

PUBLICATIONS FROM THE BSUG DATABASE

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How useful are the BSUG database outcome criteria: validation using the MESA questionnaire.

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How do urogynaecologists treat failed suburethral slings? Experience from the British Society of Urogynaecology database and literature review. (*journal article review*)

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Tension-free vaginal tape insertion for stress urinary incontinence: A 6-year analysis

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What can we learn from large data sets? An analysis of 19,000 retropubic tapes. (Journal article)

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An analysis of 10,500 mid urethral slings (MUS) and the impact of pre-operative urodynamic studies

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Surgery for recurrent stress incontinence in the UK 2007-2015 (Neurology and Urodynamics)

Abstracts

2008

Outcome measures after TVT for mixed urinary incontinence.

Author(s): Sinha, D; Blackwell, A; Moran, P A

Source: International urogynaecology journal and pelvic floor dysfunction; Jul 2008; vol. 19 (no. 7); p. 927-931

Publication Date: Jul 2008

Publication Type(s): Clinical Trial Journal Article

PubMed ID: 18250947

Abstract: This study assessed the outcome of tension-free vaginal tape (TVT) in the treatment of mixed incontinence using the Medical Epidemiologic and Social Aspects of Ageing (MESA) questionnaire and other outcome measures used by the British Society

of Urogynaecology (BSUG) database. Forty women undergoing TVT completed a MESA questionnaire pre-operatively and at 6 months post-operatively. Information was also obtained about three outcome measures of the BSUG database-patients' global impression of outcome and stress and urge symptom analyses. Stress and urge incontinences were either cured or improved in 78 and 75 % of women, respectively, after TVT. The results of post-operative patients' global impression of outcome showed great or moderate improvement in 75% of cases and had 69% reduction in mean MESA scores (p value less than 0.001). Symptom improvement based on MESA scores relates well with the basic outcome measures for stress and urge incontinences used by the BSUG database.

2009

2010

How useful are the BSUG database outcome criteria: validation using the MESA questionnaire.

Author(s): Elbiss, H M; Thomson, A J M; Moran, P A

Source: Journal of obstetrics and gynaecology: the journal of the Institute of Obstetrics and Gynaecology; 2010; vol. 30 (no. 7); p. 716-720

Publication Date: 2010

Publication Type(s): Journal Article

PubMed ID: 20925618

Abstract: Urinary stress incontinence is common, but there is a wide range of prevalence which might account for variations in definition of incontinence and variations in study methodology. Our study assessed the validity and reliability of the British Society of Urogynaecology's (BSUG) database subjective outcome scores after the tension-free vaginal tape (TVT), by correlating these with the changes in the Medical Epidemiologic and Social Aspects of Ageing (MESA) questionnaire score. A total of 100 women with urodynamic stress incontinence underwent TVT, completed a MESA questionnaire preoperatively and at 6 months postoperatively. We also collected information about three outcome measures of the BSUG database, patients' global impression of outcome and stress and urge symptom analyses. Our study showed that the postoperative patients' global impression of outcome improved significantly in 85% of cases and had 73.89% reduction in mean MESA scores ($p < 0.001$). The outcome measures of the BSUG database relates well to symptom improvement, based on MESA scores and these subjective assessments currently used by the BSUG's database are a valid assessment of TVT outcome.

Stress incontinence surgery in the UK (1). Pre-operative work up and intra-operative complications. Analysis of the British society of urogynaecology database

Author(s): Assassa P.; Moran P.; Duckett J.; Bsug B.

Source: Neurourology and Urodynamics; Aug 2010; vol. 29 (no. 6); p. 809-810

Publication Date: Aug 2010

Publication Type(s): Conference Abstract

Abstract: Hypothesis / aims of study The BSUG database is an audit tool available to UK consultants undertaking urogynaecological procedures. We have analysed the database concerning operations performed for stress continence. Study design, materials and methods The database has registered 142 centres and 68 have entered data. 44 centres (65%) are district general hospitals and these have entered 68% of the episodes. It is likely that the range of operations performed is representative of those being performed in the UK. On 26 Jan 2010 time there were 14,977 surgical episodes entered (97% performed after 1st Jan 2007). The median number of cases entered per active centre was 113 (range 1-1726, IQR 16-281). The following were excluded: 6,989 prolapsed surgery alone, 593 botox injections, 50 cystoscopy alone, 13 urethral diverticulum, 12 long term suprapubic catheters, 6 vaginal fistulas. This left 7,314 episodes of surgery for stress incontinence. We have analysed these by age, BMI and pre-operative work up together with the types of operation performed and intraoperative complication rates. Results The mean age at surgery was 53.9 (sd 12.1, range 16-99) and BMI was 29 (sd 5.6, range 10-60). Pelvic floor exercises were confirmed to have occurred in 5746 (78.6%) women. The supervision of these was recorded in 5,500 (physiotherapist 3868 (70%), continence advisor 905 (16%), nurse specialist 424 (8%), GP/self examination 303 (6%)). An entry concerning use of urodynamics was made for 6,805 cases and had been performed in 6608 (97%) of these (USI 5206 (79%), mixed 1179 (18%), normal 164 (2.5%), other 19). A procedure specific information leaflet was recorded as being given in 5945 (77.2%) cases. 1,777 (24%) had prolapsed surgery together with their incontinence surgery. There were no deaths, neurological injuries or preoperative DVTs. (Table presented) Interpretation of results. The centres entering data on the BSUG database are a mixture of both teaching centres (35%) and peripheral hospitals (65%). It is likely that participating centres are those most engaged in specialist urogynaecology and represent best current practice in this field. In line with national guidance the majority of women have undergone a course of pelvic floor muscle exercises before surgery. However, nearly all also underwent urodynamic investigations (at variance with UK national guidelines). The vast majority of surgical procedures for stress incontinence are sub urethral slings and about 10% of these are repeat surgery. Bladder injury is reported for all sling procedures. Other complications are rare but common enough to warrant regular preoperative counselling. Traditional surgery such as colposuspension and autologous slings seem to have higher intraoperative complications Concluding message Participation in national audit allows participants to compare their practice with national figures for surgical type and complication rates. (Table presented).

Stress incontinence surgery in the UK (1). Pre-operative work up and intra-operative complications. Analysis of the British society of urogynaecology database

Author(s): Assassa P.; Moran P.; Duckett J.; Bsg B.

Source: International Urogynaecology Journal and Pelvic Floor Dysfunction; Aug 2010; vol. 21

Publication Date: Aug 2010

Publication Type(s): Conference Abstract

Abstract: Hypothesis/aims of study The BSUG database is an audit tool available to UK consultants undertaking urogynaecological procedures. We have analysed the database concerning operations performed for stress continence. Study design, materials and methods The database has registered 142 centres and 68 have entered data. 44 centres (65%) are district general hospitals and these have entered 68% of the episodes. It is likely that the range of operations performed is representative of those being performed in the UK. On 26 Jan 2010 time there were 14,977 surgical episodes entered (97% performed after 1st Jan 2007). The median number of cases entered per active centre was 113 (range 1-1726, IQR 16-281). The following were excluded: 6,989 prolapsed surgery alone, 593 botox injections, 50 cystoscopy alone, 13 urethral diverticulum, 12 long term suprapubic catheters, 6 vaginal fistulas. This left 7,314 episodes of surgery for stress incontinence. We have analysed these by age, BMI and pre-operative work up together with the types of operation performed and intraoperative complication rates Results The mean age at surgery was 53.9 (sd 12.1, range 16-99) and BMI was 29 (sd 5.6, range 10-60). Pelvic floor exercises were confirmed to have occurred in 5746 (78.6%) women. The supervision of these was recorded in 5,500 (physiotherapist 3868 (70%), continence advisor 905 (16%), nurse specialist 424 (8%), GP/self examination 303 (6%)). An entry concerning use of urodynamics was made for 6,805 cases and had been performed in 6608 (97%) of these (USI 5206 (79%), mixed 1179 (18%), normal 164 (2.5%), other 19). A procedure specific information leaflet was recorded as being given in 5945 (77.2%) cases. 1,777 (24%) had prolapsed surgery together with their incontinence surgery. There were no deaths, neurological injuries or preoperative DVTs. Interpretation of results The centres entering data on the BSUG database are a mixture of both teaching centres (35%) and peripheral hospitals (65%). It is likely that participating centres are those most engaged in specialist urogynaecology and represent best current practice in this field. In line with national guidance the majority of women have undergone a course of pelvic floor muscle exercises before surgery. However, nearly all also underwent urodynamic investigations (at variance with UK national guidelines). The vast majority of surgical procedures for stress incontinence are sub urethral slings and about 10% of these are repeat surgery. Bladder injury is reported for all sling procedures. Other complications are rare but common enough to warrant regular preoperative counselling. Traditional surgery such as colposuspension and autologous slings seem to have higher intraoperative complications Concluding message Participation in national audit allows participants to

compare their practice with national figures for surgical type and complication rates. (Table Presented).

2011

Does BMI affect the results of continence surgery? An analysis of the British society of urogynaecology (BSUG) database

Author(s): Aslam N.; Moran P.A.; Assassa R.

Source: International Urogynaecology Journal and Pelvic Floor Dysfunction; Jun 2011; vol. 22

Publication Date: Jun 2011

Publication Type(s): Conference Abstract

Abstract: Objective: The aim of this study was to identify the impact of body mass index (BMI) on the efficacy of RMUS (Retropubic midurethral sling) for stress urinary incontinence and to see if there were differences in intra-operative and post operative outcome in women with differing BMI. Background: Little data is available on the outcome of retropubic mid urethral slings (RMUS) procedures in obese and overweight women. It is often thought that high BMI may be a contributing factor to intra operative complications and poor surgical outcome for continence surgery. Methods: The BSUG surgical database asks surgeons to prospectively enter their patients demographics (including BMI) when performing surgery. The database looks at all forms of both prolapse and continence surgery and has collected over 22,000 surgical episodes to date since 2007. Cases were selected from the BSUG database if they had undergone retropubic MUS, did not have any other concomitant surgery, and were having primary continence procedures. We compared pre- and postoperative evaluations, including subjective and objective outcome, complications, and quality of life assessed by validated Questionnaires. Results: Up until the end of 2010 there were 3925 cases who also had BMI data entered. BMI had no effect on anaesthetic choice; GA was most commonly used among all groups. Complications were recorded as per the BSUG database. Bladder perforation rates appear higher among the patients with low/normal BMI (4.4%VS 2%), however blood loss was similar in all groups. There seem to be no trend between BMI and return to theatre within 72 h, catheterisation beyond 72 h or return to hospital within 30 days. Outcome data was sporadic. 1529 (38%) of the cases had no follow-up data entered but this was consistent for all categories of BMI. Median follow up was 17 weeks (range 6-52 weeks) Cure/improvement rates for stress incontinence were similar throughout the BMI ranges. Morbidly obese women seemed overall less satisfied with the outcome of their surgery with respect to PGI (69% vs. 86-91%). Interestingly, cure/improvement rates for urgency/urgency incontinence appeared lower (57% vs. 72- 88%) in the morbidly obese group. In addition, a significant proportion of morbidly obese women had a worsening of their urgency symptoms post-operatively (20%vs 3-5%). The rate of new de novo urgency symptoms post-operatively did not differ between the groups (3-4%). Conclusions: Morbid obesity (BMI >40) does not seem to be associated with a poorer outcome for incontinence surgery in UK with

respect to SUI symptoms. However, morbidly obese patients seem less satisfied overall with respect to global impression of outcome for incontinence. This may possibly related to the lower impact that surgery appears to have on pre-existing urgency symptoms or indeed a deterioration in such symptoms in this particular group. This may be useful information when counselling our morbidly obese patients prior to undergoing a RMUS procedure for mixed incontinence symptoms. (Table presented).

Stress incontinence surgery in the UK (2). Post surgery success, Follow-up and complications. Analysis of the British society of urogynaecology database

Author(s): Assassa P.; Duckett J.; Moran P.; Bsg B.

Source: International Urogynaecology Journal and Pelvic Floor Dysfunction; Jun 2011; vol. 22

Publication Date: Jun 2011

Publication Type(s): Conference Abstract

Abstract: Hypothesis/aims of study The BSUG database is an audit tool available to UK consultants undertaking urogynaecological procedures. We have analysed the database concerning operations performed for stress continence. We have analysed follow up, place of follow-up, success and complication rates by surgery type. Study design, materials and methods The database has registered 142 centres and 68 have entered data. 44 centres (65%) are district general hospitals and these have entered 68% of the episodes. It is likely that the range of operations performed is representative of those being performed in the UK. On 26 Jan 2010 time there were 14,977 surgical episodes entered (97% performed after 1st Jan 2007). The median number of cases entered per active centre was 113 (range 1-1726, IQR 16-281). The following were excluded: 6,989 prolapsed surgery alone, 593 botox injections, 50 cystoscopy alone, 13 urethral diverticulum, 12 long term suprapubic catheters, 6 vaginal fistulas. This left 7,314 episodes of surgery for stress incontinence. Of these 3,697 (50.5%) had follow-up information recorded. Cure was defined as either a response of cure to the question 'Change in Stress Urinary Incontinence' or Very much better on the Global Impression of Improvement for Incontinence. Results Of the 3,697 who had recorded follow-up, 2985 (81%) were seen in outpatients, 514 (14%) completed a postal questionnaire, 192 (5%) telephone interview, and 6 on line follow-up. The range of follow up intervals was: 6 weeks 1410 (38%), 3 months (23%), 6 months 1268 (34%), 12 months 107 (3%). (Table Presented) (Table Presented) Graft problems were identified in 51/2984 (1.7%) who attended out patients, 1/514 who had postal questionnaire (0.2%) and none who had telephone interview or on line. Interpretation of results Follow up intervals and type of follow-up is inconsistent across the UK. Returns to theatre and long term catheterisation are uncommon. Cure rates vary between operations considerably. Graft problems were only usually identified in patients physically seen in outpatients. Concluding message The use of a national database allows consultants to compare their own choice of operation, complication rate and success rate with the national average. This and will hopefully improve standards and patient outcomes in the long run.

Training future urogynaecologists-is surgical experience adequate? An analysis of the British society of urogynaecology (BSUG) database

Author(s): Basu M.; Duckett J.; Moran P.; Assassa P.

Source: International Urogynaecology Journal and Pelvic Floor Dysfunction; Jun 2011; vol. 22

Publication Date: Jun 2011

Publication Type(s): Conference Abstract

Abstract: Hypothesis/aims of study An ageing population, reduction in working hours and increasing use of novel devices and technologies in pelvic floor surgery are underlining the need for robust training in order to produce a future urogynaecological workforce that is fit for purpose. There is a recognised learning curve for continence procedures, meaning that an adequate volume of surgery for trainees is an important component of a training programme. In this analysis of the BSUG database, we aimed to estimate the proportion of continence procedures that are undertaken by trainees, as well as any differences in complication rates. Study design, materials and methods The BSUG database is an audit tool that collects data from 68 centres in the UK. A snapshot of the database was taken on 26/01/2010. At that time 7314 episodes of surgery for stress incontinence had been entered. Operations performed were analysed by grade of surgeon, demographics and complications. Results See table 1. The number of procedures performed by each grade were (% total, % of these that were secondary procedures): consultant 5367 (73%, 11.9%), staff grade 128 (1.7%, 2.3%), subspecialty trainee 469 (6.4%, 6.4%), specialty trainee 1108 (15.1%, 6.1%). There were no differences in patient age or BMI between different grades of operator. Unsupervised procedures were performed in 106/1108 (9.5%) by specialty trainees and 120/469 (25.5%) by subspecialty trainees. Surgical complications (e.g. bladder perforation during retropubic tape) were more likely in procedures performed by staff grades and trainees, irrespective of whether supervised or not. (Table Presented) Most surgical procedures undertaken in participating centres were performed by consultants, with a minority being undertaken by trainees. Surgical complications were more common in procedures undertaken by trainees, which is perhaps a reflection of the learning curve for these procedures. Concluding message This analysis gives an overview of the surgical experience of UK trainees in urogynaecology. This audit database has the potential for use as a tool to evaluate surgical training. This is of critical importance in ensuring a high quality service for the future. (Table Presented).

A comparison of vaginal sacrospinous fixation and abdominal sacrocolpopexy for vaginal vault prolapse repair in the UK: An analysis of the British society of urogynaecologists' (BSUG) database

Author(s): Price N.; Jackson S.R.; Foon R.; Moran P.

Source: International Urogynaecology Journal and Pelvic Floor Dysfunction; Jun 2011; vol. 22

Publication Date: Jun 2011

Publication Type(s): Conference Abstract

Abstract: Hypothesis / aims of study The aim of this study was to identify which vault suspension procedure is most commonly employed for vaginal vault prolapse repair in the UK and determine the factors influencing choice of procedure. Vaginal vault prolapse has been estimated to occur in up to 43% of post-hysterectomy patients. Abdominal sacrocolpopexy is well described in the literature, with a reported success rate in the range 78-100%. When compared with sacrospinous fixation, abdominal sacrocolpopexy has been shown to have a lower rate of recurrent vaginal prolapse, less postoperative dyspareunia and a lower reoperation rate; however, when performed by laparotomy there is a longer recovery time (1,2). Study design, materials and methods The BSUG database is an audit tool available to UK consultants undertaking urogynaecological procedures. By January 2010 there were 142 centres registered to use the database, of which 68 had entered data on 14,977 episodes of surgery. The demographic details (age, BMI, previous prolapse surgery), preoperative assessments (point C on POP-Q) and perioperative complications of patients undergoing the vaginal sacrospinous vault fixation and abdominal sacrocolpopexy (open and laparoscopic) were compared. Results Between January 2007 and January 2010, 574 sacrospinous vault fixations (SSF) and 316 abdominal sacrocolpopexies (SCP) were reported (ratio 1.8:1). 34 (10.1%) of these sacrocolpopexies were performed laparoscopically. (Table presented) Interpretation of results Almost twice as many vault prolapse repair procedures were performed vaginally by sacrospinous fixation than abdominally by sacrocolpopexy. Only a small proportion of the sacrocolpopexies was performed laparoscopically, perhaps reflecting the general lack of laparoscopic skills among surgeons performing prolapse repair procedures. The demographic characteristics (age, BMI, previous prolapse surgery) and average degree of vault prolapse were similar for both groups of patients. Surgeons were more likely to choose the abdominal route in patients with previous failed vault surgery. Concluding message. These results show that vaginal sacrospinous fixation is chosen preferentially by UK surgeons for primary vault prolapse repair and sacrocolpopexy is the preferred option in patients with previous failed vault surgery. The preference for sacrocolpopexy in failed cases is consistent with previous findings of the lower prolapse recurrence rate (1,2). The primary choice of vault suspension procedure is not due to the differences in patient demographics and may be due to less morbidity and quicker recovery associated with sacrospinous fixation compared with open abdominal sacrocolpopexy (1), particularly as the laparoscopic approach is not widely available.

Vaginal prolapse surgery with synthetic mesh augmentation in the UK: Analysis of the British society of urogynaecologists' (BSUG) database

Author(s): Price N.; Jackson S.R.; Moran P.

Source: International Urogynaecology Journal and Pelvic Floor Dysfunction; Jun 2011; vol. 22

Publication Date: Jun 2011

Publication Type(s): Conference Abstract

Abstract: Hypothesis / aims of study Evidence suggests that surgical repair of vaginal wall prolapse using mesh may be more efficacious than traditional surgical repair. However, the data on efficacy and safety are limited. The UK's National Institute for Health and Clinical Excellence (NICE) has recommended that vaginal prolapse surgery with mesh augmentation, as a new intervention, should only be performed as part of clinical audit. (1) The British Society of Urogynaecologists' (BSUG) database is an electronic audit tool available to all UK consultants undertaking urogynaecological procedures. The aim of our study was to assess the use of mesh augmentation in the UK and the use of the BSUG database as a national audit of mesh augmentation procedures. Study design, materials and methods Operations were analysed according to the vaginal compartment repaired, the type of the mesh kit used, the type of operation (whether primary or repeat prolapse repair) and complications reported. The numbers of vaginal prolapse repair procedures using synthetic meshes entered onto the BSUG database were also compared with the numbers of mesh kits sold in the UK. Results The BSUG database has 68 active centres in the UK, each entering their episodes of surgery. From January 2007 to January 2010 8,230 prolapse operations had been entered, of these 613 (7.4%) were vaginal prolapse procedures with mesh augmentation: 321 (52.4%) had a posterior compartment repair, 240 (39.1%) had an anterior compartment repair and 52 (8.5%) were total vaginal mesh repairs. 394 (65%) were repeat prolapse repair operations and 219 (35%) were primary procedures. The most commonly used mesh kit was the Gynecare Prolift, which was employed in 265 out of 613 (43.2%) mesh augmentation procedures. Of 1197 Prolift mesh kits sold in the UK in 2009 122 (10.2%) were entered on the BSUG national audit database. (Table presented) Interpretation of results The use of synthetic mesh in prolapse surgery in the UK is still relatively uncommon, being employed in only 7.4% of all surgical operations for vaginal prolapse. Augmentation with mesh is mostly employed for repair of the posterior compartment. Industry sales data suggests that currently only a small proportion of the vaginal mesh prolapse repair procedures carried out in the UK is entered on the BSUG national database. For those procedures that are recorded, there is a high level of missing follow-up data, and long-term follow-up data is not reported at all. The level of intraoperative and postoperative complications recorded on the database is generally lower than that reported in the literature, which may reflect the reliability of self reporting. Concluding message The majority of vaginal prolapse surgery with synthetic mesh augmentation conducted in the UK is not entered on the BSUG national audit database. The current level of participation in UK national audit of these new interventional procedures is generally poor, in spite of NICE recommendations.

Database: EMBASE

Primary & redo anterior repair surgery in UK- An analysis of the BSUG database

Author(s): Bulchandani S.; Aslam N.; Moran P.; Assassa P.

Source: International Urogynaecology Journal and Pelvic Floor Dysfunction; Jun 2011; vol. 22

Publication Date: Jun 2011

Publication Type(s): Conference Abstract

Abstract: Hypothesis / aims of study Evidence suggests that surgical repair of vaginal wall prolapse using mesh may be more efficacious than traditional surgical repair, with limited data on efficacy and safety. The UK's National Institute for Health and Clinical Excellence (NICE)¹ has recommended that vaginal prolapse surgery with mesh augmentation should only be performed as part of clinical audit. Currently the use of implants both biological and synthetic in reconstructive pelvic surgery is expanding rapidly in spite of a paucity of data supporting their use. Study design, materials and methods The British Society of Urogynaecologists (BSUG) database is an electronic audit tool available to all UK consultants undertaking urogynaecological procedures. By January 2010 there were 142 centres registered to use the database, of which 68 had entered data on 14,877 episodes of prolapse surgery. The demographic details, pre-operative assessment (Ba & C on POP-Q), number of procedures using grafts, variety of grafts, grade of surgeon, complications & outcome in primary and redo anterior repair were compared. Results Between January 2009 to December 2009, 938 cases of anterior repair were reported. Of these 620 were primary, 243 were redo and 75 were unspecified with regards to primary or redo hence excluded from the analysis. Interpretation of results. In our analysis, grafts were employed in 4.6% cases in primary repair vs. 51% in redo group. The most commonly used mesh kit was Gynecare Prolift in both groups. Of the primary procedures 64% were performed by a consultant, 23.8% by ST trainee, 7.4% by sub-specialty trainee (SST) and in 2.9% cases the grade of surgeon was unanswered. In the redo group 75.6% cases were performed by a consultant, 10.5% by ST trainee, 9.9% by SST & 0.8% were unanswered. The demographic details including age and average degree of anterior vaginal wall prolapse were very similar in both groups. The complication rates were low overall with no significant difference between the two groups apart from more number of cases in the primary group requiring a catheter for more than 10 days and having to return to hospital within 30 days of operation. A more significant improvement was found in point Ba in the primary group compared to the redo group with not much difference in point C. Concluding message Follow-up was missing in over 50% cases. In the primary group the post-operative follow-up questionnaires were completed in 41% & in 39% in the redo group. In both groups post-operative POP-Q was not performed in over 80% cases. Over 90% reported an improved global impression of outcome of prolapse in both groups. More specialty trainees need to perform primary repairs to increase surgical experience. Basic trends in primary prolapse surgery remain unchanged. The increase in the use of mesh & associated graft problems is in patients with re-do repair. (Table presented) .

Which single incision mid urethral sling should you use? An audit of tvt secur and bard ajust within a single unit compared to the BSUG UK database

Author(s): Assassa R.; Thangavelu A.; Girn Z.; Moran P.; Bslug Committee B.

Source: International Urogynaecology Journal and Pelvic Floor Dysfunction; Jun 2011; vol. 22

Publication Date: Jun 2011

Publication Type(s): Conference Abstract

Abstract: Objective: To audit the results of single incision mid urethral slings (MUS), within our unit, against the British Society of Urogynaecology (BSUG) surgical database for retropubic MUS (used as comparative standard) Background: Single incision mid urethral slings (MUS) are becoming more widely used as they may be associated with low intra-operative morbidity, the opportunity to be performed under local anaesthetic and low post-operative pain. The results of Single incision MUS are however less well established and units must audit their own results to show local success rates. Methods: We have performed 245 primary operations on women with USI or mixed incontinence, without concomitant surgery, and entered their data on the BSUG database. 142 were TVT Secur (Gynaecare) and 103 were Ajust (Bard). Complications were recorded as per the BSUG database. All patients filled in an ICIQLUTSqol questionnaire (score 19-76) and 3 day urinary diary before and after surgery together with an improvement scale for both stress incontinence and urgency/urge incontinence. We have compared these results against the BSUG national data for similar cases undergoing retro pubic MUS. Results: All patients were admitted as day cases and went home the same day. (Table presented) Conclusions: Single incision MUS compare favourably with retropubic MUS in that they are easily performed under pure local anaesthetic with minimal intra-operative complications and result in significant improvement in QOL. The Ajust had a higher success rate for subjective stress incontinence in our unit than the TVT Secur. This may be a consequence of a stronger fixation mechanism or the ability to adjust the tape dynamically and individually for each patient. There is now a need to perform a randomised controlled trial assessing the best single incision MUS against standard MUS.

How do urogynaecologist treat failed suburethral slings? Experience from the British society of urogynaecology database and literature review

Author(s): Patil A.

Source: International Urogynaecology Journal and Pelvic Floor Dysfunction; Jun 2011; vol. 22

Publication Date: Jun 2011

Publication Type(s): Conference Abstract

Abstract: Objective: The aim of this study was to review the British Society of Urogynaecology (BSUG) database of continence procedures performed till January 2010 to determine what surgical treatments have been used for persistent or recurrent SUI after a failed mid-urethral sling (MUS). Background: MUS procedures have high success and satisfaction rates. However, a small percentage of MUS operations will fail and most centres have limited experience of treating this outcome. Hence, the treatment of

recurrent or persistent SUI after failed MUS is a new dilemma for the Urogynaecologist and urologist. Methods: We reviewed the available BSUG data submitted before January 2010, of which 97% of the data was entered after 1st January 2007. Total 14,977 surgical procedures for incontinence or prolapse were logged into the database by 68 centres in the U.K. Women who underwent a repeat anti-incontinence surgery for persistent USI after failed MUS were included in the cohort. Women who had previous slings with concomitant prolapse repairs were excluded because a prolapse repair may alter urinary symptoms, independent of the MUS. This cohort then was then divided into four groups depending upon the type of slings they underwent as a primary procedure: retro-pubic MUS, TVT-obturator MUS (TVT-O), transobturator MUS (TOT outside in) and short single incision sling (mini-slings). Various demographic data was collected for each group and the repeat treatment noted. Outcome data was described where available. Results: Out of total 313 failed MUS procedures, the commonest second surgical intervention was a repeat retropubic MUS and was used in 54% (170/313) of repeat procedures (table 1.). Bladder neck injections were the second commonest repeat procedure (43/313 cases: 14%). TVT-Os were used as a repeat procedure in 12% (38/ 313) and TOTs in 8% (25/313). Small numbers of colposuspensions (20/313 - 6%) and Aldridge slings (6/313 - 2%) were also used. Conclusion: Persistent or recurrent SUI after previous failed MUS poses a new challenge for surgeons. The present study suggests that the retropubic TVT seems to be the preferred choice for the management of such cases probably due to familiarity, its effectiveness, minimal invasiveness, low complication and morbidity rates as a primary procedure. Although this study provides an excellent description of current practice in a multicentre context, there is little information on success rates due to poor outcome data. Better insight into the best treatment option may only be obtained when good quality outcome data is provided. Future audit needs to concentrate on encouraging teams to supply full datasets. (Table presented).

How do urogynaecologists treat failed suburethral slings? Experience from the British Society of Urogynaecology database and literature review.

Author(s): Patil, A; Moran, P; Duckett, J; British Society of Urogynaecology Audit Committee

Source: Journal of obstetrics and gynaecology : the journal of the Institute of Obstetrics and Gynaecology; Aug 2011; vol. 31 (no. 6); p. 514-517

Publication Date: Aug 2011

Publication Type(s): Journal Article Review

PubMed ID: 21823853

Abstract: Midurethral urethral sling (MUS) procedures have high success and satisfaction rates. A small percentage of MUS operations will fail and most centres have limited experience of treating this outcome. The aim of this study was to review the British Society of Urogynaecology (BSUG) database for women who underwent repeat anti-incontinence surgery after failed MUS. A total of 313 repeat surgical procedures

were identified. For any failed MUS, the commonest second surgical intervention was a repeat retropubic MUS and was used in 54% (170/313) of repeat procedures. Bladder neck injections were the second commonest repeat procedure (43/313 cases: 14%). TVT-Os were used as repeat surgery in 12% (38/313) and TOTs in 8% (25/313). Small numbers of colposuspensions (20/313, 6%) and Aldridge slings (6/313, 2%) were also used. A variety of different surgical treatments are used for failed MUSs. From the BSUG database review, the commonest second surgical intervention was a repeat retropubic MUS.

2012

2013

Is telephone consultation an acceptable method of following-up patients after urogynaecology surgery? A pilot randomised controlled trial

Author(s): Bateman A.G.; Freeman R.M.; Neliens H.

Source: International Urogynaecology Journal and Pelvic Floor Dysfunction; May 2013; vol. 24

Publication Date: May 2013

Publication Type(s): Conference Abstract

Abstract: Objective To inform the planning of a randomised controlled trial Background Follow-up after surgical procedures is generally regarded as important for patient reassurance and for surgeons to audit efficacy and complications. Traditionally this has been by outpatient consultation with clinical examination. Telephone follow-up postoperatively might reduce the pressure on hospital services but whether this is acceptable to patients and whether important clinical problems which might be amenable to early intervention are missed is unclear. A review of existing literature in other specialties suggests that patients are receptive to the idea of telephone consultation, and are satisfied with the results of this approach (1-2). Methods A feasibility trial of a randomised controlled trial of telephone versus outpatient clinic follow-up. Patients were recruited from the British Society of Urogynaecology (BSUG) database and were block randomised; using computer generated randomly permuted block sizes in a non-systematic sequence, to either telephone or outpatient follow-up. Patient reported symptom scores (using the ICIQ-UI and ICIQ-VS questionnaires), achievement of goals, and expectations and complication rates were recorded at follow-up. Patients were telephoned 1 week after their review by an independent researcher and a validated patient satisfaction questionnaire was completed (3). Patients were also asked how reassured they were by having a clinical examination. Qualitative data from a focus group of patients who were involved in the trial is being undertaken at the end of January 2013. Results Ethical approval was granted from the NRES Committee London - Surrey Borders and recruitment began in May 2012. Thirty five patients have been randomised (see flow diagram). The RCGP patient satisfaction questionnaire was used in

the trial and includes 11 questions such as: 'Did the doctor/nurse make you feel at ease? (being friendly and warm towards you, treating you with respect; not cold or abrupt)' and 'Did the doctor/nurse fully understand your concerns? (communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)'. Patients answer 'Poor to Fair', 'Fair', 'Fair to Good', 'Good', 'Very Good', 'Excellent' or 'Outstanding' (range of scores from 1 to 7, with a maximum score of 77). Satisfaction scores were similar between the two groups (telephone= 56.8/77 and outpatient=56.0/77). Eight patients in the telephone arm stated that they would not have been reassured by an examination; however, 14 of the patients in the outpatient arm were reassured by being examined. No patients were readmitted following surgery in either arm of the study. One mesh exposure (following TVT) was detected at outpatient follow-up, which was minor and asymptomatic. Qualitative data will be available following completion of the focus group. Conclusions So far the results suggest that patients are equally satisfied with both forms of follow-up and there have been no missed complications. (Figure presented).

2014

Is MUCP useful in predicting outcome following midurethral sling surgery?

Author(s): Vij M.; Dua A.; Bombieri L.; Freeman R.

Source: Female Pelvic Medicine and Reconstructive Surgery; 2014; vol. 20

Publication Date: 2014

Publication Type(s): Conference Abstract

Abstract: Introduction: The surgical approach to stress urinary incontinence has changed significantly in recent years, with mid-urethral sling (MUS) being the most commonly performed procedure. The reported success rate is around 80%, (1) but little is known about the reasons for failure. The continence mechanism depends on efficient urethral support and an intact intrinsic urethral sphincter mechanism. Is it possible that failure of MUS is related to integrity of the urethral sphincter mechanism? Maximum urethral closure pressure (MUCP) can provide an objective assessment of urethral function but the evidence of its role in predicting outcome after MUS is controversial (2-3) and the current practice regarding pre-operative MUCP measurement is variable. Objective: The aim of our study was to determine if lower pre-operative MUCP is associated with a poor outcome following MUS. Method: The study was a retrospective review of BSUG (British society of urogynaecologist) database and Urodynamics (UDS) data. All primary sling surgeries performed by one urogynaecologist from 2007-2012 were identified from the BSUG database. Patients who reported outcome as 'no change', 'a little worse', 'much worse' or 'very much worse' on patients global impression of improvement (PGII) scale were identified as having poor outcome. Patients who reported 'a little better', 'much better' and 'very much better' on PGII were thought to have good outcome. The demographics, preoperative urodynamics parameters & diagnosis, the type of MUS and quality of life data were compared between the two groups to look at any significant differences. Result: 236 women had primary sling

surgery performed by one urogynaecologist during this period. Of these twenty four (10.2%) women were identified as having poor outcome. From the remaining women reporting good outcome, 50 cases were randomly selected and their data compared with women reporting poor outcome. The mean age and BMI were similar in the two groups ($p < 0.05$, table-1). All urodynamic parameters including mean functional urethral length (FUL), bladder capacity, Qmax and the urodynamic diagnoses were similar in the two groups. The mean MUCP was significantly lower in the failure group (table-1). The mean pre-operative scores (ICIQ-SF questionnaire), the type of MUS TVT Vs TOT, the number of complications and the mean follow up time were also similar in the two groups ($p > 0.05$). The mean post-operative ICIQ-SF score were significantly lower in the failure group. Conclusions: We conclude that lower preoperative MUCP is associated with a poor outcome after MUS and can be a useful predictor of failure. Based on this evidence, a routine assessment of MUCP prior to surgery is recommended and may be an indication for pre-operative UDS even in those with 'pure' SUI. Evidence suggests this will alter management with improved outcomes with retro pubic rather than TOT. However tension might need to be increased compared with those with normal MUCP. Further studies are required to test this hypothesis and assess the risk of retention in such cases. (Table presented).

Can a urogynaecologist make a difference in a district general hospital?

Author(s): Prince S.; Fiadjoe P.

Source: Female Pelvic Medicine and Reconstructive Surgery; 2014; vol. 20

Publication Date: 2014

Publication Type(s): Conference Abstract

Abstract: Introduction: Vaginal wall prolapse is a common condition in gynaecological practice with surgical correction rates increasing annually. Surgical repair is associated with high recurrence and subsequent re-operation rates with studies suggesting a conservative estimate of 17% within 10 years [1]. Recent studies have suggested that the use of mesh can significantly reduce failure rates when compared to traditional surgical repairs without mesh [2]. Overall there remains a lack of data regarding recurrence rates following mesh repair and it has been identified that patient satisfaction and quality of life should be the main outcome measures [3]. The National Institute of Clinical Excellence (NICE) have specified that complication rates should be <10% mesh erosion, <15% urinary incontinence, <10% dyspareunia and <9% reoperation rate at 12 months and that all procedures should be undertaken by a Urogynaecologist [3]. Objective: To compare outcomes from a previous audit prior to appointment of a Urogynaecologist of surgical repair of vaginal wall prolapse using mesh. Methods: A prospective, continuous audit from 2010-2013 was carried out on 41 patients at a District General Hospital under the care of a Urogynaecologist. Data was collected using the Validated ICIQ questionnaires and compared to a previous audit of 60 cases from 2008-2010 undertaken by two General Gynaecologists. Data was inputted and analysed using the British Society of Urogynaecology (BSUG) database. Results: Both audits

showed that 100% of patients were consented prior to the procedure however the re-audit showed that 100% of patients also received a written information leaflet whilst no patients received this in the primary audit. The primary audit followed patients up to 3 months postoperatively whilst the re-audit follow ups were over a longer time period of between 6 to 12 months. In both audits anatomical success rates were comparable; however, the table below (Table 1) shows the difference in complication rates of the 2 audits compared with national rates where available. The re-audit demonstrates a reduction in mesh erosion, urinary incontinence, dyspareunia and re-operation rate; all well below the expected complication rates as quoted by NICE. Conclusions: Surgical repair of vaginal wall prolapse using mesh is an expanding area of gynaecological practice but it remains that there are limited studies of its long term outcomes [3]. This re-audit demonstrates that an appropriately trained clinician such as a Urogynaecologist can make a difference to the quality of patient information, consent and surgical complication rates in this patient group. This is evidenced by a reduction of mesh erosion from 23% to 0% and dyspareunia from 20% to 2.44% which in turn reduces the re-operation rate at 12 months. This audit highlights the importance of continually auditing our practice to gain more long-term data on outcomes so that we can better advise our patients. (Table Presented).

Is there a need for postoperative follow-up after routine urogynaecological procedures? Patients will self-present if they have problems.

Author(s): Bateman, A G; Neilens, H; Gericke, C A; George, J; Freeman, R M

Source: International urogynaecology journal; Mar 2014; vol. 25 (no. 3); p. 381-386

Publication Date: Mar 2014

Publication Type(s): Research Support, Non-u.s. Gov't Journal Article Observational Study

PubMed ID: 24105409

Abstract: INTRODUCTION AND HYPOTHESIS The value of outpatient appointments for postoperative review has been questioned for many years, and the surgeon practice around this issue is varied. The aim of this study, as part of a larger study assessing postoperative follow-up, was to assess how many patients self-present to their general practitioner (GP) or the emergency department after surgery for urogynaecology procedures. METHODS A retrospective observational study of postoperative urogynaecology patients between 2007 and 2012 was performed using the British Society of Urogynaecology (BSUG) database to identify patients. These records were correlated with hospital and GP records to assess whether any patient was seen postoperatively for a procedure-related problem. RESULTS There were 244 patients with complete data on the BSUG database, of whom 25 (10 %) presented to hospital/secondary care in the year following their surgery; only three of these were admitted for problems related to their surgery. There was a response rate of 70 % from GPs for access to their records. This represented 171 patients, 90 of whom (52.3 %) presented to their GP within a year of surgery mostly for a minor procedure-related

event: 11 of these were re-referred to secondary care, and the remainder were treated in the community. **CONCLUSIONS** The most important aspect of patient care is safety, and this should not be compromised if, for example, postoperative review were to be moved to primary care. As expected, this study shows that patients will self-present if they have problems postoperatively.

Patient satisfaction with telephone review compared to outpatient review following urogynaecological surgery: A pilot randomised controlled trial

Author(s): Landon A.; Gericke C.; George J.; Freeman R.; Neilens H.

Source: BJOG: An International Journal of Obstetrics and Gynaecology; Jun 2014; vol. 121 (no. 7)

Publication Date: Jun 2014

Publication Type(s): Conference Abstract

Abstract: Introduction There is pressure on the NHS to reduce waiting times and improve patient care while reducing costs. Telephone follow-up postoperatively might reduce the pressure on secondary services, but do patients find this acceptable and is it safe? Methods A feasibility trial was performed to refine the planning of a main trial, the primary outcome of which will be patient satisfaction with outpatient follow-up compared to telephone follow-up. All trial processes were assessed and recruitment rates calculated. Patients were recruited from the British Society of Urogynaecology surgical database and randomised to telephone or outpatient follow-up. Patient satisfaction was measured by the Care and Relational Empathy measure. Results A recruitment rate of 44.9% and a response rate of 76.9% were achieved. Satisfaction scores were similar between the two groups (outpatient = 52.69 [SD 10.17, 95% CI 47.29-58.10], telephone = 51.14 [SD 9.77, 95% CI 45.50-56.79]). The majority of patients in the outpatient arm were reassured by an examination (94%) but 64% of the patients in the telephone arm were happy to forego an examination. All patient reported outcomes improved postoperatively. No patients were re-admitted in either arm of the trial. One complication was detected at outpatient follow-up. This was asymptomatic and did not require treatment. Conclusions These pilot findings suggest that telephone follow-up is both acceptable to patients and is a safe method of review postoperatively. A fully powered trial is needed to investigate this further, however, and this pilot trial demonstrates that such a trial would be feasible.

Prospective study of vaginal versus laparoscopic surgeries for central compartment pelvic organ prolapse

Author(s): Kung R.; Phatak M.; Agur W.; Hair M.; Abdel-Fattah M.

Source: Neurourology and Urodynamics; Aug 2014; vol. 33 (no. 6); p. 818-819

Publication Date: Aug 2014

Publication Type(s): Conference Abstract

Abstract: Hypothesis/aims of study: Surgical correction of central compartment prolapse with vaginal approach (sacrospinous fixation) has been shown to have risks of chronic pelvic pain and recurrent cystocele (1). Vaginally-assisted laparoscopic sacrohystero/colpopexy (VALS) is a relatively new procedure using prolene mesh sutured vaginally and picked up laparoscopically for promotofixation (2). Study design, materials and methods: Data was collected prospectively from the BSUG national surgical database from 2009-2012. Comparisons used questionnaire scores (ICIQ-VS) as well as objective assessment (POP-Q). We also compared the procedure time and complications at 3-month. Non-parametric Mann-Whitney test used was for statistical analysis. Results: 32 women underwent vaginal sacrospinous hystero/colpopexy and 29 had laparoscopic sacrohystero/colpopexy. Apart from a significant difference in age (Laparoscopy patients 10.4 yrs younger), all demographics were similar. There were significant improvements in ICIQ scores for vaginal symptoms (95% CI 18.5-27.5, $p < 0.01$) and sexual matters (mean change 28.11, $p < 0.05$) but no significant difference between groups. There was a significant fall in point C of POP-Q for the entire sample (without significant change in vaginal length) but no significant difference between groups. Surgery time was significantly longer in the laparoscopic group (mean difference 64.1 min, 95% CI 26.0 102.3) due to initial learning curve and choosing the laparoscopic approach for women with recurrent and complex conditions. Procedure-related risks for the two approaches and there were no mesh erosions at 3 months (Table Presented). Interpretation of results: There is no significant difference in subjective or objective outcomes between vaginal and laparoscopic suspension of the central compartment at 3 months. The longer time for the laparoscopic procedure is due to the learning curve effect and selecting the laparoscopic approach for complex and recurrent conditions. Concluding message: VALS procedure is safe and as effective on the short term as the vaginal sacropexy procedure for the treatment of central compartment prolapse in women.

2015

Rectal packing at infracoccygeal sacropexy: A novel approach

Author(s): Israfil-Bayli F.; Toozs-Hobson P.; Latthe P.; Mayne C.

Source: BJOG: An International Journal of Obstetrics and Gynaecology; Apr 2015; vol. 122 ; p. 334

Publication Date: Apr 2015

Publication Type(s): Conference Abstract

Abstract: Introduction Infracoccygeal vaginal vault suspension is used in selected patients to correct vault prolapse. The objective of the video is to demonstrate an additional modification to the procedure which can reduce risk of rectal injury. Methods The featured is 75-year-old woman with posterior predominant stage 3 POP. The video outlines the steps/surgical principles necessary to achieve a successful infracoccygeal sacrocolpopexy (Posterior I-STOP (CL Medical) procedure) with minimal risk of injury to the rectum and increased reassurance about the positioned tape due to suggested

preoperative rectal packing with gauze. Results Our unit performs over 400 prolapse procedures per annum. According to BSUG database in the 5 years (2008-2013), we performed 48 posterior I-STOP procedures. There have been no bowel injuries and 1 tape erosion reported. Conclusion Packing the rectum may actually reduce risk of bowel injury by assuming a smaller diameter and therefore allowing the trocar to be positioned slightly wider of the rectum. In our experience since adopting this technique the tape feels further away from the rectum on rectal examination at the end of the operation and this simple procedure has helped intraoperatively to help reassure the surgeon with regard to the positioning of the tape.

355 single incision ajust tapes performed under local anaesthetic: A retrospective case series

Author(s): Ford A.A.; Assassa R.

Source: International Urogynaecology Journal and Pelvic Floor Dysfunction; Jun 2015; vol. 26 (no. 1)

Publication Date: Jun 2015

Publication Type(s): Conference Abstract

Abstract: Introduction: Mid-urethral slings (MUS) are a recognised standard minimally invasive surgical treatment for stress (SUI) and often mixed urinary incontinence (MUI). The data for the use of MUS in MUI is less robust. Single incision slings (SIS) are a shortened tape inserted through a single incision at the mid urethra. Less dissection potentiates their insertion under local anaesthetic (LA). The evidence thus far suggests these tapes are less effective than their standard counterpart. The latest generation of SIS are adjustable and have better fixation mechanisms with the tape being fixed beyond the obturator membrane potentially improving their efficacy while having the same advantages. Whether these tapes can successfully be performed under LA still needs assessment. In this study we have assessed the feasibility of performing the Ajust procedure under LA in a general clinical setting. Objective: To assess the feasibility and effectiveness of Ajust SIS in the treatment of urodynamic stress incontinence (USI) in women when performed under LA. The primary outcome assessed the number of procedures completed under LA. Secondary outcomes were perioperative complication rates, patient reported pain scores, analgesic requirements and subjective cure assessed by Patient Global Improvement (PGI-SS). Methods: We have analysed the results of patients in our unit undergoing Bard Ajust procedure on the British Society of Urogynaecology (BSUG) database between 2009 and 2014. Included were women with USI and MUI after failed lifestyle modification and conservative management. All women underwent pre-operative urodynamic studies (UDS). All women had the Ajust sling inserted under LA. Pre-operatively patients received Emla cream, Instillagel (per urethra), Acetaminophen (1g), Ibuprofen (400 mg) and Augmentin (625 mg). In theatre 15mls of 0.25 % Levobupivacaine was injected bilaterally along the obturator tract and 20mls around the urethra and vaginal wall. After insertion the tape was adjusted according to a cough test. Pain scores were assessed on a scale of 0 to 10 (no pain to

severe pain). Follow up was performed between 6 weeks and 6 months. Patient-reported success was defined as "very much improved" or "much improved" on PGI-SS. Peri-operative complications were obtained from the BSUG database. Data was analysed using SPSS package version 12. Results: 382 Ajust procedures were performed within this time frame. Five had concomitant surgery and were excluded. Of the 377 remaining 22 (5.8 %) were performed under general anaesthesia (GA), and 355 (94.1 %) were performed under LA of which 2 (0.6 %) patients also had sedation. Baseline characteristics are as shown in table 1. 96 % of women underwent UDS. Eight women had prior incontinence surgery (1 colposuspension, 3 MUS and 4 intramural urethral bulking procedures). All procedures undertaken were completed under LA with a 0 % conversion rate to GA. 329 women completed their follow up. Overall patient reported success rate was 308/324 (95 %) (outcome data missing for 31 women). For women with SUI success rates were 162/167 (97 %) (outcome data missing for 11 women), whereas for MUI success rates were 132/142 (92 %) (outcome data missing for 13 women). There were no major intra-operative complications (urethral/bladder/ureteric injury, neurological or major vascular injury/haematoma). One case of returned to theatre for reactionary haemorrhage; bleeding from the vaginal epithelial edge requiring a single haemostatic suture, and one woman required catheterisation for longer than 10 days post-operatively. Six (1.7 %) patients required overnight stay and there were 14 re-attendances to hospital with minor complaints (none required admission). Table 2 shows the affect of Ajust insertion on detrusor overactivity (DO)/overactive bladder symptoms (OAB). In total 11 patients required pharmacotherapy for de-novo or worsening OAB symptoms. Conclusions: This is a large case series demonstrating the feasibility of performing Ajust procedure under LA. The vast majority of patients are discharged on the day of surgery potentiating the possibility of outpatient procedures. Ajust procedure has been shown to be both a safe and effective treatment for SUI and MUI with minimal adverse events. (Table Presented).

Extra peritoneal laparoscopic colposuspension for SUI: Short term follow up

Author(s): Ibrahim S.; Beatty L.; Sokolova I.; Agur W.; Hawthorn R.

Source: Gynecological Surgery; Oct 2015; vol. 12 (no. 1)

Publication Date: Oct 2015

Publication Type(s): Conference Abstract

Abstract: Background Laparoscopic colposuspension has been shown to be equivalent to the open procedure in Cochrane reviews (July 2006), however, it did not catch momentum due to the technical demand of the procedure the emergence of tension-free vaginal tapes (BJOG.2006). Methods Prospective study the first cohort of patients who underwent extraperitoneal laparoscopic colposuspension as primary operation for SUI in 2013-2014. Data was collected from BSUG database. Veress needle was used to insufflate 1 litre of CO₂ into the retropubic space (RS). A 10 mm trocar introduced at the umbilicus then pierces the rectus sheath midway between the umbilicus and the symphysis pubis to access the retropubic space without opening the peritoneal sac. Two

5 mm suprapubic trocars are introduced and, using perineo-abdominal approach, the vagina at the level of the bladder neck is dissected and attached to Cooper's ilio-pectineal ligaments with 2 non-absorbable sutures on each side as usual. Catheter was removed the following day. Follow up time was 9-18 month. We compared pre and postoperative ICIQ-UI questionnaire and PGI-I. Results Fourteen patients underwent EP-LC in a period of 24 months. The mean age is 46 years and mean BMI is 31.7 kg/m². All patients had PFMT and urodynamics showed 14.2% mixed UI and 85.7% USI. No concomitant procedures were performed and there were no intraoperative complications. Average blood loss is <50 mls. The length of hospital stay 1-3 days. 2 patients had temporary urinary retention that resolved. One patient had persistent haematuria but negative cystoscopy. One patient was readmitted with UTI that responded well to antibiotics. Global impression of improvement after surgery 6 patients answered very much improved, 2 patients much improved and 6 patients didn't answer. Mean postoperative IEF is 2.5, amount is 3.3, QoL is 6.3 and pads 1.3. 2 patients had urgency postoperative. Vaginal symptom is 3.4 and sexual matters 13.7. Conclusions Our initial experience confirms that extraperitoneal laparoscopic colposuspension is safe, easy to learn and effective procedure on the short term, that could be offered to women with SUI as a minimally invasive alternative to vaginal mesh tapes.

2016

Telephone follow-up after day case tension-free vaginal tape insertion.

Author(s): Jefferis, Helen; Muriithi, Francis; White, Beverly; Price, Natalia; Jackson, Simon

Source: International urogynaecology journal; May 2016; vol. 27 (no. 5); p. 787-790

Publication Date: May 2016

Publication Type(s): Journal Article Observational Study

PubMed ID: 26590807

Abstract: INTRODUCTION AND HYPOTHESIS Post-operative review allows assessment of individual patient outcome, evaluation of any on-going symptoms and an audit of departmental surgical outcome and therefore represents best clinical practice. Current TVT surgery follow-up practice varies widely, with most centres routinely seeing patients face to face in an outpatient setting. However, unnecessary outpatient attendance can be inefficient and inconvenient for patients and staff. One proposed alternative is telemedical follow-up, as introduced by our unit in 2010. We report on 5 years of experience with telephone follow-up. METHODS The British Society of Urogynaecology (BSUG) database was searched for all cases of primary retropubic TVT slings performed by the unit in the period 1 January 2010 to 31 December 2014. Cases identified from the BSUG database then had their case notes reviewed. Patients having additional surgery were excluded from analysis. This yielded a cohort of 356 patients. No ethical approval was required for this investigation as it was a simple observational study (clinical audit).

RESULTS Two hundred and sixty-two patients were initially followed up via telephone; the remaining 94 were seen in a conventional outpatient clinic setting. Of the 262 followed up by telephone, 28 patients (10 %) subsequently required review in an outpatient clinic for a variety of reasons. **CONCLUSIONS** Telephone follow-up is an appropriate mode of follow-up for uncomplicated primary incontinence surgery. By using telemedicine, 234 patients who would previously have been seen in clinic were followed up remotely, saving valuable clinic time for patients with greater clinical need.

Database: Medline

Pelvic floor surgery as day case procedures

Author(s): Burgess S.; Burton C.; Ahmed A.; Morgan H.

Source: BJOG: An International Journal of Obstetrics and Gynaecology; Jun 2016; vol. 123 ; p. 180-181

Publication Date: Jun 2016

Publication Type(s): Conference Abstract

Abstract: Objectives With increasing pressure on secondary care the role of day surgery is evolving. There are advantages for trusts as no inpatient beds are required freeing them for emergency admissions. For patients the advantages are avoidance of exposure to hospital acquired infections, prolonged immobility and high satisfaction rates with day surgery. The British Association of Day Surgery states surgical procedures suitable for day surgery should carry low risk of complications requiring surgical intervention, have pain that can be controlled through oral or local analgesia and patients are able to maintain hydration via oral fluids. Pelvic floor repairs fulfil these criteria and are appropriate operations to be performed in this setting. Methods A standard was set of performing 90% of pelvic floor surgeries (vaginal repairs, colpocleisis and sacrospinous fixation) as day case procedures. The BSUG database of our two Urogynaecologists was used to identify patients having pelvic floor surgery who were medically fit for day surgery with these factors being our inclusion criteria for analysis. Our primary outcome was whether patients were discharged on the day of surgery. We assessed patient follow-up data with regards to satisfaction of outcome and any readmissions within 2 weeks of surgery with a surgery related complication. Results 126 patients were identified as suitable for day surgery. These included 99 vaginal repairs, 3 perineorrhaphys, 7 sacrospinous fixations and 12 colpocleisis. The patients had an average age of 62 with a range of 25-90. Of these cases 103 were performed as day case procedures (82%). The reasons for admission included failure to pass urine and the need for catheterisation (30%), something that with education is avoidable and would increase the day case rate to 87%. 3 of the admissions were for pain and 4 patients were scheduled to have their surgery as inpatients in spite of meeting day case criteria - likely due to patient preference. Six cases re-attended within 14 days of surgery (5%), 2 for a TWOC, 1 in urinary retention, 2 with pain and 1 with a wound infection. None of these required readmission. 28 patients had completed their six month postal follow-up with 71% stating they were very much better or much better and only 7% had no change.

Conclusions Pelvic floor surgery as a day case procedure offers good post-operative outcomes with the advantage of avoiding a hospital stay with few re-attendances and no readmissions.

Prospective observational study of sacrospinous fixation at a UK district general hospital

Author(s): Ankers D.; Ramage J.; Kozman E.; Hasan E.

Source: BJOG: An International Journal of Obstetrics and Gynaecology; Jun 2016; vol. 123 ; p. 179

Publication Date: Jun 2016

Publication Type(s): Conference Abstract

Abstract: Objectives To assess outcomes of patients undergoing sacrospinous fixation at Warrington hospital. Methods Prospective analysis during a 4 year period December 2011 until September 2015 to highlight all patients who had sacrospinous fixation for pelvic organ prolapse, recorded on the British Society of Urogynaecology database. Results Out of 231 patients who underwent a prolapse repair, 60 had sacrospinous fixation with the Capiro device. The majority of patients 58/60 reported either a complete cure or significant improvement. ICIQ scores pre and post SSF showed an average improvement in 93% of cases. There were 2/60 patients who had failed trial without catheter and necessitated longer catheterisation but no long term complications were encountered. Conclusion Significant improvement in ICIQ scores and global impression of improvement scores were noted. Low rate of complications and patient satisfaction make sacrospinous fixation a particularly useful technique for vault suspension. This is consistent with the recently published national guidance and evidence base (1,2).

How well are we recording our procedures onto the British Society of Urogynaecology (BSUG) national database? A retrospective audit of current practice in a urogynaecology centre

Author(s): Wong J.; Das M.

Source: BJOG: An International Journal of Obstetrics and Gynaecology; Jun 2016; vol. 123 ; p. 182

Publication Date: Jun 2016

Publication Type(s): Conference Abstract

Abstract: Objectives To determine current rates of compliance to recording urogynaecology procedures consisting of pre-operative quality of life (QoL), pre-operative preparation, surgery recorded, postoperative follow-up, global impression of improvement and postoperative QoL. Minimum compliance rates for unit accreditation are set at 90% of procedures recorded on the BSUG database with 50% of follow-ups recorded. Local target rates are 90% of procedures recorded and 80% of follow-ups

recorded. Methods All urogynaecology procedures carried out between 1st October 2014 to 30th September 2015 by four consultants specialising or having an interest in urogynaecology over two hospital sites in the same trust were obtained from hospital theatre records. These patients were searched on the BSUG database. Parameters entered onto the database should be preoperative QoL, pre-operative preparation, surgery recorded, postoperative follow-up and postoperative QoL. Data were entered and analysed with Microsoft Excel spreadsheet. Results Compliance to recording procedures onto the database varied between the four consultants. One surgeon did not record any of their procedures onto the database. Between the three that did, actual surgery recorded ranged between 83.3% to 97.4% with unit average being 67.8%. Whole unit compliance rates for other parameters measured were lower; pre-op QoL was 50.39%, preoperative preparation 51.8%, post-operative follow-up 63.3%, global impression of improvement 61.3% and post-operative QoL 29.7%. Conclusion Target rates for number of procedures recorded onto the database were not met. Post-operative follow-up recorded rate for minimum unit accreditation was met, but was not met at the local target. Consultants are recording their procedures on an ad hoc basis which leads to variable compliance rates. Compliance may improve if the role for data entry is assigned to a specific person who will be able to record procedures on a regular basis. There may well be scope to expand the roles of our urology specialist nurses to include this into their job specifications.

What can we learn from large datasets? an analysis of 19,000 retropubic tapes

Author(s): Bach F.; Tooze-Hobson P.

Source: International Urogynaecology Journal and Pelvic Floor Dysfunction; Aug 2016; vol. 27 (no. 1)

Publication Date: Aug 2016

Publication Type(s): Conference Abstract

Abstract: Introduction: The BSUG surgical database is a unique resource for the analysis of trends with roles in patient safety, surveillance & benchmarking of personal practice. Objective: To Establish: 1. Complication rates in routine (non-trial) conditions 2. Complication rates for trainees & consultants To Explore 1. A case study of an outlier 2. Perforation as a surrogacy of quality Methods: All patient consented to their anonymous data being used, ethics was not required and this had gone through the Caldicott Guardian process. Approval was given by BSUG to use data on retropubic tapes. Data analysed using Excel. A funnel plot of confidence intervals for perforation rate was calculated. Detailed analysis of a single unit undertaken with breakdown of individual surgeons. A Chi2 used to explore the effect of perforation on outcome defined by PGI. Results: 18,763 records were retrieved. 14,156 were performed by Consultants, 64 by Associate specialists, 1140 by Subspecialty trainees, 2549 by Registrars, 201 by Staff Grades & 377 other. Trainee perforation rate was statistically higher than consultants ($p < 0.05$). Graph 1 Perforation rates (%) per centre are shown in the funnel plot (graph 2). The mean rate was 3.52 %. The overall rate of other "standard" complications recorded

was 1.16 % (not included on graph). In our institution, the raw data was an outlier; the trainee operation rate was 44 % versus 15 % in the overall data. The trainee operating equates to a 3 % effect on our 7.7 % raw perforation rate. The individual consultants' data are plotted on the funnel plot (A, B, C) and are all within the upper limit. In terms of quality there was a significant difference ($P < 0.05$) in global impression of improvement for incontinence between perforations and no perforations (10425/10871 vs 311/333) suggesting a small effect of perforation on the outcome. Conclusions: 1. Complication rates in "routine" conditions The overall bladder perforation rate was 3.52 %, which varied between consultants, based on the numbers performed. This rate is lower than the Cochrane figure of 4.9 % (1) (bladder & urethral injury: BSUG equivalent was 3.64 %). 2. Complications rates for trainees and consultants. Trainees have a significantly higher perforation rate ($p < 0.05$) which is likely to remain until the learning curve is completed (2, 3). 3. Outliers Outliers can easily be identified. Our centre shows a significant effect from trainees operating. Further analysis shows individuals to be within the funnel plot. Outliers should be encouraged to explore reasons for variation. 4. Perforation as a surrogacy for quality Our study confirms that perforation rate is a valid surrogate for quality with a small but measurable difference. This is likely to be an under estimate of effect based on factors such as case complexity and grade of operator.

Does age affect the outcome of suburethral tape surgery? The importance of national registries in answering bigger questions.

Author(s): Toozs-Hobson, Philip; Devani, Pooja; Pick, Joseph; Moran, Paul A; Assassa, Philip; Burton, Claire

Source: International urogynaecology journal; Oct 2016; vol. 27 (no. 10); p. 1541-1545

Publication Date: Oct 2016

Publication Type(s): Journal Article

PubMed ID: 26992726

Abstract: INTRODUCTION AND HYPOTHESIS The objective of this article was to use the British Society of Urogynaecology (BSUG) database to assess the impact of age on success rates and insertion complications of suburethral tapes for primary procedures using the Patient Global Impression of Improvement (PGII) as the primary endpoint. METHODS We carried out a retrospective analysis of data at a national level (BSUG database) using PGII as the primary outcome measure. Secondary outcomes included improvement in stress incontinence and complications from surgery. All episodes of suburethral tapes on the database were extracted and analysis was by decade of life. RESULTS A total of 7,600 cases were identified on the database, of which 757 were in women over 70 years of age, with 119 in women over 80. Just over 80 % of the cases on the database involved retropubic and just under 20 % transobturator tapes. Short-term follow-up was available for 54 % of the cases. The PGII remained high in all age groups, but did decrease slightly with age, with more than 90 % of women under 50 scoring highly, which reduced to 70 % in those over 80. Improvement in stress incontinence was globally high, with 98 % scoring highly in the women aged under 50 and 85 % in the 80+

group. This suggests that the suburethral tapes worked well in treating stress incontinence. Reassuringly, complications did not increase with age, although short-term voiding difficulties were higher with increasing age. **CONCLUSION** Contributing to national databases gives useful information that may be difficult to ascertain from RCTs. Suburethral tapes appear to have good efficacy and low complications with increasing age.

Should maximal urethral closure pressure be performed before midurethral sling surgery for stress incontinence? A time to revisit.

Author(s): Vij, Monika; Dua, Anupreet; Freeman, Robert M

Source: International urogynaecology journal; Oct 2016; vol. 27 (no. 10); p. 1491-1495

Publication Date: Oct 2016

Publication Type(s): Journal Article

PubMed ID: 27010558

Abstract: **INTRODUCTION AND HYPOTHESIS** Maximum urethral closure pressure (MUCP) provides an objective assessment of urethral integrity, but its role in predicting outcome after midurethral sling (MUS) placement is debatable and current practice in the UK is variable. The study was carried out to determine if lower preoperative MUCP is associated with poor outcome following MUS. **METHOD** The study was a retrospective review of the British Society of Urogynaecology (BSUG) database and urodynamics (UDS) data. Patients who reported outcome as "no improvement", "worse" or "much worse" on the Patient Global Impression of Improvement (PGII) scale were identified as having a poor outcome. Patients who reported "a little improvement", "improved" and "very much improved" on the PGII were thought to have a good outcome. The preoperative demographics, UDS findings and quality of life (International Consultation of Incontinence questionnaires [ICIQ-SF]) data of the two groups were compared. **RESULT** A total of 236 women were identified for the study. Of these, 24 women (10.2 %) had a poor outcome. Of the remaining women reporting a good outcome, 50 cases were randomly selected. All urodynamic parameters, including mean functional urethral length (FUL), bladder capacity, and Qmax, were similar, except for mean MUCP 37.05 cm H₂O, which was significantly lower in group 1 (poor outcome 37.05 cm H₂O) compared with a mean MUCP of 50.6 cm H₂O in group 2 (good outcome; p = 0.005). **CONCLUSION** We conclude that failure following MUS is associated with preoperatively lower MUCP, which can be used as a predictor of failure.

Tension-free vaginal tape insertion for stress urinary incontinence: A 6-year analysis

Author(s): Pounds R.; Hayes R.; Matharu G.

Source: BJOG: An International Journal of Obstetrics and Gynaecology; Dec 2016; vol. 123 ; p. 18

Publication Date: Dec 2016

Publication Type(s): Conference Abstract

Abstract: Introduction Tension-free vaginal tape (TVT) procedures have proven efficacy in managing stress urinary incontinence (SUI) when conservative methods have failed. However, voiding difficulties following surgery are a known complication. This retrospective review of TVT cases at Heart of England NHS Trust evaluates the associated complications, postoperative morbidity and improvements reported at follow-up. Methods All cases performed from January 2010 to December 2015 were identified from the British Society of Urogynaecology (BSUG) audit database. Electronic records were utilised to retrieve clinical letters, surgical documents and discharge summaries. Results TVT insertion was undertaken in 515 women and simultaneous anti-incontinence procedures performed in 111 (21.6%). Complications occurred in 142 (27.6%); 4 (0.8%) intraoperatively and the remaining postoperatively, with voiding difficulties in 92 (17.9%). Complications were observed more frequently with concomitant surgery (47.7% compared to 22.0% with TVT alone), including the risk of voiding difficulty (26.1% compared to 15.6%, $P = 0.01$). In 8 cases the TVT was loosened and another 8 required tape division. Follow-up questionnaires demonstrated improvements in urinary symptoms in the majority (70.3%), but others found no change or a deterioration. Of those with advantageous results, 81.2% had a TVT inserted only. Worsening incontinence was associated with additional procedures (9.5% compared to 2.6% ($P = 0.004$)). Prolonged catheterisation (over 10 days) or intermittent self-catheterisation was necessary in 23 (4.5%); these patients were less likely to benefit from symptomatic improvement ($P = 0.009$). Conclusion TVT insertion successfully treats SUI, with improvements in the majority. Morbidity, especially voiding difficulty, is not uncommon. Simultaneous anti-incontinence surgery seems to increase complications and be associated with poorer long-term outcomes. Voiding difficulties can be managed effectively with tape adjustment or catheterisation; when the latter is required, patients may have less favourable results. Further evaluation of the risks associated with coinciding surgery as well as the appropriate management of postoperative voiding difficulties are required.

2017

What can we learn from large data sets? An analysis of 19,000 retropubic tapes.

Author(s): Bach, Fiona; Toozs-Hobson, Philip

Source: International urogynaecology journal; Apr 2017; vol. 28 (no. 4); p. 629-636

Publication Date: Apr 2017

Publication Type(s): Multicenter Study Journal Article

PubMed ID: 27738733

Abstract: INTRODUCTION AND HYPOTHESIS Retropubic tapes are successful for treating stress urinary incontinence (SUI), but there is controversy around risk profiles. The British Society of Urogynaecology (BSUG) database allows analysis of surgery for patient

safety, surveillance and benchmarking. Objectives of this study were to establish success and complication rates in routine practice, determine complication rates for trainees and consultants, explore reasons for outliers and assess perforation as a surrogacy of quality. METHODS Approval was obtained from BSUG to use data on retropubic tapes. Data was anonymised, and patients gave prior consent. Analysis was done using the χ^2 test, and a funnel plot of bladder perforation rate was calculated. RESULTS There were 18,763 procedures recorded: 14,156 were performed by consultants, 64 by associate specialists (64), 1140 by subspecialty trainees, 2549 by registrars, 201 staff grades and 377 other. We found a 3.5 % bladder perforation rate, which was statistically higher for trainees than consultants ($p < 0.05$). The rate of other "standard" complications were low: 95.8 % of patients felt better on the Patient Global Impression of Improvement of Incontinence (PGI) scale. There was a significant difference ($p < 0.05$) in PGI and SUI outcome between patients who did and did not experience perforation. CONCLUSIONS Success rates with retropubic tapes are high, with low complication rates. Bladder perforation in "real", not "trial" data was 3.5 %, which is lower than reported by the Cochrane review (4.5 %). Trainees have a higher perforation rate ($p < 0.05$) because of learning curves. Outliers are easily identified, and reasons for this should be explored, including proportion of trainees doing the surgery. This analysis confirms that bladder perforation is a valid surrogate for quality with a small but measurable difference. We have a responsibility to analyse data to improve patient care and encourage colleagues to support the International Urogynaecology Association (IUGA) database initiative.

What can we learn from large data sets? When we use bulking procedures and comparison to mid urethral slings (MUS)

Author(s): Bach F.; Toozs-Hobson P.; Duckett J.

Source: International Urogynaecology Journal; Jun 2017; vol. 28 (no. 1)

Publication Date: Jun 2017

Publication Type(s): Conference Abstract

Abstract: Introduction: Bulking agents are used in patients with stress urinary incontinence (SUI) by patient choice, if unsuitable for other treatments or following treatment failure. Objective: The aim of this study was to use the BSUG database to gain insight into clinicians' choices about patient selection, complications and efficacy in real life use. Methods: Permission was given to analyse 1386 cases of bulking agents from the BSUG database. Anonymised data were compared to a previous analysis of MUS. Results: Outcome 1 Age: The average age of primary bulking patients was higher (57.9 years) than primary MUS (52.3). The age range was more widely distributed for bulking. Outcome 2 Re-do surgery: 783 (56%) bulking were a primary procedure and 539 (39%) had previously had a continence procedure (64 unanswered 5%). Outcome 3 Intra-operative complications (no concomitant surgery): None for bulking, compared to 3.5% bladder perforation, 0.6% >500ml blood loss, 0.1% urethral & vascular injury for MUS. Outcome 4 Hospital stay (no concomitant surgery): Shorter with bulking when compared with MUS. Outcome 5 Patient outcomes: Patient global impression of

improvement (PGI-I) is lower for bulking compared to MUS (graph 1). Change in OAB symptoms (graph 2) is a more even spread with the MUS outcome being more variable and bulking agents more likely to be neutral. Outcome 6 Success of bulking as a primary or secondary procedure: similar efficacy (graphs 1 & 2). Outcome 7 Pre-operative UDS: bulking agents are used more frequently with mixed rather than pure SUI (graph 3). Diagnoses of USI are most likely to improve PGII-I and UDO fare worst. Conclusions: Primum non nocere. Results suggest that bulking agents are more commonly used in complex cases than straightforward SUI. Whilst the success of bulking agents appears less than MUS, there were no intra-operative complications recorded and this must be put into context for patient choice. This is relevant for Value based Healthcare on an organizational and individual level. Large datasets are useful to provide insight into clinical practice and real life outcomes, and contribution should be encouraged. The inclusive nature of national databases can give patients more relevant information than strictly controlled RCTs.

An analysis of 10,500 mid urethral slings (MUS) and the impact of pre-operative urodynamic studies

Author(s): Bach F.; Tooze-Hobson P.

Source: International Urogynaecology Journal; Jun 2017; vol. 28 (no. 1)

Publication Date: Jun 2017

Publication Type(s): Conference Abstract

Abstract: Introduction: The UK NICE Guidance states urodynamic studies (UDS) are not mandated prior to MUS for symptoms of pure stress urinary incontinence (SUI). However, we are taught that "The bladder is an unreliable witness"; multiple papers have shown symptoms may not always marry up with urodynamic diagnosis. The concern of detrusor overactivity (DO) leading to symptoms of SUI and the subsequent worsening of symptoms of overactivity following MUS means that, anecdotally, many clinicians still routinely perform UDS prior to an MUS. Objective: To evaluate the effect urodynamic diagnosis has on Patient Global Impression of Improvement of Incontinence (PGI-I), change in SUI symptoms and change in OAB symptoms following MUS. Methods: With permission, 10,681 records from the BSUG database were analysed using excel and Chi. Results: 91.7% patients with urodynamic stress incontinence (USI) on UDS reported being "better" ('very much' or 'much better') on PGI-I compared to 86% with some element of DO on UDS (graph 1) ($p < 0.05$). Greater numbers of patients reported their SUI cured if there was no element of DO in the UDS. The greatest percentage of patients who found their SUI was "worse" was those with DO on UDS (graph 2). The change in symptoms of OAB is more complex (graph 3). There is the perception of cure or improvement of DO in many cases (25-55%) but the group with pure DO on UDS has the fewest reports of cure but also the highest percentage of patients reporting worsening of OAB. Voiding difficulties are associated with worse outcomes. It is unclear why patients received MUS without USI on UDS. Conclusions: Urodynamics is helpful prior to MUS as pre-operative UDO and voiding difficulties are associated with poorer outcomes.

The database gives no information on prior intervention for DO or indeed what the long-term outcomes for these patients were. Both of these questions may be answered if the ideals of ICHOM were implemented and a "disease based database" was adopted. It will be interesting to see prospectively how UDS change management as planned for INVESTIGATE. Ultimately, it is important to counsel women about individualised success rates dependent on patient characteristics following insertion of a MUS.

Surgery for recurrent stress incontinence in the UK 2007-2015

Author(s): Tincello D.G.; Bach F.; Toozs-Hobson P.

Source: International Urogynaecology Journal; Jun 2017; vol. 28 (no. 1)

Publication Date: Jun 2017

Publication Type(s): Conference Abstract

Abstract: Introduction: Although surgery for stress urinary incontinence (SUI) is effective, roughly one woman in eight will have persistent or recurrence stress incontinence. Systematic reviews reveal no data from randomised trials to inform treatment choices and little evidence of the effectiveness of recurrent SUI surgery(1,2). The British Society of Urogynaecology database has been in operation for over 10 years and contains details of most urogynaecology surgery done in the UK. We have reviewed data on recurrent SUI surgery over the last 10 years. Objective: To examine BSUG database records for treatment options for recurrent stress incontinence and to compare outcomes. Methods: Data from 2007-2015 were obtained from the BSUG database committee. After data cleaning, previous surgery patterns were compared by year, and outcomes compared by operation. Group comparisons were by Chi Square and numerical comparisons by appropriate non-parametric tests. Results: Results: 2,938 records were obtained. 269 cases were not previous continence surgery cases leaving a final cohort of 2,669, although 231 had no details of previous surgery. Median age was 59 years (20-88), with median BMI 28.4 (17.8-60.6). 2,164 (88.8%) had one previous procedure, (207) 8.5% had two, 53 (2.2%) had three, and 14 (0.6%) more than three. The first procedure was most commonly retropubic tape (28.6%), colposuspension (24.5%), transobturator tape (17.4%) or bladder neck injection (14.3%). Pelvic floor exercises were offered to 76.2% women overall. 96.2% women had urodynamic investigation performed: 76.5% women had urodynamic stress incontinence, 18.6% had mixed incontinence, 0.7% had detrusor overactivity, and 3.4% had a normal investigation. Median annual procedures were 273 with a non-linear increase across the years peaking at 500 in 2013. Midurethral tape (MUT) was most common (77.3%), followed by bladder neck injections (BNI) (10.2%) and colposuspension (5.7%). From 2012 colposuspension and fascial sling were performed more often; fascial slings increased from 1.6% to 10.9% cases ($p < 0.0001$). Follow details were available for 1,763 (66.1%) women. 89.2% women had an outpatient follow up at 6 weeks for 649 (37.4%), three months for 667 (38.5%) and six months for 354 (20.4%). Outcome data were poorly reported. Median ICIQ-UI SF score (882 women (33.0%)) fell from 16 (0-21) to 0 (0-21) (621 women (23.3%)) ($p < 0.001$). Patient Global Impression of Improvement (PGI-I)

data were available for 1,616 (60.5%) women; 1,319 (81.6%) were "much better" or "very much better". "Change in stress incontinence" data were available for 1,499 (56.2%) women. Of these, 993 (66.2%) were "cured" and 344 (22.9%) "improved". Both PGI-I scores ($p<0.001$) and "change in stress incontinence" ($p<0.001$) differed by surgery type, with midurethral tapes, colposuspension and fascial sling more likely to achieve cure or major improvement than bladder neck injection. Conclusions: MUT and bladder neck injections are the most common procedures for repeat SUI but treatment patterns have changed in the last 8 years. Follow up data in the BSUG database are incomplete but suggest MUT, colposuspension and fascial sling are superior procedures.

Value based healthcare: The effect of body mass index (BMI) on success and complications of 12,000 mid urethral slings (MUS)

Author(s): Bach F.; Toozs-HOBSON P.; Hill S.

Source: International Urogynaecology Journal; Jun 2017; vol. 28 (no. 1)

Publication Date: Jun 2017

Publication Type(s): Conference Abstract

Abstract: Introduction: Analysing surgical databases utilises "real life" outcomes rather than highly selected cases from RCTs or meta-analysis and may be more valid for planning health services/resources. MUS are the gold standard surgical treatment for stress urinary incontinence (SUI) but risks must be explained to patients. Patient characteristics may alter outcomes, rendering treatments less effective with less "value" in management pathways. It is important to identify these characteristics, particularly if modifiable, so patients and clinicians can be fully informed. Objective: To evaluate the effect of a single modifiable variable: BMI, on patient reported outcomes by analysing MUS on the BSUG database. Methods: BSUG approved analysis of 11859 anonymised MUS from 2007-2016. Data were analysed using excel and Chi2. Results: Outcome 1. As BMI increases, patient global impression of improvement (PGI-I) declines. Women with a normal (18-<25) BMI report very much better/much better PGI-I in 91.6% of cases. Fewer patients in BMI groups >30 reported this level of success (87.7-72%) ($p<0.05$). (Graph 1) Outcome 2. Patient reported outcomes for SUI inversely correlated to BMI with 97% of normal BMI stating they were cured/improved compared to 35-40 (94%), 40-45 (93%) and 45-50 (84%) ($p<0.05$) (Graph 2). Outcome 3. Patient reported outcomes for overactive bladder (OAB) show that as BMI increases, higher rates of patients report worsening symptoms ($p<0.05$). (Graph 3) Outcome 4. There is a u-shaped association between BMI and perforation rate ($p<0.05$). Conclusions: Our results suggest that raised BMI is associated with poorer outcomes, and this potentially modifiable variable may lead to an overall lower "value" to the patient. By defining characteristics that alter outcomes there is the potential to calculate a personalised prediction of success and complications. This may improve shared decision-making and give an impetus to modify characteristics to improve outcomes. Further work is required to see if reducing BMI reverses our observations. This study would ideally be undertaken as a cohort study, as an RCT would be potentially difficult to complete per protocol.

Surgery for recurrent stress incontinence in the UK 2007-2015

Author(s): Tincello D.; Bach F.; Toozs-Hobson P.

Source: Neurourology and Urodynamics; Jul 2017; vol. 36

Publication Date: Jul 2017

Publication Type(s): Conference Abstract

Abstract: Hypothesis/aims of study 10 to 40% women have recurrent or persistent SUI after surgery[1]. Clinicians base their treatment choice on clinical experience and personal preference as little evidence exists to guide them on which secondary treatment is "best". Relevant systematic reviews presented limited evidence[2,3]. No randomised controlled trials (RCT) solely recruited recurrent cases. Subgroup analysis of RCT data was inconclusive for comparisons between retropubic and transobturator MUT, or between MUT and colposuspension. Data from non-randomised studies suggest cure rates of 73% and that retropubic MUT is more effective than transobturator [12]. We examined the British Society of Urogynaecology (BSUG) database records for treatment given for recurrent stress incontinence and to compare outcomes. Study design, materials and methods Data from 2007-2015 were obtained from the BSUG database committee. After data cleaning, previous surgery patterns were compared by year, and outcomes compared by operation. Group comparisons were by Chi Square and numerical comparisons by appropriate non-parametric tests. Results 2,938 records were obtained. 269 cases were not previous continence surgery cases leaving a final cohort of 2,669, although 231 had no details of previous surgery. Median age was 59 years (20-88), with median BMI 28.4 (17.8-60.6). 2,164 (88.8%) had one previous procedure, (207) 8.5% had two, 53 (2.2%) had three, and 14 (0.6%) more than three. The first procedure was most commonly retropubic tape (28.6%), colposuspension (24.5%), transobturator tape (17.4%) or bladder neck injection (14.3%). Pelvic floor exercises were offered to 76.2% women overall. 96.2% women had urodynamic investigation performed: 76.5% women had urodynamic stress incontinence, 18.6% had mixed incontinence, 0.7% had detrusor overactivity, and 3.4% had a normal investigation. Median annual procedures were 273 with a non-linear increase across the years peaking at 500 in 2013. Midurethral tape (MUT) was most common (77.3%), followed by bladder neck injections (BNI) (10.2%) and colposuspension (5.7%). From 2012 colposuspension and fascial sling were performed more often; fascial slings increased from 1.6% to 10.9% cases ($p < 0.0001$). Follow details were available for 1,763 (66.1%) women. 89.2% women had an outpatient follow up at 6 weeks for 649 (37.4%), three months for 667 (38.5%) and six months for 354 (20.4%). Outcome data were poorly reported. Median ICIQ-UI SF score (882 women (33.0%)) fell from 16 (0-21) to 0 (0-21) (621 women (23.3%)) ($p < 0.001$). Patient Global Impression of Improvement (PGI-I) data were available for 1,616 (60.5%) women; 1,319 (81.6%) were "much better" or "very much better". "Change in stress incontinence" data were available for 1,499 (56.2%) women. Of these, 993 (66.2%) were "cured" and 344 (22.9%) "improved". Both PGI-I scores ($p < 0.001$) and "change in stress incontinence" ($p < 0.001$) differed by surgery type, with midurethral

tapes, colposuspension and fascial sling more likely to achieve cure or major improvement than bladder neck injection. Interpretation of results MUT and bladder neck injections were the most common procedures for repeat SUI but treatment patterns have changed in the last 8 years. Follow up data in the BSUG database are incomplete but suggest MUT, colposuspension and fascial sling are superior procedures. Concluding message Recurrent SUI remains a therapeutic challenge. These data suggest that repeat MUT, colposuspension or autologous fascial sling are the best options. However, low completion rates for outcomes mean these conclusions must be tentative, and robust prospective data are needed to provide evidence to guide treatment decisions.