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SLING REMOVAL FOR DYSPAREUNIA: IS SLING LOCATION A FACTOR?

Hypothesis / aims of study

Studies regarding the influence on sexual function by mid-urethral slings [MUS] are limited and rates of de novo dyspareunia vary.[1] The etiology of dypareunia is multifactorial and may include malposition of the sling relative to the midurethra, although this has not been specifically elaborated. Recently tape position relative to the urethra has been investigated as an etiology for recurrent stress urinary incontinence [SUI] after MUS.[2] Our hypothesis was that the majority of patients with dyspareunia after MUS would have slings distal to the midurethra.

The aim of the study was to evaluate the incidence of malposition of MUS in women undergoing reoperation for dyspareunia after MUS. Resolution of dyspareunia and incidence of recurrent SUI were also measured.

Study design, materials and methods

A retrospective review was performed of all patients referred and treated for dyspareunia after MUS (retropubic [RP], transobturator [TO], or single incision [SIS]). Excluded indications for revision included outlet obstruction and mesh exposure. All patients underwent preoperative cysto-urethrosopy and pelvic exam. Operative reports at time of revision/explantation provided the anatomic location of the sling. Intraoperatively the bladder neck was identified by palpation of the Foley catheter balloon.

Results

14 women with dyspareunia after MUS were operated on. 2 were found to have intraluminal mesh on preoperative evaluation [1 after TO and 1 after SIS]. 1 patient had a retained piece of the introducer from the SIS. 6 women were found to have the sling distal to the midurethra; 3 had slings at the bladder neck; 3 had slings at the midurethra. Distal location was more commonly found after SIS. Paraurethral banding was more commonly associated with both TO and SIS. All women had complete resolution of their dyspareunia after sling explantation however all women also complained of recurrent SUI within a 8 week follow-up. Dyspareunia was most common after SIS.

Interpretation of results

Dyspareunia completed resolved after revision however the rate of sling malposition was variable and SUI recurred in all women

Concluding message

While dyspareunia was most common after SIS in this series, randomized trials with sufficient power to determine which route of sling placement is best regarding sexual function, are lacking. The incidence of malposition of MUSs in patients without dyspareunia is unknown.

References

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2. Gilchrist AS, Rovner ES. Sling location in women with recurrent stress urinary incontinence following midurethral sling. Urology. 2012 Jan;79(1):76-9. Epub 2011 Oct 19.

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