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OUTCOMES WITH REPLACEMENT TRANSOBTURATOR SLING AFTER MIDURETHRAL SLING REMOVAL FOR DYSPAREUNIA

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. The etiology of dyspareunia is multifactorial. There are minimal data estimating the rate of recurrent stress urinary incontinence [SUI] after removal of MUS and about the subsequent management and what the ideal secondary procedure is based on efficacy and sexual function. A previous study had a 15% rate of recurrent SUI after removal of the MUS for dyspareunia and these patients were successfully treated with retropubic suspension and urethral bulking. [1] There is little guidance in the literature regarding choice of procedure for recurrent SUI after failed MUS.

The aim of the study was to examine outcomes with transobturator sling placement for recurrent SUI after explantation of MUS's for dyspareunia.

Study design, materials and methods

A retrospective review was performed on all patients referred and treated for dyspareunia after MUS (retropubic [RP], transobturator [TO], or single incision [SIS]) excluding those with outlet obstruction and mesh exposure, who had recurrent SUI.

Results

14 women underwent sling explantation for dyspareunia after MUS. 2 patients required urethrotomy and reconstruction for intraluminal mesh exposure. All women had complete resolution of their dyspareunia after sling explantation. However all had recurrent SUI at their 8 week follow-up. All patients underwent TO sling for recurrent SUI. All patients had resolution of their SUI and none complained of de novo dyspareunia after the TO sling.

Interpretation of results

Our rate of recurrent SUI after explantation is higher than reported in the literature and this may be an effect of the route of placement of the original sling, time course to removal, and amount of mesh left in situ. Dyspareunia was most common after SIS in this series. Patients in this series were able to have secondary slings [TO] without recurrent dyspareunia but we can't be certain if surgical technique, route of placement, or location of the MUS in relation to the mid-urethra led to the improvement.

Concluding message

Randomized trials with sufficient power to determine which route of sling placement is best regarding sexual function, are lacking. The ideal procedure for treatment of recurrent SUI after explantation or failed MUS remains undecided. In this small series we were able to resolve SUI without causing subsequent dyspareunia after TO sling placement. Factors responsible for dyspareunia after MUS remain variable.

References

1. Kuhn A, Burkhard F, Eggemann C, Mueller MD. Sexual function after suburethral sling removal for dyspareunia. *Surg Endosc* (2009) 23: 765-768

Disclosures

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