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EDITORIAL

"If You Build It, They Will Come"*

If they come, they will use it. If they use it, someone else will build it too!

And so it was with bone anchors. Someone thought it would be a good idea to use bone anchors to attach sutures to bones because the periosteum isn't strong enough to hold the tendinous attachments of rotator cuffs and other powerful muscles. For orthopedic surgeons and their patients, bone anchors have proven to be a major technologic advance.

For urologists and their patients, bone anchors have proven to be . . . ubiquitous. The periurethral and vaginal musculofacial tissues, though, are not so strong. They certainly aren't as strong as the rotator cuff, and, as far as I can see, when incontinence or prolapse recurs after surgery, it is not because the sutures pull out of their attachments. Rather, it is because the periurethral and vaginal tissues themselves are weak. In fact, the sutures don't do anything at all. They don't pull out. The vaginal wall moves. It pulls out of the suture. That's why the prolapse or incontinence occurs in the first place. In fact, it seems to me that if these rather delicate tissues are suspended from bone anchors by long sutures, the likelihood that the sutures will pull through is even greater, because the natural shock absorber effect of the soft tissue will be lost.

Lots of companies make bone anchors for incontinence and lots of surgeons use them. The proponents of bone anchor techniques liken them to the Burch or Marshall-Marchetti Krantz operations, which suture the periurethral tissue to Cooper's ligament and the pubis, respectively. They make incontinence surgery sound all so easy. There are prepackaged kits that do practically everything for the surgeon, including idiot-proof techniques for determining how tight to tie the sutures and how to pass a long needle between the bladder and the pubis without entering either.

But, do they work? What are the short-term results? What are the long-term results? For sure, no one knows. Yet.

None of this makes very much sense to me. The main problem with incontinence and prolapse surgery is on the vaginal side, yet all this attention is directed at the other side, the abdominal side, where the bone anchors reside. When incontinence surgery fails it is because the musculofacial tissue of the vaginal wall and sphincter weakens and gives way. That's why I prefer a fascial pubovaginal sling, because 1) it adds strength to the vaginal side, 2) it works, and 3) it works for a long time because the sling doesn't weaken like the vaginal wall.

There is one problem that a bone anchor can address, though. Imagine if you could sort of staple the anterior vaginal wall to the undersurface of the pubis, without the need to pass long needles or sutures from the abdominal side to the vaginal side.

*From the movie *Field of Dreams.*

That would avoid or minimize the most serious complication of these surgeries—injury to the urethra or bladder from an errant suture (resulting in a fistula). Moreover, the mechanics of this arrangement would theoretically reduce the likelihood of the sutures cutting through the vaginal tissues. A procedure like this might actually work and it might be as good as a pubovaginal sling.

So, how will we ever find out whether these bone anchors work? The answer is that, unless we start doing good clinical research, we won't. As soon as it looks like a new procedure doesn't work very well, someone modifies it. Then lots of people start doing the modified procedure until it is obvious that that doesn't work either. Then, they modify the modified procedure. . .

The answer is simple. Let the pioneers do the new procedures. Let them do good clinical research until we have some answers. I'll continue to do fascial pubovaginal slings and someone else can do bone anchors and someone else can do bone anchors using a sling. Vaginal wall slings, Burch, Marshall-Marchetti Krantz, paravaginal repair—you do what you think is best, but stick with it until it's clear that something else is better.

We all owe that to our patients.

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