

EXCISION SURGERY OF A MESH CAUSING TOTAL OBSTRUCTION AFTER CONTINENCE SURGERY

Introduction

Previously, risk of mesh erosion or extrusion was about 10%(1). Today, mesh erosion or extrusion rates have been decreased because new meshes which are monofilament and large pore size are widely used. In this case, we present a woman which is that cystoscopy revealed a mesh eroding urethra and causing total obstruction in a patient presented with voiding difficulty after continence surgery.

Design

A 65 year-old woman who has continence surgery history in 1996 and a mid-urethral sling surgery in 2007 was admitted to our outpatient clinic with pelvic pain. During physical examination; urethral kinking and a mesh at bladder neck level was detected. Obstructive pattern was observed in uroflowmetry test(maximum flow rate, voided volume and residual urine volume were 3 ml/sn,100 ml and 447 ml, respectively). Thus, mesh excision surgery has been planned.

Results

Patient was positioned in the lithotomy position and urethra was evaluated with a 21F urethrocystoscope. An urethrovaginal fistule was seen at distal urethra. A mesh which is eroding urethra was seen at bladder neck level. It was not possible to send a guide through the mesh. Methylene blue was given to bladder via cystostomy catheter and no passage of methylene blue to urethra was observed. After lone star retractor placement, inverted U incision was made on anterior vaginal wall. Vaginal flap was prepared. Mesh was found and excised with prolene sutures from its most proximal end that was possible to reach. No remaining mesh was palpated. Methylene blue was seen at vagina and it was observed that bladder neck and urethra was dissected from each other inferiorly. Guide was sent to bladder and a 14F foley catheter was placed over the guide. Bladder neck and urethra was anastomosed to each other. A guide was placed through the fistule localised at distal urethra, dissected and repaired surgically. A longitudinal incision was done over the labia majora. Vascularised fibroadipous flap was prepared. A tunnel under right labia minora was prepared and flap was passed through this tunnel and fixed under the anastomosis. A redon drain catheter was placed. Incision layers were closed. Tampon with antibiotics was placed to vagina at the end of procedure. Her symptoms improved completely and maximum flow rate and residual urine volume were 12 ml/sn and 38 ml, respectively in control uroflowmetry.

Conclusion

High-tension in mid-urethral sling surgeries can cause urethral erosions and management of this complication can be quite challenging.

References

1. Domingo S, Alamá P, Ruiz N, Perales A, Pellicer A.Diagnosis, management and prognosis of vaginal erosion after transobturator suburethral tape procedure using a nonwoven thermally bonded polypropylene mesh.J Urol. 2005;173:1627-30.

Disclosures

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