



SOUS LA PRÉSIDENTENCE DU DR LOÏC LE NORMAND

LA BAULE

PALAIS DES CONGRÈS

DU 16 AU 18 SEPTEMBRE 2015



L'urodynamique rentable pour la ou le patient ?

XAVIER FRITEL, POITIERS

Rentable : Qui produit un bénéfice

Avantages pour la santé

- ▶ Réduire les risques et complications liés à la pathologie sous-jacente
- ▶ Maximaliser le résultat du traitement
- ▶ Réduire les risques et complications liés traitement

Prédiction

- Informer le patient des risques liés au traitement ou à la pathologie

Risques pour la santé

- ▶ Anxiété liée à l'examen,
- ▶ Intolérance liée à l'examen,
- ▶ Complications liées à l'examen,
- ▶ Refus de l'examen,
- ▶ Retard de traitement

~~Valeur diagnostique du BUD~~

- ~~Non traitée~~



Sources

AUA/SUFU Guideline

**ADULT URODYNAMICS:
AUA/SUFU GUIDELINE**

J. Christian Winters, Roger R. Dmochowski, Howard B. Goldman, C.D. Anthony Herndon, Kathleen C. Kobashi, Stephen R. Kraus, Gary E. Lemack, Victor W. Nitti, Eric S. Rovner, Alan J. Wein

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 Authoritative decisions of peer-reviewed journals and editorial contributions appear at the end of the article.
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Purpose: This guideline is intended to review the literature regarding the use of urodynamic testing in common lower urinary tract symptoms (LUTS) conditions. It presents the principles of application and technique to guide the clinician in the role of urodynamics in complex LUTS disorders. As urodynamics is only one part of the comprehensive evaluation of LUTS, the findings of this guideline are intended to assist the clinician in the appropriate selection of urodynamic tests following an appropriate evaluation and symptom characterization.

Methods: A systematic review of the literature using the MEDLINE® and EMBASE® databases (search dates January 1, 1996 to March 10, 2011) was conducted to identify peer-reviewed publications relevant to the use of urodynamic tests for diagnosis, prognosis, guidance of clinical management decisions and improvement of patient outcomes in patients with various urologic conditions. The review yielded an evidence base of 393 studies after application of inclusion/exclusion criteria. These publications were used to inform the statements presented in the guideline as Standards, Recommendations or Options. When sufficient evidence existed, the body of evidence for a particular treatment was assigned a strength rating of A (high), B (moderate) or C (low). In the absence of sufficient evidence, additional information is provided as Clinical Principles and Expert Opinion.

Guideline Statements

Stress Urinary Incontinence (SUI)/Prolaps

1. Clinicians who are making the diagnosis of urodynamic stress incontinence should assess urethral function. (Recommendation; Evidence Strength: Grade C)
2. Surgeons considering invasive therapy in patients with SUI should assess post-void residual (PVR) urine volume. (Expert Opinion)
3. Clinicians may perform multi-channel urodynamics in patients with both symptoms and physical findings of stress incontinence who are considering invasive, palliative, medical or irreversible treatments. (Option; Evidence Strength: Grade C)
4. Clinicians should perform repeat stress testing with the urethral catheter removed in patients suspected of having SUI who do not demonstrate this finding with the catheter in place during urodynamics testing. (Recommendation; Evidence Strength: Grade C)
5. Clinicians should perform stress testing with reduction of the prolapse in women with high grade pelvic organ prolapse (POP) but without the symptoms of SUI. Multi-channel urodynamics with prolapse reduction may be used to assess for occult stress incontinence and detrusor dysfunction in these women with associated LUTS. (Option; Evidence Strength: Grade C)

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 Kurtz, Ph.D., for his methodological expertise and assistance with literature review, analysis and documentation.

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Guidelines on Urinary Incontinence

M.G. Lucas (Chair), D. Bedretdinova (Guidelines Associate), L.C. Berghmans, J.L.H.R. Bosch, F.C. Burkhard, F. Cruz, A.K. Nambiar, C.G. Nilsson, A. Tubaro, R.S. Pickard

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AUGS
 Advancing Female Pelvic Medicine and Reconstructive Surgery

COMMITTEE OPINION

Number 302 • June 2014

Committee on Gynecologic Practice
 American Gynecologic Society

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Evaluation of Uncomplicated Stress Urinary Incontinence in Women Before Surgical Treatment

ABSTRACT: Stress urinary incontinence (SUI) is a condition of involuntary loss of urine on effort, physical exertion, sneezing, or coughing that is often bothersome to the patient and frequently affects quality of life. When women are evaluated for SUI, counseling about treatment should begin with conservative options. The minimum evaluation before primary midurethral sling surgery in women with symptoms of SUI includes the following six steps: 1) history, 2) uroanalysis, 3) physical examination, 4) demonstration of stress incontinence, 5) assessment of urethral mobility, and 6) measurement of postvoid residual urine volume. For women with uncomplicated SUI in whom conservative treatment has failed and who desire midurethral sling surgery, evidence indicates that the performance of preoperative multichannel urodynamics testing versus a basic evaluation does not affect treatment outcomes. However, women who have complicated SUI may benefit from multichannel urodynamics testing and other diagnostic tests before initiation of treatment, especially surgery. Clinical judgment should guide the health care provider's decision to perform preoperative multichannel urodynamics testing or to refer to a specialist with appropriate training and experience in female pelvic medicine and reconstructive surgery.

Stress urinary incontinence (SUI) is a condition of involuntary loss of urine on effort, physical exertion, sneezing, or coughing that is often bothersome to the patient and frequently affects quality of life. It is estimated to affect 15.7% of adult women (1). Among women with SUI, 72.2% report their symptoms to be bothersome, and of this group 26.8% report their symptoms to be moderately to extremely bothersome; the degree of bother is associated with the severity of SUI (2).

Treatment options for SUI range from conservative to surgical. Conservative options include pelvic muscle exercises with or without physical therapy, behavioral modification, continence-support pessaries, and urethral inserts (3). In 2010, approximately 260,000 women in the United States underwent surgical treatment of SUI (4). Surgical treatment options include anti-incontinence procedures, such as retropubic urethropexy, midurethral (cylindrical, urethral bulking agents, and synthetic midurethral slings. An evaluation of symptoms of SUI needs to be completed before performing surgery. In this joint document, the American College of Obstetricians and Gynecologists (the College) and the American Urological Association provide recommendations for the basic evaluation of a patient with symptoms of uncomplicated SUI (1) before primary surgical repair with a midurethral sling.

Basic Evaluation of Stress Urinary Incontinence

When women are evaluated for SUI, counseling about treatment should begin with conservative options. The minimum evaluation before primary midurethral sling surgery in women with symptoms of SUI includes the following six steps: 1) history, 2) uroanalysis, 3) physical examination, 4) demonstration of stress incontinence, 5) assessment of urethral mobility, and 6) measurement of postvoid residual urine volume.

History

The purpose of history taking is to determine the type of urinary incontinence (UI) that is bothersome to the patient. Urinary incontinence is commonly classified

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INCONTINENCE

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5th International Consultation on Incontinence, Paris February, 2012

5th EDITION 2013

ICUD

Recommandations pour la pratique clinique

Diagnostic et prise en charge de l'incontinence urinaire de la femme adulte

Élaborées par le Collège national des gynécologues et obstétriciens français

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Synthèse des recommandations pour le traitement de l'incontinence urinaire féminine non neurologique

Synthesis of the guidelines for the treatment of non-neurological urinary incontinence in women

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MOTS CLÉS
 Incontinence urinaire ; Traitement médical ; Traitement chirurgical

KEYWORDS
 Urinary incontinence; Medical treatment; Surgical treatment

Resumé
 Ces deux dernières décennies ont permis de voir apparaître de nouveaux traitements médicaux ou chirurgicaux modifiant la prise en charge de l'incontinence urinaire féminine non neurologique. De nombreuses études ont permis d'établir des recommandations, avec des niveaux de confiance, et permis de valider les bases cliniques thérapeutiques en dehors des effets de mode et des pressions commerciales. L'Association Française d'Urologie, par le biais de son Comité d'Urologie et de Pelvipériologie de la Femme, propose ses recommandations. Cette-ci est ainsi établie par un groupe d'experts des spécialités concernées (Urologie, Gynécologie, Radiobiologie), à partir d'une revue de la littérature, mais en tenant compte des pratiques quotidiennes universitaires et hospitalières. Extra Evidence Base Analysis et comité de travail, ses recommandations ont été proposées des attitudes validées et applicables.
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Summary
 The last two decades have brought about new medical and surgical treatments revolutionizing care for non-neurological urinary incontinence in women. Many studies, often randomized prospective studies with sufficient follow-up, have validated therapeutic choices and shown them not to be part of a fad or marketing pressure. The French Association of Urology (L'Association Française d'Urologie, through its Committee on Women's Urology and Pelvipériology (Comité d'Urologie et de Pelvipériologie de la Femme) proposes its recommendations. This is thus established by a group of experts of the specialties concerned (Urology, Gynecology, Radiobiology), starting from a review of the literature, but taking into account daily university and hospital practices. Extra Evidence Base Analysis and committee of work, its recommendations have been proposed as validated attitudes and applicable.
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Chez la femme ?

Profil urétral (PMCU, VLPP)

Prédiction

- ▶ Pas de valeur prédictive pour le traitement par rééducation [NP3 : Rosier ICI 2013]
- ▶ Valeur prédictive controversée pour le succès de la chirurgie de l'IUE de la femme [NP3 : Rosier ICI 2013]
- ▶ Une PCMU faible est un facteur de risque d'urgenturie après BSU [NP3 : Houwert AmJOG 2009, Gamble AmJOG 2008, Lee IUGJ 2013]
- ▶ Pas de valeur prédictive pour l'IU après chirurgie du prolapsus [NP3 : Rosier ICI 2013]

Avantage

- ▶ Meilleurs résultats de la BSU-RP en cas d'IS comparée à la BSU-TO [NP1 : Schierlitz OG 2012]
- ▶ N'apporte pas de bénéfice dans le cadre de la chirurgie de l'IUE non-complexe de la femme [NP1 : Nager NEJM 2012, van Leijsen OG 2013 ; Clement Cochrane 2013]

Chez la femme ?

Remplissage vésical (CNI du détrusor)

Prédiction

- ▶ Pas de valeur prédictive pour le traitement médical du syndrome d'hyperactivité vésicale (HAV) idiopathique de la femme [NP3 : Rosier ICI 2013]
- ▶ Plus d'échec (40 vs 19%) des BSU pour IUE chez la femme si instabilité du détrusor [NP3 : Houwert AmJOG 2009; EAU 2015]

Avantage

- ▶ N'apporte pas de bénéfice dans le cadre de la chirurgie de l'IUE non-complexe de la femme [NP1 : Nager NEJM 2012, van Leijsen OG 2013 ; Clement Cochrane 2013]
- ▶ Absence de données pour l'HAV idiopathique de la femme

Chez la femme ?

Vidange (débitmétrie, pression/débit)

Prédiction

- ▶ Un débit préopératoire faible serait prédictif du risque de dysurie après BSU [NP3 : Hong JU 2003]

Avantage / Risque

- ▶ Non invasif
- ▶ Non étudié de manière spécifique

Chez la femme ?

BUD avant chirurgie, essai randomisé # 1

Méthodes

- ▶ IUE non complexe opérée
 - ▶ IUE prédominante
 - ▶ Mobilité urétrale
 - ▶ Test à la toux positif
 - ▶ Résidu <150 ml
- ▶ Un groupe avec BUD préopératoire et un groupe sans

Résultats

- ▶ 630 femmes incluses, 586 opérées, 93% de BSU
- ▶ A 12 mois : Succès identique (77%)
- ▶ Aucune autre différence (effets secondaires, satisfaction, qualité de vie, etc.)

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

A Randomized Trial of Urodynamic Testing before Stress-Incontinence Surgery

Charles W. Nager, M.D., Linda Brubaker, M.D., Heather J. Litman, Ph.D.,
de TOULOUSE

Chez la femme ?

BUD avant chirurgie, essai randomisé #2

Méthodes

- ▶ IUE non-complexe prédominante
- ▶ BUD systématique
- ▶ Tirage au sort en cas de BUD discordant avec la clinique
 - ▶ Un groupe avec chirurgie (BSU) sans tenir compte du BUD
 - ▶ Un groupe avec traitement spécifique adapté à la pathologie mise en évidence par le BUD

Résultats

- ▶ 46% de BUD discordants (268 femmes)
- ▶ 126 femmes randomisées
- ▶ A 12 mois : Succès identique (74 vs 75%),
la majorité sont opérées (97 vs 98%)
- ▶ Aucune autre différence

Value of Urodynamics Before Stress Urinary Incontinence Surgery

A Randomized Controlled Trial

Sanne Adriana Lucia van Leijsen, MD, PhD, Kirsten B. Kluivers, MD, PhD, Ben Willem J. Mol, MD, PhD,

Chez le patient neurologique ?

Prédiction

- ▶ Les hautes pressions vésicales mettent en danger la fonction rénale [NP3 : MacGuire JU 1981]
- ▶ Un résidu élevé est prédictif du risque d'infection [NP3 : Dromerick APMR 2003]
- ▶ Peu ou pas de données sur la prédiction
 - de la réponse thérapeutique ou
 - des modalités de surveillance [Rosier ICI 2013]

Avantage / Risque

- ▶ Absence de données comparatives (fréquence, modalités du BUD) sur les avantages apportés [Rosier ICI 2013]

Chez l'homme ?

Prédiction

- ▶ Pas de valeur prédictive pour le traitement médical du syndrome d'hyperactivité vésicale de l'homme [NP3 : Rosier ICI 2013]
- ▶ Pas de valeur prédictive pour la continence après RTU [NP3 : Rosier ICI 2013]
Valeur prédictive pour le résultat sur l'obstruction : si CNI préopératoire plus d'amélioration des symptômes d'obstruction après laser [NP3: Cho Urol 2010]
- ▶ Pas de valeur prédictive pour la continence après prostatectomie radicale ou radiothérapie [NP3 : Rosier ICI 2013 ; NP4 : EAU 2015]

Avantage

- ▶ Absence de données

Chez le sujet âgé ?

Prédiction

- ▶ Pas de valeur prédictive de la MUCP avant BSU [Sevestre EurUrol 2003]

Avantage / Risque


- ▶ Absence de données sur les effets secondaires ou les complications du BUD chez le sujet âgé [Rosier ICI 2013]

Résumé

Recommendations	GR
(NB: Concerning only neurologically intact adults with urinary incontinence)	
Clinicians carrying out urodynamics in patients with urinary incontinence should: <ul style="list-style-type: none"> • Ensure that the test replicates the patient's symptoms. • Interpret results in the context of the clinical problem. • Check recordings for quality control. • Remember there may be physiological variability within the same individual. 	C
Advise patients that the results of urodynamics may be useful in discussing treatment options, although there is limited evidence that performing urodynamics will predict the outcome of treatment for urinary incontinence.	C
Do not routinely carry out urodynamics when offering conservative treatment for urinary incontinence.	B
Perform urodynamics if the findings may change the choice of invasive treatment.	B
Do not use urethral pressure profilometry or leak point pressure to grade severity of incontinence or predict the outcome of treatment.	C
Urodynamic practitioners should adhere to the standards laid out in the ICS document "Good Urodynamic Practice" [80].	C

Guidelines on Urinary Incontinence

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Conclusion

- ▶ Le bilan urodynamique est utilisé comme aide au diagnostic et aide à la décision thérapeutique
- ▶ Il doit être interprété en fonction de la clinique
- ▶ Le bénéfice apporté par le BUD comparé à la clinique seule reste incertain
- ▶ Il est urgent de travailler sur le bénéfice apporté au patient par le BUD