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STRATASIS TUS: TENDINEOUS URETHRAL SUPPORT FOR URINARY STRESS INCONTINENCE.

Synopsis of Video

Tendineous Urethral Support is a promising alternative for minimally invasive anatomical reconstruction of the urethral support. Several materials have been used with acceptable success and complications rates. The SIS (Small Intestine Submucosa) is a biocompatible, absorbable material that creates a self “neoligament”, adding strength to the damaged urethral support. The aim of this video is to present refinements of the tendineous vaginal support previously described.

The procedure is performed with the patient in the lithotomy position, either under spinal or local anesthesia with intravenous sedation. Previously to the implant, the Stratasis TUS tape is hydrated in saline for 15 minutes. A 2 cm long vaginal incision is performed at 0.5 cm from the urethral meatus. The vaginal wall is dissected from the underlying periurethral fascia, bilaterally to the inferior ramus of the pubic bone. Skin incisions are made in the genito-femoral fold 1 cm above the vaginal fornix bilaterally, in order to be close to the white line. A proper needle is used to delivery the self-anchoring Stratasis TUS tape. The needle is introduced through the skin, obturator membrane and muscles, urethropelvic ligament at the level of the tendinous arc and through the vaginal incision, guided by the surgeon’s index finger. The thread loop at the tip of the tape is introduced at the eyelet at the tip of the needle and brought through the skin incision. The same maneuvers are repeated on the other side. No cystoscopy is necessary. A Metzenbaum scissors is introduced between the urethra and the tape to avoid undue tension. The exceeding anchoring tails are cut. The vaginal and skin incisions are closed in the usual manner.

Stratasis TUS is a safe reconstructive procedure. Because it rebuilds the natural urethropelvic ligament, obstruction and urinary retention is quite rare. Biocompatibility may be the reason for the few post-operative irritative voiding symptoms. This procedure is easy to perform and to teach and avoids visceral traumas. Further studies and longer follow-up are warranted to determine its role in the management of female SUI.