

# Pubovaginal Sling

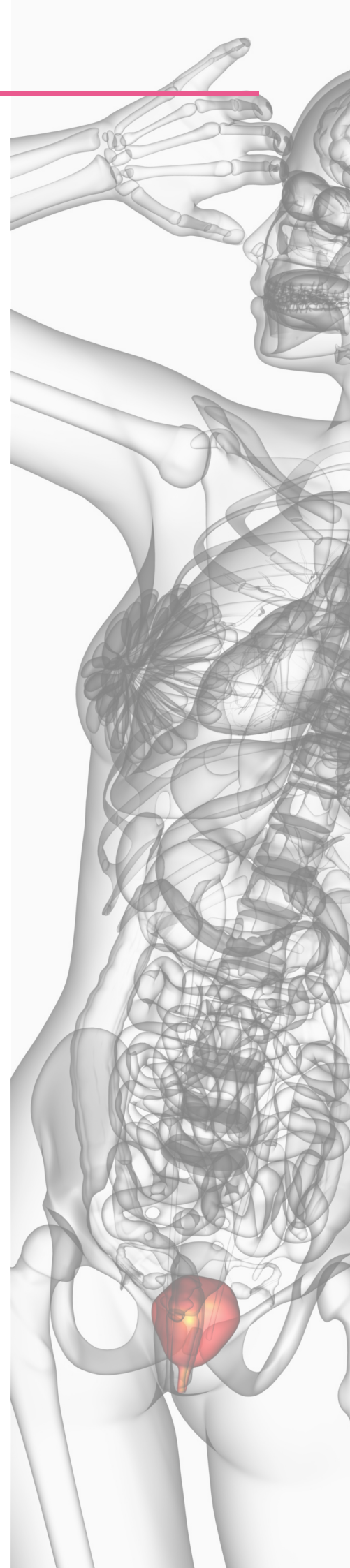
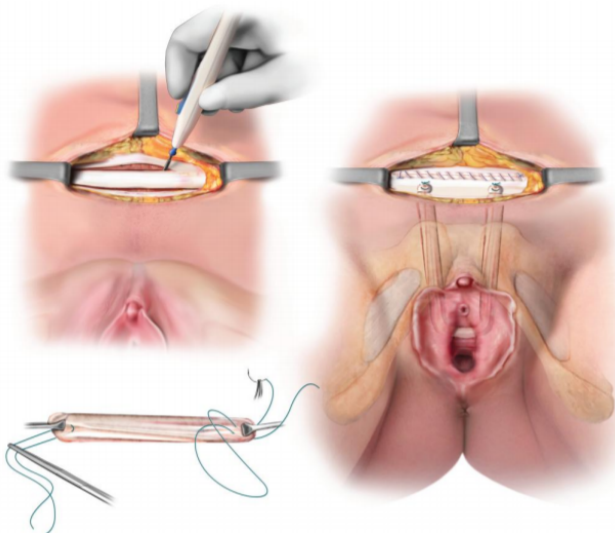
THE UROGYNÆCOLOGICAL SOCIETY OF AUSTRALASIA

### Aim

- To correct stress urinary incontinence (SUI, urinary leakage with coughing, sneezing or with exercise).  
While the synthetic mesh mid-urethral sling (MUS) procedure remains the first-line surgical treatment for most women with SUI, the pubo-vaginal sling (PVS) is an option to consider in some cases. It has been performed for many years, with a similar success rate to the synthetic slings (although not as widely-studied). The PVS is recommended in some cases of recurrent incontinence after previous surgery or when the use of surgical mesh is not suitable or not desired by the patient.
- The operation is more extensive with a longer operating time, hospital stay and recovery period than the MUS. After the surgery there is a greater risk of urinary retention (incomplete bladder emptying) along with the other complications noted below.

### Surgical technique

A combination of abdominal and vaginal surgery is performed to place the sling. The abdominal surgeon performs the surgery through a lower abdominal incision. Strong tissue from the deep abdominal wall (rectus sheath) is fashioned into a sling approximately 2cm wide and 10–15cm in length. With the aid of the vaginal surgeon, the harvested sling is placed under the upper urethra and the sling material is secured to the anterior abdominal wall. Finally, the abdominal and vaginal incisions are closed and a cystoscopy is performed to ensure the bladder and urethra are intact.



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Surgery will be covered with antibiotics to decrease the risk of infection and blood-thinning agents will be used to decrease the risk of clots forming in the postoperative phase. A catheter will drain your bladder for the first day following surgery.

Serious complications are rare with this type of surgery. However, no surgery is without risk and the main potential complications are listed below:

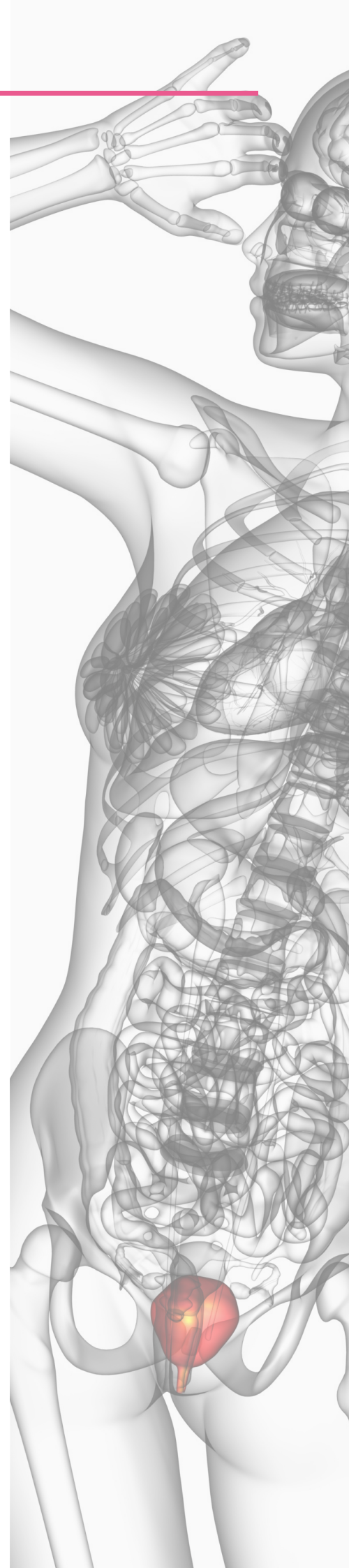
- Failure rate of 10–15%
- Developing urgency, or urge incontinence after the operation in 10%
- Urinary tract infections in 5%
- Wound infections in 5%
- Difficulty emptying the bladder that necessitates prolonged self-catheterisation in 10%
- Re-operation to loosen a 'tight' sling may rarely be required
- Damage to the bowel, bladder or lower urinary tract requiring further surgery in less than 2%
- Blood loss requiring transfusion or re-operation in less than 1%
- Clotting in the legs or lungs in 1%
- Wound complications or hernia in 2%.

## In Hospital

You can expect a 2–3 day hospitalisation. After the operation you will have an intravenous drip in your arm and a small catheter will drain your bladder for 24 hours. Once the catheter is removed, the nurses will check that you are emptying your bladder appropriately. Skin sutures (stitches) are absorbable and do not need to be removed.

## Recovery

In the early postoperative period you should avoid situations where excessive pressure is placed on the repair (lifting, straining, coughing, constipation), this is especially so in the first 2 weeks. During this time, you should not drive but it is important to mobilise slowly around the home. Regular paracetamol (up to eight a day) is the mainstay of your pain relief at home and further pain relief options will be available from your doctor. After 3–4 weeks you can generally return to driving and start mobilising further, including gentle walking.



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You can return to work at 4–6 weeks, depending upon the amount of strain placed upon your repair at work and this should be discussed with your doctor. If you develop urinary burning, frequency or urgency or redness or inflammation of the wound you should see your local doctor.

Maximal fibrosis (scarring) around the sling occurs at 3 months and care needs to be taken during this time period to ensure straining and lifting do not negatively impact upon the repair sutures and your continence status. You will see your doctor at 6 weeks for a review and sexual activity can usually be safely resumed at this time. You will be able return to most daily activities and sport at 6 weeks. All aerobic activities such as walking, running, gardening, Pilates, swimming, tennis and cycling can be resumed at this time; however, weight-bearing exercises at the gym, crunches and sit-ups create high intra-abdominal pressure on the repair and are best avoided.

Avoiding heavy lifting (more than 15kg), weight gain, constipation and weight-bearing exercises can minimise the risk of failure of the procedure in the long-term. If you have any questions about this information, you should speak to your doctor at the six-week visit.

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

Disclaimer: This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

