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WEIGHT LIFTING AND PHYSICAL ACTIVITY LIMITS IN PATIENTS AFTER ANTI-INCONTINENCE AND ANTI-PROLAPSE SURGERY

Hypothesis / aims of study

Most of the surgical treatments require a period of rehabilitation and activity restriction to achieve better outcomes. Despite large number of urogynecologic procedures performed each year, one uniform set of criteria limiting physical activity and weight lifting was never created. In this study we attempted to create such a criteria by polling the members of American Urogynecologic Society about postoperative instructions they provide for their patients.

Study design, materials and methods

Study was approved by Scientific Committee of AUGS and our Clinic Institutional Rreview Board. All 895 US physician members were mailed a questionnaire regarding weight lifting and duration of limitations, as well as types of procedures they most commonly perform and surgical outcomes associated with these procedures.

Results

Four hundred and twenty three members responded to the questionnaire (47.3%).. Two hundred and seventy two physicians (64.3%) ask their patients not to lift anything over 4.5 kg (10 pounds) in the immediate postoperative period, and 117 (27.7%) request the weight to be less than 9 kg (20 pounds). Out of 319 physicians who answered the question 196 (61.4%) believe that this postoperative period of strict restrictions should be 6 weeks or less, while 123 (38.6%) consider this not to be long enough. In late postoperative period 165 physicians (39%) do not impose any restriction of activities on their patients, where 130 (30.7%) ask their patients not to lift over 13.5 kg.. Remaining 128 (30.2%) physicians request that their patients lift less than 9 kg. Descriptive instructions other than weight limit are given by 251 physicians (59.3%), with the most common “do not strain or valsalva” 87 physicians (20.6%) and “nothing heavier than the gallon of milk” (3.7 liters) by 74 physicians (17.5%). Majority of the physicians 189 (44.7%) acquired the knowledge of the lifting/activity limits in their training, 120 (28.4%) gained it as a personal experience and 69 (16.3%) did not know where such limits came from with several surgeons stating there was no scientific rationale in the limits. Only 15 (3.5%) suggested there was an evidence in the literature to use the limits they were using. Interestingly, physicians who imposed stricter (< 4.5 kg) limitations in the immediate postoperative period had in their own experience lower risk of recurrence of incontinence after the Burch procedure that the physicians who used higher limits (70.4% risk of recurrence < 10% vs. 62% risk of recurrence < 10%). Same was true for the risk of recurrent prolapse after anterior/posterior colporraphy, uterosacral ligament plication (53.9% risk of recurrence < 10% vs. 43.1% risk of recurrence < 10 %). This difference was not seen in the recurrence of urinary incontinence in patients undergoing TVT procedure.

Interpretation of results

Limitations given to patients most often are no lifting more than 4.5 kg for 6 weeks, and no limits thereafter. This may be higher for patients undergoing TVT procedure alone. More research on wound healing and post operative limitations is necessary to improve outcome in patients undergoing antiincontinence / antiprolapse procedure.