen by the end of 2011 and IUGA members on the ground in 2012.

Annual Meeting workshop We will be holding our 5th workshop on fistula in Lisbon. This year we plan on focusing less on the actual repair of fistulas and address the even larger problem of prolapse and incontinence. It should be balanced enough to satisfy those who sign up to attend.

Research/Foundation The subcommittee’s efforts may lead to the formation of a new Fistula Foundation. If that occurs, it is the perfect opportunity for IUGA to fund patient care efforts and research projects particularly at our future collaborative site.

Members Key IUGA members who have been very helpful in IUGA’s effort include Dr. Lauri Romanzi and Dr. Tracy Capes.

cont’d. on page 5
A separate IUGA Newsletter, in a bi-monthly electronic format, will continue to disseminate information on society activities, educational programs, to welcome new members and to allow members to familiarize with the society structure. This, I hope, will bring a sense of community to the organization, which will then promote further participation and member activity.

Once again, I would like to thank the IUGA Members for your support of my role to serve and guide the Publication Committee for the next three years. Remember that the Newsletter is the IUGA Member’s voice and magazine. Please do not hesitate to contact me regarding your ideas, questions, suggestions and requests about any topic you think it will be worth to cover and discuss. I look forward to working with you all to promote the communication among Members within IUGA.

Alex Digesu
Chair, Publications Committee
London, UK

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**IUGA PATIENT BROCHURES**

**TAKE A LOOK....**

This is an example of a Thai Patient Brochure. If you feel you could benefit from having these brochures translated into your own language for your patients, please help us translate.

Do you have a few spare hours you could give to IUGA to help in this work?

If you can help please contact Monika at monika@iuga.org. We look forward to working with you!

Best wishes and thank you.
Lynsey Hayward
Chair, PR Committee

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**Example of a Thai brochure**

We would like to thank the following IUGA members who are currently working hard translating brochures into their native languages:

**Arabic:** Ahmed Al-Badr, Hazem Al-Mandeel, Fatma Al-Shangiti, Maysoon Al-Adham, Sameera Al-Basri, Faisal Kashgari

**Dutch:** Astrid Vollebregt, Robert Hakvoort, Hans van Geelen

**German:** Kaven Baessler

**Greek:** Stergios K. Doumouchtsis, Angelos Liapis

**Portuguese:** Renato Martins, Luciana Pistelli, Aparecida Pacetta, Rodrigo Castro, Raquel Arruda, Maria Augusta Bortolini, Anabela Serranito

**Spanish:** Henrique Arnal B, Vanda López G, Glenda Vervest

**Thai:** Jittima Manonai, Rujira Wattanayingcharoenchai, Komkrit Aimjirakul

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**2011 IUGA ELECTION RESULTS**

**International Board**

Peter Delong (Africa) new
Lisa T. Prodigalidad - Jabson (Asia) new
Hans Peter Dietz (Australia) new
Mauro Cervigni (Europe)
Gamal Ghoniem (North America)
Rodrigo Castro (Latin America)

**Executive Board**

H.A.M. Vervest, President
G. Willy Davila, Vice-President
Peter K. Sand, Past President
Søren Brostrøm, Secretary-Treasurer

**Committee Chairs**

new Michele Meschia (Scientific)
new Jan Paul Roovers (Education)
new Dorothy Kammerer-Doak (R&D)
new Alex Digesu (Publications)
new Lynsey Hayward (Public Relations)
Sylvia Botros (Fellows)
Bernard Haylen (Terminology)
Overlapping compared with end-to-end repair of third- and fourth degree obstetric anal sphincter tears. A randomised controlled trial.

This randomised controlled trial compared overlapping to end-to-end repair of third- and fourth degree obstetric anal sphincter tears. Inclusion criteria were complete third or fourth degree anal tear. The primary outcome was faecal incontinence at six months. Faecal incontinence, quality-of-life scores, integrity of the internal and external sphincters and anal sphincter function were the secondary endpoints. 149 primiparous women who met the inclusion criteria were randomised to having either an end-to-end (n=75) or an overlapping repair (n=74). The baseline characteristics of the 2 groups were similar. The rate of faecal incontinence was higher in the overlapping repair group (61%) compared to end-to-end technique (39%) (Odds ratio 2.44, 95% confidence interval 1.18─5.04, p=0.015). The faecal incontinence rate was also higher in the overlapping repair group, although this was not significant. Defects in the external and internal sphincter and anal sphincter function did not differ significantly between the two groups.

The Cochrane review could not recommend one type of repair above the other due to heterogeneity of the included studies. Inclusion of multiparous women and patients with partial tears were found to be weaknesses in these studies as well as the variation of the outcome measures. This randomised controlled trial overcame these disadvantages by using primiparous patients with complete 3rd degree tears and had clear objectives and methods of measurement of the outcome. The trial was adequate on quality criteria like randomisation, concealment, blinding, power calculation, follow up and intention to treat analyses. The authors mention the possibility of greater denervation and scarring during dissection for optimal overlapping of the external anal muscle affecting its function and accounting for these results. This grade 1 evidence seems to providing convincing evidence in favour of end to end repair short term but long term data is awaited.

Our Opinion

Urogyn Wine

Dr. Retto and Dr. Colaco searched the Wine Spectator and did some testing for us. Here are their recommendations for when we are in town:

Quinta do vesuvio Douro, 2007

Winemaker’s notes:
Deep ruby in color. On the nose showing a concentrated intensity of lifted aromas of brambly black fruits which develop into subtle mineral elements and notes of perfumed sweet honeysuckle. On the palate, the wine is concentrated and rich, without being overwhelming, a blend of power and elegance. The opulent and intense raspberry and dark plum flavors are perfectly integrated with the toasty vanilla of the oak and follows through to a backbone of sweet refined tannins and a long seamless finish. A wine of great pedigree.

Critical acclaim:
A powerful, full-bodied red from Portugal, oozing with kirsch, dark plum and dark cherry flavors that are flanked by concentrated dark chocolate, bourbon and tobacco leaf flavors. The long finish features rich spice and smoke notes.

- Tempting now
- Best from 2010 through 2015
- 1,000 cases made

[Source: Wine Spectator]
Lisboa is the capital of Portugal and lies on the European Atlantic coast. The westernmost European capital is a charming city, whose origin goes back to the ancient Greek and Roman empires. In the 14th and 15th centuries Lisboa watched the departure of the caravels, which “gave new worlds to the world”.

Try out the exquisite cuisine and wines. Don’t miss the sweets and pastries. Walk through the Medieval quarter of Alfama, the Baixa’s commercial avenues or the elegant Chiado shopping area, next to Bairro Alto, home of much of the Lisbon nightlife.

Visit the Belem quarter dedicated to the Portuguese Discoveries with Jerónimos monastery as its Master piece. Visit also the Castle of S. Jorge and its quarter with a breathtaking view over Lisbon and river Tejo.

Lisboa’s location, spread over seven hills, overlooking the river Tejo, futures a cultural diversity, a pleasant climate all year-round and people that by longstanding tradition offer visitors a warm welcome.

Around Lisbon, don’t miss Sintra and Queluz, famous for their Exquisite Romantic Palaces as well as Estoril and Cascais, an elite region, with luxurious beaches and gardens.

More wine?

Winemaker’s notes:
Color: Deep red color
Aroma: Richly fruited with spicy blackberry and mulberry notes
Palate: Well balanced tannins and good quality oak ageing notes.

Best regards,
Teresa Mascarenhas
President
2011 Local Organizing Committee

[Source: Wine Spectator]
Affiliate News: **URPSSI** Urogynaecology & Reconstructive Pelvic Surgery Society of India

**Serving the poorest of poor** A remarkable beginning of 2011

*by Prof. N. Rajamaheswari*

A unique Urogynaecological teaching & training endeavour with an objective of “Improving Qol of women of underprivileged Indian women” was conducted under the auspices of Urogynaecology & Reconstructive Pelvic Surgery Society of India (URPSSI an affiliate society of IUGA). It was held at Government Kasturba Gandhi Hospital, Chennai, Tamil Nadu, and India from 10th to 28th of January 2011.

This Urogynaecological teaching and training endeavour involved three consecutive sessions for a small group of 25 young Urogynaecologists serving the underprivileged women of different states of India. The following eminent, dedicated international faculty motivated, inspired, guided and trained the 25 young Urogynaecologists.

**Prof. Paul Riss & Prof. George Ralph - Austria**
**Dr. Ouida Leniane Westney, Associate Prof. MD - USA**
**Prof. Bobby Lewis Shull, Dr. Richard Wasserman & Dr. Sylvia Botros - USA**

Women requiring surgical repair and reconstruction for different varieties of pelvic organ prolapse and women requiring surgical cure for continuous urinary leakage due to irreparable VVF were operated. In total, 32 female patients were operated. One-on-one training is the distinctive feature of the training. Prof. Bobby Lewis Shull led the team and trained the specialists exclusively on fascial repairs and high utero sacral ligament suspension for POP.

Prof. Paul Riss and Prof. George Ralph made their valuable contribution by demonstrating the European way of performing vaginal repair of POP. Richard Wasserman and Sylvia Botros did impressive repair for POP which was least invasive. Surgical management of continuous urinary leakage due to irreparable VVF cases were surgically managed by varieties of continent urinary diversions with catheterizable stomas by Ouida Lenaine Westney. Reconstruction of lower urinary tract for developmental anomalies were performed by Ouida Lenaine Westney and N. Rajamaheswari.

Parenthetically, Sylvia Botros and Richard Wasserman had the opportunity to assist and learn about VVF repair from Prof. N. Rajamaheswari. Especially vaginal repair of supratrigonal VVF - a least invasive and highly beneficial approach for the unfortunate fistula patients were taught. The programme was not sponsored by any surgical industries and none of the faculty were “thought leaders”. The programme was conducted at a government institution, which is serving the poorest of the poor.

The trained specialists also are serving the economically compromised section of society in accordance with our prime objective of improving Qol of underprivileged Indian women. None of the faculty were paid “Honorarium,” nor were their travel expenses reimbursed.

The astonishing and utterly moving service of these great human beings is highly commendable.

This Education endeavour was organized by Prof. N. Rajamaheswari (President - URPSSI) with the whole hearted support and commitment of the above mentioned International Faculty.

Thanking you sincerely,

Prof. N. Rajamaheswari
President-URPSSI
Professor of Urogynaecology
Govt. Kasturba Gandhi Hospital and Madras Medical College,
*Chennai, India*
2011 Membership renewal
Membership starts on sign up date and is valid for 1 year

$100 membership includes: Renew online at www.iuga.org!

- 12 issues of the International Urogynecology Journal (IUJ)
- Substantial **discount on 2011 IUGA annual meeting registration**
- Members only content via www.iuga.org
- IUGA quarterly newsletter

To renew by FAX, please fill in the fields below and fax in to the IUGA office at +1-954-933-1648.

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IUJ – From Submission To Acceptance by Paul Riss - Co-Editor in-Chief, IUJ

What are the chances that my manuscript is accepted by the IUJ?

After all the hard work, every author wants to see his or her manuscript in print. However, the chances of a manuscript being accepted by a particular journal will depend on many factors and the overall so-called "rejection rate" is only a rough guide. Some general remarks might be helpful.

The first question every author should consider is whether the manuscript fits into the spectrum of articles published in the journal. It is surprising how often manuscripts are submitted which are outside the field of a particular journal. Then there is the question whether a manuscript will be of sufficient interest to the readership of the journal. Is it a clinical study or basic science article? Is it dealing with research in animals? And last but not least, is everything in order with the manuscript and is all the compulsory information provided which the journal requests?

Once the first hurdle is passed, there is the review process. Not all manuscripts are subjected to a full review process. Some papers might be invited editorials or clinical opinions and are evaluated by the editors-in-chief either alone or in consultation with other editors. Letters to the editor and replies by the authors normally do not undergo a review process but are edited by the editor responsible for this section.

So what are the rejection rates – or to put it in a more positive perspective – the acceptance rates of IUJ? The table below shows the rates for the year 2009 taken from the annual publisher's report by Springer International. This table shows the “final disposition” which means the final decision on a manuscript after submission or after one or two revisions.

In 2009, a total of 533 manuscripts were submitted to the IUJ. These included 416 original articles and 89 case reports. The overall acceptance rate was 49% (48% for original articles and 51% for case reports).

Is the glass half full or half empty? If half of all manuscripts submitted are accepted this is probably a sign of a mature and well-established journal. The impact factor of 2.412 (2009) is high, and authors will try to take advantage of the wide distribution of the journal to get their work known to their peers in the scientific community. On the other hand some authors might give it a try submitting manuscripts to see how they are reviewed.

Next issue: The role of the publisher.

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Table 1. Final disposition of manuscripts submitted to the IUJ in 2009

- Please feel free to submit your questions about IUJ to iujeditorialoffice@gmail.com -
The History of Urogenital Fistulae Repair

Urogenital fistulae remain one of the most challenging problems in modern female urology. The problem of urogenital fistulae resulting from obstetric trauma has almost been eradicated from the developed countries, but it remains a major problem in the developing world. In a report from the USA only 5% of genitourinary fistulae were of obstetric origin, while studies from Nigeria, India, and Pakistan indicate obstetric causes to be responsible for 92%, 81%, and 68% of such fistulae respectively. The United Nations Population Fund estimates that there are more than 2 million women currently living with fistulae in the sub-Saharan belt of Africa and that another 50,000 to 100,000 join their ranks each year.

Although it is likely that urogenital fistulae of obstetric etiology was known to the physicians of ancient Egypt, the association with difficult labor was not made until 1000 AD when it was described by the Perso-Arab physician Avicenna (Ibn Sinna) in his text Al Kanoun. He was the first to associate prolonged obstructed labor with fistula formation. In 1663 Henrick van Roonhuyse gave a proper account on the principles of treatment of vesicovaginal fistulae and proposed a method of repair using stitching needles made of stiff swans’ quill.

Since then, the literature on this subject has been extensive, although largely based on anecdote, small retrospective case series, and opinions rather than facts. As a result, much of our knowledge and practice in this area is based on the experience of a small number of individuals working in areas of high fistula prevalence, rather than firm scientific evidence.

The modern era of successful fistula repair is credited to James Marion Sims who has been referred to as the father of vesicovaginal surgery. He reported a successful urogenital fistula closure in 1852. In 1855 the fistula hospital was opened as the result of Dr. Sims’ determination.

In 1928 the German physician Heinrich Martius proposed the Martius graft. He used the bulbocavernous muscle inserted between the bladder and vaginal sutures in an attempt to improve the fistula repair. This important technique continues to be used today, and most surgeons recommend that it should be used with all fistulas except the very small and very large, when it would be inadequate.

It has been widely accepted and adopted for the repair of urethrovaginal, vesicovaginal and rectovaginal fistulae, for damaged urethra reconstruction, vaginal or rectal stenosis, and postradiation rectal or vaginal fistulae, with success rates close to 100%.

Recently many efforts have been made in the direction of reconstructive urology. Primarily this has affected issues such as tissue engineering, organ regeneration, and graft fabrics. In 2003 Atala started elegant work on tissue engineering with a cell culture in order to create a urethral tube. Unfortunately, it is too early to fully assess the clinical data.

Preliminary findings on fabrication of a urethral graft using reinforced collagen-sponge tubes show that urethral tissue regeneration depends not only on the biomaterial composition, but also on the fabrication technique. Guan et al. (2004) state that human vascular endothelial growth factor may be a suitable approach to increase the blood supply in tissue engineering for treatment of urethral damage.

So with a better understanding of the historical context of obstructed labor, the obstetric fistulae and the surgical principles of fistulae closure, we can begin to improve the healthcare status of women suffering from this problem around the world.

Dmitry Pushkar
Urology Department, MSMSU
Moscow, Russia

2011 CALL FOR NOMINATIONS!
Please view the procedure for Nominations at www.iuga.org. IUGA Policies may be found through the link for Documents on the top orange tab of the IUGA website homepage.
The following positions will be requesting nominations:

- International Board - Europe
- International Board - North America
- International Board - Latin America
- Fellows Committee Chair
- Terminology & Standardization Committee Chair
- Scientific Committee Member(s) - 5 members
Meetings Calendar

August 29 - September 2, 2011
International Continence Society (ICS)
Meeting: Annual Meeting
Location: Glasgow, United Kingdom
Website: http://www.icsoffice.org

September 14-17, 2011
American Urogynecologic Society (AUGS)
Meeting: 32nd Annual Scientific Meeting
Location: Providence, Rhode Island
Website: http://www.augs.org

September 27-30, 2011
Royal College of Obstetricians and Gynaecologists (RCOG)
Meeting: 9th International Scientific Meeting
Location: Athens, Greece
Website: http://www.rcog2011.com

Please visit www.iuga.org for a full Calendar of Meetings.