

REMOVAL OF MULTIPLE VAGINAL MESH EROSIONS AFTER AN ANTERIOR AND POSTERIOR VAGINAL MESH PLACEMENT

Introduction

Vaginal mesh erosion is one of the most frequent complications following the placement of synthetic meshes for the treatment of pelvic organ prolapse (POP). Some of such cases can be treated either conservatively with local estrogens and/or antibiotics or by local excision of the eroded mesh. However the treatment of extensive vaginal mesh erosions might be difficult requiring a challenging surgical approach.

Design

Case report of an extensive and persistent multiple vaginal mesh erosion in a young sexually active woman following a transvaginal placement of a synthetic mesh kit for the treatment of POP. The accompanying video demonstrates the surgical excision of the mesh from both the anterior and posterior vaginal wall.

Results

A 44 year-old woman was referred in a tertiary Urogynaecological Department complaining of vaginal discharge, bleeding and dyspareunia following the placement of a transvaginal synthetic mesh kit for the treatment of POP 14 months earlier. She had no previous history of other prolapse or anti-incontinence surgery. The initial procedure was uncomplicated with a good postoperative recovery. However, two months later she noticed blood stained vaginal discharge and following resumption of sexual intercourse she suffered from severe dyspareunia. A diagnosis of vaginal mesh erosion was made by her surgeon who prescribed local antibiotics and attempted on many occasions to remove the eroded mesh under local anesthesia. Despite a transient improvement, the symptoms recurred and got worse to the point of affecting significantly her quality of life. Following referral to our unit a gynecological examination revealed multiple and extensive vaginal mesh erosions on both the anterior and posterior vaginal wall. The vaginal mucosa was well estrogenised with normal capacity and no evidence of stenosis. She was treated with local antibiotics (clindamycin 2% administered vaginally) for 10 days and was admitted for surgical removal of the eroded mesh under general anesthesia.

The vaginal wall was initially infiltrated with diluted hemostatic solution in order to facilitate dissection and to minimize bleeding. The vaginal mucosa surrounding the eroded area was grasped with Allis forceps and excised using a scalpel. Sharp dissection was used to separate the vagina from the mesh and the dissection was extended laterally until 'clear' non-infected mesh was visible. The eroded mesh was then grasped and separated carefully from the underlying bladder. A similar technique was followed in order to remove the eroded mesh from the posterior wall. The vaginal wall was sutured with interrupted non absorbable polyglactin 910 2/0 sutures. At the end of the procedure all suture lines had no tension and the vagina had adequate capacity and satisfactory support. The haemostasis was good with an estimated blood loss of approx. 150ml and no vaginal pack was inserted. The patient's recovery was uneventful and was discharged on the 2nd postoperative day. The patient returned for a follow-up appointment at 6 weeks and reported no vaginal discharge or bleeding 4 weeks after the procedure. Physical examination revealed a well healed vaginal wall with no evidence of erosions. She was seen again six months postoperatively and reported no dyspareunia.

Conclusion

Extensive vaginal erosions after synthetic mesh placement often need a generous removal of the graft and the surrounding vaginal wall around the eroded area in order to accomplish a satisfactory reparative result.

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<i>Is this a clinical trial?</i>	No
<i>What were the subjects in the study?</i>	HUMAN
<i>Was this study approved by an ethics committee?</i>	No
<i>This study did not require ethics committee approval because</i>	none needed
<i>Was the Declaration of Helsinki followed?</i>	Yes
<i>Was informed consent obtained from the patients?</i>	Yes