COMMENTARY

Importance of counseling and patient selection in treatment of male stress incontinence

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Utilizing device purchasing data as a surrogate, the authors report AdVance male sling (AS) and artificial urinary sphincter (AUS) utilization trends from 2007-2015. Accordingly, following a surge in AS utilization coinciding with market introduction, AS utilization relative to AUS has more recently decreased. The authors suggest that AS overutilization may have been seen following its introduction in 2007, with a trend toward AUS use being more recently observed in conjunction with further understanding of optimal patient selection criteria for AS.[1]

Indeed, patient selection when considering the surgical treatment of male stress urinary incontinence (SUI) is often complex. Early reports following AS introduction demonstrated efficacy and safety in a general patient population.[2] Given its minimally invasive quality, AS was not surprisingly popularized as a generalized treatment option for male SUI. With experience, however, it has become clear that patient selection is important to optimize outcomes following AS.

Foremost, numerous investigations demonstrate that patients with a history of pelvic radiation are suboptimal candidates for AS.[3,4] Further, multiple studies demonstrate AS to be more efficacious in patients with mild to moderate urinary incontinence, suggesting that AUS is preferable in patients with more significant SUI.[5] Finally, additional clinical findings such as detrusor overactivity and detrusor hypocontractility may be associated with poor outcomes.[6] The importance of patient selection is highlighted by Sturm and colleagues, who demonstrated superior outcomes following AS when comparing "ideal" and "nonideal" patients based on selection criteria described above.[7]

Nonetheless, there are several characteristics that make AS attractive to patients even though they may not be ideal candidates. Foremost, AS is a more minimally invasive option that does not require dynamic activation during voiding. AS is also associated with a lower complication rate.[8] Further, AUS placement is feasible after failed AS and even demonstrates similar outcomes to primary AUS.[9] This data is notable because, knowing that AUS is a viable secondary option, patients may choose AS even when counseled that they are suboptimal candidates. Anecdotally, I have found that when considering their surgical options, patients often ask whether AUS is possible in the event of AS failure and that additional factors as described above are often as important as SUI cure rate.

Combined, these data highlight the importance of patient education and the role physician counseling may have on treatment choice for male SUI. To provide optimal counseling, it is important that physicians are not only well informed about clinical outcomes but also patient preferences that also influence decision making. It will be interesting to follow comparative utilization of AS and AUS as I suspect many of these factors will continue to influence utilization trends moving forward. □

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