

Voiding Function and Dysfunction, Bladder Physiology and Pharmacology, and Female Urology

Re: Urological Surveillance and Medical Complications after Spinal Cord Injury in the United States

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Editorial Comment: The authors report a survey that shows us just how poor the surveillance of urological complications in spinal cord injury patients in the United States really is. The simplest recommendations are from the Paralyzed Veterans of America, who suggest that patients undergo an annual visit with a urologist, serum creatinine and renal ultrasound. These authors used a 5% sample of Medicare administrative data from the years 2007 to 2010. The minimum adequate urological surveillance was defined as a urologist visit, serum creatinine and upper tract imaging study within a 2-year period of followup. Of the patients 4.9% received no surveillance studies during the 2-year period. Only 36% of patients saw a urologist, 91% had a serum creatinine evaluation and 49% had some form of an upper tract evaluation, the majority being computerized tomograms, followed closely by abdominal ultrasound. In total, only 25% of this spinal cord injury population received the minimum urological surveillance.

A spinal cord injury think tank from the United Kingdom proposed in 2008 that surveillance be performed at 6 months after injury, 12 months and then annually thereafter. Surveillance consisted of imaging with ultrasound, renal function assessment (creatinine clearance at 12 months and serum creatinine thereafter), a frequency volume chart and a review of bowel/sexual/fertility issues. Repeat urodynamic studies were recommended only for specific indications for previously concerning urodynamic findings.

The European Association of Urology published in 2009 a more intensive guideline. The minimum required investigations included a urinalysis, an ultrasound of the bladder and upper tract every 6 months, an annual urology visit, blood biochemistry and urine culture. They recommended video-urodynamics every year for patients with detrusor overactivity or poor compliance and every 2 years for the remainder. Adherence to these guidelines is difficult to assess but the surveys that have been done have indicated that at least in some areas it is not optimal. For instance a survey in The Netherlands published in 2008 found that only 18% of urologists followed the European Association of Urology guidelines frequently, 35% occasionally and 47% not at all. Spinal cord injury patients are an at risk population that needs to be better served.

Alan J. Wein, MD, PhD (hon)

Re: The Underactive Bladder: A New Clinical Concept?

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Abstract available at <http://www.ncbi.nlm.nih.gov/pubmed/25770481>

Editorial Comment: These authors point out that the current International Continence Society standardization committee definition of detrusor underactivity is one about which a remarkable lack of consensus exists. It is a pseudo-urodynamic definition with no specified parameters for reduced contraction strength, prolonged bladder emptying or normal time span for micturition. Chapple brought together a consensus group that has proposed a working definition for a symptom complex that they call underactive bladder, which suggests detrusor underactivity but is not synonymous with it, much as the term overactive bladder symptom syndrome suggests detrusor overactivity but is not synonymous with that. The working definition is as follows: “The underactive bladder is a symptom complex suggestive of detrusor underactivity and is usually characterized by prolonged urination time with or without a sensation of incomplete bladder emptying, usually with hesitancy, reduced sensation on filling and a slow stream.” The working definition still leaves urodynamic criteria for detrusor underactivity without specifics, and on this particular subject there is no doubt that there will be a great deal of discussion over the next few years regarding not just the urodynamic findings that would characterize detrusor underactivity, but also the pathophysiology, indications for treatment and management strategies for the “underactive bladder symptom syndrome” both with and without detrusor underactivity, however we define it.

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Re: Drug Adherence and Clinical Outcomes for Patients under Pharmacological Therapy for Lower Urinary Tract Symptoms Related to Benign Prostatic Hyperplasia: Population-Based Cohort Study

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Abstract available at <http://www.ncbi.nlm.nih.gov/pubmed/25465970>

Editorial Comment: The reason I included this article on drug therapy for lower urinary tract symptoms in patients with benign prostatic hyperplasia is because the compliance rate seems to be approximately the same for medications in patients being treated for the overactive bladder symptom syndrome. The 1-year adherence rate was 29% in patients exposed to at least 6 months of therapy. As in similar articles regarding drug compliance in patients with overactive bladder, the authors speculate that the high discontinuation rate may be attributable to a combination of drug side effects and expectations (the perceived improvement is lower than what was expected). All of this assumes, of course, that the diagnosis for which the medication was prescribed was accurate. Assuming this, it looks as though we need either a better explanation to patients as to what their expectations should be or other drugs.

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