

TRANSVAGINAL APPROACH TO URETHRAL RECONSTRUCTION AFTER MIDURETHRAL SLING COMPLICATION

Introduction

Urethral mesh erosion is an uncommon complication after surgical correction of urinary incontinence. We present the case of a 45 year-old woman who presented with 3 years of persistent urethral pain, voiding dysfunction and stress incontinence following transobturator tape placement for severe stress incontinence. She had been previously managed with pain medication including Pregabalin for neuropathic pain. A cystogram was unremarkable but cystoscopy revealed an intra-urethral mesh with stones at the level of the distal urethra. We present a video demonstrating the surgical technique of a transvaginal approach to urethral reconstruction for urethral mesh extrusion.

Methods

An inverted "U" incision was made horizontally in the anterior vaginal wall and sharp dissection was carried out to mobilize the urethra proximally from the anterior vaginal wall. The lateral wall of the urethra was dissected sharply on each side and mobilized. The mesh entering the urethra was identified and clamped on both lateral side and the urethral wall overlying the mesh was incised vertically, exposing the mesh inside the urethra. The mesh was clamped with an Alice Clamp, freed from the urethra, and isolated over a right angle instrument. The lateral exit sites of the mesh were identified on either side and the exiting mesh was clamped and the attachments sharply divided. The mesh was then sharply dissected from the adhesions and the mesh was pulled out of the right lateral urethral wall through the midline urethral incision. A distal flap was used in the urethral closure to prevent narrowing of the urethral lumen and the urethra was reconstructed with a series of 5-0 Vicryl sutures. The previously mobilized paraurethral tissue was then used to create 2 additional closure layers.

Results

There were no complications and the patient was discharged home the following day with an indwelling foley catheter which was removed 10 days following the procedure. A Cystogram confirmed the lack of a urine leak and urethro-vaginal fistula. The patient's symptoms improved dramatically, with complete resolution of her urethral pain and only mild residual stress urinary incontinence.

Conclusion

Transvaginal approach can be utilized to successfully perform urethral reconstruction after intra-urethral mesh erosion.

Disclosures

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