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Masata J[1], Svabik K[2], Zamecnik L[3], Martan A[4]
1. *Dept. of Obst. Gyn., Charles University Prague,* ***2.*** *Dept. of Obst. Gyn. Charles University Prague,* ***3.*** *Urology Dept., Charles University Prague,* ***4.*** *Dept. of. Obst. Gyn. Charles University Prague*

LAPAROSCOPICAL REMOVAL OF INTRAVESICALLY INSERTED TRANSOBTURATOR TAPE

Introduction

Erosion or insertion of the tape mesh to adjacent organs is one of the serious possible complications of tension-free vaginal tapes. These complications are mostly related to retropubic trajectory of insertions and are rare after the use of transobturator tape. Management of such complications is difficult, and there is no common surgical approach about resolving them. The aim of this video is to provide a step-by-step description of our approach to laparoscopical removal of transobturator tape after previous failure of repeated cystoscopic tape resection.

Design

A 68-year-old woman (G3/P2) was referred to our department with tape erosion to the urinary bladder after repeated cystoscopic tape resection, recurrent stone formation in the urinary bladder, and repeated lithotripsy, with recurrent urinary tract infections, OAB with urgency incontinence. All those symptoms followed the insertion of transoturator tape in 5/2005. The patient also described severe hematuria following the procedure, which was treated with indwelling catheter for 9 days. Cystoscopy revealed the presence of stone on the bladder wall above the left ureteral orifice.

Results

Surgical procedure

Cystoscopy was performed and ureteral stents were bilaterally inserted. Laparoscopy was performed, using a 10 mm port inserted in the inferior edge of the umbilicus to accommodate the laparoscope and three other ports (one 10 mm and two 5 mm). After filling the urinary bladder with 150 ml of sterile saline, the peritoneum was opened and the Retzius space was reached. Tape was identified in the left obturator muscle, cut near the obturator muscle and dissected up to the bladder wall. Afterward a vertical 2 cm incision was made in the bladder wall, the stone was removed and the rest of the tape was dissected from the bladder wall.
A two-layer suture of the bladder wall was performed using 2-0 Vicryl running suture, and the bladder suture line integrity was tested with retrograded filling of the urinary bladder to 300 ml with “Patent blue” diluted in sterile saline.

Postoperative course

The postoperative course was uneventful. An indwelling Foley catheter was left for ten days. The patient was discharged from hospital on the third day after surgery. In follow-up visits 3 and 6 months after surgery the patient was continent; with no symptoms of OAB, and a cystoscopy check established adequate healing of the bladder wall.

Conclusion

Cystoscopic resection of protruded mesh is inadequate in many cases, because part of the tape could remain in the bladder was and cause further complications. In such cases it is required to remove the mesh from the urinary bladder wall completely. Laparoscopy allows minimally invasive complete removal of the tape, combining resection of the extravesical and intravesical part of the tape.

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