

they have a chance to observe the child at home and complete a bladder diary. A bladder diary could be an important adjunctive measure to objectively assess these and other parameters.

In conclusion, terminology and a bladder diary could be a useful tool when a questionnaire survey about lower urinary tract symptoms in children was conducted.

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

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To the Editor:

The publication of this article follows the recent increase in interest for new minimally invasive solutions in the treatment of post-prostatectomy incontinence (PPI). The authors present a new technique to treat PPI using a polypropylene monofilament mesh via a transobturator approach. The surgical technique is described in detail and so far, 4 patients have been treated. There is no information about postoperative outcomes.

Patient selection was restricted to mild to moderate PPI, using 3 pads/day on average. Although

the artificial urinary sphincter (AUS) is considered the gold standard in the treatment of PPI, there is a need for more minimally invasive treatment options for two reasons. First, many patients do not want to undergo a surgical intervention associated with a reoperation rate up to 37% within 10 years (1). Second, many patients suffer from a mild to moderate incontinence due to an intrinsic sphincter deficiency (ISD) which can be well treated with a less invasive treatment and lower morbidity. Furthermore, if treatment fails an AUS can be implanted in a second stage.

Minimally invasive procedures for PPI consist of bulking agents, readjustable periurethraly implanted balloons (ProAct®), perineal bone-anchored male slings (Invance®), readjustable retropubic slings (Argus®) and the newly presented transobturator sling (Advance®). Except the AUS all minimally invasive procedures have the limitation that compression can only be exerted in one direction which has to be similarly appropriate for continence and micturition (2-5). This limitation applies also to the transobturator sling.

After radical retropubic prostatectomy the Retzius' space is scarred due to dissection of the prostate. One major advantage of the transobturator approach is that bladder perforation can be avoided which is more likely using the retropubic approach.

The most important issue in male slings seems to be finding the force of compression on the urethra to develop continence and to enable micturition. In this context the transobturator sling shifts the bulbar urethra cranially and serves more as a suspension rather than a compression. The idea behind this sling is to mimic the rectourethralis muscle. Interestingly, after placing the sling a minimal gap remains between the sling and the bulbar urethra giving the impression that the urethra is less or not compressed. A sophisticated tensioning of the sling is not necessary during the procedure.

It should be considered that the transobturator sling is not readjustable. Further studies are needed to determine whether there is a need for a readjustable sling to maintain continence in the course of several months.

Despite these limitations, the transobturator sling poses a promising option in the field of minimal invasive treatment of post-prostatectomy incontinence.

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