CIS present increased over the years from 33% in the eighties to 52% in period from 2001 to 2003. The majority of patients had grade 3 tumors (82.5%) and/or pT2 and pT3 disease (60.8%). Roughly, half of the patients had lymphovascular invasion, one-fourth (24.9%) had lymph node metastases. Accordingly, after 5 years, half of the patients with concomitant CIS had recurrences and half of the patients with concomitant CIS had died from bladder cancer. Patients without concomitant CIS fared better than those with concomitant CIS (7-year recurrence-free survival 58.1% and 41.5%, respectively). Interestingly, the incidence of concomitant CIS was highest in patients with organ-confined disease (pTa excluded) and higher in lower-stage and higher grade disease. Involvement of the urethra was more common in CIS patients.

The authors state correctly, that presence of concomitant CIS worsens the outcome significantly. In practical terms, early radical treatment should be considered if CIS is present.

Dr. Andreas Bohle
Professor of Urology
HELIOS Agnes Karll Hospital
Bad Schwartau, Germany

NEUROUROLOGY & FEMALE UROLOGY

Urodynamic studies in women with stress urinary incontinence: Significant bacteriuria and risk factors

Choe JH, Lee JS, Seo JT
Department of Urology, Cheil General Hospital, Kwandong University College of Medicine, Seoul, Korea
Neurourol Urodyn. 2007; 26: 847-51

Aim: A prospective study was performed to determine the incidence of significant bacteriuria and to identify the risk factors for bacteriuria after urodynamic studies (UDSs) in women with urodynamic stress urinary incontinence (SUI).
Methods: A total of 225 women with urodynamic SUI were evaluated. All women were negative on double-screened urine cultures, in clean-catch midstream urine (MSU) specimens, before UDS. Another urine specimen was obtained for urinalysis and culture at 3-7 days after UDS. Urinary culture with 10(5) CFU/ml or more was regarded as significant bacteriuria. To identify the risk factors for significant bacteriuria, the clinical characteristics of all patients including age, BMI, parity, medical and operation history, degree of pelvic organ prolapse, results of urinalysis, and UDS were evaluated.
Results: The prevalence of significant bacteriuria was 6.2%. The most common identified microorganism was Escherichia coli (57.1%). Univariate analysis demonstrated that a history of recurrent urinary tract infection (UTI; P = 0.002) and urological surgery or procedure (P = 0.02) were significant predictors of significant bacteriuria. On multiple logistic regression analysis the past history of recurrent UTI was the only significant independent risk factor (OR = 28.5, 95% CI = 4.309-188.488, P = 0.009).
Conclusions: This study suggests that for most women with SUI it may be unnecessary to use preventive prophylactic antibiotics in UDS. However, our results suggest that in patients with a previous history of recurrent UTI or urologic surgery the risk for significant bacteriuria is increased and use of prophylactic antibiotics should be considered. Neurourol. Urodynam. 26:847-851, 2007. (c) 2007 Wiley-Liss, Inc.

Editorial Comment

Investigators performed a prospective study examining the prevalence of significant bacteriuria after urodynamic studies and to identify risk factors for same. It was noted that recurrent cystitis and previous urologic instrumentation or procedures were significant risk factors of bacteriuria. The authors obtained urine approximately one week before the urodynamics, at the time of the urodynamic studies, as well as 3-7 days after urodynamic studies were done. These investigators concluded that because the cultures were sterile for the procedure that all acquired infections within the week after the urodynamic studies were most likely due to the urodynamic studies. Of note is that the bacteriuria after the urodynamic studies was most likely non-nosocomial. It would have been or great interest if the authors had been able to query the patients on the frequency and intensity of coitus for the period immediately after the urodynamic studies to the time that the post-procedure urine studies were obtained. The existence of "honeymoon cystitis" is well known even in the mature or infirmed population.

Dr. Steven P. Petrou
Associate Professor of Urology
Chief of Surgery, St. Luke's Hospital
Associate Dean, Mayo School of Medical Education
Jacksonville, Florida, USA

Outcomes following repeat mid urethral synthetic sling after failure of the initial sling procedure: rediscovery of the tension-free vaginal tape procedure

Lee KS, Doo CK, Han DH, Jung BJ, Han JY, Choo MS
Department of Urology, Samsung Medical Center, Sungkyunkwan University School of Medicine, Seoul, Korea
J Urol. 2007; 178: 1370-4; discussion 1374

Purpose: We evaluated outcomes of the repeat mid urethral sling to treat recurrent or persistent stress urinary incontinence after failure of an initial mid urethral sling.
Materials and Methods: We retrospectively analyzed data on patients who underwent the repeat mid urethral sling procedure due to persistent or recurrent stress urinary incontinence. Repeat slings were placed without removal of the previous sling. All patients were followed at least 1 year after the second mid urethral sling.
Results: Of the 31 female patients with a repeat mid urethral sling 29 were followed, including 13 with a retropubic and 16 with a transobturator sling. For the first mid urethral sling 17 patients received a retropubic sling (tension-free vaginal tape) and 12 received a transobturator sling (6 inside out and 6 outside in procedures). Cure and improvement rates irrespective of the approach were 75.9% (22 of 29 patients) and 6.9% (2 of 29), respectively. Cure rates for the retropubic and transobturator slings were 92.3% (12 of 13 patients) and 62.5% (10 of 16), respectively, a difference that did not quite attain statistical significance ($p = 0.089$).
Conclusions: The repeat mid urethral sling for persistent or recurrent stress urinary incontinence has a lower cure rate than the initial sling. However, the retropubic approach tends to have a higher cure rate than the transobturator approach in repeat sling cases.

Editorial Comment

The authors review their very large experience with suburethral slings and report on patients who underwent a repeat suburethral sling. The study group included retropubic suburethral slings as well as the

transobturator approaches. The surgeons noted that their repeat suburethral sling procedure that was a re-do operation had a lower success rate than the initial operation success rate. This has been noted as well for patients undergoing re-do pubovaginal slings using autologous fascia for operative failures (1). The trend towards a lesser cure rate with a repeat transobturator procedure versus a retropubic approach could potentially be explained by both the urethral angle theory as discussed by the authors as well as the level of suburethral support that can be provided by the different techniques. The diminished efficacy of transobturator slings in patients with lower Valsalva leak point pressures is currently being explored in the literature (2).

References

1. Petrou SP, Frank I: Complications and initial continence rates after repeat pubovaginal sling procedure for recurrent stress urinary incontinence. J Urol. 2001; 165: 1979-81.
2. Guerette NL, Bena JF, Davila GW: Transobturator slings for stress incontinence: using urodynamic parameters to predict outcomes. Int Urogynecol J Pelvic Floor Dysfunct. 2007, Jun 5; [Epub ahead of print].

Dr. Steven P. Petrou
Associate Professor of Urology
Chief of Surgery, St. Luke's Hospital
Associate Dean, Mayo School of Medical Education
Jacksonville, Florida, USA

PEDIATRIC UROLOGY

Efficacy of combined anticholinergic treatment and behavioral modification as a first line treatment for nonneurogenic and nonanatomical voiding dysfunction in children: a randomized controlled trial

Ayan S, Topsakal K, Gokce G, Gultekin EY
Department of Urology, Cumhuriyet University School of Medicine, Sivas, Turkey.
J Urol. 2007; 177: 2325-8; discussion 2328-9

Purpose: This randomized blinded clinical study was designed to compare the efficacy of tolterodine treatment combined with behavioral modification, behavioral modification alone and behavioral modification plus placebo in children with nonneurogenic, nonanatomical voiding dysfunction.
Materials and Methods: A total of 72 children meeting inclusion criteria were randomly allocated to 1 of 3 groups. One group received tolterodine (1 mg twice daily) along with behavioral modification, 1 received behavioral modification only and 1 received placebo with behavioral modification. A dysfunctional voiding scoring system questionnaire was completed for all patients at the beginning of the study, and at 1 and 3 months of treatment.
Results: A total of 71 patients were evaluated. The groups did not differ with respect to age, gender and symptom score before study enrollment ($p > 0.05$). Repeated calculations of symptom scores at 1 month of the treatment revealed a significant decrease in symptoms in all 3 groups, with a significant decrease in patients receiving tolterodine. In addition, at month 3 the symptom score of the tolterodine group was significantly lower compared to month 1, while scores remained steady in the behavioral modification and behavioral modification plus placebo groups.
Conclusions: Tolterodine combined with behavioral modification for voiding dysfunction in children without neurological or anatomical abnormality can be recommended as a first line treatment before invasive evaluation.