

THE SUCCESS RATE OF UROLOGICAL SURGICAL INTERVENTION IN THE TREATMENT OF SPHINCTER WEAKNESS INCONTINENCE IN POST- SACRECTOMY BLADDER: A 10-YEAR REVIEW

Hypothesis / aims of study

To assess the success rate of continence surgery in patients who underwent partial or total sacrectomy in a specialised tertiary centre.

Study design, materials and methods

Retrospective analysis identified 78 patients who underwent sacrectomy between 1997 and 2007. Only 27 patients were referred to the dedicated neurourology service for bladder management. The mean age was 53yrs (range 21-80yrs). Fourteen patients were males and 13 were female. Videocystometrogram (VCMG) was carried out to assess bladder activity and to rule out Sphincter Weakness Incompetence (SWI).

Results

Of the 27 patients, 12 patients had partial sacrectomy and 15 underwent total sacrectomy (3 of whom had initially had partial resection). Indications were chordoma (59%), chondrosarcoma (11%), ependymoma (7%), giant cell tumour (7%) and others (16%). The mean age at time of sacrectomy was 51yrs (range 19-81yrs). VCMG was performed on 21 patients only. The remaining 6 had VCMG in other institutions and results were inaccessible. Seven patients were deceased at a mean follow-up of 1.75yrs (range 1-4yrs). VCMG showed detrusor acontractility and SWI in 17 patients. Three patients either declined or are awaiting continence surgery and 14 patients underwent continence surgery; artificial urinary sphincter (AUS) in 5 male patients (36%), bulking agents in 3 males and 1 female patient (28%), and transobturator tape (TOT) in 5 female patients (36%). Bladder drainage with either a long-term or intermittent self-catheterisation was performed. Out of the 14 patients, only 6 (43%) were dry at the time of this review.

Interpretation of results

All patients with SWI had symptoms warranting surgical intervention. Seven patients (26%) died as a result of metastatic disease.

Concluding message

SWI is a common consequence of sacrectomy often requiring urological surgical intervention. Surgery has poor outcomes in controlling incontinence. Death from metastatic disease is not uncommon; therefore cost-effectiveness should be taken into account when such interventions are planned.

<i>Specify source of funding or grant</i>	NONE
<i>Is this a clinical trial?</i>	No
<i>What were the subjects in the study?</i>	HUMAN
<i>Was this study approved by an ethics committee?</i>	No
<i>This study did not require ethics committee approval because</i>	it is a review of urological surgical outcomes and did not require any addition contact or clinical intervention with the patients.
<i>Was the Declaration of Helsinki followed?</i>	Yes
<i>Was informed consent obtained from the patients?</i>	No