

Supplementary Appendix

This appendix has been provided by the authors to give readers additional information about their work.

Supplement to: Brubaker L, Cundiff GW, Fine P, et al. Abdominal sacrocolpopexy with Burch colposuspension to reduce urinary stress incontinence. *N Engl J Med* 2006;354:1557-66.

SUPPLEMENTAL APPENDIX B. Description of Standardized Techniques for Burch Colposuspension, Abdominal Sacrocolpopexy and Paravaginal Repair

Burch Colposuspension

The Burch colposuspension was performed through the same laparotomy incision as the sacrocolpopexy. Two figure-of-eight braided polyester stitches of zero gauge swedged onto a tapered needle were placed through the vagina on each side at the mid-urethra and the urethrovesical junction. Both strands of each suture on each side were passed through Cooper's ligament and tied above it. Removal of fat from the vagina was not required as part of the standard technique. The Burch stitches were tied to elevate the vagina into a minimally retropubic position. Allowable modifications included use of retropubic drains for clinical indications, and use of hemostatic agents such as Surgicel for hemostasis only.

Abdominal Sacrocolpopexy

The sacrocolpopexy was performed through a laparotomy approach. The type of incision was not standardized. Graft material was sutured to the anterior and posterior vaginal walls. The free ends of the grafts were secured to the anterior longitudinal ligament overlying the sacrum with a minimum of two permanent sutures in such a way as to avoid tension on the graft. The type of graft material was not standardized. Surgeons could select a material from the following list: autologous tissue (such as rectus fascia or fascia lata); synthetic material (such as polyester, polypropylene, or polytetrafluoroethylene); allograft material (such as cadaveric rectus fascia or fascia lata); or xenograft material (such as sheep intestinal submucosa). Synthetic absorbable material

(such as Vicryl mesh) was NOT allowed. The type of graft material was recorded. The choice of suture material used to secure the graft to the vagina and sacrum as well as concomitant procedures, such as culdeplasty and peritoneal closure, were recorded but not standardized.

Paravaginal Repair

A minimum of two interrupted paravaginal stitches were placed through the vagina and the fascia overlying the obturator internus muscle of the pelvic sidewall at the level of the arcus tendineus fascia pelvis on each side. The suture material was limited to braided polyester of zero gauge swedged onto a tapered needle. The number of stitches placed was recorded. When tied, the paravaginal stitches approximated the lateral vagina to the pelvic sidewall without suture bridging.

Modifications that were NOT Allowed

1. Anterior colporrhaphy or other anterior vaginal plication/narrowing procedures
2. Continence procedures other than Burch (no slings)
3. Metallic or bone anchors
4. Laparoscopic Burch or paravaginal repair

Cystoscopy was required after all procedures regardless of randomization to confirm bilateral ureteral patency and the absence of injury or foreign material in the bladder. All subjects received prophylaxis against deep vein thromboses by a method chosen by each surgeon.