Recovery After Mid-Urethral Sling Surgery for Stress Incontinence

THE UROGYNAECOLOGICAL SOCIETY OF AUSTRALASIA

Mid–urethral sling (MUS) surgery for stress urinary incontinence is a generally well-tolerated procedure.

Pain

Mild pain or discomfort in the vagina and/or around the skin incisions is to be expected. This can usually be managed successfully with a combination of paracetamol and anti-inflammatories (for example, Nurofen or Voltaren). Sometimes women need stronger pain relief for the first few days after surgery. If you experience severe pain at home, please contact your gynaecologist.

Bladder

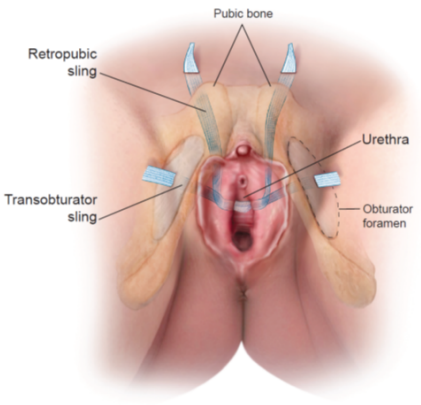
You may notice a change in your urine stream – it may be slower or spray a little. This is normal. It is important that you relax completely when passing urine and do not strain or push to empty your bladder. A specialised pelvic floor physiotherapist may be able to help you improve these symptoms after your initial healing period of 6 weeks.

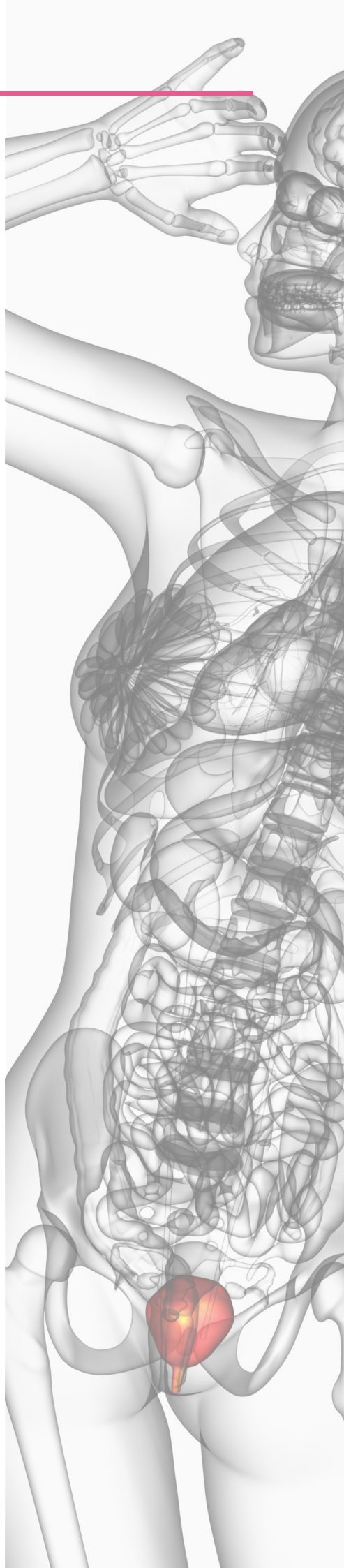
Fluid Intake

Maintain a normal fluid intake (aim for a total intake of 1.5 – 2 litres a day) and try to pass urine around every 4 hours. You may experience a burning sensation when you pass urine for the first 2 days after the surgery. This is normal and is related to the catheter and cystoscope used during the operation. Taking Ural sachets can often ease this discomfort. If this sensation persists for more than 2 days then you may have developed a bladder infection. Please see your local doctor for a urine test and commence antibiotics if an infection is present. A small number of women may have difficulty emptying their bladder following the MUS. This may require a catheter to help empty the bladder initially. Rarely the tape may need to be loosened.

Bowels

Bowel function is generally not affected by the surgery but pain medications containing codeine, reduced oral intake and reduced activity can all contribute to the development of constipation. Maintain your fluid intake and increase your dietary fibre during this time. If constipation develops, taking simple laxatives such as Coloxyl or Lactulose (available over the counter), is usually adequate.





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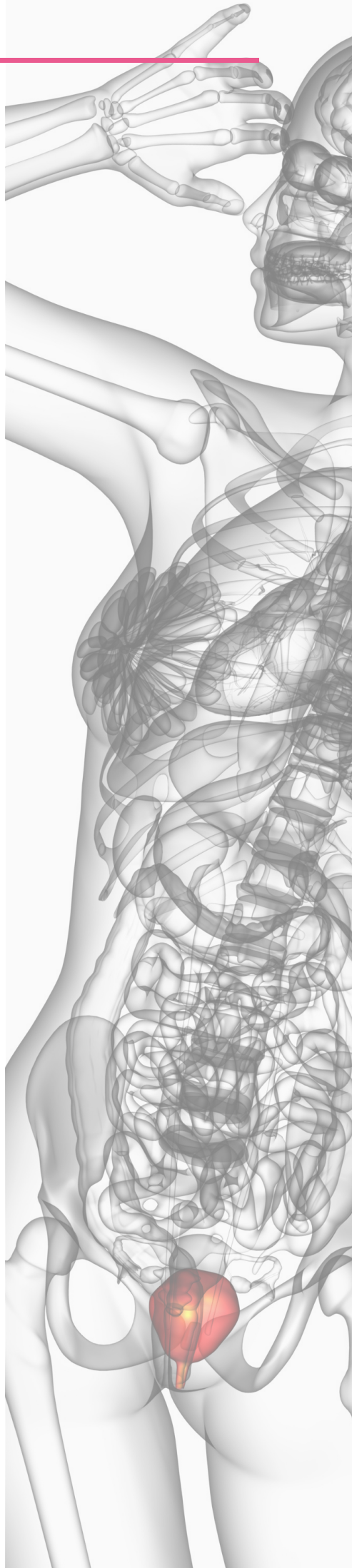

Wound care

During the surgery, a small incision is made just inside the vagina. There may be a small amount of bleeding from the vagina which turns into a brownish discharge. This is usually
present for days to a few weeks until the vaginal skin has healed. If the discharge increases in amount, becomes bright red or smells please contact your gynaecologist as an infection may have developed. The small skin incisions will heal very quickly.

Sexual Activity

Avoid sexual activity until your review with your gynaecologist. It is important that the vaginal skin incision has completely healed before you start sexual activity again.

Physical Activity

For the first 2-4 weeks light activity only – no heavy lifting (not more than 15kg), no straining, no strenuous exercise. Following this gradually increase your activities but listen to your body and if you feel tired then rest. General anaesthetic can continue to have an effect on your energy levels for weeks after the surgery.

Driving

You should not drive if you are taking strong painkillers or if you are not confident that you could perform an emergency stop if needed. As a general guide avoid driving until you are pain-free. Some insurance companies place restrictions on driving after surgery, so check your policy details.

Return to work

You should be ready to return to work 2-4 weeks after surgery. The timeframe depends on your recovery and the type of work you do. It is best to discuss this directly with your gynaecologist.

Follow-up

A review appointment is usually scheduled at 6 weeks following surgery. If you were on blood thinners (Aspirin, Plavix) prior to your surgery, these can normally be commenced 24-48 hours postoperatively however this should be discussed with your gynaecologist.

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