

**Purpose:** We studied treatment delay, and the impact on disease specific survival and stage progression in a series of patients who had undergone cystectomy.

**Materials and Methods:** All 141 patients underwent radical cystectomy between 1990 and 1997 due to locally advanced bladder cancer. Treatment delay was defined as time from pathological confirmation of invasive disease to performance of cystectomy, and was registered retrospectively from the patient charts. Two patients received neoadjuvant chemotherapy and were excluded from further analyses. Followup continued until April 2003 with death due to bladder cancer as the end point. Causes of death were retrieved from the Swedish Cause of Death Registry.

**Results:** The median treatment delay was 49 days, but was significantly longer for the 71 cases who were referred from other hospitals (63 vs 41 days,  $p < 0.001$ ). Treatment delay did not influence cumulative incidence of death from bladder cancer. Considering all cases, there was no significant correlation between treatment delay and stage progression. For clinical stage T2 tumors, median treatment delay was 76 days among patients with stage progression compared to 41 and 48 days for those with stage regression and stage equivalence, respectively ( $p = 0.20$ ).

**Conclusions:** Treatment delay was not found to influence disease specific survival in the present study. Furthermore, treatment delay was not significantly longer in cases that progressed compared to those with equal or lower pathological stage in the cystectomy specimen.

### **Editorial Comment**

Does delay of radical cystectomy confer an increased risk of progressive bladder cancer? Several authors have addressed this issue with contradictory results. These authors from Sweden did not find an influence if radical treatment was given before or after 60 days post diagnosis. Median time to surgery (treatment delay) was only 48 days among those alive at the end of follow-up and 4 days longer (52 days) among those who died of bladder cancer.

Why did the authors chose 60 days threshold? It seems that in a relatively well-organised health care system as in Sweden a relevant delay ( $> 90$  days or 3 months) is a rare event. It is noteworthy to read the editorial comment from M. Cookson who states that the window for curability is not open for all time and may begin to close from 90 days.

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## **FEMALE UROLOGY**

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### **The effect of fluid intake on urinary symptoms in women**

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**Purpose:** We determined the effect of caffeine restriction and fluid manipulation in the treatment of patients with urodynamic stress incontinence and detrusor overactivity.

**Materials and Methods:** This was a 4-week randomized, prospective, observational crossover study in 110 women with urodynamic stress incontinence (USI) or idiopathic detrusor overactivity (IDO) to determine the effect of caffeine restriction, and of increasing and decreasing fluid intake on urinary symptoms. Data were recorded in a urinary diary for the entire study period on urgency episodes, frequency, pad weight increase, wetting episodes and quality of life.

**Results:** A total of 69 women with a mean age of 54.8 years completed the study, including 39 with USI and 30 with IDO. In the IDO group decreasing fluid intake significantly decreased voiding frequency, urgency and wetting episodes with improved quality of life. In the USI group there was a significant decrease in wetting episodes when fluid intake was decreased. Changing from caffeine containing to decaffeinated drinks produced no improvement in symptoms.

**Conclusions:** Conservative and life-style interventions are first line treatments in the management of incontinence and storage lower urinary tract symptoms. This study shows that a decrease in fluid intake improves some of these symptoms in patients with USI and IDO and, therefore, it should be considered when treating such patients.

### **Editorial Comment**

The authors reviewed the effect of restricting caffeine and manipulating fluid intake in patients who had been diagnosed urodynamically with stress incontinence or detrusor overactivity. The study cohort was a 69 woman. The participants were analyzed after a 4-week randomized prospective observational crossover study where they underwent caffeine restriction and either increase or diminution of fluid intake. Data was recorded in the urinary diary. Findings included that changing from caffeine to non-caffeine drinks did not improve symptoms. They also found that in patients suffering from detrusor overactivity, decreased fluids significantly diminished the urgency and frequency syndrome and improved the quality of life, which was also mirrored in the stress urinary incontinent patients.

An excellently written article that provides sound scientific analysis for the common advice given to patients for the conservative management of urinary incontinence. It is noteworthy that by not taking in caffeine there was no true improvement in the patients' urinary symptoms while diminishing fluid intake did significantly help diminish incontinent episodes whether the patient had overactive bladder or stress urinary incontinence. This lack of effect by diminishing caffeine has been noted by other researchers (1). The authors make a very salient point that in by asking patients to stop caffeine a serendipitous secondary effect may be that overall fluid intake is diminished as well thus causing the perception that less caffeine improves overall bladder control. It would be of interest to find that if patients who suffered from urinary urgency and frequency with the diagnosis of interstitial cystitis would also not have an improvement in their voiding symptoms when stopping caffeine in view that caffeine may be a mild urothelial irritant as well as a mild diuretic. Nevertheless, the authors should be complimented on analyzing a very common first line treatment and illuminating the readership to the value of this counsel.

### **Reference**

1. Bird ET, Parker BD, Kim HS, Coffield KS: Caffeine ingestion and lower urinary tract symptoms in healthy volunteers. *Neurourol Urodyn.* 2005; 24: 611-5.

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### **The completely dry rate: a critical re-evaluation of the outcomes of slings**

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**Objective:** To critically evaluate sling outcomes and revisit the realistic goals of anti-incontinence surgery.

**Materials and Methods:** A review of an Institutional Review Board-approved prospective database revealed the outcomes of four different sling techniques that are utilized at our institution.

**Results:** Four hundred ninety-eight patients had a mean follow-up varying from 9 to 24 months (range 6-50) after undergoing one of four different sling techniques utilized at our institution. The techniques had similar results with regard to completely dry rate, overall success rate, and rate of urgency regardless of the variation in follow-up time. Success was defined as completely dry or leakage = 1/week or = 70% improved by questionnaire in those patients who leaked 1/week. Success, by this definition, varied from 74.9% to 85.7%, but the completely dry rate varied from 36.1% to 45.2%. An additional 31.0% to 33.3% leaked = 1/week, and of the remaining patients, 24.5% to 44.4% considered themselves = 70% improved despite leakage > 1/week. Urge incontinence was reported by 24.4% to 33.3% of patients.

**Conclusion:** As surgeons, we must constantly reevaluate the outcomes and purposes of the procedures we perform on our patients.

#### **Editorial Comment**

The authors retrospectively reviewed the outcomes of 4 different sling techniques that they had performed in their practice. They were able to identify 498 patients with follow-up ranging from 6-15 months. Success in their patient population was well defined. The authors found a completely dry rate in the range of: 36.1 - 45.2%. Urge incontinence was reported at 24.4 - 33.3% of patients. Success in this patient population was noted to be 74.9 - 85.7%.

This is an important paper to read in view of the large patient population, which was retrospectively analyzed, and the forthrightness of the authors' report of their results. The authors noted that with this large population they were able to find that their completely dry rate was fewer than 50%. In addition, the urinary urge rate was also between almost one-fourth to one third of the patients studied. These < 90% completely dry rates combined with definite rates of urinary urge incontinence have been mirrored in the literature in the past by others (1). Despite the completely dry rate at < 50%, the success rate was still greater than three-fourths of patients treated. When reading this report the reader may well identify with the results noted by these surgeons as I did during my review.

#### **Reference**

1. Haab F, Trockman BA, Zimmern PE, Leach GE: Results of pubovaginal sling for the treatment of intrinsic sphincter deficiency determined by questionnaire analysis. *J Urol.* 1997; 158: 1738-41.

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