Functional urology 2015

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Functional urology is rapidly expanding and specifically the management of stress urinary incontinence in women. This issue focuses on several key aspects of this evolution over the past decade.

The first manuscript by O. Kalejaiye, M. Vij, and M. Drake covers the classification of SUI. A detailed description of the underlying pathophysiology of this condition is offered, which reviews the history behind each SUI mechanism concept. And although these concepts are many, in real life, our simplistic analysis of SUI revolves around two main conditions: urethral hypermobility and/or intrinsic sphincteric deficiency. What really differs is what are the causative factors for a given individual and what the clinician ultimately decides to treat based on his/her assessment, diary, questionnaires, and additional testing as indicated, such as urodynamic testing or imaging.

The second main review by V. Phe addresses the key outcome measures to consider in the follow-up of surgical treatments for SUI. After reviewing the most common outcome measures used in SUI research, the author provides a useful summary table outlining subjective, objective, and expectation measures. In addition to patient-reported outcomes, she also emphasizes sexual function and complication outcome measures, two domains oftentimes overlooked. There is an urgent need to agree on a minimal

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set of outcome measures that all articles should document in order to permit realistic comparison of articles in meta-analyses.

Armed with this set of information, T. Rashid, D. de Ridder and F. Van der Aa present their thoughts on the role of the traditional native tissue repairs to correct SUI. Foremost is the Burch colposuspension, a procedure which has stood the test of time and which despite its higher invasiveness compared to a vaginal procedure remains a trustworthy procedure with durable outcomes. As shown by the UITN well-publicized SISTEr trial, this procedure has many “happy failures” but a higher level of patient satisfaction than the sling procedure, an oftentimes overlooked conclusion of this RCT [1].

Because of our sling era, with the midurethral sling being so prominently selected for managing SUI, A. Dobberfuhr and E. De reviewed the concept of sling and obstruction. Their article took a close look at the data linking obstruction to dryness, and specifically the consequences of obstruction over time on detrusor function, irritative symptoms, retention and possible chronic urinary tract infections. Dryness can be achieved with suspension alone, whether the repair technique is accomplished transvaginally by needle suspension-type techniques or retropubically with colposuspension. Since the art of tying a sling with the proper tension escapes everyone, including the most experts—because beyond the intraoperative technique, there is the unavoidable healing phase with tissue retraction of the synthetic material—one growing aspect of functional urology is MUS removal followed by complex and somewhat unpredictable secondary procedures when incontinence persists.

Finally, C. Hillary, N Osman, and C. Chapple present their views on the difficult management of SUI secondary to ISD. Their review thoroughly covers injectables, sling (both synthetic and autologous) and the less frequent use of

the artificial urinary sphincter. They also present intriguing data on regenerative medicine to correct ISD using precursor cells, a promising field still somewhat far away from the clinical realm.

This technical article is then followed by the last one of this special edition by A. King and H. Goldman covering the management of SUI during prolapse repair and proposing a clinically simplified algorithm. This is always a challenging decision because one wishes to prevent a patient who did not leak beforehand to be bothered by secondary leakage once the prolapse has been corrected, while at the same time not operating on those who will never leak afterward and did not need any additional repair to start with. Furthermore, since the perfect operation for SUI does not exist yet, and complications can occur with any technique no matter how short or “mini” [2] the decision to add an anti-incontinence procedure to the prolapse repair remains a matter of expertise, interaction with the patient, and specifically expectations.

Overall, this unique series of articles provide a fresh look at an old problem, managing SUI surgically, bringing the expertise and points of view of several expert teams across the globe. We, as editors, are indebted to all our contributors for their excellent contributions and balanced opinions.

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