

EDITORIAL: FEMALE UROLOGY

In 1978 McGuire published the first report on the use of pubovaginal sling for sphincteric incontinence. In this issue of the Journal Cross et al (pages 1195 and 1199) report their recent experience with the same operation. During the ensuing 2 decades only 2 minor modifications have been made in surgical technique. The sling is shorter than in that first report (8 to 10 cm.) and the sling is no longer secured to the rectus fascia on either side. Rather, long sutures attached to either end of the sling are tied together in the midline effectively completing a circle that goes from the rectus fascia on 1 side through the retropubic space, around the vesical neck and then back up through the retropubic space on the other side, finally to be tied in the midline above the rectus fascia. The short-term and long-term results of this essentially unaltered operation speak for themselves.

Contrast this with the results of the Gittes modification of the Pereyra operation. Although short-term success is documented in the majority of patients, only 20% were still continent after 5 years. The original Pereyra operation has been modified so many times that "modified Pereyra procedure" has become its own separate category in urological lexicon. The original Pereyra procedure, the modified Pereyra, as modified by Pereyra, the Stamey, the Cobb-Ragde, the original Raz and the first few modifications of the Raz have all failed the test of time with respect to durability of results. The reasons for this are obvious. In all of the modified Pereyra procedures (the needle bladder neck suspensions) the repair tissue has 1 common trait—it becomes weakened once and fails to the point that it has causes sphincteric incontinence. If it failed once, it only makes sense that that same tissue reinforced with itself, might fail again and indeed that is what happens.

On the other hand, for the fascial pubovaginal sling strong resilient tissue is used, which does not appear to weaken with time. There are 2 ramifications of this fact: 1) long-term

success and durability of fascial slings with respect to sphincteric incontinence are excellent, 2) if the sling is made too tight, it does not tend to loosen with time, which is why urethral obstruction occurs from making the sling too tight. It does not remit over time.

The widespread appeal of the modified Pereyra procedures is a function of its presumed ease, simplicity and relatively low complication rate. At first glance these appear to be compelling reasons to continue to do these operations. However, when one considers a 50% or less success rate in less than 5 years, a 50-year-old woman could reasonably be expected to undergo 7 more operations during normal life expectancy (assuming that the subsequent operations have the same success rate as the previous surgery). The fact that most women do not undergo 7 operations for incontinence suggests 1 of 2 things, either the operations work much better than we think (I doubt that) or the women simply give up and accept incontinence as a fact of life. Fast, easy, effective and complication-free surgery is an admirable goal, one to which I adhere. However, we should not mix myth with reality. The reality is that the fast surgeries are not efficacious in the long term. Fascial pubovaginal sling on the other hand has withstood the test of time.

What we need then is not more modifications of the modified Pereyra but a simple complication-free method to obtain a strong strip of tissue or other substance that can be used as a sling but is biocompatible and does not cause erosion as the currently available synthetic sling. Until such a technique or substance is found, I will continue to perform fascial pubovaginal slings for women with all types of stress incontinence.

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