There has been a revolution in the treatment of stress incontinence in the last 20 years. Traditionally Burch colposuspension (B.C) and Autologous fascial sling (AFS) were the gold standard procedures. Their role has largely been superseded by the advent of the synthetic midurethral sling via either retropubic or transobturator routes. (1)

There has been an overwhelming predominance in the number of synthetic slings performed for stress incontinence. This shift in practice is mainly due to reduced operative time, lower complication rates and an improved success rate despite the simplicity of the procedure. (2)

The question being posed is whether AFS and BC are to be consigned to history, or do they still have a place in the treatment of stress incontinence? Welk and Herschorn have described a role for such procedures in extremely complex patient populations with recurrent stress incontinence. (3) In their study over 50% of the population had mesh erosions, urethral diverticuli or trauma, and the remaining 50% underwent at least 2 prior surgical procedures before undergoing AFS. The surgical outcomes and patient satisfaction rates are quite impressive considering the complexity of the patients. Average pad use went down from 5 to 1 daily and improvement in quality of life consisting of the Urogenital Distress Inventory [UDI-6] and the Incontinence Impact Questionnaires [IIQ-7] was over 60%.

There is however a concern that should be raised throughout urogynaecology practice. Despite the fact that BC and AFS may occasionally be indicated in some clinical settings or even as a first choice for patients who want to avoid synthetic slings, it has become difficult to gain and retain experience for surgeons to offer these procedures. This is due to the sharp rise in the number of synthetic slings at the expense of the more invasive BC and AFS procedures. Wu and colleagues found that the number of retropubic suspension surgeries in the United States fell from 52.8% of SUI procedures in 1998 to 13.8% in 2007. (4)

On the other hand, the distinctive high success rate and the solid body of evidence that support the use of the synthetic suburethral slings as a standard procedure for the treatment of stress incontinence has to some extent mitigated the low rate of complications which include mesh exposure and denovo pain associated with mesh procedures.

In an ideal setting where a multidisciplinary delivery of urogynaecology service is the norm, the workload for the BC and AFS should be directed to a small numbers of urogynaecologists in a pelvic floor unit. This will help to build up the surgical expertise to perform such procedures.

With the growing experience of all of our surgical techniques for stress incontinence, it should become possible to select patients for certain procedure rather than routinely offer one favoured procedure. A local and national audit database will both help in assessing surgical outcomes and help the urogynaecologist in selecting the best procedure for each patient.

References

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