Bladder and Bowel Community

Fact sheet: Your guide to surgery for stress urinary incontinence

Introduction

In some people, stress urinary incontinence does not sufficiently improve with other treatments, and that is when you may wish to consider surgery. Every person is different, and a surgeon will be able to discuss with you what exactly is causing your problem, and how surgery may help. Whatever your particular condition, it is important to really think through the pros and cons of having surgery.

If your doctor or nurse refers you to see a surgeon, then this is an ideal time to ask lots of questions. Ask your doctor as many questions as you want, and never be afraid to go back or telephone to get more information or a clearer explanation. Before meeting the surgeon it may help to note down your questions on a piece of paper, so you don't forget what you wanted to ask. Make sure you write down the answers you are given; it's easy to come out of a consultation and forget what has been said.

At any stage of the process if you are not clear about anything the doctor or surgeon says, ask them to explain again, a bit slower this time. The surgeon can also explain why they consider one operation particularly suitable for you.

Colposuspension

In the past, Colposuspension was the most commonly performed operation for the treatment of stress incontinence. This is a major operation that requires a general anaesthetic. The abdomen is opened and the bladder neck is lifted upwards by stitching the lower part of the front of the vagina to a ligament behind the pubic bone. This lift helps to prevent leakage by improving pressure transmission and compression of the neck of the bladder.

No surgical operation can guarantee success in treating incontinence. The Colposuspension has a success rate of between 50% and 70%. That means that over half the women having the operation will be cured or greatly improved. The remainder may still suffer from incontinence. Considered to be the 'gold standard' operation for stress incontinence, it still has the best outcome for long-term cure rates of any operation.

There are two versions of the operation:-

Open Colposuspension, which gives better long-term success rates, but involves making a large cut in the abdomen.

Laproscopic Colposuspension, which involves making a smaller cut to do the operation; sometimes called keyhole surgery[1]. After this operation, most people recover and get back to work more quickly than with Open Colposuspension, but its success rate is less good. This operation can cause extra problems - problems with emptying the bladder (some people need to use intermittent catheters after the operation), irritable bladder and urgency, and pain during sexual intercourse

Sometimes it is not possible to do a Colposuspension, because of previous surgery. There are other similar operations that can be performed in these cases: the aim is still to provide extra support to the bladder neck and reduce the risk of leaking. Sometimes, for example, a 'sling' is placed under the bladder neck.

Other operations have been found to be not particularly effective in helping people with stress incontinence, amongst these are 'needle suspensions' and 'anterior repair', which have poor success rates and normally would not be considered.

Tension-free Vaginal Tape (TVT)

Tension-free vaginal tape (TVT) is an operation for women with stress incontinence. It is usually not considered suitable for women with neurological disease or those women considering having children, or for women with other conditions like a cystocele or a vaginal prolapse.

The operation is gaining popularity because of its relative simplicity and cost-effectiveness. It has an 85-90% success rate. The procedure can de done as day surgery, with only a local anaesthetic which is given by the surgeon, in combination with painkillers and tranquillisers given by the anaesthetist. These work throughout the operation so you feel no pain and are calm and relaxed during the operation. Some surgeons do perform this under general anaesthetic. Although recovery time after the operation is less than some operations for this problem, it should not be considered a minor procedure.

During the operation the tape is inserted through a small incision in the vaginal wall. It lies between the vagina and the urethra, so it supports the middle of the urethra. Each end of the tape is threaded through two small holes on the abdomen just above the pubic bone. This support reduces the effect of any sudden increase in abdominal pressure (coughing, sneezing) that causes stress incontinence.

Sometimes there can be problems associated with this operation: bleeding, injury to the bladder, difficulty emptying the bladder, urgency, and urinary tract infections. In addition tape erosion is a small possibility. Long-term success rates and side effects are yet to be identified. A cystoscope (a small telescope) is always inserted into your bladder to check for abnormalities and to ensure that your bladder and urethra have not been injured.

As with all treatments, this operation has its advantages and its risks. Everyone needs to discuss with their doctor the options available to them. More research over the next decade will give a clearer indication of the success and failure rates.

One known disadvantage of the TVT is that it cannot be adjusted post op. So if it needed tightening or loosening this wouldn't be possible.

Trans Obturator Tape (TOT)

The TOT procedure is similar to the TVT described above. It is a relatively new operation, so the long-term results are not yet known. It may be easier or safer to do than TVT in some patients, as the tape is further away from the bladder and the lower abdomen (tummy). In the short and medium term however, it seems to be as safe and as effective as TVT.

The TOT tape is inserted through 3 small cuts, one in the vagina, and one in each side of the upper inner thigh. A cystoscope (a small telescope) is always inserted into your bladder to check for abnormalities and to ensure that your bladder and urethra have not been injured.

Unlike the TVT operation, the TOT can be adjusted post op if needed.

Injectable Treatments - an alternative to major surgery

A less invasive treatment option and an alternative to major surgery, bulking agents can be injected into the wall of the urethra to improve the closure mechanism (sphincter) of the bladder neck. There are a number of options to choose from, some with better results than others.

Teflon, collagen and silicone have all been used to treat bladder neck insufficiency with limited success due to the skill requirements of the procedure. Although the procedure is short and can sometimes be done under local anaesthetic, it is usually carried out under general anaesthetic. Unfortunately the substances used for the injectable have been linked to various complications including allergic reactions and tissue damage.

Injectable treatments are not yet widely available; however, there are now a number of treatment centres providing one injectable treatment option called Deflux TM. During the procedure, a gel is injected into the urethra endoscopically to obtain a bulking effect, which helps to prevent urine leakage. The simple procedure consists of a number of small injections into the wall of the urethra close to the bladder neck. A cystoscope is introduced into the urethra, and then a needle is used to inject the gel into the urethral wall to form a cushioning or bulking effect. This process is then repeated as required, usually two or three times, to ensure regular filling around the bladder neck. Please visit our Injectable Treatment section on our website for more information.

Sometimes, the patient's own fat can also be used as an injectable treatment, to reduce the risk of infection, but the results are not long lasting.

As with all injectable treatments, the results are not permanent and effectiveness diminishes over time. Top-ups may be required but this varies from one individual to another. Some women have been shown to continue to have good results three years after treatment. Your healthcare professional can run through the different kinds of injectables available to you to help you decide whether this method is right for you.

Anyone considering any kind of surgery should be given the maximum information by their doctor. You can't try before you buy, but you can make an informed decision.

Further Information

Ref:

1. Van Kerrebroeck P, Meulen F, Farrelly E et al. Treatment of stress urinary incontinence: recent developments in the role of urethral injection. Urol Res 2003;30:356-62

2. Robinson D, Anders K, Cardozo L, et al. What do women want? Interpretation of the concept of cure. Journal of Pelvic Medicine and Surgery 2003; 9:273-7

This factsheet was originally provided and distributed by the Bladder & Bowel Foundation Charity through until July 2016. Whilst every attempt to keep it current and accurate is being made any input will be welcomed by the Community.

The Bladder and Bowel Community provides information and support for people with bladder and bowel issues. We publish a wide range of user friendly booklets and factsheets.

For more information please call us on 01926 357220, email **help@bladderandbowelfoundation.org** or write to us at The Bladder and Bowel Community, 7 The Court, Holywell Business Park, Northfield Road, Southam, CV47 0FS.

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Updated May 2014