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Sling now or later?

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One of the continuing challenges in prolapse surgery is occult stress urinary incontinence (SUI): leakage that develops after a successful prolapse repair. The mechanism for this, traditionally thought to be the 'unkinking' of the urethra, is somewhat unclear. Predicting its occurrence reliably is even less so.

Often it is clear that if a woman has symptomatically bothersome SUI prior to surgery she should have that problem surgically addressed with her prolapse repair. We know that midurethral slings have a high success rate, and that prolapse repair alone is unlikely to fix SUI. This review by van der Pleog et al. supports this view. But in the preoperative patient who leaks without bother or who is presently dry, what to do?

The authors of this systematic review and meta-analysis of ten randomised trials comparing prolapse surgery with and without concomitant incontinence surgery try to add to this difficult decision process. Included in the analysis are oft-cited and well-designed multicentre trials, such as CARE and OPUS, which also include many subanalyses and long-term follow-up reports.

As seen throughout this paper, the definition of preoperative SUI can be difficult. If a woman leaks a few times a month, or only with a severe respiratory infection, is that SUI? If she never leaks at home but can be provoked to do so during urodynamic testing with prolapse reduced, is that SUI? Work performed by Nager et al. (*N Engl J Med* 2012;366:1987–97) showed that urodynamics does not predict treatment outcome better than simple office evaluation, suggesting that the test does not define SUI. Postoperatively, comparative studies of incontinence surgeries can point in opposite directions if looking at subjective or objective cure rates, raising the concern that patients and their surgeons may not speak the same outcome language.

Incontinence surgery added to prolapse surgery does not come for free, which is also supported by this review. The decision to perform a concomitant midurethral sling has to take into account risks like longer operating room (OR) time, bladder perforation, mesh erosion, urinary retention, urinary tract infection, voiding dysfunction, need for sling revision, and patient dissatisfaction, amongst other concerns. An unsatisfying number of patients still had SUI in these trials despite concurrent incontinence surgery. Yet the decision to wait and perform a staged procedure if needed is also complex, factoring in additional time away from work and patient satisfaction. More than one patient has told me she would prefer to have a little bulge again rather than a perfect prolapse repair but new SUI.

This review shows the nuances in interpreting postoperative outcomes that complicate preoperative planning in women not overtly bothered by SUI. Any guidance from this review is valuable. A calculator designed by Jelovsek et al. (*Obstet Gynecol* 2014;123:279–87) is available in an easy-to-use smartphone app that draws on some of these trials to inform a specific patient about her specific risks. That is, of course, the specific goal. After factoring in all of these electronic and intellectual variables, we are obligated to discuss them with the person who, when appropriately informed, should most contribute to this decision: the patient.

Disclosure of interests

None declared. Completed disclosure of interests form available to view online as supporting information. ■