822 – Management of bladder outlet obstruction after stress urinary incontinence surgery in women: Results of a North American Survey among surgeons

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Hypothesis / aims of study

BOO management after surgical treatment of SUI in women varies broadly depending on patient characteristics, type of procedure performed, material used, and patient or surgeon preferences.

Our study aim to gather expert opinion and describe trends in the management of early and prolonged BOO following SUI surgery.

Study design, materials and methods

Expert physicians and members of the Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (SUFU), were queried by means of an online survey regarding the management of BOO following SUI surgery.

The survey has an epidemiological section as well as clinical scenarios.

Results and interpretation

From 652 SUFU members on the distribution list, 60 answered the questionnaire (9 %).

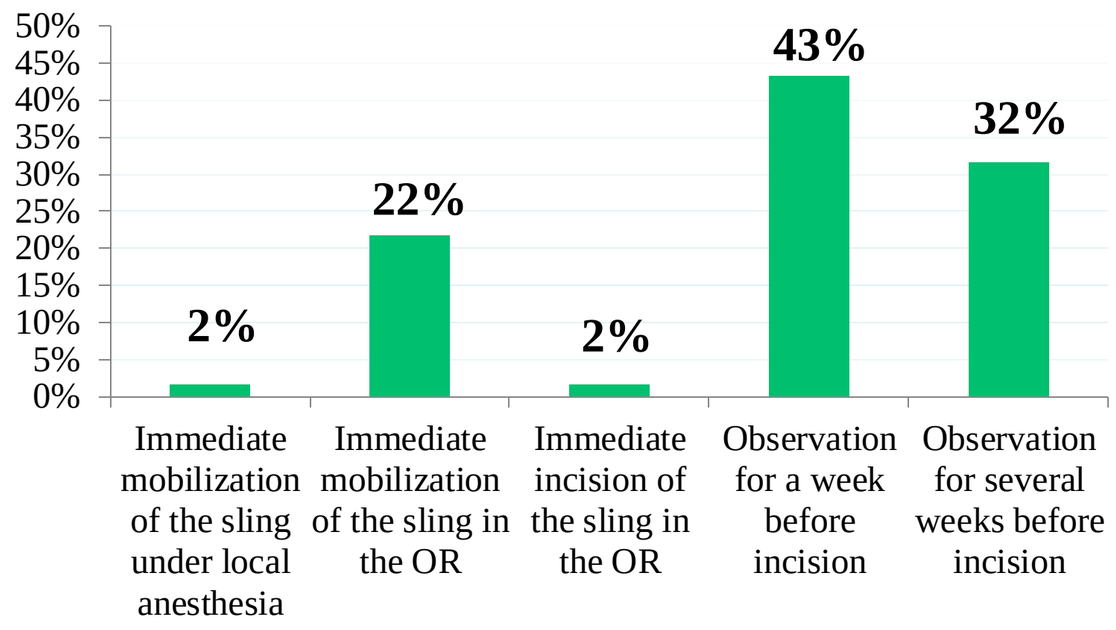
The number of sling procedures performed over a year among the responders was 1-5 by 3% of them, 6-10 by 7 % of them, 11-20 by 20 % of them, 21-50 by 38 % of them and >50 by 38 % of them. Among these sling procedures, responders estimated that approximately 15% (SD ±26) were autologous fascial pubovaginal slings.

Responders estimated the prevalence of complete postoperative urinary retention to be approximately 3% (SD ±7). The prevalence of partial postoperative urinary retention, defined as a post-void residual volume ≥200 ml, was estimated around 8 % (SD ±11).

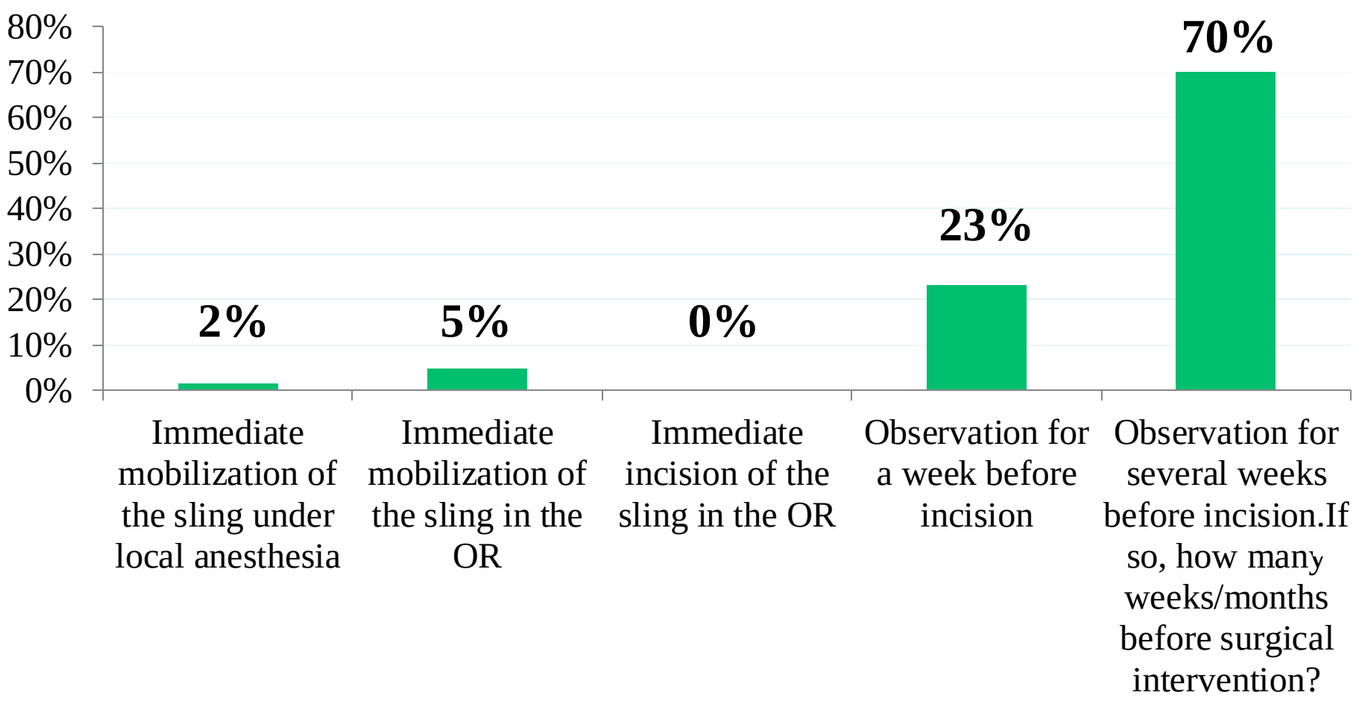
Of those patients presenting with partial urinary retention, approximately 35 % (SD ±29) were symptomatic.

One surgeon used the adjustable synthetic mid-urethral sling (Remeex®) and was able to correct the bladder outlet obstruction by adjusting the tension in an outpatient setting.

Management of *complete* urinary retention 48 hours after *MUS*



Management of *complete* urinary retention 48 hours after *AFS*



In patient developing complete urinary retention 48 hours following autologous fascial pubovaginal sling procedure, most participants would offer observation for a mean of 6.3 weeks (SD ±3.6) before planning a surgical revision.

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In the situation where the same population would present with partial urinary retention, again several weeks observation would be recommended by most of the surgeons quired, who would follow the patients for a mean of 7.1 weeks (SD ±3.8) before planning surgery.

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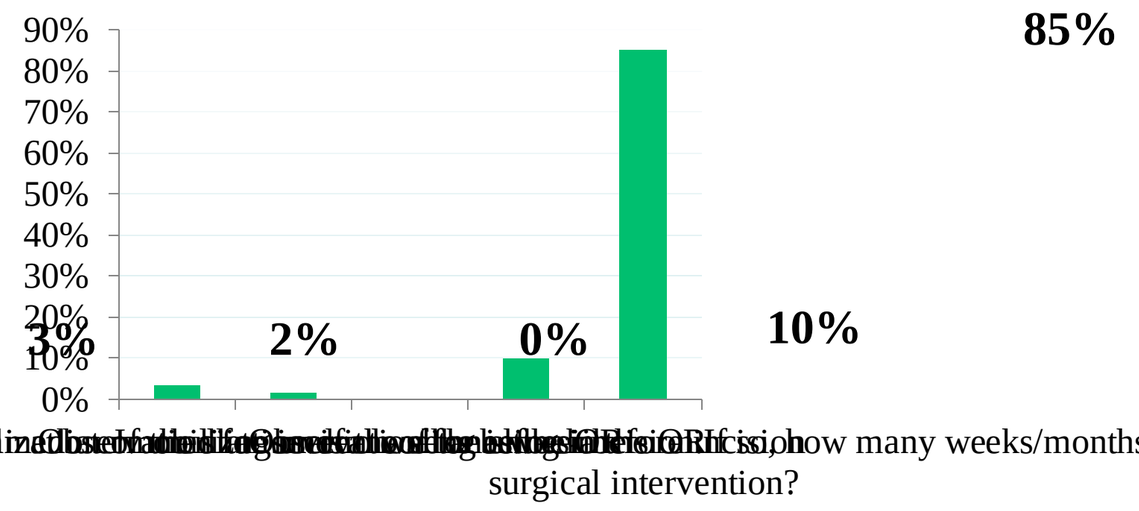
Management of *partial* urinary retention 48 hours after *AFS*



Conclusions

According to expert opinion, although we could highlight some trends in the management of bladder outlet obstruction associated with urinary retention following the surgical management of female stress urinary incontinence, particularly with regards to observation, there was no clear consensus on the management in terms of method or timing of surgical revision. Well-conducted randomized clinical trials are needed to look at the optimal management of these complications and to observe the outcomes following surgical revision.

References

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