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Symposium on Female Urology &  
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(www.urogyn-cme.org).

### **FAST TRACK**

**Whenever possible,  
remove an  
indwelling catheter  
and teach the  
patient intermittent  
self-catheterization**

### **VIEW AN ACCOMPANYING VIDEO**

To watch a demonstration  
of the surgical takedown of  
anti-incontinence procedures,  
visit [www.obgmanagement.com](http://www.obgmanagement.com)

## **PELVIC SURGERY CONTROVERSIES**

# **How to work up and treat voiding dysfunction after surgery for stress incontinence**

Postop complications call for systematic evaluation and an informed plan for surgery when indicated. First in a series

**V**oiding dysfunction—either difficulty voiding or urinary retention—after surgery for stress incontinence distresses the patient and challenges the surgeon. Here is our systematic approach to evaluating and managing such cases.

### **■ What does the operative note say?**

Determine exactly what operation the patient underwent and whether appropriate steps were taken during surgery to evaluate the lower urinary tract. Remember: There are well over 30 different synthetic midurethral slings on the market; a variety of biologic materials are used for slings; and conventional suspension procedures are still being performed. Sling composition and surgical technique are the major determinants of subsequent treatment, so it is imperative to obtain the operative note.

### **■ Is intermittent self-catheterization an option?**

If the patient has an indwelling catheter—of any type—remove it whenever possible and teach her intermittent self-catheterization.

### **■ Are symptoms consistent with expected outcome?**

In the case of a patient who had a large cystocele repair in conjunction with an anti-incontinence procedure, for example, it is common for some form of retention or voiding dysfunction to be present for 2 weeks or longer. On the other hand, if a patient had a synthetic midurethral sling but no other procedure, it is highly unlikely, during a normal postoperative course, that she would be in retention 2 weeks after the procedure—unless the sling was placed too tightly.

### **■ Is there actual (or impending) lower-tract injury? Foreign body penetration?**

Good endoscopic evaluation, with visualization of the urethra, of the vesical neck and anterolateral walls of the bladder, will answer these questions.

### **■ What is the condition of the pelvic floor?**

Make certain that the patient has the ability to appropriately relax the pelvic floor when she attempts to void.

CONTINUED

FOSAMAX® (alendronate sodium) for either two or three years. In these studies the overall safety profiles of FOSAMAX 5 mg/day (n=642) and placebo (n=648) were similar. Discontinuation of therapy due to any clinical adverse experience occurred in 7.5% of 642 patients treated with FOSAMAX 5 mg/day and 5.7% of 648 patients treated with placebo. In a one-year, double-blind, multicenter study, the overall safety and tolerability profiles of once weekly FOSAMAX 35 mg (n=362) and FOSAMAX 5 mg daily (n=361) were similar. The adverse experiences from these studies considered by the investigators as possibly, probably, or definitely drug related in ≥1% of patients treated with FOSAMAX 5 mg/day or placebo for the two- or three-year studies were *Gastrointestinal*: dyspepsia 1.9% and 1.4%, abdominal pain 1.7% and 3.4%, acid regurgitation 1.4% and 2.5%, nausea 1.4% and 1.4%, diarrhea 1.1% and 1.7%, constipation 0.9% and 0.5%, abdominal distention 0.2% and 0.3%; and *Musculoskeletal*: musculoskeletal (bone, muscle or joint) pain 0.8% and 0.9%, respectively. For the one-year study with FOSAMAX 5 mg/day and once weekly FOSAMAX 35 mg, corresponding values were *Gastrointestinal*: dyspepsia 2.2% and 1.7%, abdominal pain 4.2% and 2.2%, acid regurgitation 4.2% and 4.7%, nausea 2.5% and 1.4%, diarrhea 1.1% and 0.6%, constipation 1.7% and 0.3%, abdominal distention 1.4% and 1.1%; and *Musculoskeletal*: musculoskeletal (bone, muscle or joint) pain 1.9% and 2.2%, respectively. *Treatment of glucocorticoid-induced osteoporosis*. In two, one-year, placebo-controlled, double-blind, multicenter studies in patients receiving glucocorticoid treatment, the overall safety and tolerability profiles of FOSAMAX 5 and 10 mg/day were generally similar to that of placebo. The adverse experiences considered by the investigators as possibly, probably, or definitely drug related in ≥1% of patients treated with either FOSAMAX 5 mg/day (n=161) or FOSAMAX 10 mg/day (n=157) or placebo (n=159) were *Gastrointestinal*: abdominal pain 1.9%, 3.2%, and 0.0%; acid regurgitation 1.9%, 2.5%, and 1.3%; constipation 0.6%, 1.3%, and 0.0%; melena 0.0%, 1.3%, and 0.0%; nausea 1.2%, 0.6%, and 0.6%; diarrhea 0.0%, 0.0%, and 1.3%; and *Nervous System/Psychiatric*: headache 0.0%, 0.6%, and 1.3%, respectively. The overall safety and tolerability profile in the glucocorticoid-induced osteoporosis population that continued therapy for the second year of the studies (FOSAMAX: n=147) was consistent with that observed in the first year. *Paget's disease of bone*. In clinical studies (osteoporosis and Paget's disease), adverse experiences reported in 175 patients taking FOSAMAX 40 mg/day for 3-12 months were similar to those in postmenopausal women treated with FOSAMAX 10 mg/day. However, there was an apparent increased incidence of upper gastrointestinal adverse experiences in patients taking FOSAMAX 40 mg/day (17.7% FOSAMAX vs. 10.2% placebo). One case of esophagitis and two cases of gastritis resulted in discontinuation of treatment. Additionally, musculoskeletal (bone, muscle or joint) pain, which has been described in patients with Paget's disease treated with other bisphosphonates, was considered by the investigators as possibly, probably, or definitely drug related in approximately 6% of patients treated with FOSAMAX 40 mg/day versus approximately 1% of patients treated with placebo, but rarely resulted in discontinuation of therapy. Discontinuation of therapy due to any clinical adverse experience occurred in 6.4% of patients with Paget's disease treated with FOSAMAX 40 mg/day and 2.4% of patients treated with placebo. *Laboratory Test Findings*— In double-blind, multicenter, controlled studies, asymptomatic, mild, and transient decreases in serum calcium and phosphate were observed in approximately 18% and 10%, respectively, of patients taking FOSAMAX versus approximately 12% and 3% of those taking placebo. However, the incidences of decreases in serum calcium to <8.0 mg/dL (2.0 mM) and serum phosphate to ≤2.0 mg/dL (0.65 mM) were similar in both treatment groups. *FOSAMAX PLUS D™ (alendronate sodium/cholecalciferol)*: In a fifteen week double-blind, multinational study in osteoporotic postmenopausal women (n=682) and men (n=35), the safety profile of FOSAMAX PLUS D was similar to that of FOSAMAX once weekly 70 mg.

**Post-Marketing Experience.** The following adverse reactions have been reported in post-marketing use with alendronate: *Body as a Whole*: hypersensitivity reactions including urticaria and rarely angioedema. Transient symptoms of myalgia, malaise, asthenia and rarely, fever have been reported with alendronate, typically in association with initiation of treatment. Rarely, symptomatic hypocalcemia has occurred, generally in association with predisposing conditions. Rarely, peripheral edema. *Gastrointestinal*: esophagitis, esophageal erosions, esophageal ulcers, rarely esophageal stricture or perforation, and oropharyngeal ulceration. Gastric or duodenal ulcers, some severe and with complications have also been reported (see WARNINGS, PRECAUTIONS, *Information for Patients*, and DOSAGE AND ADMINISTRATION). Localized osteonecrosis of the jaw, generally associated with tooth extraction and/or local infection, often with delayed healing, has been reported rarely (see PRECAUTIONS, *Dental*). *Musculoskeletal*: bone, joint, and/or muscle pain, occasionally severe, and rarely incapacitating (see PRECAUTIONS, *Musculoskeletal Pain*); joint swelling. *Nervous system*: dizziness and vertigo. *Skin*: rash (occasionally with photosensitivity), pruritus, rarely severe skin reactions, including Stevens-Johnson syndrome and toxic epidermal necrolysis. *Special Senses*: rarely uveitis, scleritis or episcleritis.

For more detailed information, please read the Prescribing Information.

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## ■ Is urethral dilatation or medication an option?

We believe that urethral dilatation is contraindicated because it might cause urethral erosion of the sling. It is also generally ineffective.

No pharmaceutical agent hastens the return of voiding. Cholinergic agents such as bethanechol are ineffective and cause considerable discomfort. Some experts recommend empiric diazepam (Valium) for patients who are unable to relax sufficiently.

## ■ Will intervention succeed?

Ultimately, you and the patient must agree on whether urethrolisis is to be performed or whether the suburethral sling or tape should be cut. Undertake a detailed discussion with her about the potential for, first, persistent voiding dysfunction and, second, recurrent stress incontinence. Cutting a synthetic, allograft, xenograft, or autologous sling will almost always result in resumption of normal voiding, provided the sling is appropriately detached from the urethra and there were no preoperative voiding symptoms. With synthetic, allograft, and xenograft slings, stress incontinence recurs in at least 50% of patients over time. With an autologous sling, the recurrence rate of stress incontinence is less than 10%.

## ■ Is it time to operate?

When urinary retention after a synthetic sling procedure is believed to be caused by obstruction, consider surgery within a few weeks. For a patient in retention who has an autologous, allograft, or xenograft sling, it is best to wait approximately 3 months before operating.

## ■ Be aware of the risk of failure!

Takedowns of Burch and Marshall-Marchetti operations are much more technically challenging, and yield a much lower success rate, than takedowns of sling procedures. No matter what the prior operation, there is a risk of recurrent sphincteric incontinence. ■

### **FAST TRACK**

**Cutting a synthetic, allograft, xenograft, or autologous sling almost always restores normal voiding**