Mid-Urethral Slings

THE UROGYNAECOLOGICAL SOCIETY OF AUSTRALASIA

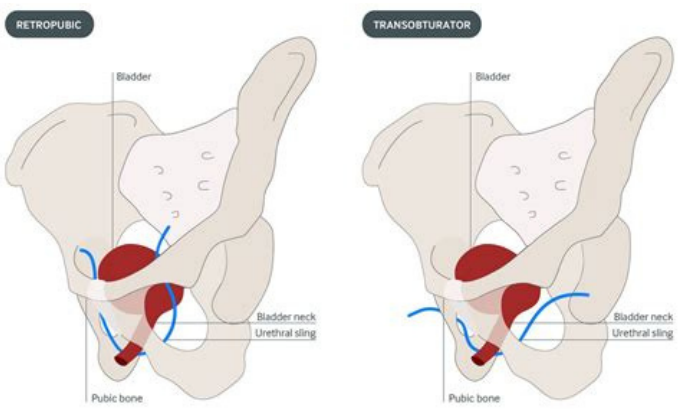
What are Midurethral Slings?
Mid-urethral slings (MUS) are tapes made from synthetic polypropylene. These tapes are inserted underneath the middle part of the urethra (water-pipe). Scar tissue forms around the tape holding it in place, which acts like a hammock to support the urethra during moments when the abdominal pressure is increased, reducing any urine leakage.

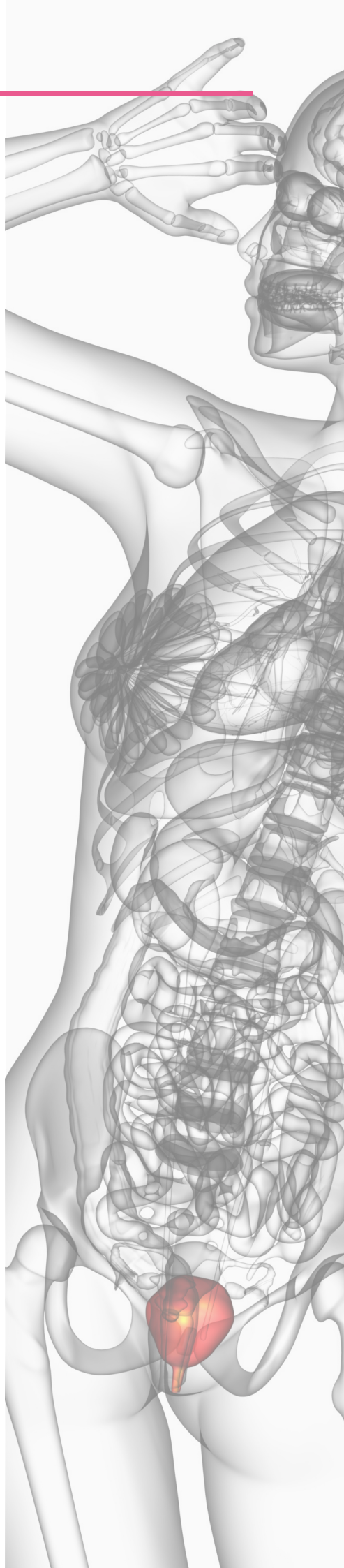
MUS is a minimally invasive procedure, usually performed under general anaesthesia and may be performed as a day procedure. Women normally return to work after 2 weeks depending upon their duties performed. They are the most extensively studied continence surgery in history and are widely regarded as the treatment of choice for stress urinary incontinence.

While 90-95% of women are highly satisfied with the surgery, no surgery is without risk. MUS complications include:

- Failure: not achieving the desired effect (5-10%).
- Voiding difficulty: Not emptying the bladder completely occurs in about 2% of women. Initially you may need to learn how to empty your bladder with a small catheter or have the tape loosened in theatre. In a very small number of women the tape may need to be cut to resolve urinary retention with a 50% chance of the stress leakage returning following this.
- Overactive bladder: There is a 5% risk of the bladder becoming overactive resulting in symptoms of having to void more frequently or needing to rush to the loo when you have the urge to go. Overactive bladder can be treated (see separate leaflet).
- Mesh complications: 2-5% of women experience mesh exposure, erosion or infection.. Symptoms can be bleeding, vaginal discharge and pain during sexual intercourse, and may require revision surgery and rarely removal of the sling.
- Rarely the tape may cause pain or pain during intercourse due to scar tissue.
- Bleeding requiring transfusion or reoperation occurs in less than 1%.

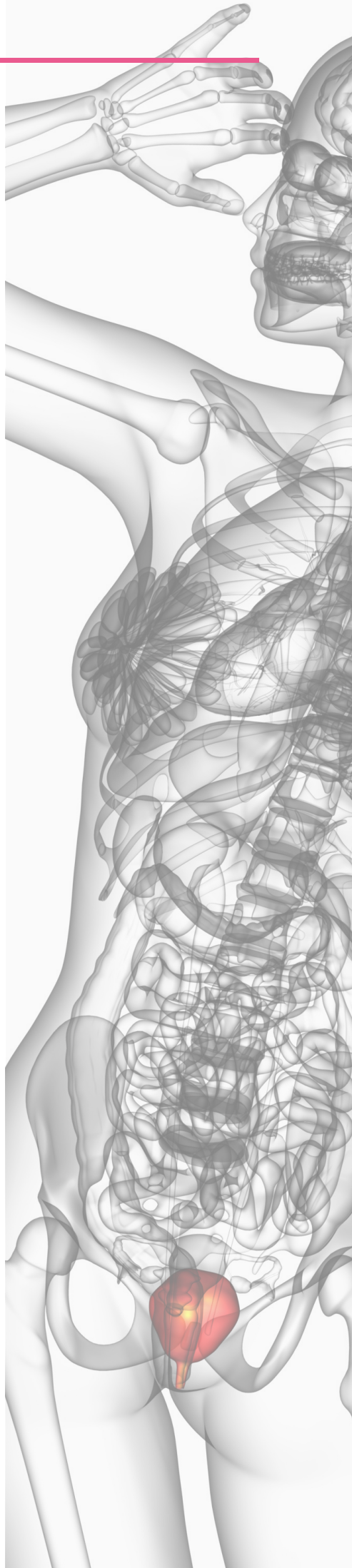
There are three different types of mid-urethral slings and your Gynaecologist will discuss the advantages and disadvantages of each approach based upon your individual case.





Mid-Urethral Slings

THE UROGYNAECOLOGICAL SOCIETY OF AUSTRALASIA



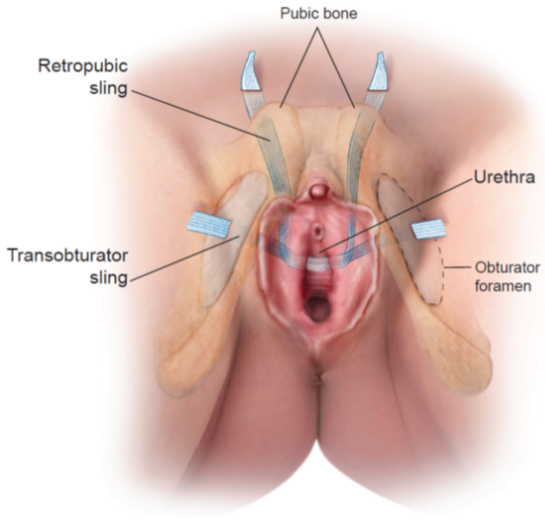
Retropubic tapes

Retropubic tapes were first performed in the 1990's and they are very effective with 80% of women cured and 95% significantly improved. Follow-up studies have demonstrated their effectiveness for at least 17 years, explaining why this approach remains the most utilised. The tape is inserted with special needles through a cut in the vagina and is pushed up through 2 small cuts just above the pubic bone securing the tape. Your surgeon will look inside the bladder with a small camera (cystoscope) to make sure the bladder and water pipe have not been punctured. If this is the case the tape is removed and reinserted. A catheter will be left in the bladder for approximately 24 hours to allow for the small hole to heal.

Trans obturator tapes

Trans obturator tapes were first performed in 2003. As seen in the diagram the special needles that insert the mesh under the urethra in the vagina come through small cuts made in the groin rather than through the abdomen.

Obturator tapes have a higher rate of reoperation for urinary incontinence in the medium term (8-9 x) than retropubic tapes and are associated with low rates of groin pain (4%) that can be difficult to treat. However, obturator tapes have some advantages including lower rates of bladder injury and voiding dysfunction.



This statement has been developed by the Urogynaecological Society of Australasia (UGSA).