AN AMERICAN UROGYNECOLOGIC SOCIETY (AUGS) / INTERNATIONAL UROGYNAECOLOGICAL ASSOCIATION (IUGA) / JOINT REPORT ON THE TERMINOLOGY FOR SURGICAL PROCEDURES TO TREAT STRESS URINARY INCONTINENCE IN WOMEN

NEED FOR A WORKING GROUP ON SURGICAL PROCEDURES TO TREAT STRESS URINARY INCONTINENCE

Background

In Female Pelvic Medicine and Reconstructive Surgery (FPMRS), a field dedicated to the improvement in quality of life of women who suffer from pelvic floor disorders, there is an inherent drive to minimize risk and maximize efficacious treatments. To this end, research is indispensable and necessary as advancements in surgical procedures are made. Additionally, the practice of FPMRS, a field approached by trainees in Urology as well as Obstetrics and Gynecology, requires the propagation of knowledge of procedures and their steps to new learners. Neither research nor teaching can be effective without language that has the same meaning to all involved stakeholders. For this reason, well-considered terminology surrounding major topics in FPMRS is essential. Stated simply, "The use of a common terminology is mandatory when experts from different branches of medicine have to cooperate."[1]

[1] Artibani W, et al. The International Continence Society terminology for the lower urinary tract: the importance of standardization. Nature Clinical Practice Urology 2005 2(12): 576-7

Surgical treatment of stress urinary incontinence, the "involuntary loss of urine on effort or physical exertion, or on sneezing or coughing,"[2] has seen many changes since its inception. Surgical approach (abdominal versus vaginal), anatomic space (retropubic versus transobturator), and materials utilized (grafts, sutures or native tissue) vary widely between procedures. Furthermore, different eras in the history of FPMRS practice have seen some procedures, such as needle suspensions, become obsolete as others, like midurethral slings, have become the standard of care. In order for research to produce meaningful data about risks or efficacy of specific procedures, correct terminology describing various procedures must be used. In order for new surgeons in the field to understand the historical context of FPMRS surgeries to treat stress incontinence, a broadly meaningful lexicon must be adopted. Each term must indicate to researchers, clinicians, and learners a specific and reliable set of steps. The adoption of an appropriate set of terms for surgeries to treat stress incontinence could also improve the quality of the literature surrounding these procedures.[3]

At present, there are no universally agreed upon, evidence-based terms for the surgical procedures to treat female stress urinary incontinence. Such terms should clearly and specifically describe the approach, materials, and instruments used. For example, a Burch retropubic urethropexy has been used to describe procedures where grafts are used to suspend the periurethral tissues to Cooper's ligament, as well as procedures which utilize suture bridges.

---

[2] Haylen BT, et al. An International Urogynecological Association (IUGA) / International Continence Society (ICS) Joint Report on the Terminology for Female Pelvic Floor Dysfunction. *Neurourology and Urodynamics* 2010 29:4-20

[3] Hofmeester I, et al. Impact of the International Continence Society (ICS) report on the standardization of terminology in nocturia on the quality of reports on nocturia and nocturnal polyuria: a systematic review. BJU International 2014 115: 520-36

SCOPE

AUGS, in concert with IUGA, seeks to produce a clinically-based document that comprehensively assigns terms to widely practiced surgical procedures employed by obstetrician-gynecologists, urologists, and urogynecologists to treat stress urinary incontinence in women. Each term description should:

1. Describe the procedure in clear language in a step-wise manner.
2. Include specific materials and equipment utilized in the procedure where appropriate
3. Include detailed illustrations to clarify the procedure wherever possible
4. Describe the mechanism of action through which the procedure is thought to restore continence
5. Address, if appropriate, specific clinical scenarios or historical contexts in which the procedure is / was commonly practiced.
6. Combine input from all 2 organizations with the assistance of designated referees
7. Be clinically meaningful in communications about surgeries between teachers and learners, researchers, clinicians, physiotherapists, and continence nurses.

WORKING GROUP

The working group will consist of:

1. 6 contributing writers including the chair

Members of the working group should be members of 1 or more of IUGA or AUGS societies. Each member should be a practicing a) urogynecologist, b) urologist, or c) general obstetrician-gynecologist.

DURATION

The expected commitment of the working group will be 18-24 months. The maximum duration of the project will be 36 months.