



European Association of Urology



Letter to the Editor

Reply to Maurizio Serati, Stefano Uccella and Stefano Salvatore's Letter to the Editor re: Annette Kuhn, Caroline Eggeman, Fiona Burkhard and Michael D. Mueller. Correction of Erosion after Suburethral Sling Insertion for Stress Incontinence: Results and Related Sexual Function. Eur Urol 2009;56:371–7

We would like to comment on the letter to the editor by Serati, Uccella, and Salvatore [1].

One criticism was that 9% of our patients were not sexually active. In a small study of 21 patients, we must not quote percentages, as this does indeed give a wrong impression overall. For this reason, we mentioned raw numbers only and not percentages. The authors quote a study by Dalpiaz et al [2] that describes female sexual dysfunction with a variety of prevalence rates ranging from 0.6% to 64% and stresses “the wide range of the reported percentages depends on the impact of different concomitant factors on sexual function, such as interpersonal, emotional relationship and self well-being, and psychological factors.” In no way should our study be understood as an epidemiologic study; the study population is a very small selection of women with a very specific problem of suburethral erosion after sling insertion for urinary incontinence. Epidemiologic data from Switzerland do not exist yet; however, a study among respondents aged ≥ 60 from the United States reported that for 73% of participants, maintaining an active sex life is an important aspect of their relationship with their partner [3], and we should not underestimate sexual interest in the elderly population.

Median follow-up was 6 mo, which is definitely short term, as stated in the manuscript; however, we should emphasize that the primary outcome was correction of sling erosion. There is some evidence that erosions may occur even several years after sling insertion [4], and we are just in the process of following up our patients after correction of erosion and after sling insertion.

We fully agree that a comparison to sexual function before sling insertion would be very valuable; however, as we say in the manuscript, the initial incontinence procedure was not performed by us, so the first contact with the

patient occurred at the time when erosion was already a problem.

The two groups in the two quoted studies were different in that one group had sling erosion; the other group did not have erosion but had male and female dyspareunia with an onset after sling insertion. I assume that in the latter it is not mainly scar tissue but the sling itself causing painful intercourse, and this was the reason to remove the sling instead of providing further local therapies. We can only speculate, however, why dyspareunia occurs; the propylene sling may be generally too superficial, and the lateral parts of the transobturator tapes may be located very close to the sulci, resulting in less elasticity of the covering vaginal tissue, causing friction and discomfort during intercourse.

Investigating populations with small numbers may be helpful if a particular complication is rare or if the management of a complication is not clearly defined, which was the case in both studies. Obviously, referring surgeons were not familiar with the treatment of de novo dyspareunia, and the time interval between insertion and removal would not have been up to 10 mo.

Finally, we would like to quote the editorial that was written by Roger Dmochowski referring to our article: “The importance of global assessment of the presenting vignette is clear, as is the essential necessity to inform the patient of aspects of her life that may be positively, or perhaps adversely, affected. Caveat emptor” [5]. This is probably the main issue in reporting complications [6].

Conflicts of interest: The author has nothing to disclose.

References

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