men with prostate cancer in whom conservative management might be the preferred option. Men with worrisome clinical features in contrast might benefit from treatment that is more active.

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NEUROLOGY & FEMALE UROLOGY

Identification of risk factors for genital prolapse recurrence

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Aims: To assess the relationship between prolapse recurrence and some risk factors in a group of women submitted to reconstructive pelvic surgery.
Methods: Women referred to our Urogynaecological Units complaining of prolapse symptoms were prospectively included. We excluded women who were affected by apical vaginal prolapse > stage I after a previous hysterectomy. All women had pelvic surgery with traditional techniques without using grafts. Each woman was reassessed at 1, 6, and 12 months and then yearly postoperatively. We defined as prolapse recurrence a vaginal descent > or = II stage involving the operated compartments.
Results: A total of 360 consecutive women were recruited and submitted to vaginal reconstructive pelvic surgery. At a mean follow-up of 26 months, 36 women (10%) had a recurrent prolapse. A preoperative vaginal descent > or = III stage was the only significant risk factor for recurrence (P = 0.02, OR 2.4, 1.1-5.1 95% CI).
Conclusions: Women with prolapse > or = III stage had a significant higher risk of developing prolapse recurrence after surgical repair without grafts.

Editorial Comment

The authors review their population of females who underwent reconstructive vaginal surgery for pelvic prolapse. They excluded patients who had already had prolapse surgery or who had > stage II vaginal prolapse after previous hysterectomy. None of their patients had graft utilized in the reconstructive repair or had a synchronous concomitant anti-incontinence operation. The authors found that the only truly significant risk factor for recurrence of pelvic prolapse in their study was preoperative vaginal prolapse ≥ stage III.

An interesting study in that it treats a relatively pure population of patients who were treated for prolapse that had no previous anti-prolapse procedure performed, did not utilize any graft as part of the repair and did not have a synchronous anti-incontinence operation performed at the time of the surgery. The authors do self identify one of the weaknesses of this study in that they define recurrent prolapse as > stage II in the same operating vaginal compartment thus ignoring any potential vaginal vector shifts causing a production of prolapse in a separate compartment. That being said, I found it to be an excellent article of reference, which reviews classic pelvic floor reconstructions without potential complicating factors of graft material or concomitant anti-incontinence operations. Though current reports are highlighting the downside of graft materials, the

authors wisely point out that the use of graft in > stage III prolapse may be rewarding in view of the potential recurrence rates of same.

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The adjustable continence therapy system for recurrent female stress urinary incontinence: 1-year results of the North America Clinical Study Group

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Purpose: We determined the efficacy, safety, adjustability and technical feasibility of the adjustable continence therapy device (Uromedica, Plymouth, Minnesota) for the treatment of recurrent female stress urinary incontinence.
Materials and Methods: Female patients with recurrent stress urinary incontinence were enrolled in the study and a defined set of exclusionary criteria were followed. Baseline and regular follow-up tests to determine eligibility, and to measure subjective and objective improvement were performed. A trocar was passed fluoroscopically and with digital vaginal guidance to the urethrovesical junction through small incisions between the labia majora and minora. The adjustable continence therapy device was delivered and the balloons were filled with isotonic contrast. The injection ports for balloon inflation were placed in a subcutaneous pocket in each labia majora. Device adjustments were performed percutaneously in the clinic postoperatively. An approved investigational device exemption Food and Drug Administration protocol was followed to record all adverse events.
Results: A total of 162 subjects underwent implantation with 1 year of data available on 140. Mean Stamey score improved by 1 grade or more in 76.4% (107 of 140) of subjects. Improvement in the mean incontinence quality of life questionnaire score was noted at 36.5 to 70.7 ($p < 0.001$). Reductions in mean Urogenital Distress Inventory (60.3 to 33.4) and Incontinence Impact Questionnaire (54.4 to 23.4) scores also occurred ($p < 0.001$). Mean provocative pad weight decreased from 49.6 to 11.2 gm ($p < 0.001$). Of the patients 52% (67 of 130) were dry at 1 year (less than 2 gm on provocative pad weight testing) and 80% (102 of 126) were improved (greater than 50% reduction on provocative pad weight testing). Complications occurred in 24.4% (38 of 156) of patients. Explantation was required in 18.3% (28 of 153) of the patients during 1 year. In terms of the complications 96.0% were considered to be mild or moderate.
Conclusions: The Uromedica adjustable continence therapy device is an effective, simple, safe and minimally invasive treatment for recurrent female stress urinary incontinence. It can be easily adjusted percutaneously to enhance efficacy and complications are usually easily manageable. Explantation does not preclude later repeat implantation.

Editorial Comment

The authors describe a balloon system to provide support and urethral coaptation in those patients plagued with female stress incontinence. The authors describe a 52% dry rate at 1 year as well as an 80% im-