OBG MANAGEMENT

Mickey M. Karram, MD
Director of Urogynecology, Good Samaritan Hospital, and Professor of Obstetrics and Gynecology, University of Cincinnati, Cincinnati, Ohio

Jerry G. Blaivas, MD
Clinical Professor of Urology, Weill Medical College of Cornell University, New York, NY

Drs. Karram and Blaivas cochair the 6th Annual International Symposium on Female Urology & Urogynecology, to be held April 26–28, 2007 in Las Vegas (www.urogyn-cme.org).

PELVIC SURGERY CONTROVERSIES

How to work up and treat voiding dysfunction after surgery for stress incontinence

Postop complications call for systematic evaluation and an informed plan for surgery when indicated. First in a series

Voiding dysfunction—either difficulty voiding or urinary retention—after surgery for stress incontinence distresses the patient and challenges the surgeon. Here is our systematic approach to evaluating and managing such cases.

What does the operative note say?

Determine exactly what operation the patient underwent and whether appropriate steps were taken during surgery to evaluate the lower urinary tract. Remember: There are well over 30 different synthetic midurethral slings on the market; a variety of biologic materials are used for slings; and conventional suspension procedures are still being performed. Sling composition and surgical technique are the major determinants of subsequent treatment, so it is imperative to obtain the operative note.

Is intermittent self-catheterization an option?

If the patient has an indwelling catheter—of any type—remove it whenever possible and teach her intermittent self-catheterization.

Are symptoms consistent with expected outcome?

In the case of a patient who had a large cystocele repair in conjunction with an anti-incontinence procedure, for example, it is common for some form of retention or voiding dysfunction to be present for 2 weeks or longer. On the other hand, if a patient had a synthetic midurethral sling but no other procedure, it is highly unlikely, during a normal postoperative course, that she would be in retention 2 weeks after the procedure—unless the sling was placed too tightly.

Is there actual (or impending) lower-tract injury? Foreign body penetration?

Good endoscopic evaluation, with visualization of the urethra, of the vesical neck and anterolateral walls of the bladder, will answer these questions.

What is the condition of the pelvic floor?

Make certain that the patient has the ability to appropriately relax the pelvic floor when she attempts to void.

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FAST *TRACK*

Whenever possible, remove an indwelling catheter and teach the patient intermittent self-catheterization

VIEW AN ACCOMPANYING VIDEO

To watch a demonstration of the surgical takedown of anti-incontinence procedures, visit www.**obgmanagement**.com

Is urethral dilatation or medication an option?

We believe that urethral dilatation is contraindicated because it might cause urethral erosion of the sling. It is also generally ineffective.

No pharmaceutical agent hastens the return of voiding. Cholinergic agents such as bethanechol are ineffective and cause considerable discomfort. Some experts recommend empiric diazepam (Valium) for patients who are unable to relax sufficiently.

Will intervention succeed?

Ultimately, you and the patient must agree on whether urethrolysis is to be performed or whether the suburethral sling or tape should be cut. Undertake a detailed discussion with her about the potential for, first, persistent voiding dysfunction and, second, recurrent stress incontinence. Cutting a synthetic, allograft, xenograft, or autologous sling will almost always result in resumption of normal voiding, provided the sling is appropriately detached from the urethra and there were no preoperative voiding symptoms. With synthetic, allograft, and xenograft slings, stress incontinence recurs in at least 50% of patients over time. With an autologous sling, the recurrence rate of stress incontinence is less than 10%.

Is it time to operate?

When urinary retention after a synthetic sling procedure is believed to be caused by obstruction, consider surgery within a few weeks. For a patient in retention who has an autologous, allograft, or xenograft sling, it is best to wait approximately 3 months before operating.

Be aware of the risk of failure!

Takedowns of Burch and Marshall-Marchetti operations are much more technically challenging, and yield a much lower success rate, than takedowns of sling procedures. No matter what the prior operation, there is a risk of recurrent sphincteric incontinence. ■

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Cutting a synthetic, allograft, xenograft, or autologous sling almost always restores normal voiding