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ORIGINAL ARTICLE

Tension-free transvaginal (TVT) and transobturator (TOT) tapes in women with multiple failed incontinence procedures or complex urogynaecological intervention

Jeremy L. Ockrim*, Tamsin J. Greenwell, P. Julian Shah

Institute of Urology, University College London Hospital, 235 Euston Road, London NW1 2BU, United Kingdom

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KEYWORDS
Bladder;
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Summary
Objectives: We report the outcomes of transvaginal (TVT)/transobturator (TOT) tape in women with multiple or complex urogynaecological intervention and persistent stress urinary incontinence (SUI).
Patients and methods: Thirty-seven patients with multiple procedures (median 3) or complex urogynaecological intervention for SUI, McGuire classified on video-urodynamics, underwent TVT ($n = 26$) or TOT ($n = 11$) placement. Patients categorised outcome as excellent, good or poor. Excellent was defined as dry, asymptomatic and completely satisfied. Good was defined as no SUI but residual or de novo urgency, or lack of complete satisfaction. Poor was defined as minimal improvement of symptoms. All patients with residual symptoms underwent repeat video-urodynamics.
Results: Mean follow-up was 37 months. Thirty-two patients (86%) were cured of SUI. According to the outcome definitions 46% were excellent, 30% good and 24% poor. Of six patients with McGuire type III SUI, five (83.3%) had persistent SUI, accounting for all with persistent SUI. Bladder perforation and de novo urgency occurred in 11.5% and 19.2% of TVT, but none of those with TOT. Temporary voiding difficulty occurred in 11.5% TVT and 9.1% TOT. Protracted retention occurred in two TVT cases, of which one required tape division.
Conclusions: TVT/TOT cured SUI in 86% of patients with multiple SUI procedures or complex urogynaecological intervention, with minimal morbidity. Subjective outcomes were less than objective outcomes mainly due to urgency. The TOT

* Corresponding author. Tel.: +44 2073809210; fax: +44 2073809063.
E-mail addresses: ockrim@hotmail.com, jeremy.ockrim@uclh.nhs.uk (J.L. Ockrim).

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route reduced the risk of bladder injury and de novo urgency. Type III SUI on preoperative urodynamics predicted failure.
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Introduction

The efficacy of tension-free transvaginal (TVT) and transobturator (TOT) tapes for stress urinary incontinence (SUI) has now been established in large comparative study [1], and supported by numerous smaller series [2—6]. Almost all of these series report outcomes for highly selected groups of women having TVT/TOT as a primary procedure for 'simple' SUI. A few report outcomes for secondary TVT in those who have failed a single previous surgical intervention for SUI [7—11]. The literature relating to outcome in patients who have had multiple failed procedures or complicated urogynaecological intervention and persistent SUI is sparse [12]. We report the medium term outcomes of TVT/TOT for women tertiary-referred with complex, persistent SUI.

Patients and methods

Data has been collected prospectively on all patients having tape procedures at our institution between January 2000 and January 2004. Thirty-seven patients had been referred with persistent SUI despite multiple previous SUI procedures or complex urogynaecological interventions (Table 1). Twenty-seven of these patients had had one or more open procedures for SUI as well as at least one other urogynaecological procedure. Five patients had complex gynaecological intervention alone (two radical hysterectomy with radiotherapy for cervical carcinoma, two hysterectomy and anterior colporraphy with subsequent pelvic pain syndromes and one simple hysterectomy with subsequent chronic retention and incontinence). Five patients had complex urological intervention alone (four ileocystoplasty, one detrusor myomectomy and multiple periurethral injections). Eleven (29.7%) patients had concomitant detrusor overactivity (DO), although this was not considered to be the primary cause of their incontinence. Four patients performed intermittent catheterisation for incomplete bladder emptying prior to surgery. The median patient age was 54 (range 36—72). Mean parity was two (range 0—5) and four patients were nulliparous.

All patients had urodynamic stress incontinence (USI) diagnosed after video and classified according to McGuire et al. [13], $n = 27$; or urodynamics independent of their video component, $n = 10$ (Table 2). These studies were performed according to guidelines proposed by the International Continence Society [14]. Twenty-six (70.3%) of the procedures were performed by the suprapubic route (TVT Gynecare®) as originally described by Ulmsten et al. [15], and latterly 11 (29.7%) procedures by transobturator tape placement (TOT Porges®, Gynecare®) as per manufacturers' instructions. All tapes were placed without tension, to ensure that the risk

Table 1 Previous surgery for incontinence, lower urinary tract dysfunction or pelvic organ prolapse in 37 tertiary referral patients undergoing TVT/TOT tape procedures

Previous procedures	TVT ($n = 26$)	TOT ($n = 11$)
Incontinence		
Colposuspension	13[a]	7
Autologous (fascia lata) sling	1	1
Tension-free vaginal tape	2	0
Needle suspension	10	3
Periurethral injection[b]	16	7
Other urological intervention		
Clam ileocystoplasty	0	4
Detrusor myomectomy	1	0
Vesicovaginal fistula repair	4	0
Urethral diverticulectomy	1	0
Bladder neck reconstruction/urethroplasty	0	4
Gynaecological intervention		
Radical hysterectomy with radiotherapy	2	1
Simple abdominal/vaginal hysterectomy	13	8
Anterior colporrhaphy	6	3
Posterior colporraphy	4	1
Ureterosacral plication	2	0
Total number procedures	1143	
Mean number procedures per patient	(range 2—6)	

[a] Includes one laparoscopic colposuspension.
[b] A periurethral injection alone was not considered of sufficient complexity to be included in the procedure count.

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