

MESH EXCISION IN A PATIENT PERFORMING CLEAN INTERMITTAN CATHETERIZATION FOR TWO YEARS AFTER TOT PROCEDURE

Introduction:

Currently, midurethral sling procedures are preferred for the surgery of the stress urinary incontinence (SUI), as a first choice. Although these surgeries are minimal invasive, morbidities including hemorrhage, voiding dysfunction, infection, pain, skin infection, mesh erosion, and bladder injuries may be occurred. In our video, we presented mesh excision, in a patient performing clean intermittent catheterization for two years after transobturator tape (TOT) procedure.

Design:

A female patient underwent TOT procedure at May 2014, in a Private Hospitale. At the postoperative 2th day, uretral catheter was extracted, but the patient could not void, and a foley catheter was implanted for 2 weeks. But after the catheter was removed, the patient could not micturate again. Clean intermittent catheterization (CIC) was recommended to patient. After two years, the patient consulted to our clinic. The patient underwent gynecological examination, complete urine analysis, urine culture, pressure flow study, and cystoscopy. Then, we planned to perform mesh excision, on July 2016. Under spinal anesthesia, 0.9% sterile normal saline was injected into the vaginal epithelium, surrounding the urethra to provide hydrodistention. An inverted U-shaped incision was performed for exposure of the urethra and the bladder neck. Mesh was seen at the bladder neck, then mesh dissected and cut in the middle. Each part of the mesh extracted from the surrounding area by blunt and sharp dissection through the obturator channel. Mesh was extracted, as far as we reached. Urethral catheter was removed at postoperative 2th day. Maximal flow rate (Q_{max}) was calculated by uroflowmetry, and postvoiding residual urine volume (PVR) was detected by ultrasonography, postoperatively.

Results:

The patient's age was 32, and she had 3 vaginal birth history. There was not any prolapse, and vaginal extrusion on gynecological examination. Leukocyturia was observed in urine analysis, with a negative urine culture. Bladder capacity and the detrusor pressure were calculated as 415 ml and 42 cmH₂O respectively, on pressure flow study. There was not any abnormalities on cystoscopic examination. The patient underwent mesh excision surgery, transvaginally. Postoperative 2th day, the urethral catheter was removed, and the patient voided easily. Q_{max} was calculated as 24 ml/s by uroflowmetry, and only 45 cc PVR was detected by ultrasonography. At the postoperative 8th month follow-up, Q_{max} was 27 ml/s, and PVR was noted as 15 cc.

Conclusions:

Mesh excision is a safe and a reliable procedure, for the patients who can not urinate and have higher PVR, after midurethral sling surgeries. A long time passing through the midurethral surgery does not make the mesh excision surgery so harder.

Disclosures

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