VOIDING DYSFUNCTION—either difficulty voiding or urinary retention—after surgery for stress incontinence distresses the patient and challenges the surgeon. Here is our systematic approach to evaluating and managing such cases.

**What does the operative note say?**
Determine exactly what operation the patient underwent and whether appropriate steps were taken during surgery to evaluate the lower urinary tract. Remember: There are well over 30 different synthetic midurethral slings on the market; a variety of biologic materials are used for slings; and conventional suspension procedures are still being performed. Sling composition and surgical technique are the major determinants of subsequent treatment, so it is imperative to obtain the operative note.

**Are symptoms consistent with expected outcome?**
In the case of a patient who had a large cystocele repair in conjunction with an anti-incontinence procedure, for example, it is common for some form of retention or voiding dysfunction to be present for 2 weeks or longer. On the other hand, if a patient had a synthetic midurethral sling but no other procedure, it is highly unlikely, during a normal postoperative course, that she would be in retention 2 weeks after the procedure—unless the sling was placed too tightly.

**Is there actual (or impending) lower-tract injury?**
Foreign body penetration? Good endoscopic evaluation, with visualization of the urethra, of the vesical neck and anterolateral walls of the bladder, will answer these questions.

**Is intermittent self-catheterization an option?**
If the patient has an indwelling catheter—of any type—remove it whenever possible and teach her intermittent self-catheterization.

**What is the condition of the pelvic floor?**
Make certain that the patient has the ability to appropriately relax the pelvic floor when she attempts to void.
FOSAMAX® (alendronate sodium) for either two or three years. In these studies the overall safety profiles of FOSAMAX® 5 mg/day (n=642) and placebo (n=484) were similar. Discontinuation of therapy due to any clinical adverse experience occurred in 7.5% of 642 patients treated with FOSAMAX® 5 mg/day and 5.7% of 649 patients treated with placebo. In a one-year, double-blind, multinational study, the overall safety and tolerability profiles of once-weekly FOSAMAX® 5 mg/day or placebo for the two- or three-year studies were gastriocutaneous dyspepsia 1.9% and 1.4%, abdominal pain 1.7% and 3.4%, acid regurgitation 1.1% and 2.5%, nausea 1.4% and 1.4%, diarrhea 1.1% and 1.7%, constipation 0.9% and 0.5%, abdominal distension 0.2% and 0.3%, and Musculoskeletal musculoskeletal (bone, muscle or joint) pain 0.6% and 0.3%, respectively. For the one-year study with FOSAMAX® 5 mg/day and once-weekly FOSAMAX® 5 mg/day, corresponding values were gastriocutaneous dyspepsia 2.2% and 1.7%, abdominal pain 4.2% and 2.2%, acid regurgitation 4.2% and 4.7%, nausea 2.5% and 1.4%, diarrhea 1.1% and 0.8%, constipation 1.7% and 0.3%, abdominal distension 1.4% and 1.1%, and Musculoskeletal musculoskeletal (bone, muscle or joint) pain 1.9% and 2.2%, respectively.

Treatment of glucocorticoid-induced osteoporosis. In two, one-year, placebo-controlled, double-blind, multinational studies in patients receiving glucocorticoid treatment, the overall safety and tolerability profiles of FOSAMAX® 5 and 10 mg/day were generally similar to that of placebo. The adverse experiences considered by the investigators as possibly, probably, or definitely drug-related in 1% of patients treated with either FOSAMAX® 5 mg/day (n=161) or FOSAMAX® 10 mg/day (n=157) or placebo (n=158) were gastriocutaneous abdominal pain 1.9%, 2.2% and 0.0%, acid regurgitation 1.9%, 2.5% and 1.3%, constipation 0.6%, 1.3% and 0.0%, melena 0.0%, 0.0% and 0.5%, nausea 1.2%, 0.6% and 0.0%, diarrhea 0.0%, 0.0% and 1.3%, and Nervous System Psychiatric headache 0.0%, 0.6%, and 1.3%, respectively. The overall safety and tolerability profile in the glucocorticoid-induced osteoporosis population that continued therapy for the second year of the studies (FOSAMAX® n=147) was consistent with that observed in the first year. Paget's disease of bone. In clinical studies (osteoporosis and Paget's disease), adverse experiences reported in 175 patients taking FOSAMAX® 40 mg/day for 3-12 months were similar to those in postmenopausal women treated with FOSAMAX® 10 mg/day. However, there was an apparent increased incidence of upper gastrointestinal adverse experiences in patients taking FOSAMAX® 40 mg/day (17.7% FOSAMAX® vs. 10.2% placebo). One case of esophageal and two cases of gastritis resulted in discontinuation of treatment. Additionally, musculoskeletal (bone, muscle or joint) pain, which has been described in patients with Paget's disease treated with other bisphosphonates, was considered by the investigators as possibly, probably, or definitely drug-related in approximately 6% of patients treated with FOSAMAX® 40 mg/day versus approximately 3% of patients treated with placebo. All adverse experiences in patients treated with placebo. However, the incidences of decreases in serum calcium to ≤2.0 mg/dL (50 μmol/L) were 0.6% and 0.3% in patients treated with FOSAMAX® 40 mg/day and 2.4% of patients treated with placebo. Laboratory Test Findings — In double-blind, multicenter, controlled studies, asymptomatic, mild, or transient decreases in serum calcium and phospho-

Is urethral dilatation or medication an option? We believe that urethral dilatation is contraindicated because it might cause urethral erosion of the sling. It is also generally ineffective.

No pharmaceutical agent hastens the return of voiding. Cholinergic agents such as bethanechol are ineffective and cause considerable discomfort. Some experts recommend empiric diapedazem (Valium) for patients who are unable to relax sufficiently.

Will intervention succeed? Ultimately, you and the patient must agree on whether urethral erosion is to be performed or whether the suburethral sling or tape should be cut. Undertake a detailed discussion with her about the potential for, first, persistent voiding dysfunction and, second, recurrent stress incontinence. Cutting a synthetic, allograft, xenograft, or autologous sling will almost always result in resumption of normal voiding, provided the sling is appropriately detached from the urethra and there were no preoperative voiding symptoms. With synthetic, allograft, and xenograft slings, stress incontinence recurs in at least 50% of patients over time. With an autologous sling, the recurrence rate of stress incontinence is less than 10%.

Is it time to operate? When urinary retention after a sling repair procedure is believed to be caused by obstruction, consider surgery within a few weeks. For a patient in retention who has an autologous, allograft, or xenograft sling, it is best to wait approximately 3 months before operating.

Be aware of the risk of failure! Takedowns of Burch and Marshall-Marchetti operations are much more technically challenging, and yield a much lower success rate, than take-downs of sling procedures. No matter what the prior operation, there is a risk of recurrent sphincteric incontinence. •