

# IUGA Survey of Practice Patterns-2014

## Demographics

1. Specialty
  - a. Urogynecology
  - b. Urology
  - c. Obstetrics/gynecology
  - d. Other
  
2. Location of practice
  - a. North America
  - b. Latin America
  - c. Europe
  - d. Asia
  - e. Oceania/Australasia
  - f. Africa
  
3. Age
  - a. <40 years old
  - b. Between 40 and 55 years old
  - c. >55 years old
  
4. Gender
  - a. Male
  - b. Female
  
5. Fellowship training
  - a. Yes
  - b. No
  
6. Years since finishing training
  - a. < 5 years
  - b. Between 5 and 10 years
  - c. > 10 years
  
7. Practice setting
  - a. Academic
  - b. Private
  - c. Other
  
8. How did the latest FDA safety communication of serious complications of using transvaginal mesh for prolapse change your practice?
  - a. Decreased use of mesh
  - b. Increased use of mesh

- c. No effect
  - d. I don't use mesh for transvaginal prolapse repair
9. When do you use mesh for prolapse repair? (may choose >1)
- a. Never
  - b. Primary prolapse repair – transvaginal
  - c. Primary prolapse repair – abdominal sacrocolpopexy
  - d. Primary prolapse repair – transvaginal, select cases only (severe prolapse, weak pelvic floor muscles, connective tissue abnormality)
  - e. Primary prolapse repair – abdominal sacrocolpopexy, select cases only (severe prolapse, weak pelvic floor muscles, connective tissue abnormality)
  - f. Recurrent prolapse repair – transvaginal
  - g. Recurrent prolapse repair – abdominal sacrocolpopexy

## Urodynamics

1. Would perform urodynamics prior to surgical correction for uncomplicated stress urinary incontinence (stress leak is demonstrable on exam, no other lower urinary tract complaints)?
  - a. Strongly agree
  - b. Agree
  - c. Neutral
  - d. Disagree
  - e. Strongly disagree
  
2. Prior to surgical correction for stress urinary incontinence, what investigation do you usually perform?
  - a. Multichannel urodynamics
  - b. Stress test only
  - c. Stress test and post void residual
  - d. Stress test, uroflow, and post void residual
  - e. Physical examination only
  
3. Would perform urodynamics prior to surgical correction for uncomplicated stress urinary incontinence (stress leak is NOT demonstrable on exam, no other lower urinary tract complaints)?
  - a. Strongly agree
  - b. Agree
  - c. Neutral
  - d. Disagree
  - e. Strongly disagree
  
4. In cases of mixed urinary incontinence (stress>urge), would perform urodynamics prior to surgical correction for stress urinary incontinence

- a. Strongly agree
  - b. Agree
  - c. Neutral
  - d. Disagree
  - e. Strongly disagree
5. Would perform urodynamics prior to surgical correction for pelvic organ prolapse to rule out occult stress incontinence?
- a. Strongly agree
  - b. Agree
  - c. Neutral
  - d. Disagree
  - e. Strongly disagree
6. Prior to surgical correction for prolapse, what urinary incontinence investigation do you usually perform (regardless of patient's incontinence symptoms)?
- a. Multichannel urodynamics
  - b. Stress test only
  - c. Stress test and post void residual
  - d. Stress test, uroflow, and post void residual
  - e. Physical examination only

## **Incontinence**

1. Preferred surgical treatment for stress urinary incontinence with normal urethral pressure studies and urethral hypermobility
- a. Burch procedure
  - b. Mid-urethral sling – retropubic kit
  - c. Mid-urethral sling – transobturator kit
  - d. Suburethral sling (biological) – allograft, xenograft, or autograft
  - e. Single incision slings (SIS)
  - f. Bladder neck needle suspension
  - g. Kelly plication
  - h. Urethral bulking agent (UBA) injection
2. Preferred surgical treatment for stress urinary incontinence with decreased urethral pressure studies/intrinsic sphincter deficiency and urethral hypermobility
- a. Burch procedure
  - b. Mid-urethral sling – retropubic kit
  - c. Mid-urethral sling – transobturator kit
  - d. Suburethral sling (biological) – allograft, xenograft, or autograft
  - e. Single incision slings (SIS)
  - f. Bladder neck needle suspension

- g. Kelly plication
  - h. Urethral bulking agent (UBA) injection
3. Preferred surgical treatment for stress urinary incontinence with a diagnosis of decreased urethral pressure studies/intrinsic sphincter deficiency and urethral hypermobility
    - a. Burch procedure
    - b. Mid-urethral sling – retropubic kit
    - c. Mid-urethral sling – transobturator kit
    - d. Suburethral sling (biological) – allograft, xenograft, or autograft
    - e. Single incision slings (SIS)
    - f. Bladder neck needle suspension
    - g. Kelly plication
    - h. Urethral bulking agent (UBA) injection
  4. Preferred secondary surgical treatment of stress urinary incontinence after failure of initial procedure
    - a. Burch procedure
    - b. Mid-urethral sling – retropubic kit
    - c. Mid-urethral sling – transobturator kit
    - d. Suburethral sling (biological) – allograft, xenograft, or autograft
    - e. Single incision slings (SIS)
    - f. Bladder neck needle suspension
    - g. Kelly plication
    - h. Urethral bulking agent (UBA) injection
    - i. Overlap of sling
    - j. Tape tightening
  5. Preferred surgical treatment for proven stress urinary incontinence when performing a concomitant surgery for pelvic organ prolapse
    - a. Burch procedure
    - b. Mid-urethral sling – retropubic kit
    - c. Mid-urethral sling – transobturator kit
    - d. Suburethral sling (biological) – allograft, xenograft, or autograft
    - e. Single incision slings (SIS)
    - f. Bladder neck needle suspension
    - g. Kelly plication
    - h. Urethral bulking agent (UBA) injection
    - i. Perform staged procedure at two separate times
  6. Preferred surgical treatment to prevent de-novo stress urinary incontinence when performing a concomitant surgery for pelvic organ prolapse
    - a. Burch procedure
    - b. Mid-urethral sling – retropubic kit
    - c. Mid-urethral sling – transobturator kit
    - d. Suburethral sling (biological) – allograft, xenograft, or autograft

- e. Single incision slings (SIS)
  - f. Bladder neck needle suspension
  - g. Kelly plication
  - h. Urethral bulking agent (UBA) injection
7. Do you perform prophylactic anti-incontinence procedures during pelvic organ prolapse repair in cases that have no incontinence
- a. Yes
  - b. No
8. Material preferred for sub-urethral sling
- a. Autologous fascia
  - b. Cadaveric fascia lata
  - c. Synthetic material
  - d. Biological graft
9. Preferred type of bulking agent (UBA)
- a. Calcium hydroxylapatite (Coapatite)
  - b. Polydimethylsiloxane (Macroplastique)
  - c. Bovine collagen (Contigen)
  - d. Carbon beads (Durasphere)
  - e. Polytetrafluoroethylene (Teflon, PTFE)
  - f. Fat
  - g. Polyacrylamide (Bulkamid)
10. Preferred management of post-operative bladder drainage after treatment for stress urinary incontinence
- a. Transurethral catheterization with foley catheter
  - b. Transurethral catheterization with clean intermittent catheterization
  - c. Suprapubic catheterization
  - d. No catheterization

## **Prolapse**

1. How often do you use pessaries for treatment of pelvic organ prolapse?
- a. Always
  - b. Frequently
  - c. Sometimes
  - d. Occasionally
  - e. Never
2. Preferred approach for treatment of apical vault prolapse
- a. Abdominal
  - b. Vaginal

3. Preferred method of treatment for apical vault prolapse via abdominal approach
  - a. Open abdominal sacrocolpopexy
  - b. Laparoscopic abdominal sacrocolpopexy
  - c. Robotic abdominal sacrocolpopexy
  - d. Open ureterosacral ligament suspension
  - e. Laparoscopic ureterosacral ligament suspension
  
4. Preferred method for treatment of apical vault prolapse via vaginal approach
  - a. Sacrospinous ligament suspension
  - b. Ureterosacral ligament suspension
  - c. Endopelvic fascia repair
  - d. Iliococcygeus fascial suspension
  - e. Infracoccygeal sacropexy
  - f. Mesh kit
  
5. Preferred approach for hysterectomy for prolapse
  - a. Vaginal
  - b. Laparotomy
  - c. Laparoscopic
  - d. Robotic
  
6. Preferred technique for surgical repair of anterior vaginal wall prolapse (cystocele)
  - a. Anterior colporrhaphy
  - b. Vaginal paravaginal repair
  - c. Laparoscopic paravaginal repair
  - d. Abdominal repair concomitant with abdominal hysterectomy
  - e. Abdominal sacrocolpopexy
  
7. Preferred material for anterior colporrhaphy
  - a. Native tissue
  - b. Synthetic graft repair
  - c. Biological graft repair
  
8. Preferred approach for treatment of paravaginal defect
  - a. Open abdominal
  - b. Laparoscopic
  - c. Vaginal
  
9. Preferred abdominal technique for surgical treatment of an enterocele
  - a. Halbans operation
  - b. Moschowitz procedure
  - c. Ureterosacral plication
  - d. Site-specific repair

10. Preferred vaginal technique for surgical treatment of an enterocele
  - a. McCall Culdoplasty
  - b. Vaginal Moschowitz
  - c. Obliteration of the cul-de-sac
  - d. Site-specific repair
  
11. Preferred technique for surgical repair of posterior vaginal wall prolapse (rectocele)
  - a. Posterior colporrhaphy
  - b. Levator plication
  - c. Site-specific repair
  - d. Graft augmentation
  - e. Combination of two or more of the above
  
12. Preferred approach to posterior wall (rectocele) repair
  - a. Vaginal repair
  - b. Endorectal repair
  - c. Open abdominal repair
  - d. Laparoscopic/Robotic repair