was still requiring self-catheterizing 4.5 years after the PVS. A second patient required self-catheterization for de novo voiding dysfunction but was dry.

Overall, 71% (5/7) of women were completely cured and 86% (6/7) were satisfied. The rate of de novo OAB in women with a stable bladder preoperatively was 80% (4/5). One woman, with a history of known thrombophilia, suffered a large pulmonary embolus on postoperative day 12 but recovered fully.

We agree with the comments of Steele that autologous PVS still has a role as a salvage procedure in complex recurrent female SUI. We found that PVS was associated with a low failure rate, but a high rate of de novo OAB at 5 years in a small population of women with previous failed synthetic MUS. Although the case of pulmonary embolus in our population raises some concern, previous work from the Urinary Incontinence Treatment Network reported a low rate (0.3%) of venous thromboembolism after PVS, which is reassuring.[5]

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Correspondence: Professor Kate Moore, Pitney Clinical Sciences Building, St. George Hospital, Kogarah, Sydney, NSW 2217, Australia; k.moore@unsw.edu.au

The role of the surgeon in managing patients with midurethral slings: Response

Blayne Welk, MD, FRCSC, MSc

Assistant Professor, Division of Urology, Western University, London, ON

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There is currently little evidence available to guide surgeons on the management of a patient with a failed midurethral sling.[1] The reported results by Walsh and colleagues suggest a pubovaginal sling is effective at treating stress incontinence after a failed midurethral sling.[2] In our cohort of patients,[3] 16/33 had a previous midurethral sling, and half of these had experienced a vaginal or urethral erosion. The subset of patients who had recurrent incontinence after a previous midurethral sling showed a trend towards better outcomes compared patients undergoing a pubovaginal sling for other reasons, (median 0 (interquartile range [IQR]: 0-3) versus median 3 (IQR: 1-5) pads per day, $p = 0.12$).

The management of patients who have failed a midurethral sling or suffered significant complications from one will continue to be challenging. The autologous fascia pubovaginal sling continues to have a role in the management of patients with complex stress incontinence.

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Correspondence: Dr. Blayne Welk, Division of Urology, Western University, Room B4-667, St Joseph's Health Care, 268 Grosvenor St., London ON N6A 4V2; fax: 519-646-6037; bkwelk@gmail.com