What to do?

Over 200 operations for the treatment of stress incontinence were described before the recent onslaught of synthetic slings in the mid 1990s. Since then, another 30 or so have been added to our repertoire. This, despite the fact that there is little in the peer review literature to distinguish one from another. Of course, anterior repairs and transvaginal needle suspensions (the darlings of the late 80’s and 90’s) were discredited by the AUA Guidelines panel of 1997, and are not done nearly as often any longer. But they were discredited by studies so flawed by lack of credible outcome data that one can only surmise the reasons why. In that same report, retropubic operations and autologous fascial pubovaginal slings were found to have the highest success and a low complication rate. Insofar as retropubic procedures were mostly done for uncomplicated and pubovaginal slings for complicated stress incontinence, it was only logical that pubovaginal sling became the unofficial gold standard.

That paved the way for the synthetic slings of the 21st century. It seems reasonably clear (based on a plethora of new somewhat improved studies) that, with respect to treatment of stress incontinence, the doctors and patients believe that the new generation of synthetic slings fare at least as well as those that came before. The widespread appeal of these new techniques is that they are truly minimally invasive. Most of these are outpatient surgeries that can be performed in 30 min or less, most patients void immediately afterwards and can return to their usual activities within days. Complications are said to be low and urinary retention, the bane of anti-incontinence procedures, (2) vaginal extrusions of the sling causing recurrent granulomas with persistent draining sinuses and dyspareunia that defied multiple attempts at surgical excision and repair. And, do not forget the deaths.

It has been estimated that over 1 million of these synthetic slings have been performed worldwide; the denominator is very big, the numerator very small. Small, but real, and the followup is short; the numerator may grow over time. None of these complications occur with autologous tissue, nor with allografts and xenografts (but they may have their own set of complications).

I have little doubt that a synthetic will be developed (or may have already been developed) that will mitigate these concerns. I have little doubt that a synthetic will become the new gold standard for sling surgery, but for the present, there are too many women with sling complications that cannot be readily fixed.

It leaves me asking, when it comes to my own patients, what to do?

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