

## EFFECT OF INCONTINENCE TYPE ON TRANSOBTURATOR TAPE OUTCOMES

### Hypothesis / aims of study

Transobturator tape (TOT) is a safe and effective procedure for the surgical treatment of stress urinary incontinence (SUI). We compare the treatment outcomes for pure SUI and stress predominant mixed urinary incontinence (MUI) subtypes in this study.

### Study design, materials and methods

A total of 165 patients who have undergone TOT procedure were included. Preoperative incontinence status of the patients was either pure SUI (Group 1, n=39) or MUI (Group 2, n=126). Descriptive data including age, vaginal delivery, comorbidities and previous gynaecologic or vaginal surgery were evaluated. Medical records such as pad-usage, cystocele grading, postoperative complications and preoperative International Consultation on Incontinence Questionnaire-Short Form (ICIQ-SF) were analyzed. All patients were checked for final continence status with ICIQ-SF. Success was defined as complete dryness (Postoperative ICIQ-SF 3 score = 0). Postoperative ICIQ-SF scores and success rates were compared using SPSS 15.0 software between two groups.

### Results

Average age, pad-usage/day, vaginal delivery numbers, previous gynaecologic or vaginal surgery numbers, prevalence of comorbidities were similar between groups (Table 1). Mean preoperative ICIQ-SF scores were  $15.1 \pm 0.5$  and  $16.7 \pm 0.2$  ( $p=0.109$ ) and postoperative ICIQ-SF scores were  $3.5 \pm 1.1$  and  $6.0 \pm 0.7$  ( $p<0.05$ ) in group 1 and 2, respectively. Success rates were 75% in group 1 and 54.9% in group 2 ( $p<0.05$ ). Considering the overall complication rates, 5.1% and 10.3% of patients in group 1 and 2 experienced one of the following complications including mesh erosion, voiding dysfunction, dyspareunia or vaginitis (Table 2). When we compare failed patients (defined as postoperative ICIQ-SF3  $\geq 1$ ) versus dry patients in group 2, 5 dry patients (8%) and 10 failed patients (19.6%) had complications; with vaginal erosion the most encountered complication (6/10) requiring mesh removal in failed group.

### Interpretation of results

TOT effectively reduces ICIQ-SF scores in both SUI and MUI. However, TOT success in stress predominant MUI is not as good as pure SUI in long-term. Vaginal erosion frequency requiring intervention is much higher in failed MUI group in our study, which may opt for the relatively lower success rates in MUI group.

### Concluding message

TOT is recommended for both pure SUI and stress predominant MUI with favourable outcomes and low complication rates. Decreasing vaginal erosion rates may improve outcomes in stress predominant MUI subtype.

**Table 1.** Descriptive data of patients for both groups.

	Group 1 (n=39)	Group 2 (n=126)	p
Age (years)	56.0 $\pm$ 2.0	57.1 $\pm$ 1.0	0.664
Pad-use (/day)	2.6 $\pm$ 0.2	3.3 $\pm$ 0.2	0.207
Cystocele (%)	56.4	55.6	0.502
Vaginal delivery	2.4 $\pm$ 0.4	3.0 $\pm$ 0.2	0.939
Previous gynaecologic or vaginal surgery (%)	15.4	19.8	0.335
Prevalence of comorbidities (%)	64.1	61.9	0.467

**Table 2.** Complications in SUI and MUI groups.

	<b>SUI group</b>	<b>MUI group</b>	
		<b>Dry patients</b>	<b>Failed patients</b>
<b>Vaginal erosion</b>	2 (5.5%)	2 (3.2%)	6 (11.7%)
<b>Dyspareunia</b>	-	1 (1.6%)	2 (3.9%)
<b>Voiding dysfunction</b>	-	1 (1.6%)	1 (1.9%)
<b>Bleeding</b>	-	-	1 (1.9%)
<b>Vaginitis</b>	1 (2.7%)	1 (1.6%)	-

Disclosures

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