

MANAGEMENT OF POSTOPERATIVE URINARY RETENTION IN MEN WITH STRESS URINARY INCONTINENCE CORRECTED WITH TRANSOBTURATOR TAPE

Hypothesis / aims of study

To share our experience in the management of postoperative urinary retention in men who underwent surgical correction of stress urinary incontinence (SUI) with transobturator tape (TOT) after prostatic surgery.

Study design, materials and methods

From 25 male patients diagnosed with SUI after prostatic surgery (prostate adenoma or carcinoma) between January 2006 and January 2012, 18 underwent TOT surgery (Advance®, AMS®) between January 2009 and September 2012. Our protocol states that we must wait a minimum of 12 months after the prostatic surgery, and a urethroscopy must be performed before surgery. The TOT is performed in a short-stay regime, with a hospital stay of one day and outpatient catheter removal 48 hours after surgery. Patients answered the ICIQ-SF and SF-36 questionnaires when the TOT was indicated, and one, six and twelve months after surgery and yearly.

Age, indication, protocol's deficiencies, continence and urinary retention after surgery and the management of the urinary retention were investigated. Also changes in ICIQ-SF and SF-36 questionnaires were recorded.

Descriptive statistics, ANOVA, Student's t-test; $p < 0.05$ was considered significant.

Results

Mean age 67.12 years (range 54-73). 10 patients presented SUI after radical prostatectomy and 8 after open prostatectomy. 4 patients with prostate carcinoma had received adjuvant radiotherapy. In 6 patients no urethroscopy before TOT was performed, and 5 of them did have a fibrotic urethrovesical anastomosis which could be catheterised with a 12 Ch Foley catheter intraoperatively. 16 of 18 patients were 100% continent, not needing any type of absorbent (88.88%), even those patients with adjuvant radiotherapy. 2 patients needed one absorbent daily. 10 patients developed urinary retention after the TOT procedure: catheterization with a fine 12 Ch Foley catheter and abundant lubrication was performed, and we attempted to remove the catheter after 48-72 hours. 3 patients required catheterization during 7 days, 5 patients during 14 days and 2 during 20 days. It was not necessary to re-operate any patient to relax the TOT sling. Catheterization was more necessary in patients with previous urethral or anastomosis stenosis ($p = 0.0002$). Answers to ICIQ-SF ($p = 0.0003$) and SF-36 ($p = 0.0001$) questionnaires improved in all patients.

Interpretation of results

In patients with moderate SUI after prostatic surgery, with or without adjuvant radiotherapy, the TOT procedure achieves an 88.88% of continence. It is not rare to have a concurrent stenosis at the anastomosis site, which must be diagnosed and treated before the TOT procedure. By using our surgical approach dissecting and exceeding the bulbocavernous muscle, it is not rare to have post-TOT urinary retention which is transitory and which must be managed with intermittent or permanent catheterization during no more than 21 days, recommending a very fine catheter.

Concluding message

The TOT procedure is a first-line treatment in male patients with moderate SUI after prostatic surgery. Radiotherapy does not contraindicate the TOT in men. When urinary retention appears after TOT, it can be managed with a fine 12 Ch catheter during 7-20 days without re-operation.

Disclosures

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