are significantly correlated to the underactive detrusor in EDS patients with or without OT. Can we explain this by the conjunctive tissue modification due to EDS? There is a strong correlation between underactive detrusor, respectively PVR and OT. So we can’t conclude to any LUTS specific to EDS.

Conclusion. Dysuria and PVR are frequent in EDS but strongly correlated with the OT.

Further reading

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Long-term follow-up and failure predictors of Botox® 300 UI injections in the treatment of neurogenic detrusor overactivity (NDO)

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Keywords: Intravesical botulinum toxin; Neurogenic detrusor overactivity

Objective. To determine in daily practice, the failure rate of treatment with Botox®, 300UI of NDO and analyze the causes of failure and their predictors.

Method. Retrospective (2002–2011) monocentric study of patients with overactive bladder, treated with 300 IU Botox® and self-catheterized. The evaluation criteria were clinical, urodynamic and ultrasound. The time to occurrence of failures was estimated by the Kaplan Meir. Groups were compared by the log rank test and Cox model.

Results. One hundred and eighty-three patients were included (165 SCI, 18 multiple sclerosis (MS)). At 3 years, 152 patients continued injections of intravesical botulinum toxin (83%) and 138 patients after 5 years (75.4%). We differentiated the true failures (32 patients), from discontinuation of treatment for side effects, poor tolerance of injections or neurological outcome. In the group of MS, there was only one true failure, other patients discontinued treatment for other reasons, including the worsening of the disease. In the group of patients who failed treatment, we find significantly in univariate analysis:

– leakages after first injection, at 3 years (p < 0.0001) and at 5 years (p < 0.0001);
– presence of febrile urinary tract infection after 1st injection, at 3 years (p = 0.01);
– existence of detrusor overactivity after first injection, at 3 years (p = 0.05);
– poor compliance before first injection, at 5 years (p = 0.04);
– maximum detrusor pressure after first injection, at 3 years (p = 0.005) and at 5 years (p = 0.0004).

In multivariate analysis, the following were significantly predictive of failure: leakages after 1st injection at 3 years (p = 0.01) and at 5 years (p = 0.0004), sex of patients at 5 years (p = 0.01).

The rate of symptomatic urinary tract infections was significantly reduced after toxin injection (p < 0.0001).

Conclusion. This study, which is representative of daily practice in a neuro-urology center, confirmed the effectiveness and safety of injections of 300 IU of Botox®. Some factors seem predictive of failure of intra-detrusor botulinum toxin (i.e. leakage after first injection).

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 Continent catheterizable vesicostomy and injections of intravesical botulinum toxin for the treatment of overactive bladder: Case series

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Keywords. Continent cystostomy; Botulinum toxin; Enterocystoplasty; Overactive bladder; Multiple sclerosis

Introduction. The aim was to evaluate neurologic patients with stable and capacitive bladder under injections of intravesical botulinum toxin who are unable to perform self-intermittent catheterization through the native urethra who need continent vesicostomy, without augmentation enterocystoplasty.

Patients. We identified all patients with stable neurogenic bladder under injection of botulinum toxin realizing self-catheterization or by a helper but unable to achieve them through urethra, that underwent a continent vesicostomy between 2008 and 2012. Indication, surgical technique, complications, voiding method and quality of life were analysed.

Results. We considered four women suffering from spinal cord injury (one) or multiple sclerosis (three), unable to achieve self-catheterization through urethra because of functional loss of upper limbs or adductors spasticity or increase of weight. The surgical technique was vesicostomy using the Mitrofanoff principle, without enterocystoplasty, because of bladder stability under medical treatment and comorbidities; the native bladder was fixed to the inner face of the abdominal wall. The mean operation time was 188 min. Minor complications (stoma stenosis and wound dehiscence) and quality of life were not different from patients who underwent enterocystoplasty. One patient had a Bricker three years after first surgery.

Conclusion. Injection of botulinum toxin for overactive bladder seems to be an alternative to enterocystoplasty when realizing continent cystostomy in neurologic patients with comorbidities like multiple sclerosis. However, evolutivity of the pathology may lead to a second surgery due to inability to achieve catheterization through urethra or loss of efficiency of botulinum toxin.

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Botulinum toxin type A injections in the augmented bladder after failure of augmentation enterocystoplasty in neurological patients: A retrospective multicenter study

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Keywords. Botulinum toxin; Bladder augmentation; Enterocystoplasty; Neurogenic detrusor overactivity; Neurogenic bladder

Objectives. Augmentation enterocystoplasty (AE) is a third-line treatment for neurogenic detrusor overactivity (NDO). When the outcome of an AE is