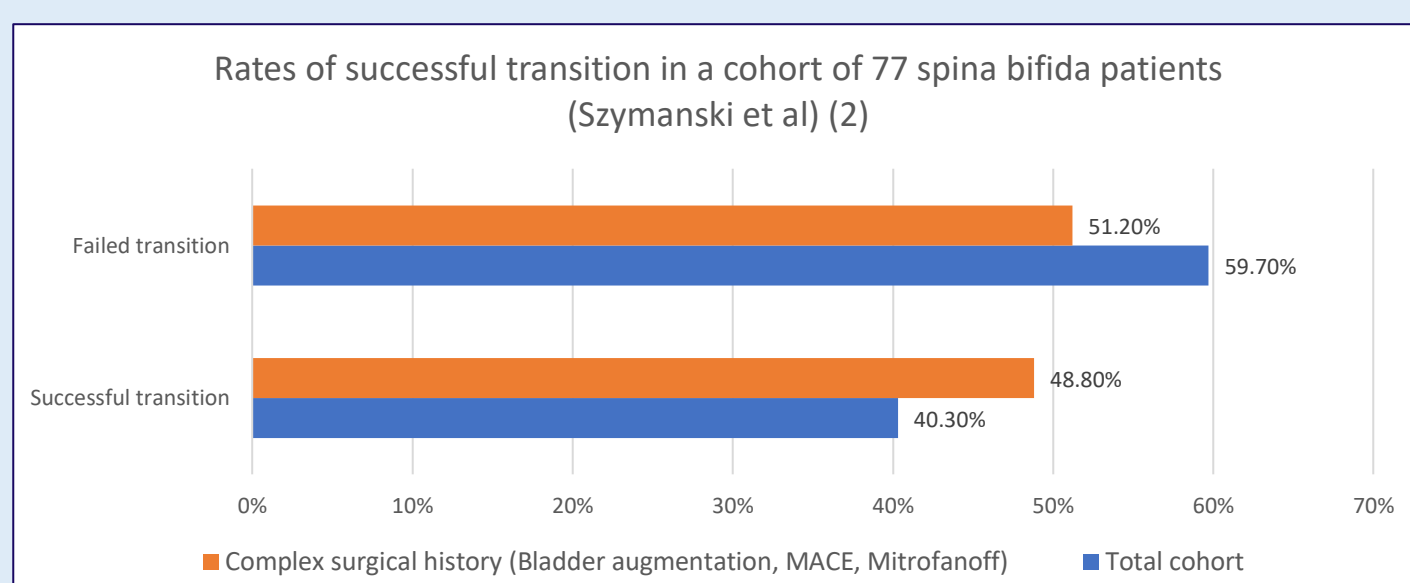


## Aims and Methods

- Perform a narrative review of literature pertaining to transitional care (from paediatric to adult urology) of individuals with voiding dysfunction secondary to congenital abnormalities.
- Majority of studies pertained to spina bifida and bladder exstrophy, hence emphasis placed on these in this review.
- Barriers to transition and methods to facilitate successful transition were described.

## Barriers to Transitional Care

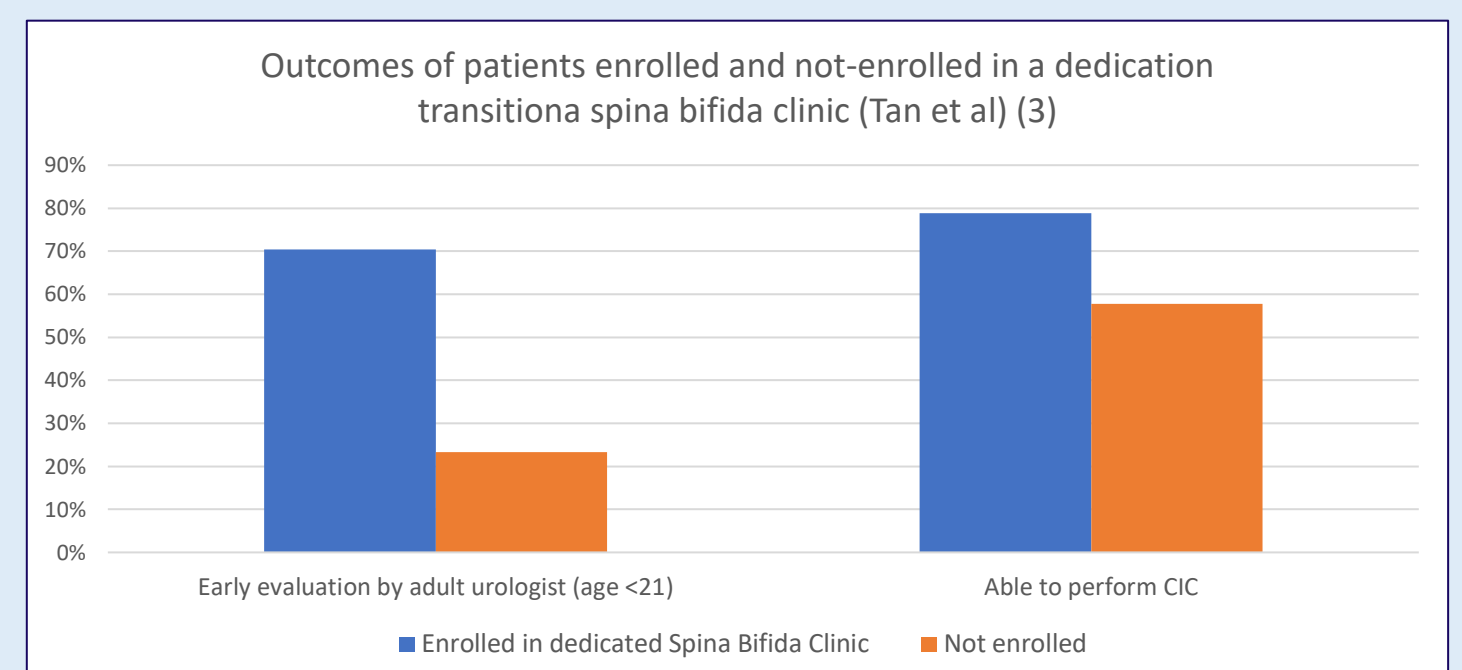
- **Rates of successful transition in spina bifida are low**
- Szymanski et al found, in their analysis of 77 patients discharged from a multidisciplinary paediatric spina bifida centre, only 40.3% had successful follow-up (defined as any follow-up with a urologist within 2 years post discharge from paediatric centre) (1).
- Concerningly, complex patients with significant surgical history i.e. bladder augmentation, MACE or Mitrofanoff also had poor rates of transition with only 48.8% successfully transitioning.
- Documented non-compliance was not a statistically significant predictor of failed transition in this cohort ( $p = 0.79$ ).
- Intuitive logistical issues i.e. travel time, distance to clinic, hospital familiarity not at play – as paediatric and adult clinics were collocated in this cohort, even sharing the same office staff.



- **Rates of successful transition in bladder exstrophy also low**
- Haddad et al found in their cohort of 67 bladder/cloacal exstrophy patients, that 24% had unsuccessful transition – defined as no follow-up within 2 years (2).
- Similarly, no significant difference in distance to clinic, sex, insurance status or history of bladder reconstruction was found between those with successful vs failed transition.

## Strategies to Facilitate Successful Transition

- **There is growing consensus in the literature for dedicated transitional urology clinics**
- Tan et al compared outcomes of 71 patients enrolled in a dedicated transitional spina bifida clinic, and 116 not enrolled. Those enrolled had earlier evaluation by an adult urologist (70.4% below 21 vs 23.3% below 21), and were more likely to perform CIC (78.9% vs 57.8%) (3).



- Eastman found that a short interval between paediatric discharge and adult follow-up (<1 year) was associated with lower rates of UDS abnormality ( $p = 0.0215$ ). 42% of patients required intervention on adult follow-up, hence delay in adult followup indicates in delay in intervention (4).
- Cox found that urological or neurosurgical outcomes did not impact transitional SB patient or parent satisfaction – rather financial or employment issues were the most common grievance (5).
- Grimsby found that TRAQ (transitional readiness assessment questionnaire) scores were lowest in financial domains in their cohort of paediatric patients with voiding dysfunction (6).
- **A biopsychosocial approach with allied health involvement is therefore key**

## Conclusion

- Rates of successful transition in voiding dysfunction due to congenital issues (i.e. spina bifida, bladder exstrophy) are low.
- Intuitive factors such as travel time, distance to clinic, hospital familiarity and documented history of non-compliance are NOT predictive of failed transition.
- Management strategies described in the literature include dedicated transition clinics, short interval between paediatric to adult follow-up, and biopsychosocial focus with allied health involvement.

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