

**Abstract Reproduction Form B-1**

Author(s): JPWR Roovers<sup>1</sup> MD, JH Schagen van Leeuwen<sup>2</sup> MD PhD, CH van der Vaart<sup>1</sup> MD, JG van der Bom<sup>3</sup> MD PhD, APM Heintz<sup>1</sup> MD PhD.

**Institution :**

- <sup>1</sup> Department of gynecology, University Hospital Utrecht
- <sup>2</sup> Department of gynecology, Antonius Hospital Nieuwegein
- <sup>3</sup> Julius Centre for Patient Oriented Research, University Hospital Utrecht

City           Utrecht  
Country       The Netherlands

Title (type in CAPITAL LETTERS)  
COMBINATION SURGERY FOR GENITAL PROLAPSE COMBINED WITH STRESS INCONTINENCE;  
ABDOMINAL VERSUS VAGINAL APPROACH.

**Aims of study.**

About 40 % of patients who present with genital prolapse also have urinary stress incontinence. These patients usually have a surgical correction of their genital prolapse in combination with a bladder neck suspension. The surgical procedure we use is either an abdominal sacro-colpopexy combined with a Burch colposuspension or an anterior and posterior colporrhaphy (with or without a vaginal hysterectomy) combined with a vaginal colposuspension (e.g. a Stamey Pereyra).

Randomised trials have shown that the Burch colposuspension has significant better results in treating stress incontinence compared to a Stamey Pereyra procedure. Whether this is also true when the colposuspension is part of a surgical procedure in which the genital prolapse is corrected is unknown.

The aim of this study was to examine differences in complications and duration of hospital stay, patient satisfaction and symptom relief, and general and disease specific quality of life, between patients undergoing abdominal and patients undergoing vaginal surgery for their genital prolapse and stress incontinence.

**Methods**

We performed a retrospective multi-center cohort study. In the University Hospital Utrecht and St. Antonius Hospital Nieuwegein 57 patients underwent surgery for genital prolapse in combination with stress incontinence between 1995 and 1997. We sent a questionnaire to these patients and studied their medical records.

The questionnaire consisted of three modules. The first module consisted of questions about patient satisfaction and symptom relief (self developed). The second module is a dutch version of the IIQ and UDI (Shumaker; Quality Life Res. 1994: 3; 291-306). Questions regarding defaecatory habits were added. This disease specific questionnaire scores the presence and degree of distress for urogenital and defaecatory symptoms. The third module is a dutch translation of the Short Form 36 and was used to measure general quality of life.

All medical records were studied to document medical history, operative and obstetric history, findings during pelvic examination and urodynamic examination, date of surgery, chosen surgery method, duration of hospital stay and complications during admission. Finally the follow-up of all patients was recorded.

## Abstract Reproduction Form B-2

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### Results

Mean age of the study population was 59 years (95% CI 36, 81) and the mean follow-up was 24 months (CI 14, 44). The questionnaire was returned by 46 of 57 (82 %) patients.

Abdominal surgery (sacro-colposuspension combined with a Burch colpo- suspension) was performed in 18 patients and vaginal surgery (anterior and posterior colporrhaphy combined with a Stamey Pereyra colposuspension) in 39 patients. A vaginal hysterectomy was performed in 16 of the 39 patients who underwent vaginal surgery. Patients in the abdominal group more often had a history of previous prolapse surgery (6/18 (33%) vs. 1/39 (3%)) and more often had a hysterectomy in the past (8/18 (44%) vs. 7/39(18%)) compared to the vaginal group.

13/43 (30%) patients reported to have no urine incontinence at all at the moment they answered the questionnaire. Urine incontinence had decreased, compared to before surgery, in 32/43 (74%) patients. Problems with micturition and defecation which did not exist before surgery were reported by 16/45 (36%) patients.

Abdominal surgery was associated with more complications (12/18 (67%) vs. 13/39 (33%)) and a higher prolapse recurrence rate (5/18 (28%) vs. 2/39 (5%)) than vaginal surgery. Abdominal surgery was associated with longer hospital stay than vaginal surgery (11 days (CI 0, 22) vs. 9 days (CI 5, 13)).

Patients who underwent vaginal surgery reported stress incontinence after surgery as often as patients who underwent abdominal surgery; however the risk of having more discomfort of stress incontinence was higher among those undergoing vaginal surgery as compared to those undergoing abdominal surgery (RR 2.1 (CI 0.8, 5.7)).

The risk of having pain during defecation after surgery was also higher among patients undergoing vaginal surgery as compared to patients undergoing abdominal surgery (RR 2.9 (CI 0.4, 19.6)).

There were no relevant differences in any of the other measured outcomes.

### Conclusions

Patients undergoing abdominal surgery experienced some degree of stress incontinence after surgery as often as patients who underwent vaginal surgery. However, patients who underwent vaginal surgery were at higher risk of having more discomfort of their stress incontinence as compared to patients who underwent abdominal surgery. Patients who underwent vaginal surgery also complained more often about pain during defecation.

It is not clear whether the advantages of abdominal surgery regarding stress incontinence and pain during defecation outweighs the disadvantages regarding complications and recurrence rate.