

Expert panel clarifies surgical care of stress urinary incontinence in women

📌 Guidelines from the American Urological Association highlight evidence-based evaluation and treatment strategies for SUI. They can be a useful and dependable guide for your surgical practice.

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Level-1 evidence has often been lacking to support the many shifts in the surgical management of female stress urinary incontinence (SUI) over the past 20 years. That's according to a recent expert commentary on the National Guidelines Clearinghouse Web site.¹ The commentary, by urologist Jennifer T. Anger, MD, MPH, calls attention to the lack of definitive data on many practices; it also points to a potential solution: a useful and intelligent assessment by the American Urological Association (AUA) of the evidence behind various aspects of surgical management of female SUI.²

For example, after thorough review of the data through June 2005, the AUA panel unanimously recommended that evaluation of the candidate for surgery for SUI should include:

- a focused history
- a focused physical examination
- objective demonstration of SUI
- assessment of postvoid residual urine volume
- urinalysis and, if indicated, a culture.²

The panel also unanimously agreed that intraoperative cystourethroscopy should be performed using a rigid or flexible cystoscope in all patients undergoing sling surgery. It noted that a short-beak rigid cystoscope or flexible fiberoptic cystoscope provides optimal visualization of the female urethra.

AUA guidelines are relevant to today's surgical practice

Although the AUA published these guidelines almost 2 years ago, its conclusions remain cogent and relevant today, according to Dr. Anger. More important, they are based on a comprehensive assessment of the data pub-

lished since the previous guidelines were issued in 1997. For this latest set of guidelines, the AUA reviewed 436 articles on the efficacy of surgical procedures and 155 additional articles on complications.¹

The AUA focused on SUI with or without pelvic organ prolapse, urethral hypermobility, and intrinsic sphincter deficiency. This is itself a change from the earlier AUA guidelines, which considered SUI only in patients *without* prolapse. The 2009 guidelines also cover the full gamut of SUI, from diagnosis and evaluation through management and treatment.

The AUA categorized its guidelines three ways. Advice was considered **standard** when **1)** the “health outcomes of the alternative interventions are sufficiently well known to permit meaningful decisions” and **2)** “there is virtual unanimity [among the expert panel] about which intervention is preferred.”

Advice was termed a **recommendation** when **1)** health outcomes are “sufficiently well known to permit meaningful decisions” and **2)** an “appreciable, but not unanimous, majority agrees on which intervention is preferred.”

Advice was an **option** when “health outcomes of the interventions are not sufficiently well known to permit meaningful decisions” *or* “preferences are unknown or equivocal.”

See the **TABLE** for a full summary of the panel's advice.

References

1. Anger JT. AUA's surgical management of female stress urinary incontinence provides timely update [expert commentary]. National Guideline Clearinghouse; May 16, 2011. <http://guideline.gov/expert/expert-commentary.aspx?id=32972>. Accessed May 25, 2011.
2. American Urological Association Education and Research. Guideline for the surgical management of female stress urinary incontinence: 2009 update. Linthicum, Md: American Urological Association; 2009. <http://guideline.gov/content.aspx?id=15708>. Accessed May 25, 2011.

What does AUA recommend? How strong are its recommendations?

	Diagnosis and evaluation	Treatment
Standard* recommendation	<p>Evaluation should include:</p> <ul style="list-style-type: none"> • focused history • focused physical examination • objective demonstration of SUI • assessment of postvoid residual urine volume • urinalysis and, if indicated, a culture 	<p>Counsel the patient about surgical and nonsurgical options, including both benefits and risks. Choice of the procedure should be based on the patient's preferences and the surgeon's experience and judgment</p> <p>Patients who have urge incontinence without stress incontinence should not be offered a surgical procedure for stress incontinence</p> <p>Intraoperative cystourethroscopy should be performed in all patients undergoing sling surgery</p> <p>For detection of potential intraoperative complications, the bladder and urethra should be inspected with a rigid or flexible cystoscope prior to the conclusion of the procedure. A short beak rigid cystoscope or flexible fiberoptic cystoscope provides optimal visualization of the female urethra</p> <p>The panel offers no recommendations about use of a <i>prophylactic</i> anti-incontinence procedure in a patient who has occult incontinence with high-grade prolapse</p>
Suggested† recommendation	<p>Elements of the history should include:</p> <ul style="list-style-type: none"> • characterization of incontinence • frequency, bother, and severity of incontinence episodes • impact of symptoms on lifestyle • expectations of treatment <p>Additional diagnostic studies may be performed if they aid in assessing the integrity and function of the lower urinary tract:</p> <ul style="list-style-type: none"> • pad testing or voiding diary, or both • urodynamics • cystoscopy • imaging <p>Further testing may be indicated if:</p> <ul style="list-style-type: none"> • the clinician is unable to make a definitive diagnosis based on symptoms and the initial evaluation • there are concomitant overactive bladder symptoms • the patient has had lower urinary tract surgery, including failed anti-incontinence procedures • neurogenic bladder is known or suspected • a stress test is negative • urinalysis is abnormal • residual urine volume is excessive • grade III or greater pelvic organ prolapse is present • there is evidence of dysfunctional voiding 	<p>Placement of a synthetic sling is contraindicated in stress-incontinent patients who have concurrent urethrovaginal fistula, urethral erosion, intraoperative urethral injury, and/or urethral diverticulum</p> <p>Surgical procedures for SUI and prolapse may be safely performed concomitantly in appropriately selected women. Tensioning of any sling should not be performed until prolapse surgery is completed</p>
Optional‡ recommendation		<p>The five major types of procedures (injectables, laparoscopic suspensions, midurethral slings, pubovaginal slings, and retropubic suspensions), although not equivalent, may be considered for the index patients</p> <p>The artificial urinary sphincter may be indicated in certain circumstances</p> <p>Stress incontinence procedures may be considered for patients who have mixed incontinence with a significant stress component</p>

*Based on clear data and unanimous agreement of the expert panel.

†Based on clear data and consensus of a majority of the panel.

‡Based on limited data or unknown or equivocal preferences of the panel.