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COMPARISON BETWEEN TELEPHONE AND CONVENTIONAL OUTPATIENT CLINIC SETTING FOLLOW-UP IN WOMEN TREATED WITH MIDDLE URETHRAL SLING FOR STRESS URINARY INCONTINENCE

Hypothesis / aims of study

The need for conventional clinic setting post-operative follow-up after routine middle urethral sling (MUS) for Stress Urinary Incontinence (SUI) has been recently questioned as unnecessary and some instead advocate a concept of "self-directed care" (1).

We investigated whether a telephone follow-up, in a cohort of women treated for SUI with MUS, was comparable to a follow-up in the outpatient clinic.

Study design, materials and methods

Our database was searched for all cases of primary retro-pubic and trans-obturator MUS performed between January 2000 and December 2016. All patients were called and evaluated by a telephone interview. The presence of Lower Urinary Tract Symptoms (LUTS), SUI, Urge Urinary Incontinence (UUI), dyspareunia, vaginal discharge were investigated. It was also asked to women if they had the tactile perception of abnormal vaginal mucosa. Patient Global Impression of Improvement (PGI-I) and Patient Perception of Bladder Condition (PPBC) questionnaires were administered at the phone call, and at the clinic setting. At the end of the phone call all patient were scheduled for a conventional outpatient clinic setting for the next week. In clinic setting all women have been investigated with the same questions and questionnaires by a different urologist masked to the phone outcome. It was also evaluated the objective outcome and stress test by a vaginal inspection. MUS success rate was considered when patient had no episode of SUI.

Correspondence between telephone and office follow-up was obtained with statistical evaluation by Cohen test. No ethical approval was required for this investigation as it was a simple observational study.

Results

Of 263 consecutive patients treated with MUS, 137 were followed-up via telephone and in a conventional outpatient clinic setting (52.1%). Patients' characteristics are reported in table 1. Mean follow-up was 62.83 months (51.06 SD). In table 2 are reported the different outcome between phone and office follow-up. Cohen test showed a "*substantial agreement*" (K=0.765) between the two methods of follow-up. In our study 11/35 women (31.4%) were mistakenly considered SUI recurrence by the only phone interview. Of these 11 patients with different outcome between the phone and the office evaluation, all had UUI: in 9 cases there was a de novo UUI, and in 2 cases UUI was still present before the MUS. No vaginal discharge has been reported neither the phone nor in the clinic. Most of the women were sexually not active; of the sexually active women the only one extrusion was reported during the telephone follow-up as partner dyspareunia.

Table 1: patients' characteristics.

Patient characteristics	
Total number of patients	263
Surgical treatment • TVT • TVT-O	 38.4% (101/263) 61.6% (162/263)
Patients at follow-up	52.1% (137/263)
Age – *mean (SD)*	63.21 (9.77)
Follow-up months - *mean (SD)*	62.83 (51.06)

Table 2: Different outcome between phone and office follow-up.

Outcome in all patients	**Telephone follow-up**	**Office follow-up**
SUI	25.5% (35/137)	17.5% (24/137)
Urgency	37.0% (52/137)	43.1% (59/137)
UUI	27.7% (38/137)	31.4% (43/137)
Tactile perception of abnormal vaginal mucosa	0.7% (1/137)	2.9% (4/137)
PGI-I - *mean (SD)*	1.72 (1.22)	1.64 (1.25)
PPBC - *mean (SD)*	1.87 (1.21)	1.78 (1.18)

Interpretation of results

In women treated with MUS, by using telemedicine 90% of the patients who would previously have been seen in clinic were followed up remotely saving clinic time and costs (2). In our data only in 73.7% of the cases telemedicine was able to assess accurately the urinary condition regarding continence and the type of incontinence. Indeed, our results show no significant difference in assessing patients without urinary incontinence (UI) between phone and clinical setting. The lower success rate of MUS obtained by phone was due to a wet overactive bladder mistakenly interpreted as a recurrence of SUI. At the Cohen statistical test we gained the "*substantial agreement*" class, instead of the "*perfect agreement*", because of the misunderstanding between UUI and SUI. Vaginal extrusion was easily assessed by office evaluation. However, the poor assessment of tape extrusion during the phone evaluation was due to the lack of sexual activity and vaginal discharge.

Concluding message

A criticism of telephone follow-up compared to conventional clinic outpatient setting is the inability to obtain objective outcomes. In particular, telemedical assessment of patients treated with MUS does not offer the accurate capability to evidence the type of IU, the real recurrence rate and extrusion of the tape.

References

1. Bateman AG, et al. Is there a need for postoperative follow-up after routine Urogynecological procedures? Patients will self-present if they have problems. Int Urogynecol J 2014;25(3):381-386.
2. Jefferis H, et al. Telephone follow-up after day case tension-free vaginal tape insertion. Int Urogynecol J 2016;27:787-90.

Disclosures

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