Autologous fascial sling to treat stress urinary incontinence

Gynaecology

Introduction:

This leaflet has been designed to provide information for ladies who are considering having an autologus fascial sling operation to treat their stress urinary incontinence and the likely plan of care after the operation. It will also include the benefits, risks and alternatives. Please feel free to ask a member of the team if there is anything you do not understand.

What is stress urinary incontinence?

Stress urinary incontinence is leakage of urine that occurs with activities which cause an increase in abdominal pressure such as coughing, sneezing, jumping, lifting, exercising, and in some cases, walking. This is due to a weakness in the urethra (urine pipe), and support of the bladder neck caused by childbirth, heavy lifting and constipation. This can cause distress and limit your quality of life. It must be understood that these operations will not cure all urinary symptoms. They will only cure urinary symptoms caused by a weakness in the urethra and bladder neck. Many urinary symptoms we see in clinic have other causes such as over active bladder.

What is an autologous fascial sling?

Rectus fascia sling or autologous sling is an operation to treat stress urinary incontinence. In this operation a strip of tissue (rectus fascia) is taken from the lower abdomen (tummy) and used as a sling or hammock around the bladder neck and urethra. This differs to other types of sling such as the TVT sling, which uses a synthetic material/mesh to create the sling. The rectus fascia sling therefore provides a mesh-free alternative.

The rectus fascia is the thin but very tough layer that covers the abdominal muscles.

How is an autologous fascial sling done?

The operation is usually done under general anaesthetic. A general anaesthetic will mean you will be asleep during the entire procedure.

Occasionally it is done using a spinal anaesthetic which numbs you from the waist downwards following an injection in your back.

The operation involves a bikini line cut in your lower abdomen (tummy).

A strip of the strong tissue that encases the muscle of your abdomen is removed through the incision.

A small cut is made in the vaginal wall just under the urethra

The prevention of infection is a major priority in all healthcare and everyone has a part to play.

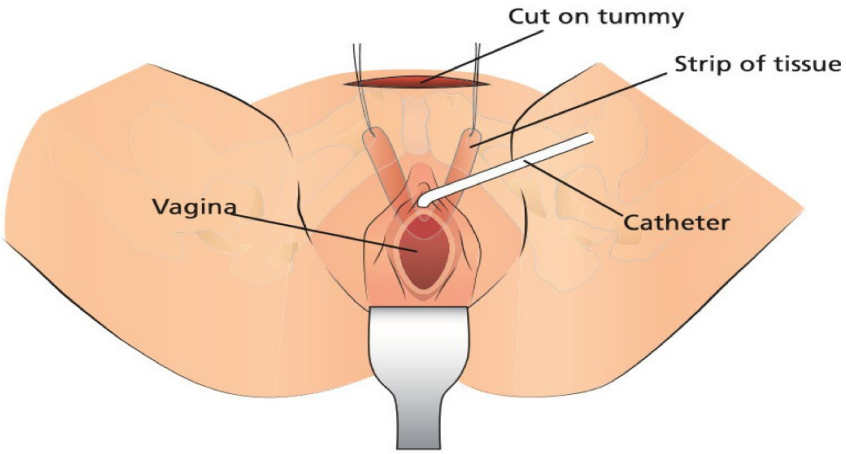
- **Please decontaminate your hands frequently for 20 seconds using soap and water or alcohol gel if available**
- **If you have symptoms of diarrhoea and/or vomiting, cough or other respiratory symptoms, a temperature or any loss of taste or smell please do not visit the hospital or any other care facility and seek advice from 111**
- **Keep the environment clean and tidy**
- **Let's work together to keep infections out of our hospitals and care homes.**

This strip of tissue is then threaded on either side of the neck of your bladder to create a sling under the urethra.

At the end of the operation a cystoscopy (camera examination of the bladder) is performed to check that there is no injury to the bladder.

A catheter is needed to drain the bladder for 1-2 days. This is likely to come out through the urethra (urethral catheter) however occasionally it will be placed through the abdomen (suprapubic catheter).

Diagram showing the position of the fascial sling



What are the benefits of stress incontinence surgery?

80-90 % of women are substantially improved. This means you may get back to:

- Physical activity – running, dancing, gym etc
- Gardening
- Sexual relations.

This also means you may have renewed confidence so that:

- You can, for example, go shopping without fear of leaking
- You do not have to worry about damp patches on clothing
- You do not worry about unpleasant odour.

It has similar success rates to a colposuspension or a suburethral synthetic mesh tape. It avoids the implantation of mesh.

Will this operation cure the sensation of "urgency"?

It is important to know that although "urgency" (the overwhelming sensation of needing to pass urine) might improve in 50-60% of patients after surgery; it may persist in 30-40% or get worse in 10-15% of patients after the operation.

What are the risks of this surgery?

General risks of surgery

Anaesthetic risk. This is very small unless you have specific medical conditions, such as a problem with your heart, or breathing. Smoking and being overweight also increase any risks.

Bleeding. There is a risk of bleeding with any operation. It is rare that we have to transfuse patients after their operation.

Infection. There is a small risk of infection with any operation (about 5 to 13 cases in 100 operations).

If it occurs, an infection can be a wound infection, vaginal infection or a urinary infection, and is usually treated with antibiotics. The risk of infection is reduced by routinely giving you a dose of antibiotic during your operation. Chest infection may also occur as a result of a general anaesthetic.

Wound complications. Wounds can become infected or occasionally stitches can become loose allowing the wound to open up or alternatively tighten up causing discomfort.

Deep Vein Thrombosis (DVT). This is a clot in the deep veins of the leg. Occasionally this clot can travel to the lungs (pulmonary embolism) which can be very serious and in rare circumstances it can be fatal (less than 1 in 100 of those who get a clot). The risk increases with obesity, severe varicose veins, infection, immobility and other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood.

Specific risks of an autologous fascial sling

Failure to cure stress incontinence (10-20% of cases).

Recurrence of stress incontinence even if it has been cured initially (about 10% of cases).

Overactive bladder symptoms (urinary urgency and frequency with or without incontinence) often improve after the operation, but can start or worsen after the operation (about 10% of cases).

Bladder emptying or voiding problems. When you first pass urine, it may be uncomfortable and the urine flow may be slower than usual. The nurses will measure the amount of urine you pass and then check a scan of the bladder afterwards to make sure you are emptying well. If your bladder does not empty well, the bladder catheter may be replaced for a few days or you may be asked to carry out self-catheterisation. This happens in about 10% of patients (1 in 10) but is rarely needed for more than a few days. If it does persist and you cannot pass a catheter yourself then you can go home with a catheter in place, returning to the hospital for it to be removed after a few days.

The problem can continue in the long term in 5-10% of women. Often before the operation you will be taught how to pass a catheter yourself when your bladder feels full (intermittent self-catheterisation or ISC) in case you do have long term difficulties emptying your bladder.

Bladder injury. As the operation requires a tunnel to be made from the vagina to the abdomen around the bladder there is a risk of injury to the bladder which occurs in 5-10% of these operations. Any injury would usually be repaired during the operation. If this occurs you may need to have a catheter draining your bladder for about 10 days to allow the injury to heal. Although it is much less common the urethra can also be damaged and this can be more difficult to repair.

Injury to other structures in the abdomen. As all structures are close together in the pelvis where this surgery is carried out there is a small risk that during surgery injury can occur to the bowel, large blood vessels or the ureter (tube from the kidney to the bladder).

Hernia formation through the scar on your abdomen. It is difficult to be certain how often this occurs but it may be in up to 10% of women.

Pain lasting more than 6 months or pain on intercourse. It is uncommon (less than 1.5%) but unpredictable.

What happens if I do not have the operation?

Your problem may remain the same, get worse or improve over time. There is no sure way in predicting this.

Are there any alternatives?

You will have been offered and tried conservative measures, including fluid advice, pelvic floor muscle training, smoking cessation as well as weight loss, before being offered surgery. It is difficult to predict what will happen to your bladder, or if you have an operation, how long the effects will last.

You should only have the operation if the stress incontinence is badly affecting your quality of life.

Non-surgical

Do nothing

If the leakage is only very minimal and is not distressing, then treatment is not always needed

Weight loss

Losing weight has been shown to reduce leakage of urine.

Pelvic floor exercises

You should have already completed a course of pelvic floor exercises before being offered surgery to treat stress incontinence. This is usually a structured programme of exercises for three to six months provided by the physiotherapist. Pelvic floor exercises can strengthen the pelvic floor and correct or reduce stress incontinence. They are the most effective non-surgical treatment for stress urinary incontinence.

Continence devices

There are numerous devices (none available on the NHS) which essentially aim to block the urethra. The devices are inserted either into the vagina or the urethra. They are not a cure but their aim is to keep you dry whilst in use, for example during 'keep fit'. A leaflet is available if you require further information.

Absorbent products

Incontinence pads or pants may provide extra ways of managing urinary problems for some women.

Duloxetine

This is a medication that can help reduce incontinence. It needs to be taken continuously as stopping the drug will result in the leakage returning.

Some women find that it causes unacceptable side effects. It is not usually recommended as a first line treatment but is an option to consider if you do not want to have a surgical procedure or are unfit to do so.

Advantages and disadvantages of different surgical options for treating stress incontinence.

The following table lists the different operations that can be considered to treat stress urinary incontinence. Further information on the operations is available in separate leaflets. Your consultant may recommend a particular operation depending on his or her preference and expertise, or your individual needs.

Treatment	Advantages	Disadvantages
Colposuspension (suspension of the neck of the bladder and urethra through the tummy).	Does not involve insertion of mesh. Can be done via key-hole surgery. Success rate similar to a mesh tape. Treats prolapse of the anterior (front) wall of the vagina (cystocele).	Usually requires a general anaesthetic. Worsened urinary urgency similar to a mesh tape. Difficulty passing urine similar to a mesh tape. Higher risk of bleeding than mesh tape. Stitches causing bladder stones if they work their way into the bladder over time. Developing a prolapse of the posterior (back) wall of the vagina (rectocele). Longer recovery.
Autologous fascial sling (a suspension of the urethra and bladder neck using your own tissue).	Does not involve insertion of mesh. Success rate similar to a synthetic mesh tape	Usually requires a general anaesthetic. Requires a cut across the bottom of your tummy (not done via key-hole surgery). Longer recovery. Higher risk of difficulty passing urine than with other procedures. Higher risk of urinary urgency than other procedures. Similar risk of bleeding to colposuspension. Risk of hernia developing through the scar Not available in all hospitals.

Urethral bulking injection	No incisions (cuts). Can be done under local anaesthetic with or without sedation. Can be done as an outpatient treatment. Less pain compared to the other operations. Lower risk of complications compared to other operations. Quick recovery.	Long term success lower than for the other procedures.
Midurethral synthetic mesh tape	Good chance of curing or improving stress incontinence.	Worsening of urinary urgency. Difficulty passing urine. Mesh complications. Mesh exposure and erosion into the vaginal urethra or bladder. Can cause pain in the pelvis which sometimes persists long term.

Is there anything else I can do to help myself?

- "Bracing" of the pelvic floor whenever there is any raise in intra-abdominal pressure (for example when you cough, sneeze, lift or shout)
- Develop healthy fluid habits:
  - Avoid caffeine and fizzy drinks.
  - Drink three pints of water and simple juice per day.
- If you get a sensation of incomplete emptying, try regular "double voiding," which means every time you go to the toilet empty your bladder twice within 10 minutes apart; do not push to empty your bladder
- Get out of the habit of going to the toilet "just in case".

Before considering surgery

It is recommended that you should have tried pelvic floor exercises for at least 3 months, supervised by a trained women's health physiotherapist, before considering surgery.

Surgery is not usually recommended if you plan to have further children as pregnancy and delivery can result in a recurrence of the stress incontinence even if you are delivered by caesarean section.

Although urodynamic tests are not absolutely essential before the first surgery that is tried to treat stress incontinence, they are often carried out to confirm that you do have stress incontinence. These tests should, however, be carried out before repeat surgery or if you also have symptoms of urgency.

Discussion at a multidisciplinary team (MDT) meeting is considered good practice before carrying out surgery for stress incontinence. Your medical notes and the results of any tests are reviewed at the MDT meeting which is attended by urogynaecologists, specialist nurses and physiotherapists.

Taking into account any preferences you have expressed, a team decision is made as to whether your proposed treatment is appropriate.

The choice about which treatment is best for you will be made together with your doctor. This will be based on the risks and benefits of the treatment and individual circumstances.

We must seek your consent for any procedure or treatment beforehand. Your doctor will explain the risks, benefits and alternatives, where relevant, before they ask for your consent. If you are unsure about any aspect of the procedure or treatment proposed, please do not hesitate to ask for more information.

Key points

- Autologous slings are used to treat stress urinary incontinence
- The sling is made from your own body tissues (i.e. there is no mesh)
- This is a medium-sized operation with a six-week recovery period
- Two thirds (66%) of women are completely dry after this operation
- 80 to 90% of women are happy with the result of their surgery even though some still have some leakage
- 10% of women develop urgency (needing to rush to the toilet)
- Some women have difficulty emptying their bladder and will need to pass a disposable catheter to empty completely.

What should I expect before the operation?

Before admission for surgery, you will be asked to attend a pre-admission clinic to ensure that you are fit and well for your surgery.

A nurse practitioner or a doctor will ask about your general health, past medical history and any medication that you are taking. Any necessary investigations will be organised, such as blood tests, ECG and chest X-rays.

You will receive information about your admission, hospital stay, operation and pre and post-operative care. You will also be given the opportunity to ask any further questions that you may have.

You are advised that you should not go on a long haul flight (more than 4 hours) in the six weeks prior to your surgery due to increased risk of clots in your legs.

Plan ahead - when you come out of hospital you are going to need extra help at home for the first two weeks. Make sure your family knows this.

If you smoke, try to stop completely. This will make your anesthetic safer, reduce the risk of complications after operation, and speed up the recovery time. If you are unable to stop completely, even doing so for few days will be helpful.

Some medicines need to be stopped or altered before the operation. You should check with your GP and bring your list of medications with you when you come to the pre-admission clinic. If you are on contraceptive pill, you should stop it at least four weeks before the operation and you should use another method of contraception.

What will happen on the day of my surgery?

On the day of your operation, you must have nothing to eat or drink for a specified time prior to your operation. You will be advised as to what time you need to stop eating and drinking.

Before your operation can take place, a doctor will see you to reconfirm your written consent, which will have already been obtained at a previous appointment. You will have the opportunity to ask any questions not covered during your pre-admission clinic appointment.

You are requested to have a bath or shower before you come into hospital. Prior to your surgery you will be asked to put on a theatre gown. You will be asked to remove all items of clothing including underwear, jewellery (except wedding rings) including all piercings, nail varnish, false nails, make up, contact lenses, hearing aids, dentures, wigs and any false limbs.

You will be requested to wear a pair of elasticated stockings (TEDS). The stockings help to prevent clots (thrombosis) in your legs. You will need to keep these on until you are discharged from hospital. The nurses will advise you how long you will need to continue to wear the stockings following your discharge from hospital.

You will be escorted to theatre by a member of the team. If a premedication (pre-med) has not been given, you may have the option of walking to theatre, otherwise a theatre trolley will be arranged to collect you from the ward.

You will be taken to the anaesthetic room where you will be asked few questions. If you are having general anaesthesia, you will be given an injection into a vein usually in the back of your hand. Once you are asleep, you will be taken into theatre.

You will wake up in recovery area once your operation is finished. A nurse will then escort you back to your bed on the ward.

What will happen after the operation?

When you wake up from the anaesthetic, you will have a drip in your hand to give you fluids and keep you hydrated until you can drink again. If there has been more than average bleeding during the operation a drain (tube) from inside the tummy to outside may be placed beside a wound to let out any blood which has collected. This is usually taken out the next day. There will also be a tube in the bladder (catheter) to avoid urinary retention. The catheter is usually removed 1 – 2 days after surgery.

Will I have any pain following surgery?

Most people experience some pain or discomfort for the first few days and you will be offered pain relief to help ease it. Initially, you may need to have pain relief by injection to keep you comfortable. After this, you will have the choice of tablets or suppositories. You will be encouraged to take regular pain relief, as being pain-free will speed up your recovery. The anaesthetist will discuss pain relief with you before your operation.

Having an anaesthetic, being in pain, and having strong pain relief can sometimes make you feel nauseous or sick. This can be relieved by injections or tablets.

Many women get wind pains a few days after the operation, which can be uncomfortable and make the tummy look distended (swollen). This should not last long and can be relieved by medicines, eating and walking about.

You should avoid constipation and once you are eating and drinking again you can do this by:-

- Drinking plenty of water or juice
- Eating fruit and green vegetables, especially broccoli
- Eating plenty of roughage, such as bran or oats.

Will there be any bleeding?

After the operation, you may have some slight vaginal bleeding and you may need to wear a sanitary pad. We advise that you do not use tampons for 6 weeks and avoid douching the vagina. Your vaginal loss should settle after about a week. (If you have any new pain, fresh bleeding or bad smelling discharge after you go home, you should contact your GP).

Will I have any stitches?

The stitches in your abdominal wound may need to be removed or may dissolve away. The ward nurses will let you know when they need removing and will advise you how to get them removed, if necessary, if you have already gone home.

Any of the stitches under the skin in the vagina will melt away by themselves. The surface knots of the stitches may appear on your underwear or pads after about 2 weeks, this is quite normal. There may be little bleeding again after about 2 weeks when the surface knots fall off, this is nothing to worry about.

Will I be able to cough?

If you need to cough, your stitches will not come undone. You will be wearing a sanitary towel, and coughing will hurt less if you press on your pad firmly to give support between your legs. Any persistent cough following discharge should be treated promptly. Please see your GP as soon as possible.

When can I return to my usual routine?

Recovery is a time-consuming process, which can leave you feeling tired, emotionally low or tearful. The body needs time and help to build new cells and repair itself.

- Preventing DVT (deep vein thrombosis). The same day or the day after your operation, you will be encouraged to get out of bed and take short walks around the ward. This improves general wellbeing and reduces the risk of clots in the legs. You may be given a daily injection to keep your blood thin and reduce the risk of blood clots until you go home or longer in some cases along with the anti-embolism stockings previously mentioned.

You are usually in hospital for between two and five days. If you require a fit note or certificate please ask.Your date of discharge depends on the reasons for your operation, your general health and how smoothly things go after surgery.

It is important to remember that everyone's experience is different; recovery time varies from woman to woman and it is, therefore, best not to compare your own recovery with that of others on the ward.

- At 6 weeks gradually build up your level of activity
- After 3 months, you should be able to return completely to your usual level of activity
- You should be able to return to a light job after about six weeks, a busy job in 12 weeks. Avoiding all unnecessary heavy lifting will possibly reduce the stress incontinence recurring.

When can I drive again?

You can drive as soon as you can operate the pedals and look over your shoulder without discomfort, generally after three weeks, but you must check this with your insurance company, as some of them insist that you should wait for six weeks.

Will I have a follow up appointment?

You usually have a follow up appointment anything between 6 weeks and six months after the operation. This may be at the hospital (doctor or nurse), with your GP or by telephone. Sometimes follow up is not required.

When can I resume sex after the operation?

For many women, following recovery, this aspect of their life is improved because there is no longer any discomfort. We advise that you avoid penetrative intercourse for about 6 weeks, until after your follow-up appointment.

Take time, feel comfortable, do not be rushed and for the first few times you might find a lubricating gel is helpful. You can buy this from the chemist. Talk to your husband or partner about this, as you will need them to be extra gentle and understanding.

Will I gain weight?

The operation itself should not cause you to gain weight. Initially, because you are feeling better, reduced levels of activity and an increased appetite, might lead to weight gain if you are not careful. By paying attention to what you eat and increasing your activity level as you recover, weight gain need not be a problem.

What happens if I feel unwell after I go home?

You may expect some minor bleeding, especially some old, brownish blood for two weeks.

You should contact your GP or the Gynaecology Ward (01902 694034 24 hours a day 7 days a week)if you notice any of the following:

- Increased temperature
- Wound swelling
- Worsening pain
- Bad smelling discharge either from the wounds on your tummy or the front passage
- Blood in your urine or bowel motions
- Abdominal distension
- Failure to open your bowels
- Warm, painful, swollen leg
- Chest pain
- Difficulty breathing.

What can I do to help myself at home?

- Mobilisation is very important; using your leg muscles will reduce the risk of clots in the back of the legs (DVT)
- Bath or shower as normal
- You are likely to feel tired and may need to rest in the daytime from time to time for a month or more, this will gradually improve
- It is important to avoid putting pressure on the sling particularly in the first weeks after surgery. Therefore, avoid constipation and heavy lifting
- Avoid constipation
    - Drink plenty of water and juice
    - Eat fruit and green vegetables

Where can I get more information?

If you would like to know more about stress urinary incontinence and the treatments available for it, you may try the following sources of information.

- Ask your GP
- Ask the Doctor or Nurse at the hospital
- Look at a website such as:-

The RCOG (Royal College of Obstetricians and Gynaecologists) leaflet on recovering well after an abdominal hysterectomy contains advice much of which is applicable to this surgery: https://www.rcog.org.uk/globalassets/documents/patients/patient-information- leaflets/recovering-well/abdominal-hysterectomy.pdf

- NHS choices at: http://www.nhs.uk/pages/home.aspx
- Patient UK at: http://patient.info/health
- The British Association of Urological Surgeons (BAUS) patient information leaflet – Autologous fascial sling at: http://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Autologous%20female%20sling.pdf
- National Institute for Health and Care Excellence (NICE). Information for people who use NHS services. – Insertion of biological slings for treatment of stress urinary incontinence in women at: https://www.nice.org.uk/guidance/ipg154/resources/insertion-of-biological- slings-for-stress-urinary-incontinence-in-women-pdf-304387597
- Patient information leaflets for your own hospital and others (usually available on line).

English

If you need information in another way like easy read or a different language please let us know.

If you need an interpreter or assistance please let us know.

Lithuanian

Jeigu norėtumėte, kad informacija jums būtų pateikta kitu būdu, pavyzdžiui, supaprastinta forma ar kita kalba, prašome mums apie tai pranešti.

Jeigu jums reikia vertėjo ar kitos pagalbos, prašome mums apie tai pranešti.

Polish

Jeżeli chcieliby Państwo otrzymać te informacje w innej postaci, na przykład w wersji łatwej do czytania lub w innym języku, prosimy powiedzieć nam o tym.

Prosimy poinformować nas również, jeżeli potrzebowaliby Państwo usługi tłumaczenia ustnego lub innej pomocy.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਪੜ੍ਹਨ ਵਿਚ ਆਸਾਨ ਰੂਪ ਜਾਂ ਕਿਸੇ ਦੂਜੀ ਭਾਸ਼ਾ ਵਿਚ, ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

ਜੇ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ ਦੀ ਜਾਂ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

Romanian

Dacă aveți nevoie de informații în alt format, ca de exemplu caractere ușor de citit sau altă limbă, vă rugăm să ne informați.

Dacă aveți nevoie de un interpret sau de asistență, vă rugăm să ne informați.

Traditional Chinese

如果您需要以其他方式了解信息，如易读或其他语种，请告诉我们。

如果您需要口译人员或帮助，请告诉我们。

Designed & Produced by the Department of Clinical Illustration,
New Cross Hospital, Wolverhampton, WV10 0QP Tel: 01902 695377.

Review Date 20.05.2022 Date Produced 2019 MI_5390714_03.07.19_V_1