International Continence Society | August 22-26, 1999 | 29th Annual Meeting | Denver, Colorado USA

Category No. 8 | Video Demonstration | Ref. No. 408

Abstract Reproduction Form B-1

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Title (type in CAPITAL LETTERS): IS URINARY RETENTION FOLLOWING ANTI-INCONTINENCE SURGERY A SURGICAL MISADVENTURE?

AIMS OF STUDY

The urinary retention ensuing after surgical correction of urinary incontinence is not an uncommon event. Its frequency has been reported from 10-50% depending upon the procedure employed. The patients always consider it as a problem created by surgery [2]. The assurance and explanation by the surgeon are of great help. Often times surgeon himself is not very clear regarding etiology and how to council the patient. We have undertaken this study to shed some light on this problem and identify risk factors preoperatively.

METHODS

We have studied 38 patients Who developed urinary retention more than 2 weeks after surgery. The urodynamics studies, Cystoscopic examination and in some cases fluroscopic studies were done in standing position with contrast medium in the bladder, resting, straining and voiding films were taken. The cystoscopy was performed in lithotomy positon with zero degree lens. The urodynamic studies conform to ICS Standard. [1]

RESULTS

Our patient could be subdivided into the following catagories ;

A. Urethral Obstruction		10
I. Urethrovesical angulation	4	
II. Mid-Urethral angulation	6	
B. Hypocontractablity of Detrusor		24
I. Idiopathic	18	
II. Diabetes	2	
III. Post radical Hystrectomies	4	
C. Areflexic Neurogenic Bladder		4
I. Lumbar Disc Prolapse	4	

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In our experience the most common cause of urinary retention was poor detrusar contractility. These patients have poor bladder contraction,poor urinary flow and variable residual urine. In majority of patients there is no obvious cause. In this group two patients had insulin dependant Diabetes mellitus and others had radical[4] hystrectomy which is known to cause denervation of the bladder.

The urethral obstruction was noted at two lacations. The bladder neck is hyperelevated and urethrovesical angulation is prominent upon flouroscopic exmination. The mid urethral angulation is more common and can be easily diagnosed with cystoscopy. The last group of neurogenic bladder with lumber disc prolapse had areflexic bladder.

CONCLUSION

Since urinary retention and incontinence cannot always be predicted and it cause severe emotional distress to the patients and undermines the confidence of the patients [5]. Its is also very harmful to the reputation of the surgeon in the community. In our experience with this group of the patients we have learnt the following;

1. Cystometrogram uroflowmetry with post void residual urine is performed in all surgical candidates. As mentioned above the poor flow with high residual and poor bladder contraction should alert the operator.

2. Neurogenic causes should be actively sought. The lumbar disc, spinal stenosis are very common in elderly females.

3. During surgery it is important to varify that the suture or sling placement is at the proper level,Undue tension must be avoided [3]. We have made a routine to teach all our patients self catherterization prior to surgery. The patients accept it much more willingly.

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