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
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
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 (Duraphere)
   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 uretersacral ligament suspension
   e. Laparoscopic uretersacral ligament suspension

4. Preferred method for treatment of apical vault prolapse via vaginal approach
   a. Sacrospinous ligament suspension
   b. Uretersacral 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. Uretersacral 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