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EDITORIAL

Female Urology/Urogynecology

> Tis but thy name that is my enemy; . . .
> . . . What's in a name? That which we call a rose
> By any other name would smell as sweet.
>
> —William Shakespeare, *Romeo and Juliet,* Act II, ii

The intrinsic qualities of a rose are apparent to all. An artificial rose looks like a rose, but only from a distance. Up close, the look and feel and smell of a rose are unique.

Not so with female urology; not so with urogynecology. Each, it seems, is trying to be the other, but neither is quite sure what it is. Both fields are composed of physicians and surgeons. Both claim the same turf, which, when viewed from the outside, extends from the urethral meatus to the anus, a distance of about 10 cm. Both treat urinary incontinence and other aspects of voiding dysfunction; both treat genital prolapse. Neither is very advanced in treating disorders of defecation. Perhaps they should be. Neither, by training, is proficient enough to lay claim to the entire field.

Urologists are exposed to a broad array of voiding dysfunctions and incontinence because they treat both sexes. They diagnose and treat prostatic urethral obstruction, primary vesical neck obstruction, prostatitis, detrusor instability, learned voiding dysfunctions, urinary tract infections, bladder and prostate cancer, interstitial cystitis, and neurogenic bladder. They know about low bladder compliance, impaired detrusor contractility, detrusor-pressure/uroflow studies, videourodynamics, and vesico-ureteral reflux. All these conditions and diagnostic studies have a counterpart in women. The experience that a urologist gains in diagnosing and treating these conditions in men is an invaluable asset when caring for women.

Gynecologists are primary care doctors. They provide well-woman care and treat women from menarche to menopause and beyond. They expect to see their patients at least yearly for life. This gives them the possibility of attaining a broad perspective about the travails of many disease processes and about long-term outcomes. They treat benign and malignant conditions of the female genital tract—cervical, uterine, and ovarian cancer; uterine myomas and hyperplasia; endometriosis; and vaginitis.

It is obvious that both urologic and gynecologic expertise is necessary to care for women with incontinence, voiding dysfunction, and genital prolapse. It is equally obvious that neither specialty provides all the necessary training; hence, the emergence of fellowships in female urology and urogynecology. Unfortunately, at the present time, the vast majority of fellowship training programs are unidimensional. Urologists train female urologists; gynecologists train urogynecologists. What we

need for the current generation of trainees are fellowship programs whose faculties are composed of both gynecologists and urologists with training in voiding dysfunctions of both sexes as well as the female genital tract. As these programs develop, their graduates will be part urologist and part gynecologist and a new specialty will emerge. The new specialty will need a new name, but none comes to mind.

For the present, though, it seems that the two specialties are more content fighting for the same turf than looking to the future. Some battles are won by the urologist, others by the gynecologist, but in both instances it is the patient who loses.

So, what's in a name? Female urology? Urogynecology? The training will tell.

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