

Managing post-prostatectomy stress urinary incontinence



The need for supervision by a health-care professional in patients undertaking pelvic-floor exercises is well recognised for women with stress urinary incontinence caused by urethral hypermobility, though the evidence base is scarce.¹ Failure to offer such supervision, for example by mere provision of leaflets on pelvic-floor muscle exercises, risks leaving women uncertain as to precisely which muscles are being referred to, and ambivalent about the need to undertake the exercises for several months. A similar approach has been adopted for men, with the International Consultation on Incontinence² recommending an initial phase of supervised pelvic-floor muscle training for men with stress urinary incontinence after radical prostatectomy, allocating a grade B recommendation in the Oxford Centre for Evidence-Based Medicine scheme.

In *The Lancet*, the Men After Prostate Surgery (MAPS) study³ assessed a structured pelvic-floor muscle training programme compared with standard care, in which exercises could be undertaken but formal teaching was excluded. Separate study groups included men after radical prostatectomy or after transurethral resection of the prostate (TURP) who reported incontinence on screening and baseline questionnaires. The primary outcomes were self-reported incontinence at 12 months, and incremental cost per quality-adjusted life year (QALY).

Although men in both intervention groups were more likely to be doing exercises than those in the control groups, this did not translate into less incontinence. After radical prostatectomy, the proportion of men with incontinence was 76% (148 of 196, intervention) versus 77% in the control group (151 of 195, adjusted risk ratio [RR] 0.97, 95% CI 0.87–1.09, $p=0.64$). After TURP the proportion was 65% (126 of 194) versus 62% (125 of 203, adjusted RR 1.06, 95% CI 0.91–1.23, $p=0.47$). QALYs were almost identical. The formal training of pelvic-floor muscle exercises was dominated (ie, not as good as the control) because it was more costly and was not effective. The absence of a clear advantage for formal training for these exercises in men, and the high rates of self-reported urinary incontinence, are important findings.

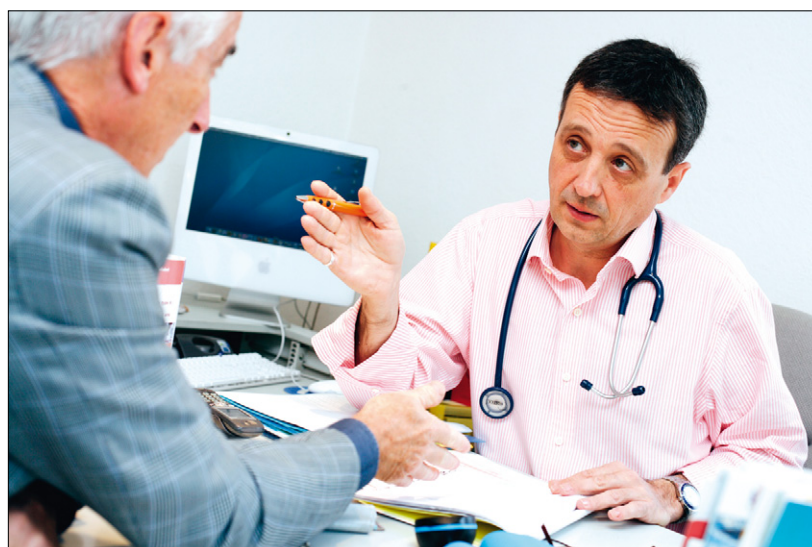
The MAPS study did not question the appropriateness of recommending pelvic-floor muscle exercises after

prostatectomy, and men were generally compliant with the advice received. However, attendance for pelvic-floor muscle training is costly to both patient and health provider, so to be worthwhile requires demonstration of improved continence rates or quality of life. The results of MAPS show that formal training achieves only a higher proportion of men reporting that they are performing pelvic-floor muscle exercises at 1 year.

Stress urinary incontinence in men is deemed a low prevalence problem, when set alongside the high prevalence in women. Yet for men after TURP in MAPS, for whom urgency urinary incontinence was the major issue, 10% (251 of 2590, the total original population) were still incontinent a year after surgery, and severe incontinence was reported by 4% (97 of 2590). The values are even more substantial for radical prostatectomy: 58% (429 of 742, the total original population) of patients reported incontinence at 6 weeks after radical prostatectomy (primarily stress incontinence), of whom 73% (299 of 411, the total assigned to study groups) were still incontinent at 12 months. This finding means an incontinence rate of at least 40% (299 of 742) after radical prostatectomy, and a severe incontinence rate of 20% (152 of 742). These values show the importance of frank discussion of continence issues with patients before surgery.

Most lay people would regard a state of continence as having no involuntary loss of urine. However,

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oncological urologists have tended to use less stringent definitions of continence, such as need for a maximum of one incontinence pad per day, which give a misleading impression of the incidence of stress urinary incontinence, and do not accord with the associated personal impact—patients regard any need to use a continence pad as detrimental to quality of life.⁴ Patients should not be misled about potential adverse effects of treatment.

Clinicians and patients understandably judge successful treatment of prostate cancer to be the greatest priority, and the follow up after radical prostatectomy focuses on this outcome. In a time-limited consultation, little opportunity will be available to explore wider aspects such as continence and sexual function. Furthermore, the extent to which a patient is worried about incontinence symptoms is very individual. Many men tolerate low-level stress urinary incontinence in the early stages after radical prostatectomy, deeming it relatively unimportant in comparison with cancer prognosis. Nonetheless, their attitudes might change with time as the life-threatening cancer diagnosis recedes, particularly if urinary incontinence gets worse. Quality of life information in MAPS was captured as a secondary outcome, though it is fundamentally important to patients.

For women, midurethral tape placement is relatively commonplace, widely known, and perceived to achieve reasonable results with low morbidity (although complications are more common and serious than generally realised⁵). Professional explanation is needed to persuade women to delay a seemingly effective, low-morbidity procedure to pursue pelvic-floor muscle exercises. The situation in men is different. Men with stress urinary incontinence after prostatectomy have

recently undergone major surgery and will generally wish to recuperate before contemplating another operation. Should that operation be for an artificial urinary sphincter, a procedure of which few family doctors are aware, and which is perceived to carry significant morbidity, there could be additional motivation to undertake pelvic-floor muscle exercises conscientiously in the hope of avoiding surgery. Finally, men seem to be comparatively confident in identifying the relevant pelvic-floor muscles. Thus factors affecting motivation and independent identification of pelvic-floor muscles are different for the two sexes. The MAPS study is important in allowing health professionals to identify where valuable resources can most gainfully be employed.

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W Retroperitoneal fibrosis: gaining traction on an enigma

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Retroperitoneal fibrosis is a rare inflammatory and sclerosing disorder that targets the perivascular tissues of the lower aorta, often affecting the upper urinary tract and sometimes proximate venous and gastrointestinal structures.¹ Although this disorder can appear in the setting of aortic vascular disease, regional malignancy, or even primary immune-inflammatory syndromes (eg, systemic lupus

erythematosus, vasculitis, auto-immune pancreatitis), it is usually idiopathic, seems to be immune in origin, has chronic inflammatory pathological changes, and, as yet, no specific inciting factors or circulating markers have been identified. Initial treatment focuses on specific organ-system complications such as ureteral obstruction, and the anti-inflammatory effects of corticosteroids have proven valuable in subduing the