35

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AN INCONTINENCE PROCEDURE PERFORMED AT THE TIME OF PROLAPSE REPAIR MIGHT BE UNNECESSARY SURGERY.

Hypothesis / aims of study

Most patients with pelvic organ prolapse (POP) and stress urinary incontinence (SUI) wish to have both conditions treated during the same surgery. This strategy also saves resources for health care providers. However, women with POP have large anatomical changes involving the lower urinary tract, and it has turned out to be difficult to predict what impact the prolapse repair has on the lower urinary tract symptoms. The aim of a multicenter prospective randomized study (recruiting women from 2002 to 2006) was to compare the tensionfree vaginal tape (TVT) incontinence procedure performed simultaneously with prolapse surgery to TVT performed three months after prolapse surgery on the condition of SUI. The final results will be available in 2007 when all women have been controlled 12 months postoperatively. This preliminary report includes only the women randomized to TVT procedure three months after the prolapse surgery, to evaluate how many women with combined POP and SUI actually were in need of an incontinence procedure after the prolapse surgery.

Study design, materials and methods

Ninety-two women with concomitant POP (all kinds of prolapse) and SUI were randomized to having the TVT performed three months after the prolapse repair. Violation of protocol occurred in two, leaving 90 women for evaluation. Prior to surgery the prolapse was evaluated by the POPQ system and SUI was diagnosed urodynamically. Women with both manifest (n=80) and masked SUI (n=12) were allowed to participate. Prolapse surgery was performed according to each hospital's routines, but all centres had agreed on not extending the incision of the anterior wall beyond the area of the bladder neck and doing no dissection in the sub-urethral area to leave room for the TVT in unscarred tissue.

Three months after the prolapse repair evaluation was performed again to ensure that the condition of SUI was still present.

Results

Twenty-five (28%) of the 90 women were cured from the symptom and sign of SUI following prolapse surgery only. Sixty-five (73%) still had SUI , but 15 (23%) of those with persistent SUI did not want to have TVT performed. Mean age was similar for the three groups, those who were cured after prolapse surgery (60.7 years) compared to those who had the TVT performed (61.0 years) and those who still had SUI, but did not want the TVT (63.3 years). Mean weight was also similar for these three groups (72.6 kg, 71.6 kg 72.1 kg) as was mean parity (2.6, 2.7, 2.5). The prolapses tended to be larger in those who were cured from their SUI (72% stage III/IV and 28% stage I/II) compared to those who were not (42% stage III/IV and 58% stage I/II). Anterior repair was more often included in the procedure in the group of women that were cured from SUI by prolapse surgery (92%) compared to the women that still had SUI and subsequently had TVT performed (75% anterior repair) and in the group of women that still leaked, but did not want TVT performed (85% anterior repair). There were no differences in peroperative prolapse surgery complications between the three groups.

Interpretation of results

Pelvic organ prolapse and stress urinary incontinence often coexist and it is tempting to treat both conditions surgically at the same time. However, a substantial number of women turned out not to need the TVT procedure following prolapse surgery. Even some patients with only posterior repair were cured of SUI. Almost a quarter of women still leaking after the prolapse repair refused a later TVT procedure, usually because they were less bothered by their incontinence. However, these women may have chosen TVT if it had been performed at the same time as the prolapse surgery. We have not identified any predictive variable prior to prolapse surgery identifying which women with concomitant POP and SUI who will need an incontinence procedure and who will not. This study was powered to evaluate the result of the TVT performed together with prolapse surgery compared to TVT at a later date, not to compare those who needed and did not need the TVT after prolapse surgery.

Concluding message

Women with concomitant POP and SUI should be informed that almost 30% are cured from the condition of SUI following prolapse surgery only, and that it is difficult to clinically predict who will be in need of TVT and who will not. Only long-time follow up will reveal whether this cure of SUI is a lasting effect. Treatment strategy for both conditions should be discussed prior to the prolapse surgery.

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