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OUTCOMES AND MANAGEMENT ON THE MESH COMPLICATIONS AFTER THE TRANS-VAGINAL MESH SURGERY

Hypothesis / aims of study

The aim of the study is to describe the various presentations of complications associated with transvaginal mesh surgery on pelvic prolapse and the subsequent management and outcome.

Study design, materials and methods

From December 2006 to March 2013, 45 patients with complications related to transvaginal mesh kit procedures were managed in an Urogynecology unit of a tertiary referral medical center. A retrospective chart review was performed to collect operative notes, demographic data and postoperative follow-up.

All patients had a comprehensive history recorded, physical and gynecological examination. Patients completed additionally the quality of life questionnaires of UDI-6, IIQ-7, POPDI-6 and PISQ-12. In an individualized approach, patients were scheduled for cystoscopy to examine the integrity of the lower urinary tracts and/or colposcopy to rule out any vagina exposure/extrusion. Complaints were expressed using the category (C), time (T) and site (S) coding as accordance to the Standardization and Terminology Committees of the International Urogynecological Association (IUGA) and the International Continence Society (ICS). Patients were then either managed conservatively, limited excision or underwent surgical removal of the mesh.

Results

18 (40%) cases of all mesh complications were performed by first authors while 11 (24%) were performed by trained urogynecologist. And the rest of 16 (36%) cases were by general gynecologist and urologist. Base on a total of 712 mesh surgeries managed by first author in the same study period was reviewed. The overall meshed erosion rate committed was 2.5 % (18/712).The mesh erosion rate on various types of mesh kits was Perigee, Avaulta A, Elevate A and Prolift T were 2.5% (10/406), 4.9% (5/102), 0% (0/67), 2.6% (3/116) and self tailed mesh 0% (0/21) respectively. Vaginal bleeding was the most common presenting symptom (73.3%, 33/45) and did not significantly differ from those presented without other symptoms.

73.3% (33/45) presented with vaginal bleeding associated with other symptoms that did not significantly differ from those presented without any vaginal bleeding. 31.1% (14/45) of patients had provoked pain. The time trend of first presentation of mesh exposure/extrusion after surgery, there appeared to be an initial peak of presentation between 3 to 4 months after surgery that reached a plateau before another rise after one-year follow-up. 66.7% (30/45) of patients were treated as outpatient office setting. 55.6% had limited mesh excision in the outpatient office setting. Fifteen patients required surgical excision of mesh with vaginal closure in the operating room. Only one patient had required extensive total excision of mesh. Overall, 12 patients (26.7%) still had mesh exposure after initial treatment.

Interpretation of results

New onset or persistent vaginal bleeding after TVM surgery should be considered a warning sign of mesh complication. Frequent follow-up in the first three to four months may identify complications earlier allowing commencement of treatment. Surgical mesh excision and trimming as the initial treatment could yield a good outcome.

Concluding message

Vaginal bleeding after TVM surgery should be considered a warning sign of mesh complication. Frequent follow-up in the first three to four months may identify complications earlier. Surgical mesh excision and trimming as the initial treatment yield a good outcome.

Disclosures

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