

EVALUATION OF OUTCOME FOLLOWING DIVISION OF TENSION FREE VAGINAL TAPE (TVT) FOR PERSISTENT SEVERE VOIDING DIFFICULTY.

Aims of Study

There is no current consensus on the management of persistent voiding difficulty (VD) (>4 weeks) following TVT (1). While some advocate early intervention with urethral leverage, division, or excision of the tape others recommend a more conservative approach (1,2). In our unit where the patient is completely unable to void at 4 weeks or has residuals (>50% capacity) we recommend division and excision of a small midline portion of the TVT without lateral urethrolisis. In this study we report our experience with this technique.

Methods

All women (179) undergoing TVT between July 2001- January 2003 were evaluated. Post-operative VD was managed by in-dwelling catheter (IDC) or clean intermittent self-catheterisation (CISC). At 4 weeks women with persistent VD were evaluated by uroflowmetry and underwent midline division and excision of the mid urethral portion of the TVT under local anaesthesia. Trial of void was undertaken following surgery and follow-up with uroflowmetry at 4 weeks and continence evaluation at 4 weeks and 6 months.

Results

7(3.9%) developed severe VD following TVT over the study period. Mean age 59(R 31-77) and median parity 2(R 0-4). None of these women had undergone previous continence surgery. Only one woman had undergone concomitant vaginal prolapse surgery at the time of TVT. None of the women had symptoms or objective urodynamic evidence of VD prior to TVT surgery. Of the 7 cases with VD following TVT, 6 were managed by CISC and one by IDC. Three women had a documented urinary tract infection following TVT placement and were treated with appropriate antibiotic therapy. There were no other peri-operative complications. At the time of division of TVT migration of the tape to the bladder neck was noted in only one patient who had undergone concomitant prolapse surgery. Blood loss was minimal and there were no cases of urethral injury. Five women passed a trial of void within 24 hours of surgery. Of the remaining two patients one required short-term CISC and the remaining case an IDC for a further two weeks before successfully passing a trial of void. There were no cases of *de novo* urgency or urge incontinence. Repeat uroflowmetry parameters at 4-6 weeks were within normal limits. There were no symptoms of recurrent stress incontinence at 4 weeks or 6 months.

Conclusions

Persistent significant voiding difficulty following TVT is uncommon. Midurethral division and excision of a small portion of the TVT under local anaesthesia is well tolerated and was successful in all cases. Although the number of cases in this series were small, none of the women developed recurrent stress incontinence. This may be due to delay in division of the TVT to 4 weeks allowing time for the sling to incorporate into the host tissues so that midline division and local excision did not compromise lateral urethral support.

References

1. Klutke C, Siegel S, Carlin B et al. Urinary retention after Tension-Free Vaginal Tape Procedure: Incidence and treatment. *Urology* 2001; 58:697-701.
2. Lo TS, Wang AC, Horng SG, Liang CC, Soong YK. Ultrasonographic and urodynamic evaluation after tension free vagina tape procedure (TVT). *Acta Obstet Gynecol Scand.* 2001;80:65-70.