

## **MEditorial, March 2012**

### **“Equal Rights: Male Slings”**

Stress incontinence (urinary leakage, e.g., with sneezing and exercise) is a common condition, which in women, often arises without any antecedent surgery. Genetic predisposition, childbirth, and deteriorating muscle and tissue tone all play a role. For many years, surgical slings have been available to treat female stress incontinence. Originally, these often were taken from the woman's own abdominal wall fascia (muscle coating), placed between the urethra and vagina, and sutured into place with “permanent” sutures. Another iteration of “self” slings utilized an island of vaginal tissue separated from the rest and also requiring sutures. These were somewhat supplanted by tissue slings derived from purified cadaveric or animal (pig/cow) sources. Synthetic slings, mainly of polypropylene mesh, are now more commonplace and have had a good track record for 20 years with a 90+ % success rate and very low chances of erosion, infection, or chronic pain; need to remove these is a rare exception.

Men can develop urinary leakage from deterioration of the sphincter's neuromuscular function and more so if the prostate has undergone surgery, even a transurethral prostatectomy (TURP). More commonly, leakage is seen after radical prostatectomy (open or robotic) performed in an attempt to cure prostate cancer. Quoted incidence of post-radical prostatectomy incontinence is fewer than 4% but one Medicare-commissioned study (it should be said, done over 20 years ago when the open and robotic cancer operations were less technically sophisticated) said that up to 30% of men, more so those older than 70, having radical prostatectomy, complained of SOME degree of even minor leakage.

Until 10 years ago, treatments for this type of leakage, short of placement of an artificial urinary sphincter (AUS), were not all that successful. These included drugs, physical therapy and cystoscopic injections of bulking agents such as collagen into the sphincter area. Men and their urologists often rejected the

AUS operation, usually successful, as “overkill”. Furthermore as much of an advance as this prosthesis represents, it does have mechanical/hydraulic parts, can have “engineering” failures in the body, and requires a man capable of manipulating/operating the device. Some men, as they age, frankly become less competent to do so—and they cannot rely on their family members to figure this out and be constantly “available” to them.

AMS (American Medical Systems, Minnesota), a bioengineering leader in the development, among other devices, of innovative treatments for impotence and incontinence, has had male slings in their armamentarium for 10 years. I myself never got used to their InVance Male Sling, which required drilling multiple small screws to anchor a wide pyramidal-shaped piece of compressive mesh over the urethra as it courses in the perineum (space between scrotum and rectum). Their newer AdVance Male Sling, to me, is better and more akin to the female slings. In common with the female slings are the anatomical/surgical approach; use of a narrow ribbon-like piece of polypropylene mesh; lack of need for suturing or bone anchors; and nearly immediate “locking in” of the sling in an immovable position by the tissue through which it passes. The male sling is a bit more technically challenging than its female counterpart, requires a deeper incision to expose the urethra underneath one of the perineal muscles crossing it and freeing up of the curved part of the perineal (“bulbar”) urethra from a tethering tendon. The male sling both repositions the urethra upwards toward the natural sphincter area--and like the female sling, provides some support.

It takes me 30-45 minutes to do this procedure and many men can go home the same day without wearing a catheter; a small percentage without a catheter may need one subsequently inserted within the 1<sup>st</sup> 24 hours, for a few days. More prolonged “retention” of urine is uncommon--as is significant bleeding, infection, severe or chronic pain, or erosion of the sling into the urinary tract.

The Advance sling works best when (1) it is done by a technically astute urologist well versed in surgery on this part of the male anatomy; and (2) the “right” patient is selected. I usually decline to do the procedure on men either who have non-bothersome leakage or have major volumes of leakage usually

**needing diapers as opposed to pads and have "soaking" as opposed to dampness. Men with more than 2-diaper leakage per day should think about an artificial sphincter. Men who have had pelvic radiation (either as a primary or "clean-up" procedure) for prostate cancer may be too technically difficult to get a good result from a male sling (e.g., the sling may not be capable of pulling the urethra upwards). They too may want to consider having an AUS (also of @ least slightly higher failure risk in the post-irradiation setting).**

**The AdVance sling gives me a great intermediate tool for treating the majority of men who actually have a low degree of embarrassing leakage. Insurances and Medicare cover it; why not consider joining all the women out there with successful outcomes and throw away the pads and diapers for good!**

**Dr. Alan Freedman**

**401 Old Newport Blvd., Suite 101**

**Newport Beach, CA 92663**

**Phone: (949) 645-3434**

**FAX: (949) 645-0277**