ORIGINAL ARTICLE

Vol. 40 (6): 790-801, November - December, 2014
doi: 10.1590/S1677-5538.IBJU.2014.06.10

One hundred cases of sui treatment that failed: a prospective observational study on the behavior of patients after surgical failure

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ABSTRACT

Objectives: Determine what happens to patients after unsuccessful SUI operations and to explore the reasons why these patients change doctors.
Materials and Methods: One hundred consecutive failed patients treated for SUI were interviewed about the exams requested after persistence of the incontinence as well as the reasons they abandoned their primary doctors through a structured questionnaire.
Results: Among the patients with cases of anterior colporrhaphy, bladder suspensions or slings, 34.3%, 13.7% and 8.3%, respectively, were not offered any further type of investigative procedures to clarify the failure. Urodynamic evaluations were recommended in 75% of failed slings, and 66.6% of the patients proceeded with these tests. In contrast, only 31% of patients with bladder suspensions and 40% of patients with anterior colporrhaphy were recommended for urodynamic investigations, and only 44.4% and 28.5% of them, respectively, proceeded with the option. Patients´ delusions were reinforced by the doctors' attitude toward the investigations. Vacuous justifications and the lack of intention to seek improvement were the driving forces causing the patients to change doctors.
Conclusion: Unsuccessful patients are evaluated in a non-protocol form. Difficulty in clarifying the reasons for surgical failure and the disruption of the doctor-patient relationship are the main reasons why patients abandon them.

ARTICLE INFO

Key words:
Urinary Incontinence; Urodynamics; Female; Urology

Int Braz J Urol. 2014; 40: 790-801

Submitted for publication:
July 22, 2013

Accepted after revision:
May 05, 2014

INTRODUCTION

The treatment failure of urinary incontinence may occur with any specialty physician dealing with irregular or difficult cases (1-4).

The rate at which patients submitted to unsuccessful treatments demand ancillary, novel or repetitive operations depends on the patient's subjective impression of the treatment as a failure. In that context, satisfaction with the results is related to the patient's expectations before the operation and the cultural pressures demanding dryness and bladder control, albeit what may represent a cure to one individual may be taken as an inappropriate result by someone else (5).

The demand for complementary treatments due to unsatisfactory clinical results is also a reflection of the patient´s myriad impressions of the complexity of the final purpose, the invasiveness and the individual discomfort and inconvenience

of repeating a surgery, especially after a failure, leading to a disrupted relationship with the primary attending doctor.

These factors may affect the clinical rate of patients being lost to follow-up in any practice or even in academic trials, although it must be recognized that some patients simply do not return because of a successful clinical result (6,7).

The causes of patients being lost to follow-up and the reasons for not pursuing the self-desired clinical result are poorly reported in the literature. Unraveling the reasons patients change doctors or refuse to proceed to complimentary exams is essential to understand the behavior of unsuccessful treatment. We herein examine the reasons that patients abandon and disbelieve their primary doctors after perceiving the surgical treatment for stress urinary incontinence (SUI) as a failure.

MATERIALS AND METHODS

During a 16-year time period, 118 consecutive patients previously treated elsewhere were referred to our tertiary referral center to evaluate their clinical failure after surgical treatment for SUI at the time the patient reconsidered to continue pursuing treatment for her problem anteriorly abandoned. At the time of the urodynamic investigation patients were prospectively queried with a structured questionnaire (Appendix).

The patients were consecutively enrolled only if the main complaint that led them to have an operation in the past was SUI and if they subjectively felt that the surgical treatment had failed after at least 5 consecutive visits of follow-up. After a pilot study with 18 cases - a development phase in which answers were simulated and analyzed - a structured questionnaire was generated (Appendix). This questionnaire allowed the data collection of the reasons that the patients abandoned their doctors, the investigative exams required or suggested to clarify the causes of failure and the therapeutic options proposed by the surgeon to investigate and correct the clinical failure. A case study was carried out prospectively for 100 consecutive patients. The study was approved by the Internal Ethics Committee at Hospital Beneficência Portuguesa and no informed consent was needed for this investigative purpose. Informed consent was signed for the well-established urodynamic protocol.

Patients were guided through structured and exclusive questions (only one main answer was allowed - Appendix) to clarify the reasons for their dissatisfaction and failure, the reasons they sought a different doctor´s evaluation and their further therapeutic options to improve or correct the surgical failure by the primary doctor when the patient demanded a better clinical result. Similarly, the doctor´s arguments regarding the patients´ perceptions of the doctor´s explanations were also studied, together with the reasons that led the patient to abandon the doctor. Exclusive answers might limit the complex feelings surrounding doctors abandonment but options were defined after an ordinary system with the most common catalogued answers during the development phase.

All of the patients were also questioned by the authors with the help of drawings and graphical materials to help identify the surgical techniques employed to treat the SUI. Their route of surgical access, the presence of any implanted material and the examined scar also helped to distinguish patients. Burch was specifically named as a group, as many doctors mentioned the name during the pre-operative interviews regarding the type of the surgical technique to be employed. However, if another technique was named or could not be precisely determined although an abdominal scar was present, it was grouped as an abdominal bladder suspension.

Patients were grouped into one of 5 surgical groups: the anterior colporrhaphy, Burch, abdominal bladder suspension, TVT or TOT techniques.

Due to its unique nature, the urodynamic investigation was easily recalled by the patients. The patients were closely questioned concerning the intention to perform such an exam for the first time (as not all patients had undergone this exam before the operation) or to repeat the exam after a failure.

Detailed descriptions and illustrations of the urological exams were also shown to easily identify the type of exams requested to investigate the failure by the primary surgeon. Multiple choices were allowed for this latter item.

When possible and the techniques could not be elucidated, the primary doctor was contacted by telephone to address any unanswered questions about the case.

The time the patient realized that from her perspective the operation was a failure was also reported.

The patients were also questioned extensively about the reasons why they did not mention the surgery failure to their primary doctor and the main reason that led them to change their attending doctor.

Finally, the patients were asked if they informed the attending surgeon that they were going to seek another specialist or if the primary doctor recommended them to seek a colleague.

Tables with the patients' answers were constructed. Logistic regression analysis was used when possible, and relationships between the surgical technique and patients´ answers were also analyzed by multivariable logistic regression analysis.

RESULTS

The mean time from when the failed SUI operation was performed until the interview and urodynamic evaluation was determined, and the age of the 100 patients with failed operations is presented in Table-1.

The patients submitted to the anterior colporrhaphy and Burch techniques were older, and they had the longest interval from the failed operation until the urodynamic evaluation. This observation reflected the use of an outdated technique to treat SUI in comparison to more contemporary techniques involving suburethral slings – Table-2.

Among the 100 patients with failed operations, the vast majority (60%) realized the operation failed after only 6 months of follow-up, although 31% could not precisely state the time to failure.

When the patients were asked about the nature of the exams that were recommended to investigate the causes of failures, 38% (14/36) of those submitted to sling procedures had undergone cystoscopy, while 12.5% (4/29) of those submitted to bladder suspension techniques and 11.4% (4/35) of those submitted to anterior colporrhaphy were recommended to undergo this exam. Urodynamic studies were recommended for 75% of the failed sling operations, while 31% of the bladder suspensions and 40% of the anterior colporrhaphy were recommended to undergo this exam.

In the same manner, IVP and UCM accounted for 68% of the requested exams for those patients operated on with anterior colporrhaphy, while only 24% of bladder suspension patients and 38% of sling patients were recommended to undergo these exams.

The urodynamic studies requested by the primary surgeon who operated on the studied population were available in only 26 cases (26%) although 50% of the failed patients were instructed

Table 1 - Demographic characteristics of 100 failed patients surgically treated for SUI.

	N	Age in years (range)	Mean time from the primary failed SUI operation to interview/ urodynamic – in years (range)
Anterior colporraphy	35	65.7 (32-81)	15.5 (0.8 - 27)
Burch	17	54.4 (48-77)	9.7 (4 - 18)
Abdominal suspension	12	53.4 (50-67)	10.6 (6 -15)
TVT	28	47.8 (38-94)*	8.2 (0.6 - 11)
TOT	8	44.3 (38-52)**	3.3 (0.8 - 5)

* - Statiscally significant as compared to Anterior colporraphy, Burch and Abdominal suspension groups
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Table 2 – Time-frame of patient realizing failure of the operation.

"How long did you take to realize the operation did not work?"

	Anterior colporraphy	Burch	Abdominal suspension	TVT	TOT	Total cases
1 month	20% (7)	35.2% (6)	33.2% (4)	7.1% (2)	12.5% (1)	21%
3 months	8.5% (3)	11.8% (2)	24.9% (3)	25% (7)	12.5% (1)	16%
6 months	17.1% (6)	0	8.3% (1)	46.4% (13)*	50% (4)	23%
9 months	0	5.9% (1)	8.3% (1)	3.6% (1)	0	3%
12 months	5.7% (2)	0	0	3.6% (1)	0	3%
18 months	2.8% (1)	0	0	3.6% (1)	12.5% (1)	3%
I don´t remember	45.6% (16) *	47.2% (8)*	24.9% (3)	10.7% (3)	12.5% (1)	31%
Total	**35**	**17**	**12**	**28**	**8**	**100**

*The marked groups were statistically significant ($p < 0.05$) in comparison to the other groups in the same row

to do it. Surprisingly, only 13 cases (50% of the urodynamic investigated patients) actually revealed SUI – Table-3.

Although urodynamic results were recommended, only 28.5% (4/14) of the anterior colporrhaphy proceeded to it, while 44.4% (4/9) of the bladder suspension cases (Burch + abdominal bladder suspensions) and 66.6% (18/27) of the sling patients (TVT + TOT) had the exam despite doctor´s recommendations. Interestingly, only 33.3% (18/6)

Table 3 – Results of the urodynamic evaluation requested after ascertainment of clinical failure of the SUI operation.

	Anterior colporraphy	Burch	Abdominal suspension	TVT	TOT	Total
N	35	17	12	28	8	100
Urodynamic requested	14	4	5	21*	6	50
Urodynamic done	4	2	2	13*	5	26
Urodynamic SUI confirmation	4	2	1	3	3	13
ISD	4	2	1	1	1	9
Urodynamic Detrusor overactivity	1	1	1	4	3	10
Poor compliance	0	0	1	2	1	4
Obstruction (Pdet > 30 cmH_2O)	0	0	1	2	1	4
ISD + detrusor overactivity	1	1	0	1	1	4

*The marked groups were statistically significant ($p < 0.05$) in comparison to the other groups in the same row

of the cases treated with sling techniques had leakage confirmed on urodynamic evaluation, whereas the others (72.8%) had diverse urodynamic findings for their failures.

Among the cases of anterior colporrhaphy, bladder suspensions or slings, 20%, 41.4% and 19.4%, respectively, could not remember the type of the exam they were recommended, whereas 34.3%, 13.7% and 8.3% of the patients were not offered any type of further examination to diagnose the failure.

Taken together, patients submitted to anterior colporrhaphy and abdominal bladder suspension techniques were recommended more often to have static exams than those with more contemporary sling techniques, whereas functional exams centered on urodynamic investigations were the mainstay to clarify the clinical failures.

As the treatment failure became evident for the patient, alternatives to overcome the failure by the primary surgeon were explored. For the failed anterior colporrhaphy, pelvic exercises were offered to 40% (14/35) of the cases, while 14.2% received anticholinergics and 14.2% were suggested to receive further slings. No bulking agents or Botox injections were offered to this group. The patients with failed abdominal techniques were recommended to try pelvic exercises in 31% (9/29) of cases, anticholinergics in 31% and sling operation in 27.5%. Those who had received slings (TVT+TOT) were offered pelvic exercises in 13.8% (5/36) of cases, anticholinergics in 52.7% (19/36) and repeated slings in 5.5% (2/36). This group also had Botox injection offered in 8.3% (3/36) of cases and tape pull-down in 5.5% (2/36).

Anticholinergic trials to control the remaining urinary leakage (if de novo or associated with previous overactive bladder) were more common in the contemporary series involving sling techniques, with 52.8% (19/36) of patients offered this option.

As patients realized failures, they left the doctors for diverse reasons. In the words of the patients, Table-4 lists the doctor´s response to their demands for further improvement or justification for the clinical failure. As seen from the patients´ perspectives, many doctors could not justify the failure or gave evasive answers to the

Table 4 – Reasons why you stopped inquiring solution to the doctor that primarily treated you.

Reasons to stop demanding treatment by the primary doctor	Anterior colporraphy	TVT	Burch	Abdominal bladder suspensions	TOT
Doctor said sometimes it happens	3	4	2	2	1
My anatomy was awkward	2	2	1	1	0
It will solve soon	9*	6	5	2	2
The other alternatives was too demanding	0	4	1	0	2
Doctor said it was my impression/could be psychological	7	1	2	0	0
I did not want to pass over another operation as the unique alternative	1	6	2	2	1
It might take longer for the final result	9*	1	1	1	1
I decided not to mention the problem any more	1	0	0	1	0
I just quit complaining	0	2	0	0	0
I resigned	1	0	2	3	0
I naturally improved	2	2	1	0	1
Total	**35**	**28**	**17**	**12**	**8**

*The marked groups were statistically significant ($p < 0.05$) in comparison to the other groups in the same row

problem, leading the patient to leave that particular attending doctor. Thus, evasive and vacuous answers such as “It will resolve soon”, “It might take longer for the final result” or “The doctor said sometime this happens” led patients to abandon their respective doctors in 60% of the anterior colporrhaphy group, 39% of the TVT group, 46% of the Burch group, 41.6% of the abdominal bladder suspension group and 50% of the TOT group.

Because the reasons to accept treatment failure or continue with the same doctor might differ from those associated with switching doctors, a further exploration of that issue was also performed.

As shown in Table-5, when the doctor positioned himself as unable to do any further treatment of the failed case, that attitude surfaced as the main reason for the patient to leave that particular doctor.

When the patients were asked if they warned their primary doctor about changing doctors, 98% said they did not mention it. However, they recalled that 43% of their primary doctors recommended them to seek an expert because the problem could not be solved by the primary doctor.

DISCUSSION

Surgical treatment failure for SUI is a recognized and current phenomenon (2, 8) contributing to resentment of the doctor and loss of confidence leading to poor adherence to follow-up regimens. Many studies focus on the long-term results, but our data reveal that unsatisfactory results may be evident with only 6 months of follow-up (60%).

The nature of patient loss to clinical follow-up is vague, being poorly studied or understood (6, 9, 10). Although little attention is paid to the loss of patients to follow-up, if such patients account for more than 10% of a given protocol, the validity of the results may not be consistent and reproducible, as already stated (11, 12).

Oncological protocols and treatments may be easier to gauge, as primary or secondary end-

Table 5 – Reasons why you change doctor.

Reasons to change doctor	Anterior colporraphy	TVT	Burch	Abdominal bladder suspensions	TOT
I lost confidence on the doctor	4	3	4	4	2
He said he couldn´t do any further	1	2	2	1	0
He said "It will solve soon" but it didn´t	11*	9*	6	4	3
The alternatives were demanding/painful	2	2	2	0	0
He said my case was "final"	2	5	2	2	1
He could not explain why that happened	2	1	1	1	0
He changed medications with no clinical result	3	1	0	0	1
My family/friend said I should seek another opinion	2	0	0	0	0
He deviated from the central problem	4	2	0	0	0
Changed health insurance - the doctor was not aligned to it	2	2	0	0	1
Changed city	2	1	0	0	0
Total	**35**	**25**	**17**	**12**	**8**

*The marked groups were statistically significant ($p < 0.05$) in comparison to the other groups in the same row

-points are objectively measured, while functional diseases are submitted to subjective, cultural and emotional backgrounds. The reasons patients do not proceed to further therapy to reach what is considered a satisfactory clinical result are not clearly understood. Such reasons may depend on the doctor´s capacity of persuasion, optimism and reliance, all of which are founded on cultural and personal factors. As patients recognize the failure, the manner in which the doctor explains the failure seems to negatively affect the patients´ perception, leading them to abandon that particular doctor. The reasons patients change doctors are not always related to the reasons they disbelieve in the treatment or failures. As our data show, refraining from complaining about urine leakage is not associated with leaving the doctor, which seems to be more associated with doubt and a lack of reasonable explanations for the unsuccessful operation.

Patients change doctors without informing the doctors or obtaining their consent more often than we think. This behavior negatively affects the doctor´s self-perception of failure and success, deluding them about proper surgical techniques and personal cumulative results. This discrepant view of lost follow-ups may involve inter-personal or cultural aspects, as 98% of our studied patients did not notify the primary doctor about changing professional care, with many offering a lack of trust in the doctor to justify the change. This finding provides new insight into the patient-doctor relationship, highlighting the false perception of success by doctors if the patient does not show up for follow-up, especially in private care systems.

Our study was very restricted in enrollment, using only patients treated for SUI which demanded long-time to enroll 100 cases. We kept all the filled-out questionnaires throughout the years, as this project required long-term data gathering before solid conclusions could be made for this particular subset of surgically treated cases.

The reasons why patients do not attend sequential follow-ups as pre-operatively recommended is not clear, but Ballert et al. stated that the most common reason for not returning was that the patient was satisfied and believed that returning was not necessary despite the pre-operative recommendation. There is no discrepancy in clinical results between those attending personally or only answering telephone queries on academic studies, as the authors reported that the success rates in these two types of follow-up were the same at 3 months, but they did not state any rates beyond that time. Interestingly, 20% of their cases that could not be accessed by validated tools at 3 months of follow-up had undergone a secondary intervention; this observation revealed a clustering of cases that were not evaluated in the early follow-up because of severe urinary problems. Similarly, the same author also discovered that patients dismissing follow-up did not return because of clinical failure and dissatisfaction (9). In a previous article from Ou et al., 58% of the 71 identified articles did not comment on the lost-to--follow-up patients (10). Although these authors identified approximately 10% as not returning due to work, death or other reasons, our population clearly indicated disappointment and a lack of confidence as the main reasons to quit on treatment and follow-up.

Cured patients believe that reevaluation is not necessary, while those who were unsuccessfully treated seek another doctor´s opinion or stop receiving treatment. We cannot comment on that issue, as our population is exclusively composed of failed cases looking for cures from a secondary surgeon.

We do not know how frequently this phenomenon occurs in community health-care centers or private health-care systems where many doctors options are available, but reports varied from 0 (6) to 100% (7) even in academic studies (1,7). This poorly studied issue seems to concentrate on a biphasic response with peaks in the first 3 months to 1 year and later than 3 years after the surgical treatment. In the first phase, those not returning may not come to the office, but they still comply with some academic requirements, such as answering questionnaires after contact by letter or telephone, while others may disappear because they might have moved or died, be dependent or frail, or simply do not want to comply any further (6,7).

Some authors assert that the failure of continuous clinical follow-ups is due to permanent clinical success, whereas others claim that the lost follow-ups are related to clinical failure

leading to patients' doubt and loss of confidence in additional therapeutic procedures. Assuming patients lost during follow-up as successes or as failures can markedly shift the rate of failure or success in a given technique or series, as prospectively demonstrated by Ward et al. (13) and Minassian et al. (14). Assuming them as failures or cured does not mean that long-term follow-up will be persistent and consistent because objective and subjective results regularly do not match perfectly (2), and recurrence and failure may become obvious only after a long-term follow-up (7,15), rendering conclusions on the long-term efficacy of the procedure more difficult to state.

An additional factor of decreased adherence to follow-up is related to the complexity of clinical follow-up schedules in academic or prospective protocols as noted by Singh M et al., who observed 9.3% refusals and 16.6% loss to follow--up despite 3 telephone contacts in 108 operated cases. Surprisingly, even after consenting to the protocol and the office evaluations, only 52% of all of the consenting cases completed their voiding diaries, questionnaires and pad-tests as ordered (16). The invasive nature of some exams, such as urodynamic investigations in our population, might explain the reasons that patients refused to continue further investigation after clinical evidence of failure. Here, the half-half law applied to this population, as half of patients were recommended to have urodynamic investigation and only half of them complied (~25%), although they underwent urodynamic studies later by the hand of a second surgeon at our referral center.

While our population was composed exclusively of failed cases, the scenario of patients changing doctors without completing the exams requested by the primary doctor is very common in clinical practice, and it may reflect the lack of trust on the first surgeon to fix the problem.

Although we could not consistently critique the nature of the proposed investigative exams, it surprised us that urodynamic studies and cystoscopy were so infrequently recommended to rule out any other cause related to failure. Post--operative urodynamic investigation was rarely requested for the abdominal bladder suspension or anterior colporrhaphy groups, most likely reflecting an older view of causes for failure compared to the more contemporary suburethral sling cases in which functional exams seem to more accurately reflect the causes of the failures than static imaging evaluations.

In this regard, urodynamic study done after ascertainment of failure confirmed pure SUI as the main cause of leakage in only 50% of the cases with another half revealing other urodynamic reasons for the clinical failure.

While, as a rule, a lack of aggressive investigation for failures was observed it was evident that second treatment must be refrained without appropriate investigation.

It is amazing to realize that doctors do not investigate failures aggressively as they should, justifying themselves by asserting the symptoms will resolve by themselves soon, in contrast to clinical attitudes regarding oncological recurrences. Likewise, numerous case-load studies access patients on regular follow-up, while the recurrent cases or those simply electing to tolerate leakage are poorly studied or dismissed from the results.

It can be seen that failures from slings led doctors to offer medications more frequently than failures from abdominal route techniques, where changing to slings operations stood as the ultimate option for treatment failure. In this regard, only a few doctors proposed a second sling as an alternative to correct the failed one. Doctor's embarrassment in trying to explain the failure possibly accounts for a more aggressive investigation attitude.

Contrary to the findings by Minassian et al. (14), who stated that only 1.85% of patients' dissatisfaction with the surgery as the main reason for poor compliance of follow-up, we noted a poor relationship with doctors and doubt for further treatment as the main reason for poor adherence. In their study, 26.8% (29/108) had poor follow-up although the clinical result could be checked by telephone interview in 15.7% (17/108) of those not returning or put in another way, 11.1% (12/108) were true missing cases despite the prospective nature of the study. Being one of the few reports on this issue, the mentioned authors concluded that the patients with good follow-ups present a higher success rate (92.4%) than those with poor reevaluation (72.4%), who additionally

showed abandonment of follow-up earlier (mean 21 versus 10 months) (14).

Academic protocols with randomized and non-randomized prospective studies were investigated by Ou et al., who revealed an incidence of patients lost to follow-up of 8.1% at 12 months, 28% at 24 months and 36% at 36 months (10). In contrast to their results, our recent study (7) revealed a much earlier patient loss to follow-up, with 10.2% of the patients not returning personally for examination at 6 months and 25% not returning at 12 months, whereas others described lack of physical examination in 100% at 5 years of follow-up (7). These observations occurred even though patients were operated on by the same surgeon at the same center, acknowledging that more stringent efforts to contact the patients must be pursued to create more solid doctor-patient relationships. These results highlight the need to constantly check on clinical results to ensure improvement.

Missing patients must be more deeply studied because we do not know the reasons they simply disappear from consecutive evaluations after an operation that is somehow meaningful to any lay person. We can speculate that SUI operations may represent a simpler operation on the lay´s conception due to the lack of prolonged hospitalization, immediate return to feeding and minimal discomfort despising the necessity for follow-up.

This population demands attention because unraveling the failures or demanding investigation does not happen on oncological counterpart treatments, be it clinical or surgical, with reevaluation accurately followed and more actively investigated and pursued by doctors and patients.

We concluded that doctors may overestimate their success rates due to the lack of prolonged and consistent follow-up for functional or anatomical diseases, as surveys display better ways to check results than charts (4).

However, this paper has flaws: 1- although prospective in nature, the majority of the information was collected from patients´ experiences, treatment references or from the past attendant doctor suggesting recall bias; 2- many missing parameters may be biased by emotional resentment; 3- not allowing direct and precise access to file reports may promote incorrect information; 4- even when urodynamic/cystoscopy was performed on a single patient, it cannot be certain that the test was related to investigative purposes of clarifying SUI failure or any other reason; 5- only those who failed and who recently sought medical treatment/evaluation were studied.

Although these flaws may be disturbing and confounding, the core conclusions center on the fact that patients abandon their doctors after a failed case for different reasons, although the doctor´s attitude regarding intangible parameters such as confidence and active investigations to clarify the causes of the failure play important roles in this relationship.

CONFLICT OF INTEREST

None declared.

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Appendix

Questionnaire used to evaluate treatment failures for SUI

1 - How long did you take to realize the operation did not work?"

1 month	( )
3 months	( )
6 months	( )
9 months	( )
12 months	( )
18 months	( )
I don´t remember	( )

2 - "What was offered to investigate or diagnose the causes of the failure"

Cystosocpy	( )
IVP	( )
Cystography	( )
CT	( )
MRI	( )
Laparoscopy	( )
Urodynamic investigation	( )
No investigation was offered	( )
I don´t remember/ I don´t know the exam	( )

3 - "What was offered to treat the undesired results from the SUI operation?"

Pelvic exercises/physiotherapy	( )
Pesaries	( )
Anticholinergics and/or pelvic exercises	( )
SUI correction through abdominal route	( )
Primary slings	( )
Repeat sling	( )
Attempt to pull-down or release the tape	( )
Bulking injections	( )
Botox injection	( )
Unknown/Not remembered	( )

4 - "Reasons why you stopped demanding solution by the doctor that primarily treated you"

Doctor said sometimes it happens	( )
My anatomy was awkward	( )
It will solve soon	( )
The other alternatives were too demanding	( )
I did not want to pass over another operation as the unique alternative	( )
Doctor said it was my impression/could be psychological	( )
It may take longer for the final result	( )
I decided not to mention the problem any more	( )
I just quit complaining	( )
I resigned	( )
I naturally improved	( )

5 - "Reasons why you change doctor"

I lost confidence on the doctor	( )
He said he couldn´t do any further	( )
He said "It will solve soon" but it didn´t	( )
The alternatives were demanding/painful	( )
He said my case was "final"	( )
He could not explain why that happened	( )
He changed medications with no clinical result	( )
My family/friend said I should seek another opinion	( )
He deviated from the central problem	( )
Changed health insurance - the doctor was not aligned to it	( )
Changed city	( )

6 - "Did you warned/said your doctor you would seek another opinion?

Yes ( ) No ( )

7 - Were you recommended by your doctor to seek another opinion?"

Yes ( ) No ( )