

## Tension-Free Vaginal Tape Procedure Effective Long-Term for Urinary Incontinence

### OBJECTIVE

To evaluate the long-term cure rates and late complication rates after treatment of female urinary stress incontinence with the minimally invasive tension-free vaginal tape operation.

### METHODS

Prospective observational, 3-center cohort study originally of 90 women requiring surgical treatment for primary urinary stress incontinence. Assessment variables included a 24-hour pad weighing test, a stress test, visual analog scale for assessing the degree of bother, and a questionnaire assessing the subjective perception of the women on their continence status.

### RESULTS

The follow-up time was a mean of 91 months (range 78-100 months). Both objective and subjective cure rates were 81.3% for the 80 women available for follow-up. Asymptomatic pelvic

organ prolapse was found in 7.8%, de novo urge symptoms in 6.3%, and recurrent urinary tract infection in 7.5% of the women. No other long-term adverse effects of the procedure were detected.

### CONCLUSION

The tension-free vaginal tape procedure for treatment of female urinary stress incontinence is effective over a period of 7 years.

### LEVEL OF EVIDENCE

II-3.

### SOURCE

Nilsson CG, Falconer C, Rezapour M. Seven-Year Follow-up of the Tension-Free Vaginal Tape Procedure for Treatment of Urinary Incontinence. *Obstet Gynecol.* 2004 Dec;104(6):1259-62.

*(continued on page 7)*

### CCC EDITORIAL COMMENT

The Green Journal, Obstetrics and Gynecology, also presented 4 other articles\* on tension free vaginal tape (TVT) this month as this procedure is 'coming of age'. The Abstract above describes the 7 year success rate in a prospective 3-center study in 2 Nordic countries. The results were comparable to the Burch procedure. One other article describes a comparison with the laparoscopy Burch.

Of special note are the 3 articles on complications associated with the TVT procedure. This

procedure has a distinct learning curve. I suggest that providers seeking to add this procedure to their therapeutic armamentarium do so with a mentor, and follow their initial results in a department quality assurance project.

There are other tape related incontinence procedures that a provider might want to explore. ANMC had been an early adapter to TVT in Indian Health, plus has experience with other helpful new methods. Please contact me directly for questions on the ANMC experience.

### THIS MONTH

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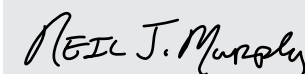
### ALSO ON LINE....

This publication is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter which is available on the Internet at

[www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm](http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm)

You welcome to subscribe to the listserv and receive reminders about this service. If you have any questions, please contact me at [nmurphy@scf.cc](mailto:nmurphy@scf.cc).

I am looking forward to hearing from you.



Dr. Neil Murphy  
Ob/Gyn Chief  
Clinical Consultant  
(OB/GYN C.C.C.)

# IHS Child Health Notes

## Dec 2004

### ARTICLES OF INTEREST

#### **Oral prednisolone in the acute management of children age 6 to 35 months with viral respiratory infection-induced lower airway disease: a randomized, placebo-controlled trial.**

*J Pediatr.* 2003 Dec;143(6):725-30.

- A 2 mg/kg dose of oral prednisolone given in the emergency department did not decrease the need for admission to the hospital for young children with viral respiratory infection induced wheezing.
- However, the above dose at emergency department presentation and continued for three days did decrease the severity and duration of symptoms and decreased the length of hospital stay.
- An accompanying editorial suggest that for steroids to be effective in bronchiolitis they need to be given early in the onset of disease to prevent airway inflammation.

#### **A randomized trial of a single dose of oral dexamethasone for mild croup.**

*N Engl J Med.* 2004 Sep 23;351(13):1306-13.

- It is known that dexamethasone is beneficial in severe croup. This study showed that oral dexamethasone was beneficial even in mild croup.
- Dexamethasone treated patients were only half as likely to need to be seen for a follow-up visit (7% versus 15%).
- The authors admit that the benefits per patient were small. However, they point out that the benefits may not be "small" to parents who had to make less return trips to the emergency room and whose children slept better.

### EDITORIAL COMMENT

When I was in residency the faculty spent a lot of energy making sure we didn't overuse steroids. Only patients who really had documented asthma should receive them. Perhaps we were trying too hard to convince ourselves. If only Jane Austen had been an attending.

The debate about how to best treat bronchiolitis is unlikely to end anytime soon. For hospitalized patients hydration and oxygen are the most important. Nebulized albuterol or epinephrine may benefit some subset of patients. Should all wheezing infants be treated with prednisolone? I don't think this paper definitively

answers that question. It does raise the issue that if patients are to be treated perhaps they need treatment early in the course of illness. Once there has been significant airway inflammation and desquamation steroids may not have much benefit.

However, the second paper extends the use of steroids for treating croup. There is good evidence to treat all patients with croup, mild to severe with steroids. In addition, the steroid may be given by mouth or by injection with equal results.

### RECENT LITERATURE ON AMERICAN INDIAN/ALASKAN NATIVE HEALTH

#### **Prevalence of dental caries among 7- and 13-year-old First Nations children, District of Manitoulin, Ontario.**

*J Can Dent Assoc.* 2004 Jun;70(6):382.

#### **Prevalence of early childhood caries among First Nations children, District of Manitoulin, Ontario.**

*Int J Paediatr Dent.* 2004 Mar;14(2):101-10.

- Two dental studies from First Nation children in Canada show that the caries rate is higher in Aboriginal children compared to the overall caries prevalence in Canadian children. This is similar to the finding in the U.S. in which American Indian and Alaskan Native children had a higher caries rate than the overall population.
- This raises the question of what factors make the caries rate higher in both of these populations? We know that caries are an infectious disease: We know from multiple studies that crowding, poverty and Strep mutans carriage rates in mothers are all risk factors. How much is diet a factor? Is there a genetic component?
- Despite the increase in caries in First Nations children the rates in Canada were not nearly as high in American Indian children. The average number of decayed, missing and filled surfaces (dmfs) in three year old Canadian Aboriginals was 7.5. In many tribes in the U.S. American Indian young children have a dmfs rate of 20. What factors make early childhood caries an even greater problem in U.S. native children compared with Canada?

The IHS Child Health Notes are available on the Internet at: [www.ihs.gov/MedicalPrograms/MCH/C/ChPedNotes.cfm](http://www.ihs.gov/MedicalPrograms/MCH/C/ChPedNotes.cfm)

Send comments and questions to Steve Holve, MD, Chief Clinical Consultant in Pediatrics at:

[sholve@tcimc.ihs.gov](mailto:sholve@tcimc.ihs.gov)

# From Your Colleagues

## ALAN WAXMAN, RETIRED IHS OB/GYN CCC

**Colposcopy training and recommendations for a level of training to obtain privileges and to maintain ones skills**

### **Certification?**

First, there is no “certification” for colposcopy.

The IHS has recommendations for initial colposcopy privileges (50 supervised exams) and ASCCP has its Mentorship program (25 exams—at least 3 high grade) with written examination. The ASCCP program is a training program that many practices use as de facto certification.

### **Maintenance of Privileges**

No one has established criteria for maintenance of privileges. When we set up the IHS program, we established 60 exams a year as a “reasonable” number to stay competent. Some providers can do fewer and remain competent, some would need to do more, but an average of 5 a month sounded reasonable. There is no data to support

one volume of experience over another.

As many ITU settings have a low volume of abnormal Paps, but geographic isolation justifies an on-site colposcopist, the IHS epidemiology program, with support from the CDC, has established a program of annual continuing colposcopy education with emphasis on small group case reviews and lots of images of high grade lesions.

I'd suggest that any non-OB/GYN provider should plan to come to the IHS Refresher course at least every other year to document competence.

The IHS offers both Basic IHS Colposcopy Workshops, and in alternating years, the IHS Advanced Colposcopy course/Refresher Workshops

### **This years course**

There will be an IHS colposcopy review on March 30 and April 1, 2005 in Albuquerque, New Mexico.

This is an ideal course for FPs, APNs, and OB/GYNs performing colposcopy.

## CAROL KOEBLE, ANCHORAGE

**New Perinatal HIV Hotline  
1-800-933-3413**

The National Perinatal HIV Consultation and Referral service also offers a Warmline and National Clinicians' Post-Exposure Prophylaxis Hotline.

The National Clinicians Consultation Center is a component of the AIDS Education and Training Centers (AETCs) program. The AIDS Education and Training Centers is a clinical resource for health care professionals, from the University of California, San Francisco at San Francisco General Hospital in partnership with Health Resources and Services Administration (HRSA), HIV/AIDS Bureau, and the Centers for Disease Control and Prevention (CDC).

*National HIV/AIDS Clinicians' Consultation Center*  
<http://www.ucsf.edu/hivcntr/>

## MARSHA TAHQUECHI, GALLUP

**How can I get those great ACOG materials when I am not a member of ACOG?**

ACOG has a special classification, Educational Affiliate Non-Physician, for any individual with an advanced degree who through professional training and/or experience in women's health care is able to further the missions of the College.

*Contact:*

*Bernice Rose, [brose@acog.org](mailto:brose@acog.org)  
(202) 863-2408 Fax: 202/479/0054*

## JAMES M. GALLOWAY, IHS CARDIOLOGY PROGRAM

Prevention of Cardiovascular Disease & Diabetes Among AI/AN

- May 16 - 19, 2005
- Denver, CO
- Co-sponsored by IHS, Joslin, ADA, NIH

## CHUCK NORTH, ALBUQUERQUE

Advances in Indian Health – Save the dates

- May 11-13, 2005
- Albuquerque, NM

Contact

[CNorth@abq.ihs.gov](mailto:CNorth@abq.ihs.gov)

## LAURA SHELBY, ALBUQUERQUE

New HPV web page is now available on CDC web site. The website contains information targeted to the general public, including an HPV Fact Sheet available in both English and Spanish and links to scientifically accurate HPV information on other credible websites.

[www.cdc.gov/std/hpv/](http://www.cdc.gov/std/hpv/)

# Hot Topics

## Obstetrics Child Health Gynecology

### OBSTETRICS

#### **IHS prenatal assessment form—ETOH, tobacco, substances, DV, other home issues**

This IHS form (for identifying potentially at risk women of childbearing age) is far superior to any form that is currently being used (e.g. CAGE) for this purpose. Aberdeen Area is implementing the form area wide. This may be a good activity for an FAS/D initiative—to go with the new GPRA indicator 11.

#### **Vaginal Delivery After Prior Cesarean Delivery May Have Low Absolute Risk**

**CONCLUSIONS:** A trial of labor after prior cesarean delivery is associated with a greater perinatal risk than is elective repeated cesarean delivery without labor, although absolute risks are low. This information is relevant for counseling women about their choices after a cesarean section.

Landon MB, et al *Maternal and perinatal outcomes associated with a trial of labor after prior cesarean delivery.* *N Engl J Med.* 2004 Dec 16;351(25):2581-9.

#### **Cesarean Risk and Labor Duration in Obese Mothers**

**CONCLUSION:** In nulliparous women undergoing labor induction, maternal weight was associated with a higher cesarean risk and longer labor and was inversely proportional to the cervical dilation rate.

**LEVEL OF EVIDENCE:** II-2

Nuthalapaty FS, Rouse DJ, Owen J. *The association of maternal weight with cesarean risk, labor duration, and cervical dilation rate during labor induction.* *Obstet Gynecol.* 2004 Mar;103(3):452-6.

### CHILD HEALTH

#### **Parents believe that they are not completely in control of their children's television**

If this is correct, parents would both welcome and benefit from tools and strategies that would help them exert more control over their children's television habits and reduce their hours of viewing. Christakis DA, Ebel BE, Rivara FP, et al. 2004. *Television, video, and computer game usage in children under 11 years of age.* *Journal of Pediatrics* 145(5):652-656.

#### **Teen contraceptive use has become more effective since 1995**

Adolescents in 2002 delayed first intercourse for longer than adolescents in 1995. -

Adolescents in 2002 used contraceptives more often than adolescents in 1995. -

Trends in sexual activity and contraceptive use as measured from 1995 through 2002 are consistent with the downward trend in pregnancies and births to adolescents that has been observed since 1991. NCHS Fact sheets available

#### **Exposure to even one cigarette raised the odds of future smoking**

Relatively small increases in the number of cigarettes consumed during childhood are associated with significantly higher odds of current, established, and daily smoking in adolescence.

Jackson C, Dickinson D. 2004. *Cigarette consumption during childhood and persistence of smoking through adolescence.* *Archives of Pediatrics and Adolescent Medicine* 158(11):1050-1056.

### GYNECOLOGY

#### **Health Care Seeking Among Urban Minority Adolescent Girls:**

##### **The Crisis at Sexual Debut**

Adolescent girls attempt to meet reproductive health needs within a context shaped by values of privacy and close mother-daughter relationships. Difficulty balancing these values often results in inadequate support and care.

McKee DA et al *Health Care Seeking Among Urban Minority Adolescent Girls: The Crisis at Sexual Debut* *Annals of Family Medicine* 2:549-554 (2004)

#### **Pelvic Floor Muscle Training Is Successful in Half of Patients Treated**

Pelvic floor muscle training is beneficial in one half of the patients who are treated in this manner. Two or more leakages per day at baseline and the chronic use of psychotropic medication significantly predicted therapy failure Cammu H, et al Who will benefit from pelvic floor muscle training for stress urinary incontinence?

*Am J Obstet Gynecol.* 2004 Oct;191(4):1152-7.

#### **Treatment of menorrhagia with Mirena™ vs endometrial resection**

**CONCLUSION:** Both treatments efficiently reduced menstrual bleeding. The high continuation rate suggests that the levonorgestrel intrauterine system is comparable with transcervical resection of the endometrium.

**LEVEL OF EVIDENCE:** I.

Rauramo I, Elo I, Istre O. *Long-term treatment of menorrhagia with levonorgestrel intrauterine system versus endometrial resection.*

*Obstet Gynecol.* 2004 Dec;104(6):1314-21.

## Family Planning

### DO COMBINATION CONTRACEPTIVES CAUSE WEIGHT GAIN?

**CONCLUSION:** Available evidence is insufficient to determine the effect of combination contraceptives on weight, but no large effect is evident. Gallo MF, Grimes DA, Schulz KF, Helmerhorst FM. Combination estrogen-progestin contraceptives and body weight: systematic review of randomized controlled trials.

*Obstet Gynecol. 2004 Feb;103(2):359-73.*

### OB/GYN CCC EDITORIAL COMMENT:

The worry about possible significant weight gain with combination oral contraceptives (OCP) use is a commonly articulated reason for patients not to use OCPs. The results can be associated with subsequent unintended pregnancy. Please share the above information from systematic review of randomized controlled trials with your patients.

## Ask a Librarian

### CHILDREN HAVING CHILDREN

The rate of 10-14 year old mothers has decreased again for American Indians according to the National Center for Health Statistics. For the latest recorded year, 2002, the rate was 2.1 per 1,000 females in that age group. In 2000, it was 2.7 and in 1999, it was 4.1. These rates are lower than for Hispanics (3.6 in 2002) and non-Hispanic black (4.7 in 2002). For all races the

2002 rate was 1.7. "American Indian" includes Aleuts and Eskimos. (National Vital Statistics Reports November 15, 2004)

Contact your Clinical Informationist - IHS, Diane Cooper [cooperd@mail.nih.gov](mailto:cooperd@mail.nih.gov)

*Diane Cooper is a Clinical IHS Informationist*

## American Family Physician

### PATIENT-ORIENTED EVIDENCE THAT MATTERS (POEMS)

Is Exercise an Effective Therapy for Menopausal Hot Flashes?

**CLINICAL QUESTION:** Is exercise an effective therapy for vasomotor symptoms in

postmenopausal women?

**BOTTOM LINE:** Exercise does not decrease vasomotor symptoms in postmenopausal women. Women should be encouraged to exercise, but not with the expectation that it will alleviate their hot flushes. (Level of Evidence: 1b) -

## Primary Care Discussion Forum

### FEBRUARY 1, 2005: SURGERY FOR OBESITY?

**Moderator: Hope Baluh**

**This discussion will ask:**

- Is it time for Obesity Surgery in the IHS?
- How are primary care providers addressing

the obesity epidemic now?

- Would non-surgical programs to address this issue be safer? easier? more effective?
- Cost effectiveness... what's cheaper? What about results?

To subscribe contact [nmurphy@scf.cc](mailto:nmurphy@scf.cc)

# ACOG

## INFORMED REFUSAL

Informed refusal is a fundamental component of the informed consent process. Informed consent laws have evolved to the “materiality or patient viewpoint” standard. A physician must disclose to the patient the risks, benefits, and alternatives that a reasonable person in the patient’s position would want to know to make an informed decision. Throughout this process, the patient’s autonomy, level of health literacy, and cultural background should be respected. The subsequent election by the patient to forgo an intervention that has been recommended by the physician constitutes informed refusal. Documentation of the informed refusal process is essential. It should include a notation that the need for the intervention, as well as risks, benefits, and alternatives to the intervention, and possible consequences of refusal, have been explained. The patient’s reason for refusal also should be documented.

*Informed refusal. ACOG Committee Opinion No. 306. American College of Obstetricians and Gynecologists. Obstet Gynecol 2004;104:1465–6.*

## CCC EDITORIAL COMMENT

Every Indian Health and tribal facility should have a vigorous program to document Informed Refusal with their patients. The document above outlines excellent basic tenets.

## ULTRASONOGRAPHY IN PREGNANCY

### Conclusions

- Ultrasound examination is an accurate method of determining gestational age, fetal number, viability, and placental location. Gestational age is most accurately determined in the first half of pregnancy.
- The ability of ultrasonography to diagnose major fetal anomalies is well established.
- The diagnosis of fetal growth abnormalities with ultrasonography is not precise.
- Ultrasonography is safe for the fetus when used appropriately.
- Specific indications are the best basis for the use of ultrasonography in pregnancy.
- The optimal timing for a single ultrasound examination in the absence of specific indications for a first-trimester examination is at 16–20 weeks of gestation.

### Summary of Recommendations

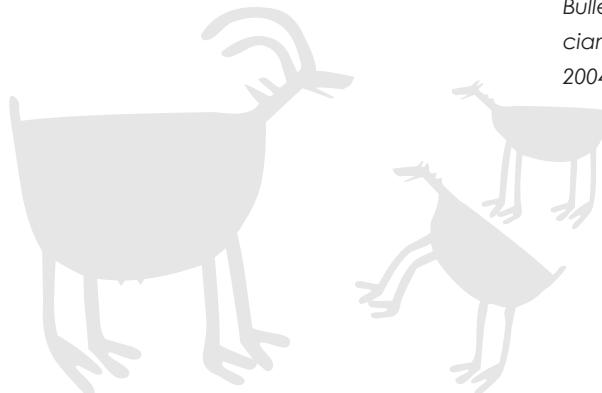
The following recommendation is based on limited or inconsistent scientific evidence (Level B):

- Serial ultrasonograms to determine the rate of growth should be obtained approximately every 2–4 weeks.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Casual use of ultrasonography, especially during pregnancy, should be avoided.
- Before an ultrasound examination is performed, patients should be counseled about the limitations of ultrasonography for diagnosis.

*Ultrasonography in pregnancy. ACOG Practice Bulletin No. 58. American College of Obstetricians and Gynecologists. Obstet Gynecol 2004;104:1449–58.*



## Midwives Corner

### NEW AVENUE TO SHARE MIDWIFERY IDEAS AND RESOURCES:

#### Starting January 2005

This new feature will begin in January 2005. The Midwives Corner will be a venue to share patient education resources, clinical guidelines, and midwifery ideas. Marsha Tahquechi at GIMC will coordinate regular midwifery input to the CCCC. Please contact Marsha Tahquechi at [Marsha.Tahquechi@ihs.gov](mailto:Marsha.Tahquechi@ihs.gov)

(continued from page 1)

### Tension-Free Vaginal Tape Procedure

#### Laparoscopic burch colposuspension versus TVT: a randomized trial.

**CONCLUSION:** The TVT procedure results in greater objective and subjective cure rates for urodynamic stress incontinence than does laparoscopic Burch colposuspension.  
**LEVEL OF EVIDENCE: I.**  
*Paraiso MF, et al. Laparoscopic burch colposuspension versus tension-free vaginal tape: a randomized trial. Obstet Gynecol. 2004 Dec;104(6):1249-58.*

#### Prevalence of persistent and de novo overactive bladder symptoms after the TVT.

**CONCLUSION:** The proportion of patients in whom de novo overactive bladder or urge incontinence symptoms developed postoperatively is

low, and approximately 57% of patients with preoperative overactive bladder symptoms can expect resolution of these symptoms after a TVT.

*Segal JL, et al. Prevalence of persistent and de novo overactive bladder symptoms after the tension-free vaginal tape. Obstet Gynecol. 2004 Dec;104(6):1263-9.*

#### Lateral excision of TVT for the treatment of iatrogenic urethral obstruction

**CONCLUSION:** Urethral obstruction after TVT is a relatively uncommon condition. It can be effectively treated with transvaginal lateral excision of the tape. Recurrent stress incontinence seems to be less likely to occur when the takedown procedure occurs

beyond 14 days after the initial TVT operation.

**LEVEL OF EVIDENCE: III.**  
*Long CY, et al. Lateral excision of tension-free vaginal tape for the treatment of iatrogenic urethral obstruction. Obstet Gynecol. 2004 Dec;104(6):1270-4.*

#### Necrotizing surgical site infection after tension-free vaginal tape.

**CONCLUSION:** This is the first case of necrotizing surgical site infection after TVT placement. Infectious morbidity risks need to be considered in these procedures.

*Connolly TP. Necrotizing surgical site infection after tension-free vaginal tape. Obstet Gynecol. 2004 Dec;104(6):1275-6.*

# Save The Dates

## 17TH ANNUAL IHS RESEARCH CONFERENCE

### International Meeting on Inuit and Native American Child Health

Innovations in clinical  
care and research

April 29-May 1, 2005

Seattle, WA

## START PLANNING NOW

**March 30 - April 1, 2005**

### **Albuquerque, New Mexico**

IHS Advanced Colposcopy course and Refresher Workshop.

Ideal for non-OB/GYN and OB/GYN performing colposcopy.

**Contact Roberta Paisano at (505) 248-4431**

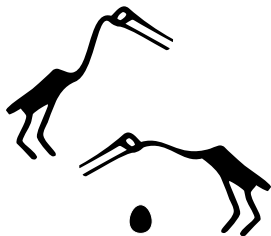
**June 19 - 23, 2005**

### **Denver, Colorado**

IHS / ACOG. Postgraduate Course: Obstetric, Neonatal, and Gynecologic Care.

The basics of all AI/AN women's health, plus a good update.

**Contact Yvonne Malloy at [YMalloy@acog.org](mailto:YMalloy@acog.org) or (202) 863-2580**



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### **From Your Colleagues**

Dr. Alan Waxman answers questions about colposcopy training and level of training and experience necessary to establish competence.

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ACOG

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