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had been able to identify those patients who had prior AUS with reasons for previous explant, but the retrospective nature of this series did not allow this. In addition, there is a clear distinction between patients with persistent vs recurrent incontinence which was not evaluated in this series. Persistent incontinence indicates a possible cuff sizing issue, while recurrent incontinence is more consistent with a device malfunction, eg, like a PRB losing pressure. In general, all surgeons in this arena could benefit from a better systematic way to trouble-shoot the AUS and especially assess for urethral atrophy. Cystoscopic inspection can be fraught with uncertainty in some cases and the premise of this manuscript is upregulating the PRB is effective when urethral atrophy has not occurred. Finally, some continued sobering reminders that irradiated patients have a higher risk of erosion and in fact constituted the 3 erosions seen in this cohort.

While AUS implanters all experience the considerable satisfaction of allowing patients to regain their quality of life when these devices work well, there is nothing more frustrating than a patient who redevelops leakage and is unable to be salvaged satisfactorily. These authors should be congratulated for adding to our understanding of possible interventions to assist men whose incontinence returns after AUS placement. Ultimately, perhaps the most honest advice we should disseminate to men is that while AUS remains the best modality in our surgical armamentarium, future revisions remain a high likelihood. Therefore, like so many purchases, caveat emptor.

Gregory T. Bales, Section of Urology, University of Chicago Hospitals, Chicago, IL

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EDITORIAL COMMENT



The paper above adds to the growing body of evidence that the pressure regulating balloon (PRB) of the artificial urinary sphincter (AUS) system plays a critical role in controlling and effecting continence rates. Many urologists who perform AUS insertion feel that the pressure generated from the PRB can be inconsistent and there is a real need for future investigations to evaluate PRBs with a manometer to better analyze pressures. Perhaps these authors will prospectively assess this in future patients to better pinpoint revision approach. Also, there are many instances when performing an AUS revision that there is fluid loss in the PRB without any discernible evidence of leak from any of the components. This presents a conundrum to clinicians and frequently necessities compete revision with an entire new AUS system. Regardless, the results of this small series suggest that improved continence rates can be obtained by switching the 61-70 cm H₂O pressure PRB to a 71-80 cm H₂O pressure in select situations. The obvious advantage to this revision technique is it greatly simplifies the procedure by avoiding urethral dissection and allows patients to immediately reactivate the device, because there will be no scrotal swelling associated with the new placement of a pump. It would have been helpful if the authors

AUTHOR REPLY



Thank you for the insightful feedback on our study evaluating exchange of the artificial urinary sphincter (AUS) pressure regulating balloon. We agree it would be beneficial to know more of the details regarding the nature of incontinence (recurrent vs persistent) and the etiologies of the prior AUS explants, which was not obtained in 64% of the cohort. Of note, however, there was no significant difference in erosion rates, perhaps the most morbid outcome, between those with a prior AUS implant/explant and those who underwent pressure regulating balloon exchange with a virgin AUS. Further, it is important to emphasize that this procedure is beneficial in a very select cohort, ideally the nonirradiated patient with pure stress incontinence lacking urethral atrophy. Despite the efficacy demonstrated by our study, there is certainly a need for multi-institutional, prospective studies evaluating this management option for post AUS incontinence.

Rachel A. Moses, Sorena Keihani, James R. Craig, Jacob Basilius, James M. Hotaling, Sara M. Lenherr, William O. Brant, Jeremy B. Myers, University of Utah, Salt Lake City, UT; Veterans Affairs Medical Center, Salt Lake City, UT

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