

TREATMENT OF MESH EROSION WITH LASER DURING CYSTOSCOPY

Introduction

The most common complications due to mesh are; lower urinary tract obstruction, urethra or bladder erosion, vaginal extrusion, voiding dysfunction, infection and pain. Erosion is defined as the opening of mesh to urinary tract (bladder, urethra or ureters). Mesh erosion occurs in the use of synthetic materials. Causes of erosion considered as: technique, poor tissue quality, poor blood supply, hematoma causing bacterial colonization, mesh size, pore size and flexibility of mesh. This complication can be caused by necrosis due to synthetic material placed with tension. Patients who develop urethral or bladder erosion may present with haematuria, voiding dysfunction, recurrent urinary tract infections and inguinal or suprapubic pain. The therapy of mesh erosion is excision of all mesh material if possible. Partial mesh resection may be necessary when the whole excision is not possible because of difficulty or danger. In this video, we aimed to present removing a mesh material from bladder wall with the use of holmium-YAG laser during cystoscopy.

Design

63-year-old female patient was admitted to our clinic with dysuria symptom. From her medical history we learned that endoscopic cystolithotomy had been performed in another country 3 months ago. We also learned that due to myoma uteri in addition to cystocele, trans-abdominal hysterectomy with bilateral salpingo-oophorectomy with concurrent open cystocele surgery had been performed 3 years ago in the same centre. When we performed computed tomography without contrast injection preoperatively we realised mesh material surrounding bladder posteriorly. When we performed diagnostic cystoscopy, we found mesh erosion and calcification on the mesh material. Thereupon we performed laser excision to the margins where the mesh joins with the bladder mucosa.

Results

Operation lasted in 40 minutes under spinal anaesthesia. No intraoperative complication was observed. We observed very little bleeding during operation. There was no need for blood transfusion. Vital signs were stable in the postoperative follow-up. 20f foley catheter which was placed at the end of the operation removed at 12. hours postoperatively. When we observed her comfortable urination without any residual urine, patient was discharged on the day after surgery.

Conclusion

Although increased success is observed after suspension operation with mesh, mesh-related complications are capable of forming problem for the surgeons and the patients. This minimally invasive procedure with shorter hospital stay, lower costs, less bleeding and high patient satisfaction, cystoscopic laser management in mesh erosion brings to minds the question: is it preferable?

Disclosures

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