487

Padmanabhan P[1], Kaufman M[1], Dmochowski R[1], Scarpero H[1]
1. *Vanderbilt University*

MANAGEMENT OF INCONTINENCE AND PELVIC RECONSTRUCTIVE SURGERY: PRACTICE PATTERNS OF AUA UROLOGISTS

Hypothesis / aims of study

The prevalence of female pelvic floor dysfunction (PFD), including incontinence and pelvic organ prolapse (POP) increases with age and has significant effects on quality of life. With increasing resident training in female urology and continually evolving treatments, our objective was to assess current practice patterns in the treatment of PFD among board certified urologists. Our hypothesis is that performance frequency of female pelvic floor procedures may be a surrogate for physician training, experience, and self-confidence in managing PFD.

Study design, materials and methods

Certification candidate log data was obtained between 2005 and 2007 for newly certified, first-time recertified, and second-time recertified urologists in the following areas: SUI, POP, UDS, refractory OAB, and complex pelvic reconstruction.

Results

Overall, the 1046 newly certified, 1122 first-time recertified and 849 second-time recertified case logs submitted were reviewed for specific codes related to female pelvic floor surgery. Demographic data, training and competency of practitioners included are unavailable. Urologists in each group utilize urodynamics, although more are performing cystometry (74.1%, 71.6%, and 67.1%) and uroflow (79.7%, 75.3%, and 75%) than pressure flow studies (55%, 52%, 41%). A high percentage of urologists are performing slings in all three groups (71%, 69.3%, and 58.7%), yet significantly fewer are managing the anterior compartment for POP (29.3%, 29.2%, and 19.4%). In regards to other compartments, the rates are even lower: posterior (6%, 6.1%, and 5.3%), enterocele (1.2%, 2.8%, and 2.1%), combined anterior and posterior (7.3%, 8.5%, and 5.2%), abdominal colpopexy (5.5%, 5.6%, and 3.9%). There are few practitioners performing complex pelvic reconstruction, specifically: vesicovaginal fistula repairs (0.76%, 0.6%, and 0.4%) and urethral diverticulum excision (10.1%, 10.3%, and 7.2%). The use of initial and subsequent female urethral dilation is unusually high despite lack of evidence supporting its benefit: initial (23.9%, 36.6%, and 41.5%) and subsequent (14.1%, 25.8%, 28.7%).

Interpretation of results

Basic urodynamic methods are utilized, but limited use of pressure flow studies may relate to a lack of understanding of its application in PFD. There is comfort in management of SUI among all urologists, yet the same is not true for POP. This does not relate to the time of their urology training. The reason for limited POP repair numbers are unclear, i.e. lack of diagnosis, lack of skill, or management by local urogynecologists. The limited number of complex pelvic reconstruction cases performed is not a surprise, with only a subset of urologists having fellowship training in PFD. There is an alarmingly high use of urethral dilation among all the groups, without evidence to support its use. This may relate to miscoding, reimbursement benefits, and lack of knowledge of disease process and the options available.

Concluding message

This observational study highlights the areas of PFD, which are highly served and disproportionately overrepresented. To meet the growing PFD need, a more structured and comprehensive training program during residency and fellowship continues to be necessary. Further research is necessary to understand the distribution of PFD in practice, type and quantity of advanced PFD training, and proportion of PFD management by urogynecology.

References

1. Melissa R. Kaufman
2. Roger R. Dmochowski
3. Harriette M. Scarpero

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