**To the NUGA board before the meeting in Copenhagen, January 2019**

It is now 10 years since I left position as Swedish representant in the NUGA board. The years before had been filled, first by the overwhelming paradigm shift in treatment of SUI by the worldwide introduction of the midurethral tensionfree support 1996. In a few years after the introduction of the TVT the old, much more invasive procedures with less good results and more complications were gone.

We have since then faced new challenges, not with the overall results worldwide with a cure rate/satisfied patient of unbelievably 85% in around 3,5 million procedures for this office procedure, but with the need for more careful selection of the right patients and for adopting strategies to avoid surgery for the wrong patient. I have scrutinized medical journals from many centers with patients with late effects, attributed to the use of mesh, where I have been able to show incorrectness in choice of patient, doctor, and also incompetent surgery. This is an unfortunate “side effect” when you introduce a brilliant new technique without necessary regulations from responsible authorities. This is the real challenge that calls for more centralization, better training programs and responsible mentorship where international associations, like the NUGA, have an important role to play. Can we handle this we have a bright future as we have the much better tools today than we had before.

This is true also for pelvic floor insufficiency where we gradually understood, through multinational research programs involving 50 centers in all the Nordic countries, that artificial support is for restoring anatomy with minimal amount of mesh, like the TVT procedure, instead of covering of defects.

So, I red the program for the NUGA meeting in Copenhagen in January 2019 with great expectations to see how these challenges were met. Instead I found myself returned some 40 years in life to the anxious time when I was a young junior doctor fighting with difficult procedures with unpredictable outcomes, lousy results and many complications. This was in fact the reason for me to later start a research program on connective tissue deficiencies associated with stress urinary incontinence.

I thought that Paul Hilton finally closed the door for the Burch procedure when he was forced to close down the famous comparative study in between the TVT procedure and the Burch procedure because the patients after a while refused to participate because of the risk of being assigned to the Burch. The autologous sling procedures are even older – before my time. Abandoned because of high rate of adverse effects, no long term results, not cost effective, but above all: extensive surgery of a kind I don´t think modern women will tolerate. Is there any surgical procedure without complications? What will happen when clinics revert to performing abdominal Burch procedures on a large scale? We will then have to start to discuss mortality rates, not morbidity rates. How many women will be offered uneffective, cost-ineffective repeat procedures with low chance of cure or no treatment at all? Is this the situation we want?

I´m also surprised to see a headline saying: “Urethral bulking – should it be first line treatment? The answer is: No. Bulking agents have been in use for almost 100 years. As you can confirm from Cochrane almost everything you inject, water, fat, macroplastique and so on have some, short term, effect. For the moment polyacrylamide seems to be the most popular bulking agent. The working principle rely on narrowing the urethra lumen moderately – not too much, not too little. Then you will have fairly good results, most often for a couple of months, sometimes a little longer for approximately 50% of the patients. Cure rates with the Bulkamid procedure is close to nil. This should be an option for patients not suitable for TVT, as it cannot produce the anatomical support necessary for curing the hypermobile urethra. I´m convinced Abdul Sultan, very much respected in Sweden for his educational contribution in how to take care of sphincter injuries after delivery, knows this, but for some reason chooses to disregard facts.

My final words are that I think the NUGA board, and advisors, are on the wrong way in trying to dig up pre-historic, unsafe procedures instead of refining the paradigm shift we introduced in 1996. Instead I would encourage you, in line with AUGS/IUGA efforts, to support training programs, introduce registers and strategies for inspections to follow up centers not to deviate from choosing the right patients, and to see that doctors execute the procedure, on regular basis, according to “the cook book”. Also, the macroporous polypropylene mesh may be the best available we have today, but other materials, like polyvinylidene fluoride (PVDF) are under study, so I suggest NUGA to follow the ongoing research closely.

I see no point in coming to the meeting this time, but please feel free to read this letter out to the audience at an appropriate occasion if you will - even if I doubt it will happen.

Happy New Year to you all,

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