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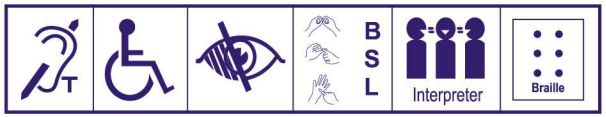

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To use the Text Relay service, prefix all numbers with 18001.

اگر نیاز به ترجمه دارید، لطفا با شماره 01932 723553 تماس بگیرید.

ਜੇ ਤੁਹਾਨੂੰ ਤਰਜਮੇ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ: 01932 723553

اگر آپ اس کا اُردو زبان میں ترجمہ چاہتے ہیں، تو براہِ کرم اس فون نمبر 01932 723553 پر رابطہ کریں

Se precisa de uma tradução por favor contacte: 01932 723553

আপনার অনুবাদের দরকার হলে এখানে যোগাযোগ করুন : 01932 723553

यदि आपको अनुवाद की ज़रूरत है तो कृपया इस नंबर पर फोन करें: 01932 723553

Jeżeli chcemy, aby te informacje w innym języku, proszę zadzwonić 01932 723553

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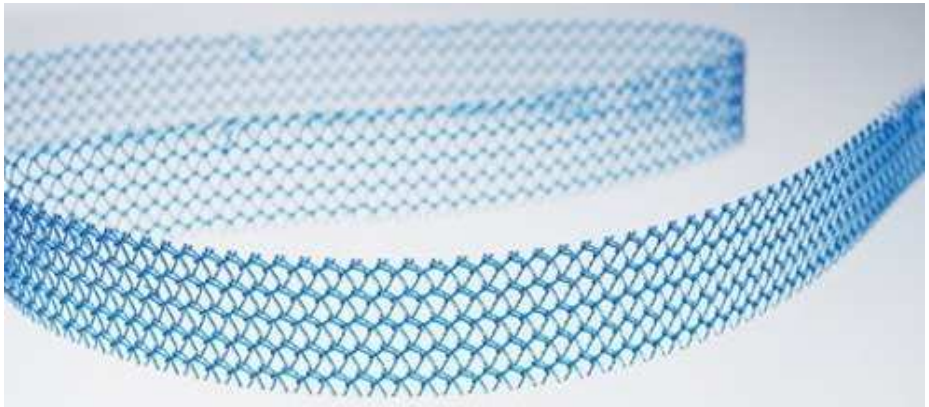
Mid-Urethral Tapes

Department of Urogynaecology



Patient Information

Further Information

We endeavour to provide an excellent service at all times, but should you have any concerns please, in the first instance, raise these with the Matron, Senior Nurse or Manager on duty.

If they cannot resolve your concern, please contact our Patient Experience Team on 01932 723553 or email asp-tr.patient.advice@nhs.net. If you remain concerned, the team can also advise upon how to make a formal complaint.

Author: Kate Anders, Lead Nurse **Department:** Urogynaecology

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Further information

* All mesh-related adverse events are required to be reported to the medical device watchdog, the Medicines and Healthcare products Regulatory Agency (MHRA)

Further information can be found at these websites

http://www.mhra.gov.uk

http://www.nice.org.uk

http://bsug.org.uk

http://rcog.org.uk

http://cochranelibrary-wiley.com

Mid Urethral Tapes

Introduction

To remain continent the muscles that make up your urethra (water pipe) and the ones around your bladder neck must be able to tighten under 'stress-related' conditions e.g. when you cough, sneeze, exercise or lift heavy items.
If you have a weakness of these muscles, you may not be able to tighten them sufficiently to stop urine leaking out.

Stress incontinence is common in women after childbirth, but can be seen in women who have not had children. A lack of oestrogen, and the effect ageing may have on you (although this is not a direct cause), can also be contributing factors. If you have a severe cough, like bronchitis, are overweight or if you are constipated the leakage may be worse.

Urodynamics (bladder function tests) are used to aid diagnosis.

What are my options?

No treatment.

Whilst the leakage can be unpleasant or distressing, it is not life-threatening and having no treatment is a perfectly reasonable option.

Lifestyle strategies

Stopping smoking, losing weight and managing your bowels will all help in alleviating symptoms. We advise a fluid intake of 1.5-

2 litres of fluid a day with a reduction or avoidance of caffeine, fizzy drinks, sweeteners and alcohol.

Devices and containment strategies

Devices and continence pessaries maybe inserted into the vagina to support the bladder neck. Most are used on an intermittent basis (e.g. when playing sport) and women are taught how to insert them and remove them. Absorbent products (pads) can provide excellent protection but should not be considered as treatment. Long term catheterisation is only considered as a last resort.

Physiotherapy

Approximately 50-60% of women with stress incontinence will be cured with supervised pelvic floor therapy and in others it can help to reduce the symptoms. Physiotherapy is the standard first line treatment prior to consideration of surgery

Medication

A drug called Duloxetine is thought to help by increasing the tone in the urethral sphincter (bladder neck) thus reducing leakage and can be successful in 60% of cases. However, some women describe unpleasant side-effects such as nausea and it must be reduced slowly when the medication is stopped to reduce withdrawal symptoms.

Surgery

Surgical procedures performed in this unit for stress urinary incontinence (SUI) include bladder neck bulking injections, mid-urethral synthetic tapes and colposuspension. You will need to have undergone urodynamic studies to confirm the diagnosis of

Follow up

You should be seen in clinic approximately 3 months after the operation by either one of our specialist nurses or doctors

If you have any acute illness, please contact your GP.
If you need to ask for advice then please ring the ward you were admitted to or the Urogynaecology department on 01932 722124 Monday to Friday.

your surgical recovery if it is likely to affect your driving and persist for more than 3 months. https://www.gov.uk/guidance/miscellaneous-conditions-assessing-fitness-to-drive#driving-after-surgery

Return to work - 2- 6 weeks. This will depend on what your work entails and whether it involves heavy manual work.

SUI. All these procedures, their risks and benefits will be discussed with you and your case reviewed by our multi-disciplinary team (MDT) before a decision, with your input, can be made on which is the right procedure for you.

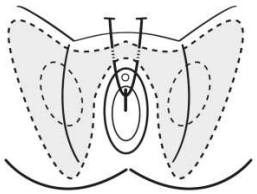
What is a mid urethral tape?

Mid urethral tapes are made from non-absorbable polypropylene (prolene) sutures (stitches) which are then woven into a mesh. The mesh "tape" is designed to support the middle of the urethra and thus alleviate stress incontinence. Mesh implants are permanent implants and are not intended to be removed.
The success rates for this procedure can vary a little depending on your individual circumstances and previous history, but can be considered around 80% at fifteen years follow up. As a rule we do not offer this procedure in women under the age of 40 years.
Mid-urethral sling operations have been the most extensively researched surgical treatment for SUI in women and have a good safety profile. The risks and complications associated with this procedure are covered in the leaflet but your consultant will discuss these with you and answer any questions you may have.

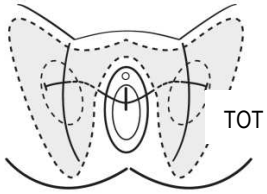
There are two main different surgical approaches 1) a retropubic tension-free or trans-vaginal tape (TVT) or 2) a trans-obturator tape (TOT).
TVT is more commonly used in this unit but this will ultimately depend on your individual previous surgical history.

How is it inserted?

The synthetic tape is inserted through a small cut in the vagina either under a general, spinal or local anaesthetic. Each end of the tape is brought out either through the abdomen (TVT) or the inner thigh (TOT)



TVT approach



TOT approach

Before the operation

Pre-operative assessment
This is done well in advance of your surgery date to ensure you are fit and well to undergo surgery and will include a review of your medications, urine and blood test and maybe other tests such as an ECG (heart monitoring test). It can often be done immediately following your consultation when you are initially added to the waiting list. If not, you will be sent an appointment. Surgery dates are usually offered with about 4-6 weeks' notice. Please notify us of any previous arrangements/ holidays so that we do not offer dates that clash.

Medications
Please bring all your medications with you when you attend for your surgery and *only* stop those medications you have been advised to

If you have been previously prescribed medication for an underlying overactive bladder, you should continue to take these unless otherwise instructed.
Any topical vaginal oestrogen cream or pessary (vagifem) should be continued as prescribed once you feel comfortable inserting the applicator (usually after 4 weeks) and any bleeding/ discharge has subsided

Sexual intercourse - avoid penetrative intercourse for 4 - 6 weeks. This will allow time for the vagina to heal and any stitches to dissolve. It may feel superficially tender to start but this should settle down with time

Lifting - You should avoid heavy lifting as a long term lifestyle change if you have had continence surgery.

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Exercise – avoid vigorous sports *and swimming* for 6- 8 weeks. As a long term rule avoid sit ups or heavy weight training. You can gradually introduce gentle exercise into your daily routine after 4 weeks.
Pelvic floor exercise should resume once you feel comfortable

Driving – You must not drive for 24 hours after a general anaesthetic or until a spinal anesthetic has complete warn off.
You should avoid driving until you feel comfortable moving around the car and you can perform an emergency stop without experiencing any pain/discomfort (up to 2 weeks) and to allow the wounds to heal.
It is your legal responsibility to remain in control of a vehicle at all times and you must ensure you remain covered by your insurance policy to drive after surgery. You only need to notify the DVLA of

erosion will usually require further surgery and possibly removal of the tape.

- *Mesh infection (Rare).* If the mesh becomes chronically infected and does not respond to antibiotics, it will normally be removed
- *Failure or recurrence of stress incontinence requiring further surgery (Uncommon).* Any recurrence of symptoms will require re assessment and investigation.

Recovery at home

Personal hygiene - It is better to shower than bathe for long periods of time for the first couple of weeks. It is advisable not to use tampons for around six weeks. Mild vaginal discharge is part of the normal healing process. If it becomes excessive or offensive it may indicate an infection

*Bowels- C*onstipation and straining when opening your bowels, puts unnecessary pressure on the repair and should be avoided in the long term.

Stitches - All stitches are dissolvable. If you see any stitch material it is better to leave it alone. If it is bothersome it can be trimmed by your GP or nurse. Do NOT pull them

Medication - Please finish the course of any antibiotics if they have been prescribed.

You will be asked to stop any anticoagulants (blood thinning medications) but we will liaise with your GP/ Haematology department about a regime to reduce and come off these medications. (These include warfarin, heparin, dabigatran, rivaroxaban, apixaban and clopidogrel)
Other medications with similar properties (e.g. Aspirin, ibuprofen and diclofenac) will need to be stopped 2 weeks before the operation.

Consent
You will be asked to sign a consent form which confirms you have agreed to the procedure. If you do not understand anything, require any further information or would like someone with you, please let the consenting doctor know **before** you sign.

Eating and drinking
You will be advised when you need to stop eating and drinking prior to the procedure depending on the type of anaesthetic and the time your surgery is scheduled.

Pre-existing bladder emptying problems
If you have had previous continence surgery, have difficulty emptying your bladder or pass urine slowly with or without the need to strain, you may need to be taught clean intermittent self-catheterisation (CISC) before going on the waiting list, in case these symptoms are made worse by the surgery.

The anaesthetic and operation

The anaesthetic

The operation can be done under a local anaesthetic (awake), spinal anaesthetic (awake but numb from waist down), or a general anaesthetic (asleep).

The operation

- The operation takes about 30 minutes
- Your legs will be raised into stirrups. Please let us know if you have any hip or back problems
- Local anaesthetic is injected into the vaginal wall and exit points
- A small incision is made on the front wall of the vagina.
- The tape is inserted under the middle of the urethra with the help of two long needles
- The two ends are pulled through two small 1cm cuts on the abdomen just above your pubic bone (TVT) or through a 1cm cut on each inner thigh (TOT)
- After insertion, a cytsoscope (camera) is inserted into the bladder to ensure the tape is in the correct position
- You will be asked to cough (when awake) so we can make any adjustments to the tape
- The vaginal and exit incisions are then closed with dissolvable stitches

After the operation

- Once you are ready you will be taken to recovery and on to the ward if staying overnight. This would be usual if you have had a spinal anaesthetic.

symptoms, you may need to increase the dose.

- *Vaginal Infection (Common)*. Symptoms include an offensive, greenish vaginal discharge. If you suspect an infection contact your G.P. as you may need antibiotics.
- *Superficial pain on sexual intercourse (Common).* There will be some scarring on the vaginal wall that can be aggravated by penetrative sexual intercourse causing superficial discomfort. Lubrications or local oestrogens (if post-menopausal) may help reduce these symptoms, but if they persist advice should be sort.
- *Long term pain in the pelvis, groin, vagina or during sexual intercourse (Uncommon).* Persistent pain needs to be investigated as it may indicate an infection or tape migration. Groin pain is generally only seen with TOT. Nerve or musculoskeletal damage may be ongoing requiring referral to physiotherapy, the pain management team, and/or the need for surgical revision
- *Mesh exposure into the vagina (Common).* This can be seen soon after surgery or several years later. Symptoms may include vaginal discharge or infection and pain on sexual intercourse (your partner may feel something sharp). If it is minor a simple surgical overlay of vaginal tissue may be enough to rectify the problem unless there is infection present which will need to be treated first.
- *Mesh erosion/ migration into surrounding structures (Rare).* These complications are dealt with on an individual case by case basis. They can be seen shortly or several years after insertion and can present in a number of ways; unexplained pain, urinary infection, vaginal discharge infection or bleeding and/or pain during sexual intercourse. Mesh

- *Injury to surrounding structures (Rare).* The introducer needles used in the operation, to insert the tape, may inadvertently cause damage to structures such as the urethra, major blood vessels *(resulting in severe bleeding)*, or bowel. These may require further investigation and/or surgery and will be discussed with you as appropriate.

<u>After surgery</u>

- *Temporary difficulty in passing urine (Common)*
  - A catheter (small tube) maybe inserted into the bladder to rest it (initially 1-2 weeks). This will be connected to a drainage bag fastened to your leg. You will be shown how to manage it and allowed home.
  - An appointment will be made to remove the catheter so that you can try again to pass urine.
  - If the problem persists (Uncommon) the catheter may be left in for a longer period or you will be taught CISC (or asked to start if taught before surgery).
- *Long-term difficulty in bladder emptying (Rare).* This may require long term self catheterisation

<u>After discharge</u>

- *Urinary frequency and urgency (Common).* Although often temporary, it can indicate a urinary infection if associated with pain when you pass urine; or an indication of an overactive bladder if it does not subside. This may mean the introduction of drug therapy to help calm the bladder down. If you are already on drug therapy to manage these

- After a local (or general) anaesthetic you should be able to pass urine normally as soon as you are awake and feel the urge. It may feel "stingy" at first but this should settle down.
- After a spinal anaesthetic you will have a catheter in place overnight and removed the following morning
- Once you are ready you will be able to drink and eat normally. You should gradually increase your fluid intake to 1.5 to 2 litres a day.
- You will be able to go home once you are passing urine normally and your bladder is emptying
- You may receive some take-home medication including painkillers and/or antibiotics

What are the risks for this type of surgery?

<u>General surgical risks</u>

- *Anaesthetic/ cardiovascular problems* – all anaesthetics carry some risks including chest infection, pulmonary embolus, stroke, heart attacks and very rarely, death. These risks are dependent on the type of anaesthetic you are having and how fit you are before your surgery. Your surgeon/anaesthetist will discuss your individual risks with you.
- *Pain & discomfort.* It is normal to experience some discomfort which could be either in the needle sites or in the vagina. Painkillers will be offered on a regular basis but if your discomfort is not well-controlled please advise the staff that are looking after you.

- *Vaginal Bleeding.* It is normal to have some vaginal bleeding for 48 hours after surgery. This should tail off and become a brown discharge for a couple of weeks before stopping altogether. If it becomes heavy or associated with pain you should visit your GP as it may indicate an infection
- *Blood in the urine.* It is not uncommon to see some blood in the urine for the first few times you pass urine. Your urine should gradually become lighter and eventually return to its normal colour.
- *Urinary infection.* Symptoms include foul smelling urine, frequency, urgency and a burning pain on passing urine. If you suspect an infection, increase you fluid intake and contact your G.P. to arrange to have a sample tested
- *Infection.* Either in the vagina, needle site wounds or in your urine. Antibiotics will be given if necessary
- *Venous vein thrombosis (VTE).* The risk of blood clots in the leg (4-5%) or lung (1%) is increased by immobility, if you are overweight or smoke. This risk will decrease by quick mobilisation and weight loss/ smoking cessation prior to your operation. You maybe required to wear TED stockings

Risks specific to this type of surgery

The terms in the table are designed to give you an idea of relevant risk are reported in medical literature and confirmed /endorsed by the National Institute of Health and Clinical Excellence.

Term	**Number of people**	**Size of group/area**
Very common	1in1 to 1in10	One person in a **family**
Common	1in10 to 1in100	One person in a **street**
Uncommon	1in100 to 1in1000	One person in a **village**
Rare	1in1000 to 1in10 000	One person in a **small town**
Very rare	1in10 000 and above	One person in a **large town**

During surgery

- *Perforation of the bladder or urethra (Common).* These are dealt with when they are identified at the time of operation and have not been associated with any long-term problems. Perforation to the bladder or urethra may require a catheter to be inserted to give time for the injury to heal. You will be sent home with the catheter during this time and an appointment will be made to have the catheter removed (1-2 weeks).