

EDITORIAL

Keeping Score

We hold these truths to be self evident:

Fat people are fat because they eat too much.
TURP is the gold standard for treating BPH.
The world is flat and the earth is the center of the universe.

Some things that we know are true; others are not. Some things that used to be true are no longer true. Most things, though, are relative. The world *is* flat for short distances. When you walk from here to there in the paved city of New York City, it's pretty flat. If you are an ant walking the same route, it's pretty bumpy. When you look backwards from a space ship on the way to Mars, it's pretty round. So, is it flat or bumpy or round? It's all of these things.

Fat people *are* fat. We know by looking at them. We don't have to weigh them and we don't have to calculate their body fat. We know that they eat too much or they wouldn't be fat. Maybe it is a metabolic problem, but they still eat more than they should or they wouldn't be fat. Of course, some have more fat content than others. Some are edematous and some, like Sumu wrestlers, are actually more muscle, at least so I'm told (I haven't measured their body fat). But they look fat and you know what I mean.

We know what we know, but how do we know if what we know is true? Most of us know because of our own experience and observations, but, like the ant walking in New York City, we don't always have the same perceptions.

That is why we need to make some measurements and keep some scores. When it comes to assessing outcomes of treatments, there are at least three perspectives—those of the patients, those of their physicians, and those derived by objective measurements. The ideal outcome instrument takes all these factors into consideration, recognizing that there will inevitably be differences between them. Two of the papers in the current issue of this journal address these important perspectives. The paper by Sandvik et al. describes a straightforward severity index for female urinary incontinence—the more urine loss there is, the worse the incontinence. That is obvious. What is not so obvious is that some patients are quite satisfied with therapies to treat incontinence that do not make the incontinence much better and others are dissatisfied with curative therapies because of seemingly minor considerations such as the appearance of a surgical scar. The physician has yet another perspective. He or she might see a normal scar and a patient cured of incontinence and not appreciate the degree to which the scar is bothersome to the patient. The patient is dissatisfied, but the incontinence is cured.

The paper by Groutz et al. (in which I had a supervisory role) presents a unique

incontinence outcome instrument that (counterintuitively) does not require pre-treatment assessment. It makes a very important point—no matter what the patient’s perspective about other issues, the most basic aim of incontinence treatment is to cure the incontinence. If there is no more incontinence, the patient is cured; if incontinence persists, he or she is not cured. Of course, there may be various degrees of clinical improvement and the suggested outcome score enables the differentiation between degrees of improvement. The incontinence severity index described by Sandvik et al. can be used to quantify further the degree of improvement.

Quality-of-life issues and patient satisfaction are also important issues, but they are different ones and should be viewed in context vis-à-vis the patient who was cured of incontinence but didn’t like her scar. I once operated on a man who won a multimillion dollar lottery on the day of his surgery. His quality of life improved, but he never filled out an outcome assessment questionnaire.

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