South Tees Hospitals
NHS Foundation Trust

Autologous Fascial Sling

An operation for stress incontinence

Obstetrics and Gynaecology
Patient information

Autologous Fascial Sling

Contents

About this leaflet

We advise you to take your time to read this leaflet, any questions you have please write them down on the sheet provided (towards the back) and we can discuss them with you at our next meeting. It is your right to know about the operations being proposed, why they are being proposed, what alternatives there are and what the risks are. These should be covered in this leaflet.

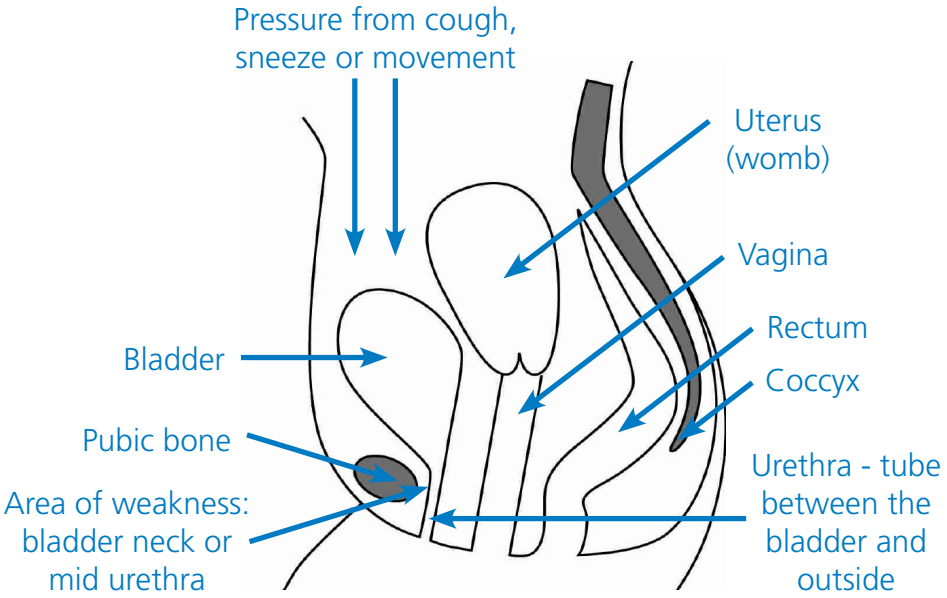
This booklet describes what Stress Incontinence is, it then goes on to describe the autologous fascial sling operation and what alternatives are available within our trust. It also explains the risks involved in surgery and what operations we can offer.

What is stress incontinence?

Stress incontinence is the leakage of urine usually caused by an increase in pressure in the abdomen (tummy) due to a weakness in the support of the urethra (urine pipe), and bladder neck (see figure 1 on following page).

Common causes of stress incontinence are childbirth, heavy lifting and constipation; these activities can all cause damage to the pelvic floor muscles. Further weakening occurs during the menopause because the quality of the supporting tissues deteriorates. The pressure in the abdomen rises with activities such as coughing, sneezing, bending down, turning or jumping. If you have stress incontinence you may experience urine leakage when doing these sorts of activities. This can cause a lot of distress and limit your quality of life.

Figure 1: Your anatomy - side view of a woman in an upright position showing pressure above the bladder and a weak bladder neck.



It must be understood that operations for stress incontinence will not cure all urinary symptoms. They will only cure urinary symptoms caused by a weakness in the bladder neck. Many urinary symptoms seen in clinic are not caused by a weakness in the bladder neck.

Alternatives to surgery

Do nothing – if the leakage is only very minimal and is not distressing then treatment is not necessarily needed.

Pelvic floor exercises (PFE) - The pelvic floor muscle runs from the coccyx at the back to the pubic bone at the front and off to the sides. This muscle supports all of your pelvic organs (uterus, vagina, bladder and rectum). Any muscle in the body needs exercise to keep it strong so that it functions properly. This is more important if that muscle has been damaged. PFE strengthens the pelvic floor and give more support to the pelvic organs. These exercises can cure stress incontinence for some people, for others the leakage will be improved and in a few cases there is no improvement in the leakage.

It is always advised to try and improve your stress incontinence by practicing pelvic floor exercise for at least three months before considering surgery. Even if you have tried doing PFE on your own we may want to refer you to see a specially trained physiotherapist to practice PFE as you might not be doing the exercises correctly and you may need supervision or additional expert advice. These exercises have little or no risk and even if surgery is required, we recommend that PFE are done regularly for the rest of your life to support the pelvic organs.

Devices - There are numerous devices (none on the NHS) which aim to support the urethra. The devices are inserted into either the vagina or the urethra. They are not a cure but their aim is to keep you dry whilst in use, some people choose to use them when exercising or if going out for the day.

Absorbant products - Incontinence pads or pants can be used long term if you do not wish to have any invasive treatment.

Alternative operations

Please read the leaflets below from our online patient information site to know what other operations are available for Stress Incontinence.

www.southtees.nhs.uk/services/gynaecology-services/leaflets

1. Urethral Bulking procedure
2. Retropubic-midurethral sling
3. Transobturator- midurethral sling
4. Colposuspension

General risks of surgery

Anaesthetic risk. As with all anaesthetics there is a risk of complications these will be discussed with you by the pre assessment staff and your anaesthetist.

Haemorrhage. There is a risk of bleeding with any operation. The risk from blood loss is reduced by knowing your blood group beforehand and having blood available to give you if needed. Please let your doctor know if you are taking an anti-clotting drug such as warfarin or aspirin. It is rare for patients to need a blood transfusion after this operation.

Infection. There is a risk of infection at any of the wound sites. A significant infection is rare. The risk of infection is reduced by our policy of routinely giving antibiotics with major surgery.

Deep Vein Thrombosis (DVT). This is a clot in the deep veins of the leg. The overall risk is at most 4-5% although the majority of these are without symptoms. Occasionally this clot can migrate to the lungs which can be very serious and in rare circumstances it can be fatal (less than 1% of those who get a clot).

There can be an increased risk of DVT if you are obese, have large varicose veins, have an infection, are immobile and with some other medical problems. The risk is significantly reduced by using special stockings and injections to thin the blood (heparin).

Specific risks of this surgery

Failure rate is approximately 20%; (2 in every 10 women).

Bladder injury. Less than 5%; (less than 5 in every 100).

Difficulty in bladder emptying. Approximately 10%; (1 in every 10 women) will have difficulty emptying their bladder immediately after surgery. Some women may need to go home, for a week or so; with a catheter in their bladder which allows the bladder to empty continuously or sometimes we teach Clean Intermittent Self- Catheterisation (CISC) this is discussed in more detail below. For some women (approximately 4%, 4 in every 100) difficulty passing urine may be a long term problem.

Overactive bladder (up to 20%; 2 in every 10). This includes symptoms of passing urine frequently, sudden urge to urinate (urgency) and leakage of urine because you can't hold on (urge incontinence). This operation will make it harder for your bladder to empty or leak which may irritate the bladder causing these symptoms.

Hernia formation (10%; 1 in every 10) when tissue is taken from the abdomen or when a cut is made on the abdomen, leaving a scar, this weakens the abdominal muscles. A hernia can form at this site, this is when the abdominal muscle splits and the abdominal contents protrude through the hole in the muscle layer. This can be uncomfortable and in some cases needs further surgery.

Chronic pain (lasting more than 6 months and rarely lifelong) may occur at the harvest site (where the graft was retrieved from) or where the sling is fixed onto the abdominal wall.

Changes in sensation / pain on intercourse. This is rare.

Problems passing urine after the operation

Some women have difficulty in emptying their bladder after their operation. This may get better, but in a small number of women it lasts forever.

It is normal to leave a small bit of urine behind after going to the toilet. We call this the 'residual volume'. However, if too much is left behind it can lead to problems such as having to go to the toilet too often and infections of the bladder.

If the residual volume is too high, you may want to learn to empty your bladder using Clean Intermittent Self Catheterisation (CISC).

CISC involves emptying out the urine that has been left behind using a fine tube, called a catheter. This is passed along the urethra (water pipe) into the bladder so the urine can drain into the toilet. Once the urine is out, the catheter is taken out and thrown in the bin. A new catheter is used each time and they are available on prescription.

Most women do not need to use the catheter every time they go to the toilet to pass urine but the number of times it is needed depends on how the bladder is behaving.

Although passing the catheters sounds unpleasant, most women find it is easy to do and gives more control and freedom than using a permanent catheter. The normal feeling of wanting to pass urine is not altered so you know when to empty your bladder. The catheters are very small and can easily be hidden in a handbag.

Sometimes the tests on your bladder (urodynamics) give a clue that you may have problems passing urine after an operation for Stress Incontinence. If your doctor thinks you may be more likely to have problems, they may suggest you learn CISC before having the operation. Then if you find trouble passing urine after Fascial sling it would not stop you going home and you would be prepared.

The operation – Autologous Fascial Sling

How is the operation performed:

Autologous fascial sling is a procedure to treat stress incontinence (leakage of urine when you exercise, sneeze or strain). Fascia is a sheet of supporting, fibrous tissue that holds body organs in their correct position. The fascia used in this operation can come from the abdominal wall or from the top of the leg.

The terms rectus fascia sling (using fascia from the abdominal wall) or fascia lata sling (using fascia from the outside of the thigh) are sometimes used to describe variations of this procedure.

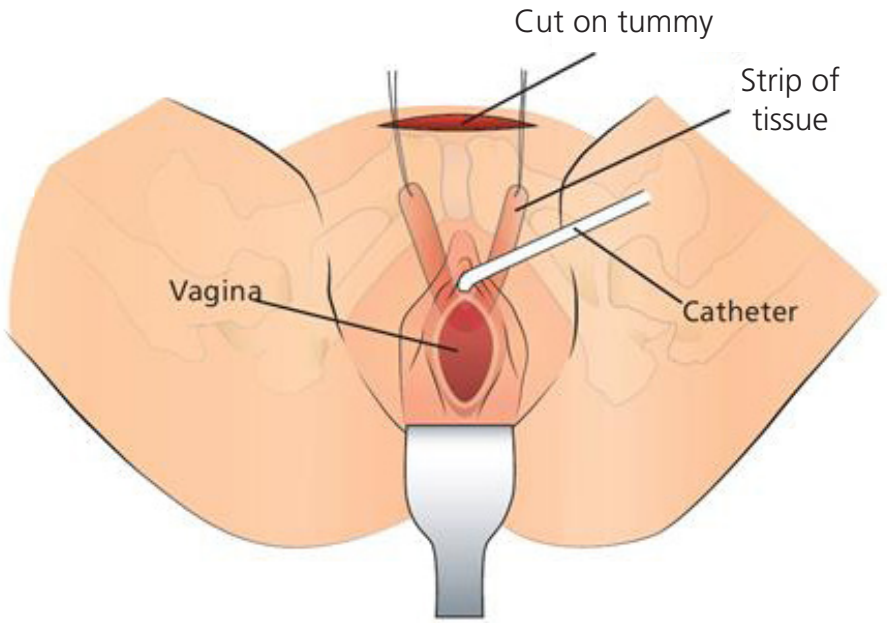
Your bladder and urethra (waterpipe) are supported by your pelvic floor muscles and ligaments. If this support is weakened, urine may leak with coughing, sneezing, laughing, lifting or exercise.

Autologous slings are placed around the waterpipe (urethra) via the vagina to treat stress incontinence. During the operation, we remove a small section of fascia (approximately 1cm by 6 cm). This is taken either from your thigh (through a small cut on the outside of the leg) or from your lower abdomen (through a small incision in your "bikini line").

The defect in the fascia is then sewn back together. This piece of fascia has a strong nylon-like suture attached at each end. This suture is non dissolvable.

The sling is placed under the urethra and cradles it like a hammock. It is then passed through the muscles of the abdominal wall and fixed to the rectus sheath, a fibrous sheet in front of these muscles. By using tissue from your body to construct an autologous sling, we reduce the risk of infection and your body's reaction to it.

The procedure usually takes approximately 1-2 hours to perform. It may be performed under general or spinal anaesthetic.



After the operation – in hospital

On return from the operating theatre you will have a drip in one of your arms with fluid running through to stop you getting dehydrated.

You may have a bandage in the vagina, called a 'pack' and a sanitary pad in place. This is to apply pressure to the wound to stop it oozing.

You may have a tube (catheter) draining the bladder overnight. The catheter may give you the sensation as though you need to pass urine but this is not the case. Usually the drip, pack and catheter come out the morning after surgery or sometimes later the same day. This is not generally painful.

The day after the operation you will be encouraged to get out of bed and take short walks around the ward. This improves general wellbeing and reduces the risk of clots on the legs.

It is important that the amount of urine is measured the first couple of times you pass urine after the removal of the catheter. An ultrasound scan for your bladder may be done on the ward to make sure that you are emptying your bladder properly. If you are leaving a significant amount of urine in your bladder, you may have to have the catheter re-inserted back into your bladder for a couple of days.

You may be given injections to keep your blood thin and reduce the risk of blood clots, normally once a day until you go home or longer in some cases.

The wound can be painful and sometimes you may require tablets or injections for pain relief.

There will be slight vaginal bleeding like the end of a period after the operation. This may last for a few weeks.

The nurses will advise you about sick notes etc. Most patients can go home later the next day or the second day after the operation if they are emptying their bladder satisfactorily.

After the operation - at home

Mobilisation is very important; using your leg muscles will reduce the risk of clots in the back of the legs (DVT), which can be very dangerous.

You are likely to feel tired and may need to rest in the daytime from time to time for a month or more, this will gradually improve.

It is important to avoid stretching the repair particularly in the first weeks after surgery. Therefore, avoid constipation and heavy lifting. The deep stitches dissolve during the first three months and the body will gradually lay down strong scar tissue over a few months.

Avoiding constipation:

- Drink plenty of water / juice aim for 2 litres per day.
- Eat fruit and green vegetables with each meal.
- Plenty of roughage e.g. bran / oats

Do not use tampons for 6 weeks.

There are stitches in the skin wound in the vagina. Any stitches under the skin will melt away by themselves. The surface knots of the stitches may appear on your underwear or pads after about two weeks, this is quite normal. There may be little bleeding again after about two weeks when the surface knots fall off, this is nothing to worry about.

At six weeks gradually build up your level of activity.

After 3 months, you should be able to return completely to your usual level of activity.

You should be able to return to a light job after about six weeks. Leave a very heavy or busy job until 12 weeks.

You can drive as soon as you can make an emergency stop without discomfort, generally after three weeks, but you must check this with your insurance company, as some of them insist that you should wait for six weeks.

You can start sexual relations after six weeks, as long as you feel comfortable enough, and you are no longer bleeding. You will need to be gentle and may wish to use lubrication (KY jelly) as some of the internal knots could cause your partner discomfort. You may, otherwise, wish to defer sexual intercourse until all the stitches have dissolved, typically 3-4 months.

Follow up after the operation is usually 3-6 six months. This maybe at the hospital with a doctor or nurse, with your GP, or by telephone.

Information about the British Society of Urogynaecology Surgical Database (Surgical Register)

The British Society of Urogynaecology (‘**BSUG**’) is a National group of gynaecologists with a special interest and expertise in the treatment of incontinence and prolapse. BSUG is a Registered Charity (Number – 1143157).

BSUG has developed a Database of clinical and surgical information which we hope will make procedures as safe and effective as possible. Hospital Trusts and individual Consultants can use this information to look at their practice and make any necessary changes to improve patient care.

We would like your permission to record some important information about you and your operation on the BSUG Database to ensure that we continue to provide the best surgical procedures possible. We emphasise that all information drawn from this will be anonymous so that nobody apart from your Consultant team will have any identifying information about you. Your Consultant team will also hopefully collect information about the outcome of your operation so that it is possible to look at success rates and potential complications associated with individual procedures. National reports looking at operations performed across the UK will also be produced by BSUG but these will contain NO identifying features relating to you personally.

The patient information held in the BSUG database comprises: Name, Hospital Number and Date of Birth (‘Patient Identifiable Data’) together with clinical and surgical information.

The ‘Patient Identifiable Data’ is held securely on the NHS computer network (N3) and can only be accessed by your consultant. The information on the BSUG database is recorded in line with the General Data Protection Regulation (GDPR) (2018).

BSUG uses the services of a specialist information technology company (ICE ICT) to host the BSUG Database. They have agreed to adopt appropriate technical and organisation measures to protect the security of your ‘Patient Identifiable Data’ and only to process it in accordance with BSUG’s instructions.

If you agree to let us enter information about your condition, procedure and outcome on the BSUG database, then you will be asked to sign a specific consent form to make sure you give your agreement. If you do not want your case to be recorded on the BSUG database your care will not be affected in any way.

Please note that you can request access to view your entry on the BSUG database from your consultant team and can request that this is deleted at any time by sending a written notice to your consultant OR to the following address:

BSUG c/o BSUG,
Registered charity no: 1143157,
Royal College of Obstetricians & Gynaecologists
27 Sussex Place
Regents Park
London NW1 4RG.

If you think that there is a problem with the way in which we are handling your data please inform us or you can complain to the Information Commissioner’s Office.

BSUG Database Committee 2018

BSUG database Consent

If you agree to allow us to enter your Patient Identifiable Data into the BSUG database this will signify your consent to the following:

1. The processing of my Patient Identifiable Data and clinical information by BSUG for research and auditing purposes as outlined on the previous two pages.
2. The disclosure by BSUG of my Patient Identifiable Data and clinical information to its information technology service providers (ICE ICT), where such suppliers have agreed to adopt appropriate technical and organisation measures to protect the security of my Patient Identifiable Data and only to process it in accordance with BSUG's instructions.

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Regents Park
London NW1 4RG.

If you consent to the above please sign in the relevant section on the operation consent form.

Further information

You may find the address and websites useful to obtain more information. We can however bear no responsibility for the information they provide.

Bladder & Bowel Foundation
SATRA Innovation Park, Rockingham Road
Kettering, Northants, NN16 9JH

Nurse helpline for medical advice: 0845 345 0165

Counsellor helpline: 0870 770 3246

General enquiries: 01536 533255

Fax: 01536 533240

Email: info@bladderandbowelfoundation.org

Website: www.bladderandbowelfoundation.org/

BSUG patient information on autologous fascial sling:
Website: https://bsug.org.uk/budcms/includes/kcfinder/upload/files/Autologous%20fascial%20sling%20BSUG%20Mar%202018-2.pdf

NICE Guidance:
www.nice.org.uk/guidance/ipg154

The Scottish Pelvic Floor Network:
www.scottishpelvicfloor.webs.com/surgical.htm

Useful contact numbers

The James Cook University Hospital
Appointments Desk: 01642 854861 / 282714 / 854883
Gynaecology Outpatients Dept. (Including Pre-admission Service): 01642 854243
Surgical Admissions Unit: 01642 854603
Gynaecology Unit / Theatre 23: 01642 282745
Women's Health Unit / Ward 19: 01642 854519

The Friarage Hospital
Appointments Desk: 01609 764814
Gynaecology Outpatients Dept: 01609 764814
Pre-admission Service: 01609 764845 / 01609 763769
Surgical Admissions Unit Reception: 01609 764847 Nursing Staff: 01609 764657
From 7am Mondays until 5pm Fridays, Allen POS.D.U.: 01609 764405
From 5pm Fridays until 7am Mondays, Allerton Ward: 01609 764404

Things I need to know before I have my operation

Please list below any questions you may have, having read this booklet, that will help you decide whether you want an operation.

1. .....

2. .....

3. .....

4. .....

5. .....

6. .....

Please describe what your expectations are from surgery. This is very important

1. .....

2. .....

3. .....

4. .....

5. .....

6. .....

Comments, compliments, concerns or complaints

South Tees Hospitals NHS Foundation Trust is concerned about the quality of care you receive and strives to maintain high standards of health care.

However we do appreciate that there may be an occasion where you, or your family, feel dissatisfied with the standard of service you receive. Please do not hesitate to tell us about your concerns as this helps us to learn from your experience and to improve services for future patients.

Patient Advice and Liaison Service (PALS)

This service aims to advise and support patients, families and carers and help sort out problems quickly on your behalf.

This service is available, and based, at The James Cook University Hospital but also covers the Friarage Hospital in Northallerton, our community hospitals and community health services. Please ask a member of staff for further information.

If you require this information in a different format please contact Freephone 0800 0282451

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