

and 49% were pN0 ($p < 0.001$). The strongest predictor of progression and mortality was bGS. PSA > 20 ng/ml associated with bGS ≤ 7 resulted in 10-yr PCSM of 5%; when associated with bGS ≥ 8 , PCSM was 35%. The main limitations of the study were retrospective design and varying treatment modalities.

Conclusions: PCa patients with PSA > 20 ng/ml have varying risk levels of disease progression and PCSM. Considering additional risk factors further stratifies this group into four subgroups that can guide the clinician in preoperative patient counselling.

Editorial Comment

Surgical therapy in patients with prostate cancer and a PSA > 20 ng/ml is a matter of debate. Most patients are considered high-risk and receive either hormonal therapy alone or are referred to external beam radiation therapy. The authors from this multi-institutional study analyze their 712 patients with PSA > 20 ng/ml who underwent radical prostatectomy. Of this group, roughly 40% had Gleason score > 7 , 50% had positive surgical margins and 15% were node-positive. The combination of these factors was predictive for patient's outcome.

Interestingly, even in this special group of patients death of disease was a rare event, with high cancer-specific survival rates of 90% and 85% after 5 and 10 years, respectively, whereas biochemical progression-free rates in the same group were as low as 65% at 5 years and 52% at 10 years.

The combination of several risk factors, expectedly, led to reduced progression-free and survival rates. In summary, radical prostatectomy is a viable option even for high-risk patients.

Dr. Andreas Bohle

Professor of Urology

HELIOS Agnes Karll Hospital

Bad Schwartau, Germany

E-mail: boehle@urologie-bad-schwartau.de

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Functional results after tape removal for chronic pelvic pain following tension-free vaginal tape or transobturator tape

Rigaud J, Pothin P, Labat JJ, Riant T, Guerineau M, Le Normand L, Glemain P, Robert R, Bouchot O

Urology Clinic, Hôtel-Dieu, Nantes University Hospital Centre, Nantes, France

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Purpose: The incidence of pelvic pain after placement of a suburethral sling for incontinence ranges between 0% and 30%. The management of this chronic pain after suburethral sling placement is complex and to our knowledge no consensus has been reached. We evaluated the functional results after removal of the suburethral tape responsible for chronic pelvic pain.

Materials and Methods: From November 2004 to August 2009, 32 patients undergoing removal of suburethral tape causing chronic pelvic and perineal pain at our department were prospectively followed. Patients were divided according to the type of suburethral sling into the transobturator tape group (15 patients) and the tension-free vaginal (retropubic) tape group (17 patients). In the TVT group tape removal was performed using

transperitoneal laparoscopy in every patient. In the TOT group tape removal was performed via a transvaginal approach possibly associated with a unilateral or bilateral incision in the proximal part of the thigh. Pain was evaluated by a visual analogue scale from 0-no pain to 10-maximal pain.

Results: The surgical exploration of suburethral tape responsible for chronic, treatment refractory pelvic pain revealed in most cases an abnormal tape position or excessive tape traction. In the overall population tape removal provided improvement of pain (at least 50% improvement of the visual analogue scale score) in 68% with a mean followup of 10 months. Mean visual analogue scale score was 7.3 +/- 1.5 before surgery and 3.4 +/- 3 after surgery. However, recurrence of incontinence was observed in 22% of cases. No significant difference was demonstrated in terms of functional results according to the type of tape insertion.

Conclusions: The surgical removal of suburethral tape improved pain in 68% of patients but with a risk of recurrence of urinary incontinence in 22%.

Editorial Comment

The authors review their experience in addressing chronic pelvic pain following the placement of a tension free vaginal tape or transobturator tape. Notable findings included that only approximately two-thirds of the patients were able to have a > 50% improvement in their pain control with resection of the tape. In addition, 1 in 5 patients had a return of their incontinence.

The physicians noted that the onset of pain after the placement of the tape was exceedingly rapid thus assisting the reader in linking the rapid temporal nature of this iatrogenic pain to the surgery. Of interest, is that cystoscopy, CT scan, and MRI's were all normal and thus are of potentially little assistance in evaluating this pain syndrome. For the TVT tapes, the authors utilized laparoscopy while for anatomic reasons with the transobturator tape, removals were performed transvaginally. Upon examination of the cause of pain with the TOT tape, it was noted that this was most likely to be secondary to a myofascial syndrome from muscle response to the tape passing through the body of the muscle.

Important take home messages include that the rapid appearance of pain after the placement of a suburethral tape should embolden the surgeon to promptly proceed with removal prior to the period of tissue ingrowth and that imaging studies with this temporal associated pain are of limited value. That the authors found that they had approximately 20% recurrence of incontinence after tape removal is understandable in view of similar findings of a very similar incontinence rate after simple sling incision for relief of urinary retention following pubovaginal slings (1). Strong consideration for long term physical therapy may be of value in view of the identified myofascial component and the less than 100% response to surgery for the pain.

Reference

1. Thiel DD, Pettit PD, McClellan WT, Petrou SP: Long-term urinary continence rates after simple sling incision for relief of urinary retention following fascia lata pubovaginal slings. J Urol. 2005; 174: 1878-81.

Dr. Steven P. Petrou
*Professor of Urology, Associate Dean
Mayo School of Graduate Medical Education
Jacksonville, Florida, USA
E-mail: petrou.steven@mayo.edu*