

Re: Surgical Technique Using AdVance™ Sling Placement in the Treatment of Post-Prostatectomy Urinary Incontinence

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To the Editor:

I am responding to the AdVance™ surgical technique paper that was recently published (1). The technique was first described by Rehder & Gozzi and the early results recently published (2). We want to draw attention to a few points of technique that seem very important built on our experience. The authors have performed more than 80 cases of AdVance™ since February 2006 in a wide range of patients.

The positioning of the patient is critical, as it should not be in extended dorsal lithotomy. Placing and tensioning the sling in this position might cause it to be loose once the legs are back in the supine position. This operative technique is based on providing dorsal support to the sphincteric urethra, which is not given when the sling is loose. The dissection on the urethral bulb is such as to mobilize it, and it is not continued for 4 cm beyond the perineal body as is stated in the article. This means that the bulb should be mobilized until a proximal movement of the proximal bulb becomes possible. When fixing the central portion of the mesh to the mobilized bulb, the distal sutures are most important, necessitating up to three sutures with a 2-0 resorbable suture. The idea is to proximally move and rotate the dorsal surface of the proximal bulb proximally utilizing a broad surface on the bulb. By doing this, the prolapsed dorsal surface of the sphincteric urethra is indirectly supported without causing direct compression on the urethral lumen. A cystourethroscopy during the procedure is not necessary, as the level of dissection and operation is below the pelvic floor and urethra. However,

it is of critical importance to make the diagnosis pre-operatively, to be able to determine the correct operative indication.

During examination of the stress incontinent patient, the following findings are helpful. The urethroscopy should be carried out in neutral dorsal lithotomy under local anesthesia of the urethra (lidocain gel). With gentle pressure of the pointed index finger directly to the midperineum well dorsal of the level of the membranous urethra the dorsal surface of the proximal bulb should be proximally displaced. A concentric coaptation (occlusion) of the urethral lumen should be appreciated indicating towards possible success with the AdVance™ sling. When this concentric coaptation cannot be obtained because of large sector defects to the sphincter or severe fibrosis limiting urethral mobility, then this patient should rather be indicated for a compressive device.

Postoperative care should include instruction to limit physical activity especially leg spreading, as this may loosen the sling leading to urinary incontinence again. The AdVance™ sling is the only product on the market focusing on restoring normal anatomy in male stress urinary incontinence (SUI). In October 2005 Gozzi & Rehder were the first to report on the possibility that urethral prolapse and dorsal sphincteric urethral descent may play a role in male SUI, and restoring this prolapse leads to the restoration of continence (Abstract at the SIU Meeting on Prostatic Disease: Recent Advances and New Technologies. Bariloche, Patagonia, Argentina).

References

1. Rapp DE, Reynolds WS, Lucioni A, Bales GT: Surgical technique using AdVance(TM) sling placement in the treatment of post-prostatectomy urinary incontinence. *Int Braz J Urol.* 2007; 33: 231-7.
2. Rehder P, Gozzi C: Transobturator sling suspension for male urinary incontinence including post-radical prostatectomy. *Eur Urol.* 2007 (epub ahead of print).

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Re: Adverse Events and Readmissions after Day-Case Urological Surgery

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To the Editor:

This valuable retrospective study looks at the complication rate and frequency of re-admission following day case (ambulatory urological surgery), under both local and general anaesthesia. The authors have reviewed all day case surgery over a 16 month period at a single institution accumulating data on 1189 patients from a possible 1420.

The importance of this paper is two fold. Firstly, it highlights the ever increasing trend toward day case surgery throughout the world with an inevitable parallel rise in the degree of surgical complexity that can be accomplished in such a setting. Not too long ago, day case ureteroscopy with stent placement was unheard of, now it is common place with excellent results and acceptable rates of complication and re-admission.

The second important issue is that of re-admission and complications following day case surgery and the distribution of these issues amongst the various procedures with identification of risk factors where possible. It is no surprise that more complex procedures are inextricably linked to a higher rate of both complication and re-admission. One would accept this as the first cousin of change and progress and it is this facet that offers the greatest opportunity for improvement and further progress.

The re-admission figures are very impressive in this series – overall 0.5 %. This compares very favourably with figures from other studies¹ and is well below the recommended re-admission rate of 3% (1). There are minor omissions from this paper, the re admission rate following GA day case procedures,