Urogynaecological Society of Australasia
Expanding the Horizons in Female Health Care

UGSA Statement on Mid-Urethral Slings

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The gold standard surgical correction of Urinary Stress Incontinence since 2002 has been the mid-urethral sling (MUS). In general, these procedures have been more successful and associated with less patient morbidity (reduced operating time, blood loss, inpatient stay and recovery time) than preceding procedures such as the colposuspension or pubovaginal sling[1]. Mid- urethral slings can be divided into three groups: retropubic, transobturator and mini-slings. The first sling to be introduced was the retropubic sling. The trans-obturator sling was introduced with the aim of reducing complications and the mini sling was similarly aimed at further reducing complications.

UGSA recommendations

UGSA recognises that not all MUS are the same. The best evidence that we have is that retropubic slings result in a very significantly reduced need for repeat procedures at 5 years compared to transobturator slings[2]. The transobturator slings have some advantages which include less risk of visceral/vascular injury and less voiding dysfunction compared to the retropubic slings. Transobturator slings have 4% risk of severe groin pain which can be difficult to manage and can be chronic[2]. Currently there is not enough high-quality evidence to draw conclusions about the possible risk/benefit profile of the mini-slings.

Therefore, UGSA recommends that the retropubic tape is the best choice in the majority of patients. Patients who may be suitable for transobturator tapes include those with risk factors for bowel injury or significant bleeding such as those with a hostile abdomen and those on anticoagulants, and those at high risk of post-operative voiding dysfunction. This decision is at clinician discretion.

UGSA recommends that mini slings are used only under the auspices of an ethics committee until further evidence is available.

Training

AS with all surgeries there is a recognised learning curve associated with the MUS procedure. UGSA recommends that training is sling specific. There are several appropriate forums for training including as a registrar, fellow or under a preceptorship. Training involves the assessment of patients, the surgical management of patients and the post-operative care of patients. It also involves the management on complications.

The evidence is that complications are minimised after 50 MUS cases and that outcomes are optimised after 20 MUS cases[3]. UGSA recommends a training period of between 12 and 18 months, during which at least 20 women are cared for including assessment, MUS procedures performed and post-operative management.

Credentialing guidelines

The evidence is that complications are less in surgeons who perform more than one MUS a month[4].

Therefore, UGSA recommends that credentialing to perform MUS operations includes the requirement of having performed at least 12 MUS operations in the preceding 12 months.

References

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