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FIVE-YEAR RESULTS AFTER CONTINENCE SURGERY

Aims of Study: To evaluate continence rates 5 years after anterior colporrhaphy, anterior colporrhaphy with needle suspension of the bladder neck, and Burch colposuspension.
Methods: 327 of 544 women (60%) operated on with a diagnosis of stress incontinence between 1989 and 1993 underwent clinical and urodynamic reevaluation 5 years postoperatively. All patients underwent preoperative urodynamics. Patients were assigned to surgery on the basis of clinical and urodynamic findings and physician preference. Continence was defined as no loss of urine during cystometry or during coughing with the bladder filled to 300 mL. The data were analyzed with chi-square tests, ANOVA, and multiple logistic regression.
Results: The 327 patients underwent a total of 334 operations. All patients with mild incontinence underwent anterior repair only; preoperatively patients undergoing anterior colporrhaphy had significantly higher maximum UCP at rest and PTRs. 45/52 patients undergoing a repeat procedure underwent a colposuspension. The objective overall continence rates at 5 years were 61% (65/107) after anterior repair, 50% (60/121) after anterior repair with needle suspension, and 80% (85/106) after Burch colposuspension. Continence rates after anterior colporrhapy were 82% (32/39) in patients with mild stress incontinence (according to the Ingelman-Sundberg classification) but 49% (23/55) in patients with moderate or severe incontinence ($P<0.02$). Continence rates in patients with moderate or severe incontinence were 50% (60/121) after anterior repair with needle suspension and 80% (85/106) after the Burch operation ($P<0.02$). For both vaginal procedures continence rates were higher in patients >50 years than in the younger ones but these differences were significant only for anterior repair (69% vs. 50., $P<0.05$). The results after colposuspension were identical in the two age groups (78% and 80%). Continence rates after Burch colposuspension for recurrent stress incontinence were nonsignificantly poorer than after primary surgery (73% vs. 84%, n.s.). In the multiple logistic regression, type of surgery, degree of incontinence, and age were significantly associated with outcome whereas BMI, primary vs. recurrent surgery, and urethral closure pressure (≤20 vs. >20 cmH_20) were not. 5/22 (23%) colposuspensions failed because of de novo detrusor instability, as compared with 3/62 (5%) failed needle suspensions and 4 /42 (10%) failed anterior colporrhaphies.
Conclusions: Anterior colporrhaphy can cure mild stress incontinence but is inadequate for severe incontinence. Additional needle suspension may be of benefit for patients with moderate to severe incontinence. Abdominal colposuspension is superior to the vaginal operations for long-term cure of stress incontinence.