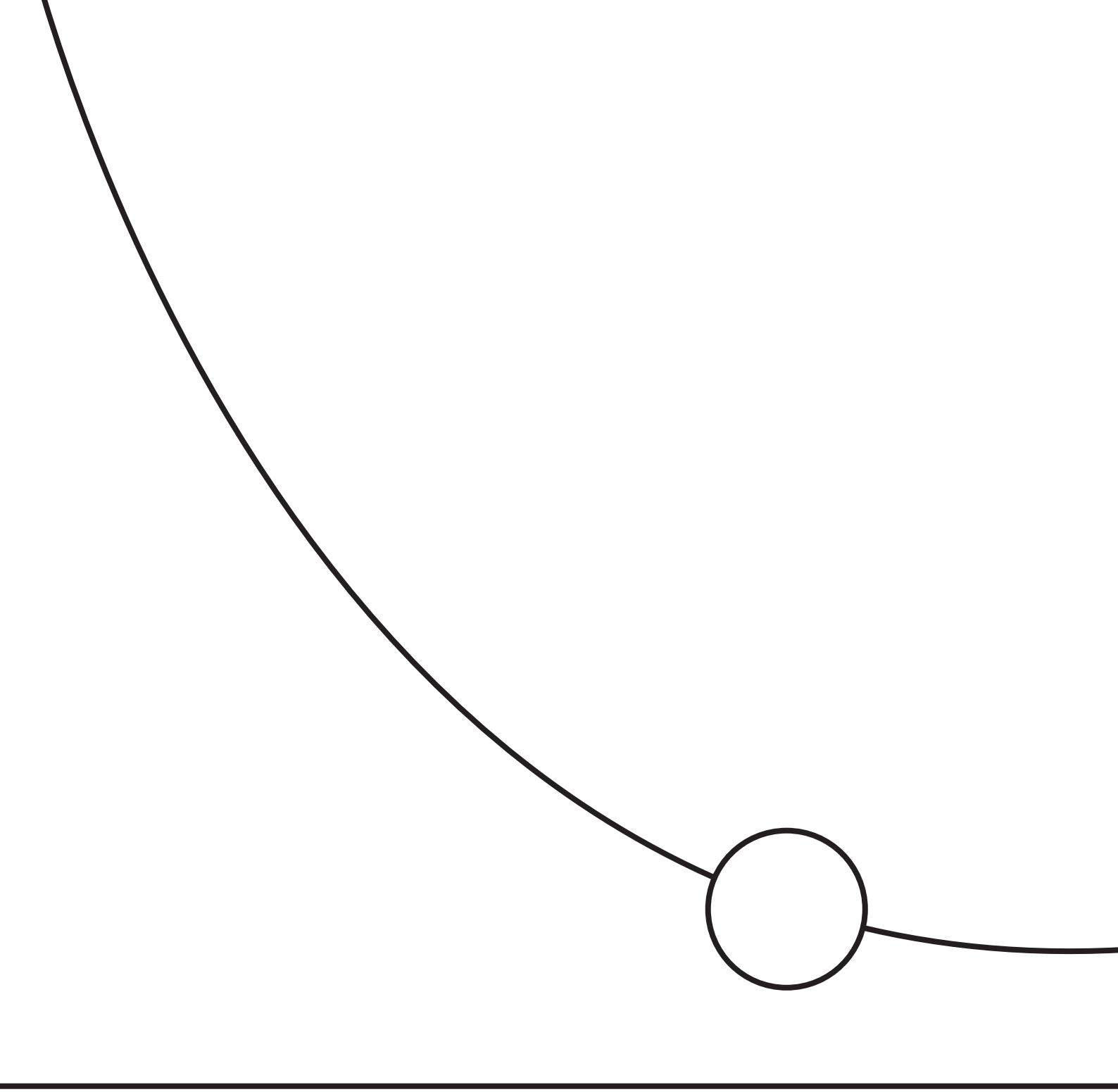

Surgery for **stress urinary incontinence**

MANATŪ HAUORA
MINISTRY OF HEALTH

Te Tāhū Hauora
Health Quality & Safety Commission

Acknowledgements:

This guide was developed with health care professionals and independent consumers some of whom have lived experience of stress urinary incontinence. A list of sources used to develop the guide is available online at: www.hqsc.govt.nz/incontinence.

All third-party images are used with permission and sources state

Note on use of mesh in surgery to manage stress urinary incontinence

This guide refers to four surgical options for managing stress urinary incontinence, one of which includes surgical mesh.

Since 23 August 2023, surgery involving mesh to manage this type of incontinence has been unavailable in Aotearoa New Zealand except in highly selected cases.

This pause in the use of mesh is to enable the health system to introduce safety measures and improvements that will help minimise the harm that has been linked to the use of mesh and improve outcomes and experience for women who have mesh inserted to manage their incontinence.

This guide includes detailed information about surgery involving mesh to manage incontinence. More information is also available via the QR code below and the list of sources used to develop the guide, available online at: www.hqsc.govt.nz/incontinence.

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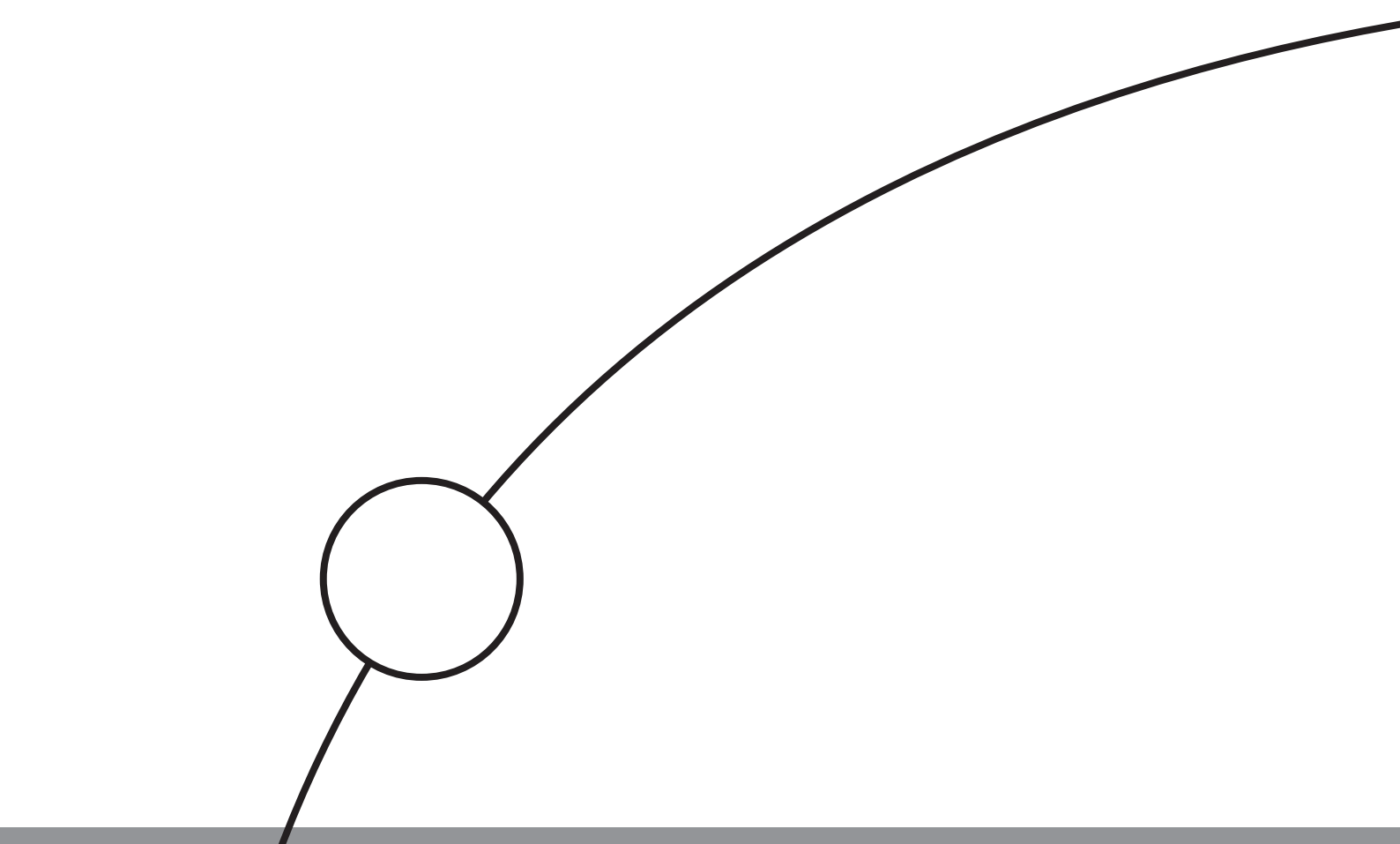


About this guide

The purpose of this guide is to help you make the best possible decision about managing your stress urinary incontinence with surgery, based on the information given here and your health care team.

It will help you gather information about your surgical options and clarify:

- your priorities and needs (what matters to you)
- your surgeon's advice about your treatment options
- your understanding of and level of comfort with the benefits and risks of each surgical option.

Understanding this information is an important part of the informed consent process. It is important you make the choice that is right for you depending on your own individual needs and how you feel about each surgical option.

Every person is different, and this guide does not cover every possibility associated with all surgical options, so ask your health care team if you would like more information.

> ! You can change your mind at any time about what surgery you would like or the timing of surgery or choose none of the surgical options.

From this point onwards, the guide uses the shortened term 'incontinence' in place of 'stress urinary incontinence'.

How to use this guide

This guide is designed to be read and discussed with your health care team, which includes your surgeon. (There is space on page 25 for you or someone else to note down who is on your health care team.)

It begins by introducing four surgical options for managing incontinence.

As every person is different, this guide does not include complication rates or cover all the potential risks and complications associated with having surgery. You can find more information here: www.nice.org.uk/guidance/ng123/resources/surgery-for-stress-urinary-incontinence-patient-decision-aid-pdf-6725286110. These numbers are best discussed and interpreted with your surgeon.

The next section is about what matters to you; you can complete this either at home or with your health care team if you wish. It includes some questions you might use when thinking about which surgical option is right for you. The final section is intended to be worked through with your surgeon to confirm you have all the information you need for making a decision about surgery. Completing this section is optional and does not mean you have given legal consent to surgery.

You do not have to get through the whole guide at your first appointment or decide straight away.

> ? If there are any terms you do not understand, please see the explanations at the back of this guide on page 28.
>
> The information in this guide might be a lot to take in. You can refer to it at home or talk it through with your surgeon or another member of your health care team.

You are not expected to decide about surgery straight away.

Non-surgical management

It is recommended that the following approaches are tried for **a minimum of 3 months** to manage your incontinence. A separate guide with more information on the below options is available to view at www.hqsc.govt.nz/incontinence.

Non-surgical options for managing incontinence

Lifestyle changes and self-management

- Adjusting food/fluid intake
- Weight management/adapting exercise
- Treating constipation

Pelvic floor muscle training

(with supervision from a pelvic health physiotherapist or continence nurse specialist)

- Individualised advice and training over at least 3 months
- May include bladder re-training
- May include nerve stimulation

Other options

- Pessaries
- Other devices, including:
  - Biofeedback devices
  - Pelvic floor muscle apps
  - Vaginal cones, weights or balls
- Pads and incontinence underwear
- Medication

If these management options are unsuccessful the options on the next page can be discussed with your health care team.

Managing incontinence with surgery

When non-surgical options have been tried and been unsuccessful, there are four surgical options available. This guide describes those options, what each involves, possible risks and complications and the main advantages and disadvantages of each.

The four options are:

1. urethral bulking agents
2. native tissue sling
3. colposuspension
4. mesh tape/sling (only available in very rare cases).

These terms may be unfamiliar to you and are explained in this guide.

Your surgeon may offer one or more of these options. You may be referred to another surgeon or district depending on what you decide. You can discuss all these surgical options with your health care team then make an informed decision in your own time about what is right for you.

Take time to consider your options and ensure you have enough information to make an informed decision.

Note: At the time of publication, the use of surgical mesh (mesh tape/sling) to manage incontinence is currently only available in highly selected cases in Aotearoa New Zealand as there is a pause on its use in place.

The use of surgical mesh has been linked to harm, so the pause is in place so the health system can introduce safety measures and improvements that will help to minimise the risks and improve outcomes and experiences for women who have mesh inserted to help manage their incontinence.

More information about surgical mesh use is available by using the QR code or via this link: www.health.govt.nz/news-media/media-releases/director-general-health-recommends-time-limited-pause-use-female-pelvic-surgical-mesh-products-treat.

Risks and complications associated with surgery

General risks associated with any form of surgery

General risks associated with any form of surgery include anaesthetic risk, damage to nearby organs, wound infection, bleeding, deep vein thrombosis and pain.

These risks increase if you have any significant medical conditions (such as diabetes), if you smoke, are overweight or if you have previously had surgery for a similar problem or received pelvic radiation.

General risks and complications associated with surgery for managing incontinence

There are also **general risks and complications associated with surgery for managing incontinence**. (Risks and complications associated *specifically* with each of the four surgical options in this guide are described further on.)

Complications can happen soon after surgery or many years later. They may not trouble you very much at all, or they could affect your quality of life a great deal. They may be minor and treatable, or they may be major and difficult to treat. **It is not always possible to treat all complications successfully**. If you have any complications, it is important to seek help as soon as possible from your doctor or specialist.

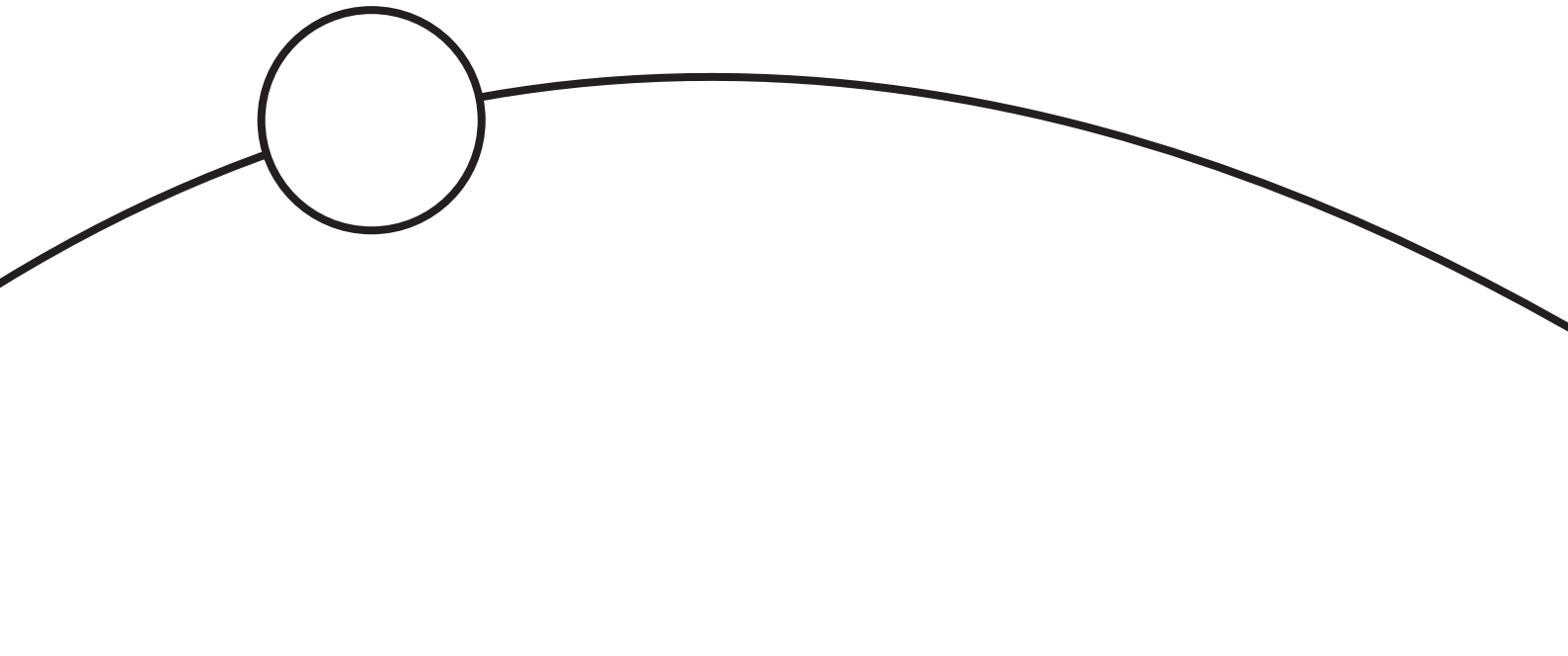
Some general risks and complications include the following.

- You may have difficulty passing urine and be unable to empty your bladder fully immediately after surgery. This is usually temporary. Your surgeon can advise if you need further surgery to address this, but further surgery is not common. In some cases, a catheter (a tube which is placed to drain urine from the bladder) may be needed for a few days or weeks, and you may need to self-catheterise at home.
- You may get a urinary tract infection. These infections can be severe, persistent and difficult to treat, although there may not be an obvious cause.
- You may experience urgency and urge incontinence (the feeling like you need to pass urine more often than usual) or have trouble getting to the toilet in time.
- There is a possibility the surgery may not fix your incontinence, and further repeat surgery may be needed.
- You may experience pain during sex (also called dyspareunia) or pain or changes in sensation in the back, abdomen, pelvis, leg, vagina, groin or the area between the front and back passages (the perineum).
- There may also be damage to the urethra, bladder or nerves.

Risks relating to pregnancy/ childbirth and surgery for managing incontinence

Incontinence may return after further pregnancies regardless of whether you have had previous surgery. Please talk to your surgeon about this.

Surgical options for **managing incontinence**



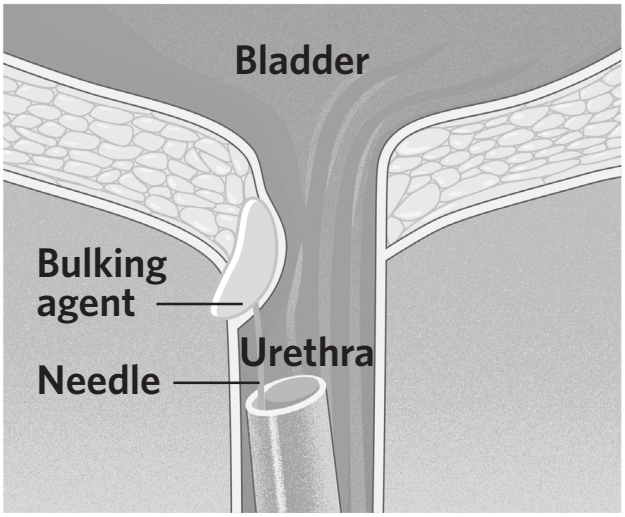
Urethral bulking agents

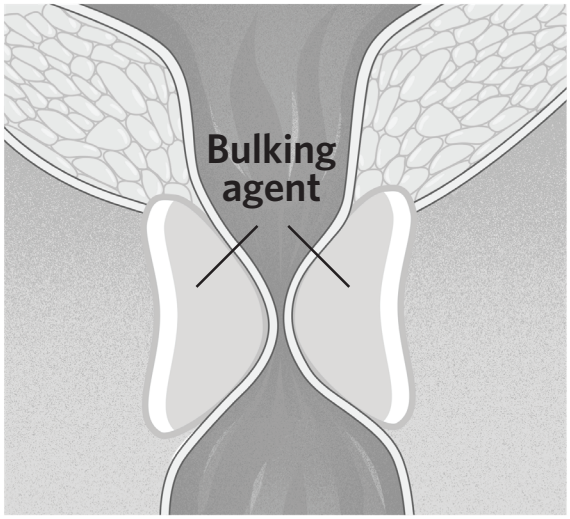
In this surgical option, a water-based gel is injected into the walls of the urethra (the tube that carries urine from the bladder to outside the body).

The bulking agent helps the urethra make a watertight seal and prevent urine leaking from the bladder.

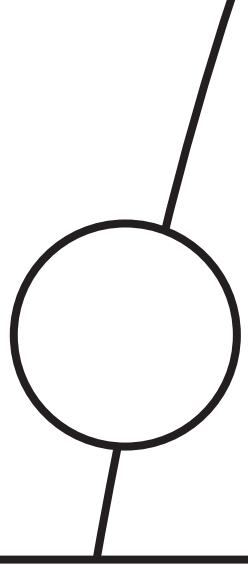
Bulking agents are permanent materials that do not dissolve.

This surgical option is often referred to by the product (trade) name, such as Bulkamid or Macroplastique. Macroplastique contains silicone.





Source: British Association of Urological Surgeons (BAUS)



Main advantages

- This surgical option involves day surgery, and recovery is quick (24–48 hours).
- It is less invasive because there are no skin cuts.
- People having this surgery have fewer issues with emptying their bladder, compared to other surgeries.
- This surgery has no impact on the success of any future surgery.
- The bulking agent can also be injected at the same time as surgery for other problems, for example, prolapse.

Main disadvantages

- This surgical option has lower success at reducing incontinence compared with other surgical options.
- Repeated injections may be needed, and there is no reliable evidence on long-term success.
- The bulking agent may need to be removed; as already mentioned, removal is currently not possible in Aotearoa New Zealand.
- Bulking agents are not natural products (foreign body), which means your body may respond to having them inside you.

Possible risks and complications

There is limited information available about long-term complications; however, the risks are less likely to be serious than with the other surgical options described in this guide.

Possible risks include:

- your incontinence returning
- your flow of urine slowing down
- getting a burning sensation or bleeding when passing urine for a short period after the bulking agent has been injected.

Other complications include:

- formation of a stone if the bulking agent is exposed into the urethra or bladder
- formation of an abscess where the bulking agent was injected due to infection
- hardening of the bulking material (Macroplastique only)
- pain lasting more than 6 months arising from scar tissue around the injection site.

Length of stay

You would go home the same day as the surgery.

Time off work

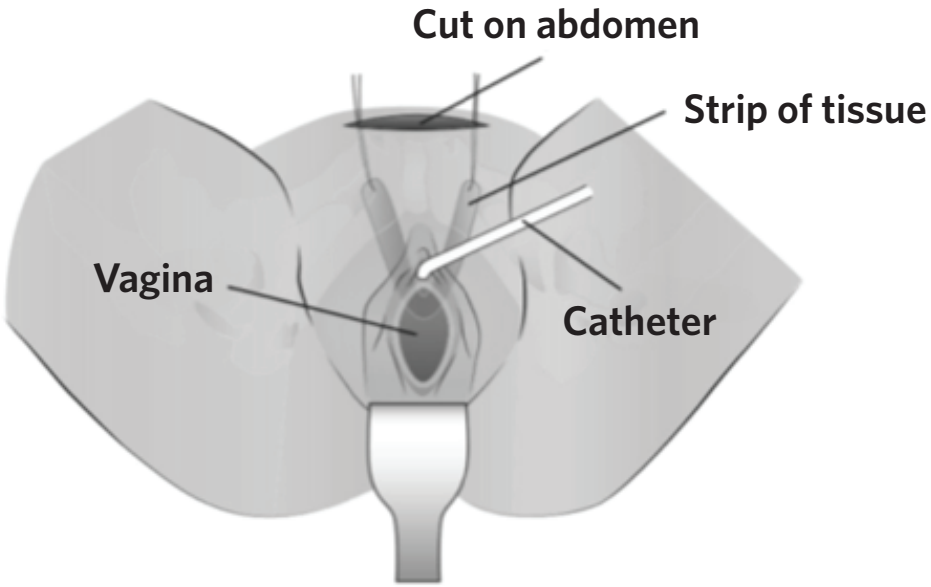
You will not require further time off work following this procedure.

Native tissue sling

In this surgical option, a 'sling' of your own body tissue taken from the abdomen or thigh is made to support the urethra.

These slings are also known as autologous slings, rectus fascial slings, pubovaginal slings and fascia lata slings.

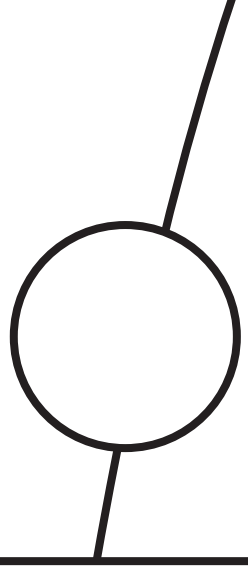
Surgeons may use dissolvable or permanent sutures (stitches). Ask your surgeon which sutures they use and ask about the benefits and risks of each.



Source: British Association of Urogynaecologists (BSUG)

A sling is made using your own body tissue (called fascia) taken from the wall of your abdomen (also called rectus fascia) or thigh (also called fascia lata).

The fascia is the thin but very tough layer that covers the muscles. To get this, a small cut will be made either just below the bikini line (as shown in the picture) or on the outside of the upper leg. It is then placed in position under the urethra through a cut in the vagina.



Main advantage

This surgical option can be undertaken at the same time as other vaginal and abdominal surgery, for example, prolapse surgery.

Main disadvantages of this surgical option

- This is invasive surgery, involving a cut on the abdomen or in the outer thigh.
- The surgery takes longer than surgery for urethral bulking agents and mesh/tape slings.
- There is a higher risk of wound complications like infection than for urethral bulking agents and mesh/tape slings, however, the risk is about the same as for colposuspension.
- Recovery takes longer (usually 4–6 weeks) than surgery for urethral bulking agents or mesh sling/tape surgery but is about the same as for colposuspension.
- When used, permanent stitches stay in the body.
- The sling may need to be loosened, cut or removed.
- You may have short-term difficulty emptying your bladder and need to use a catheter to manually empty it.
- Fascia lata surgery can cause pain and discomfort in the leg during recovery.
- Rectus fascia surgery can cause pain in the abdomen/groin/hips. This may sometimes persist.

Possible risks and complications

With native tissue sling surgery, there is a higher risk of short-term difficulty emptying the bladder (need for self-catheterisation), wound complications like infection, and urgency and urge incontinence.

There is also the risk of fluid collecting beneath the wound site (called seroma formation), thigh bulge – where the fascia was taken from your leg, and pain and discomfort in the leg or abdomen during recovery (depending on where the fascia was taken from).

Occasionally, if the sling is placed too tightly and you have ongoing difficulty passing urine, the sling may need to be cut or loosened. This is usually done within 6 weeks of surgery.

Length of stay

This type of surgery involves being in hospital for around 1–3 days (including the day of surgery).

Time off work

For surgery involving a fascia lata sling, 2–4 weeks off work is normal.

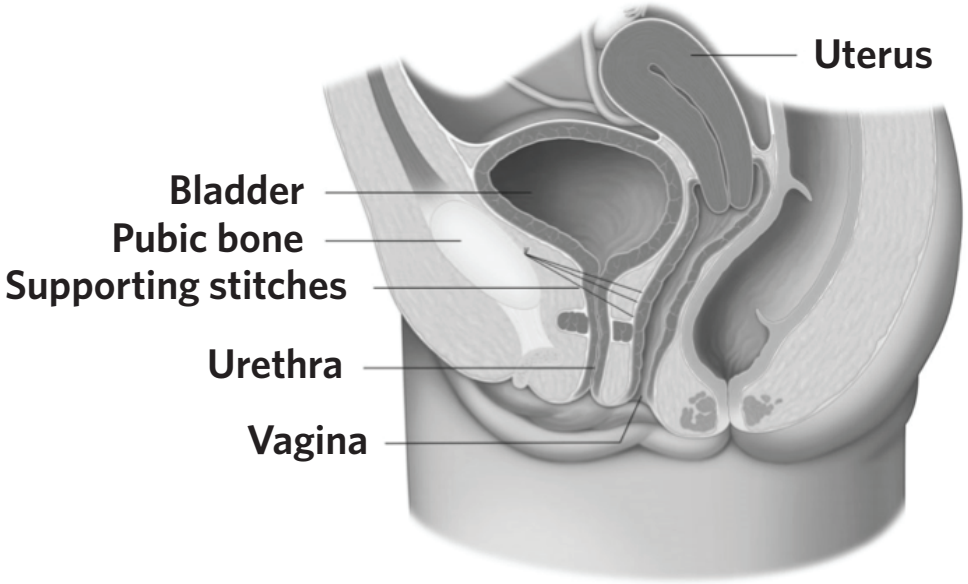
For surgery involving a rectus fascial sling, 4–6 weeks off work is normal.

Colposuspension

In this surgical option, the vagina is lifted upwards and stitched in place, providing elevation and support to the neck of the bladder.

This surgery is also known as Burch colposuspension and can be done either using open or laparoscopic (keyhole) surgery.

Surgeons may use dissolvable or permanent sutures (stitches). Ask your surgeon which sutures they use and ask about the benefits and risks of each.



Source: European Association of Urologists (EAU).

This type of surgery uses stitches to lift the neck of the bladder upwards and stitch it in place.

Main advantage

This surgical option can be done using keyhole surgery, which is less invasive than open surgery. However, not all surgeons are skilled at this method, and many will need to perform a larger incision.

Main disadvantages

- If abdominal surgery is needed, this is more invasive than keyhole and has a longer recovery time.
- When used, permanent stitches stay in the body.
- There is a higher risk of wound complications like infection with abdominal surgery than with urethral bulking agents and mesh/tape slings.
- There is a risk of future vaginal prolapse (which may require further surgery).

Possible risks and complications

- With this surgical option, you could develop vaginal prolapse (where pelvic organs move out of their normal position), especially of the back part of your vagina (rectocele). This means the back wall of your vagina may push into the canal of your vagina and you may need further surgery.
- If permanent sutures are used, there is a risk of exposure of those sutures into the vagina, for example, the sutures can come through into the vagina.
- Some people will have persistent pain after this type of surgery.
- If the repair is too tight and you have ongoing difficulty passing urine, you may need further surgery to correct this.

Length of stay

For abdominal surgery, the average stay in hospital is 1–3 days (including the day of surgery).

For keyhole surgery, the average stay in hospital is 1–2 days (including the day of surgery).

Time off work

For abdominal surgery, 4–6 weeks off work is normal.

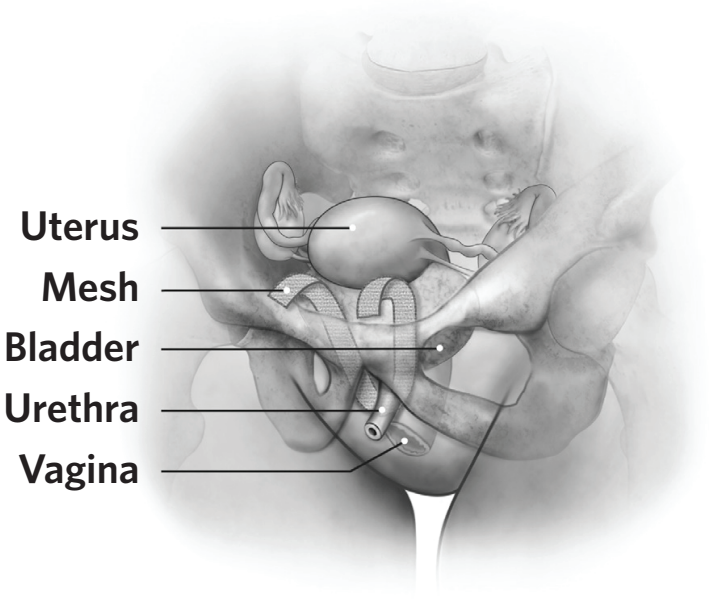
For keyhole surgery, 2 weeks off work is normal.

Mesh tape/sling

(currently not available in Aotearoa New Zealand except in very rare cases)

In this surgical option, a piece of synthetic (plastic) mesh tape is placed behind the urethra to support it in a sling. The mesh stays in your body permanently.

The sling can also be known as a retropubic mid-urethral sling, tape, TVT, transvaginal tape, patch, ribbon, graft, hammock, plastic, polypropylene or gauze.



Source: Reproduced with permission from Treatment Options for Stress Urinary Incontinence, developed by the Australian Commission on Safety and Quality in Health Care. Sydney: ACSQHC; 2018

Main advantages

- This is short surgery, involving a day stay or an overnight stay in hospital.
- Recovery is quick (usually about 2 weeks).
- It is not highly invasive because it involves only small cuts above the pubic bone.
- It can be done at the same time as other vaginal surgery, such as prolapse surgery.

Main disadvantages

- This surgery involves implanting a foreign material and there is a risk that your body may react to this.
- There is a higher risk of the bladder being injured during mesh insertion than in other procedures.
- If the sling is too tight and you have ongoing difficulty passing urine, the sling may need to be loosened or cut.
- There is a risk of exposure/extrusion, which may lead to the need for mesh removal surgery.
- There is a higher risk of long-term chronic pain and the ability to treat this than with the other procedures. The pain may be irreversible (even after mesh removal).
- It may not be possible to completely remove the tape/sling, especially if complications arise years after implantation.
- Long-term risks remain unknown.

Possible risks and complications

Mesh exposure and pain

Mesh exposure is where the mesh can come through into the vagina or enter into the bladder or urethra, surrounding tissue or nerves and organs. Exposure, along with pain (acute [severe] and chronic long term) have been reported as the most common complications associated with this surgical option.

Symptoms like pain may present late, so they can be hard to treat because there may not be an obvious cause and your doctor may not link the symptoms to mesh. **Therefore, if you are experiencing pain and have had surgery involving mesh it is important to let your doctor know this.** The resulting pain may be in the vagina or groin, pelvic, buttock and thigh, or whole leg, and can be long term, persistent and severe. Pain may be caused by mesh contraction (when mesh shrinks after being implanted), inflammation or an unknown cause.

Some women may develop significant complications such as difficulty doing everyday tasks like walking, sitting or standing for long periods.

It is impossible to predict who will have mesh exposure. In many cases mesh exposure causes no symptoms and is detected by your doctor or nurse at an examination. Common symptoms of exposure are vaginal discharge (which can be smelly), vaginal infections, abscess formation or pain during vaginal sexual intercourse (this may mean painful sex for you and your partner, or you may be unable to have sex at all).

Surgery is not always needed to treat mesh exposure, however, if it is, then more than one surgery may be required. It may not be possible to remove the mesh completely.

Mesh removal involves major surgery and can only be done by a credentialled surgeon. The New Zealand Female Pelvic Mesh Service has been set up to help people with mesh harm. www.tewhatuora.govt.nz/keeping-well/the-new-zealand-female-pelvic-mesh-service

Auto-immune conditions

Some clinical studies have shown a potential link between mesh surgery and the worsening of existing auto-immune conditions (where the immune system attacks the healthy cells of the body by mistake) or onset of new auto-immune conditions. Research is ongoing, and this link has not yet been fully established.

Difficulty urinating

Occasionally, if the mesh sling is placed too tightly and you have ongoing difficulty passing urine, the sling may need to be cut or loosened. This is usually done within 6 weeks of insertion.

Length of stay

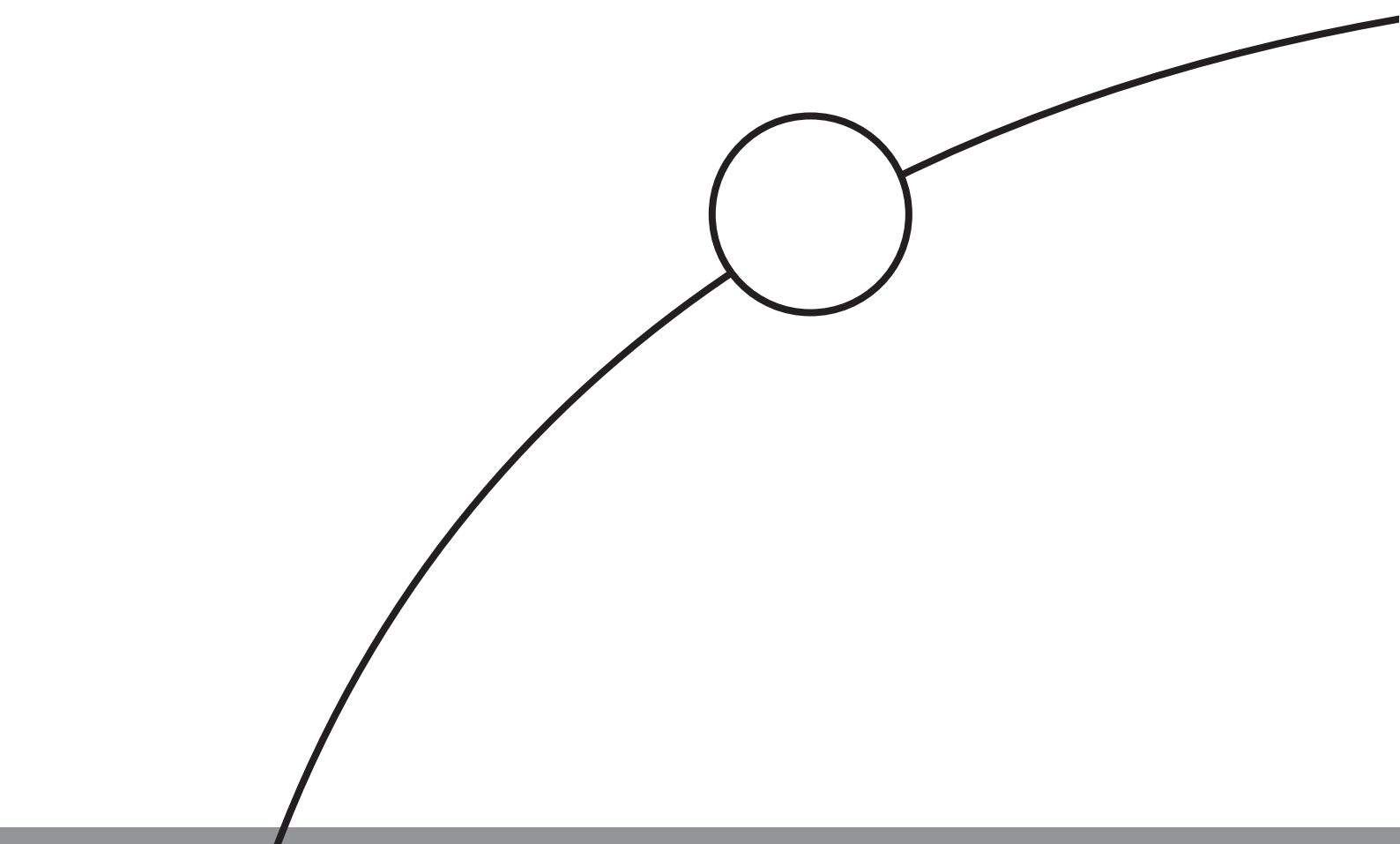
This surgical option usually involves a day in hospital, so people usually go home the same day as the surgery. An overnight stay may be required.

Time off work

For this surgical option, 1–2 weeks off work is normal.

What matters **to you?**

You can complete this section at home or with your health care team if you wish. It is entirely optional.



Your values and priorities

You can use this section of the guide to let your health care team know what matters to you, so they can see you as a whole person, not just your medical needs. This includes your whānau, social, emotional, cultural, spiritual and physical wellbeing; or it could be something completely different.

There are no 'right or wrong' answers as it is about you. A member of your health care team can help you complete the information below if you wish, or you can complete it at home.

There is a list of statements starting below you might use when thinking about which surgical option is right for you.

You can also talk to your health care team about your routine daily activities. This will help them adapt your care plan to suit your needs.

If something has been missed out below and you want to make a note about it, please write it in the blank spaces on the following pages.

Tick the boxes below to show how much each of these things matters to you:

	Matters most	Matters	Doesn't matter
I want treatment without the need for surgery	☐	☐	☐
I do not want surgical mesh	☐	☐	☐
I want to leak less and use fewer pads	☐	☐	☐
I don't want to leak at all	☐	☐	☐
I want fewer urinary tract infections following my surgery	☐	☐	☐
I want to be able to urinate freely after treatment/surgery	☐	☐	☐
I don't want to need to use catheters long term	☐	☐	☐
I want sex to be pain free	☐	☐	☐
I want a short time in hospital	☐	☐	☐
I want a quick recovery and return to my normal everyday activities	☐	☐	☐
I want treatment close to home	☐	☐	☐
I prefer surgery that doesn't involve a general anaesthetic	☐	☐	☐
I don't want major abdominal surgery	☐	☐	☐
I don't want repeat surgery in the future to manage incontinence	☐	☐	☐

Other things may also be important to you. Please write these below.

My concerns

Write down your concerns below or talk them through with your health care team so you can make an informed choice.

What I want from surgery

Note down or tell your surgeon what results you expect from your surgery, for example, what activities you would like to be able to do afterwards.

Surgical options I want to know more about

Tick the surgical option(s) you would like to discuss at your appointment:

- ☐ Urethral bulking agents
- ☐ Native tissue sling
- ☐ Colposuspension
- ☐ Mesh tape/sling

Note down anything else you would like to talk about at your appointment below.

Questions you may want to ask

These questions are a guide only for you to use when thinking about which surgical option is right for you. You can also direct them to your health care team, which includes your surgeon.

About me

- Have I tried all the options available for managing incontinence without surgery, and have I tried them for long enough?
- How likely is it that this surgery will fix my incontinence, and for how long? Will I leak again in the future?
- Are my expectations realistic?
- Am I likely to be more at risk for complications with any of the surgical options, and if so, why?
- (Ask if relevant) I have allergies and/or an auto-immune disease. Could any of the surgical options make these symptoms worse? If so, which ones and why?

About the surgical options

- Which surgical option do you think would be best for me and why?
- If I choose a surgical option you do not perform, can you refer me to someone who does?
- What kind of sutures (stitches) do you use? Do they dissolve or will anything permanent stay in my body? Are there any risks relating to sutures that I should know about?
- What is the name of the urethral bulking agent you use? Are the risks the same for the different types of products used?
- Can you talk through all the risks associated with each surgical option?
- If I do have any complications, will you know how to fix them? If not, who would you refer me to?
- What can I expect during my post-surgery recovery? If I experience anything different from that, who do I contact?
- What side effects or unusual symptoms should I report to you?
- What happens if this surgery does not fix my incontinence?
- Can I contact you before the surgery if I have more questions about it? How do I do this?
- How long after I leave hospital will you contact me to check that everything is ok?
- Is there a post-surgery check-up schedule?
- Will it be you ringing to check up on me, or will it be someone else? How often will you follow up with me?

About surgery using mesh

- If mesh is being suggested for me, w hy is that and what are the benefits for me over surgical options that don't involve mesh?
- What brand of mesh do you plan to use? Has this specific brand or products of this company ever been investigated and their use been put on hold or withdrawn? What are the risks associated with using this brand of mesh?
- Will you give me more information about the type of mesh you are using?

About my surgeon

- What type of surgery/surgeries are you credentialed in (allowed to perform) in Aotearoa New Zealand?
- (If mesh is recommended) how many surgeries involving mesh have you performed using the type of mesh recommended for me?
- How many of the other surgical options not involving mesh covered in this guide have you performed?

About risks and complications

- What side effects can I expect after surgery and what side effects should I report to you?
- What happens if I experience symptoms in years to come?
- How many of the listed complications have your patients experienced that you are aware of?
- How could long-term complications impact me, my life and my family and whānau?

About possible need for further surgery

- If I have a complication, will you be able to manage it locally?
- If I have a complication due to use of mesh, will you completely remove the mesh? What happens if it cannot be removed and what will that mean for me in the future?
- What are the possible risks and complications if only some of the mesh has to be removed or cut and some of it is left in my body?
- If only some of the mesh has been removed or cut, does this make it more difficult to fully remove the mesh later?
- If mesh removal surgery was needed, who would undertake it?

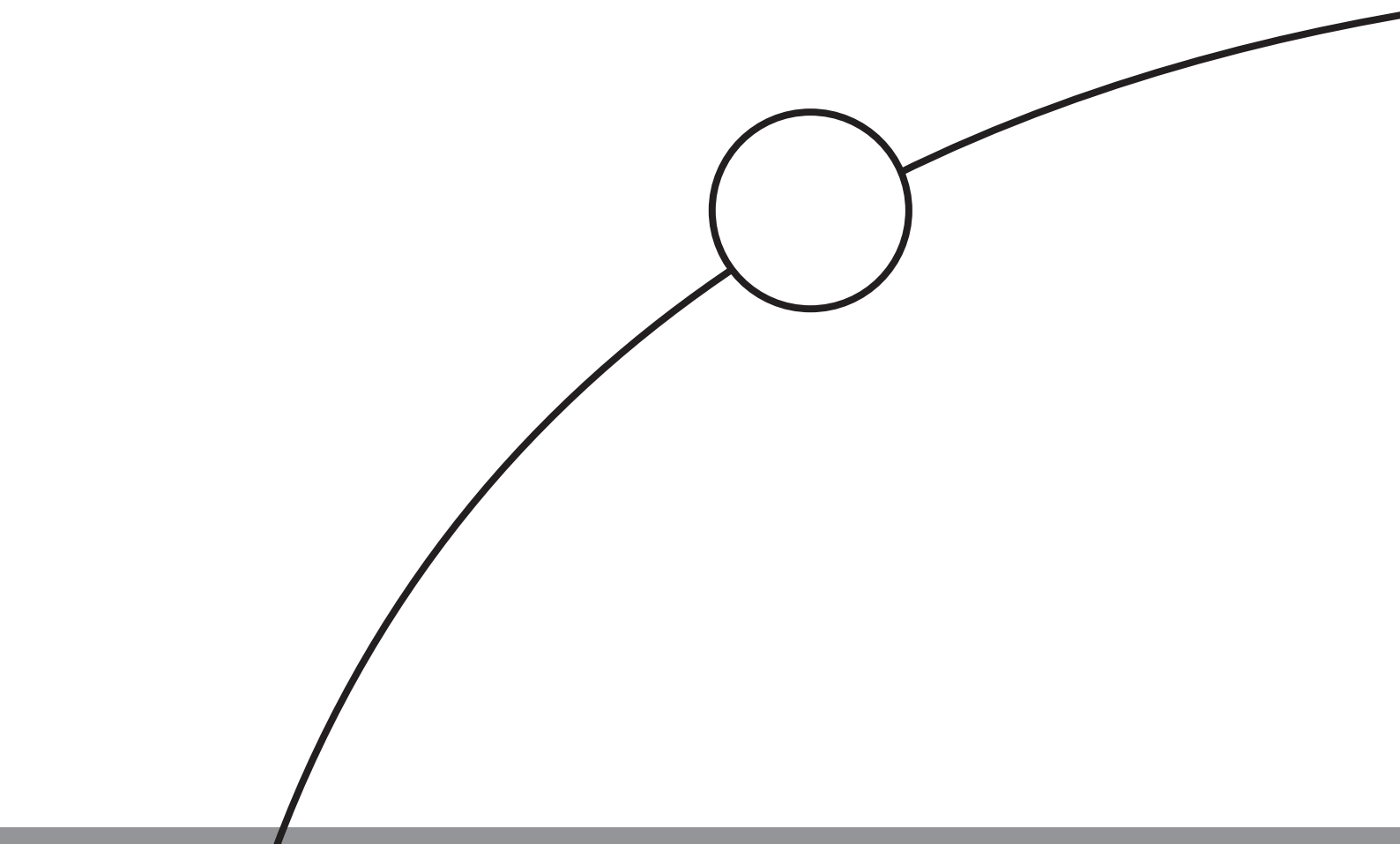
Planning ahead

- What can I do before the surgery to help me recover afterwards?
- Can you suggest any breathing, relaxation or mindfulness techniques or other things that may help me feel more confident before surgery?
- Should I keep doing my pelvic exercises and/or a lighter version before my surgery?

Your surgeon will talk to you about what surgical options are realistic for you based on what matters to you and your needs.

You can work through the next section of this guide together. It covers coming to a decision. Remember, you do not have to decide straight away.

Coming to a decision – a process to go through with your surgeon



These people are in my health care team:

The surgical option(s) I would like to consider are (tick all that apply):

- ☐ Urethral bulking agents
- ☐ Native tissue sling
- ☐ Colposuspension
- ☐ Mesh tape/sling
- ☐ I am still unsure
- ☐ None of these options

I have ticked these options because:

Use this checklist to show that you understand all the important information about your preferred surgical option.

- ☐ I understand what the surgical option involves and the outcomes I want.
- ☐ I understand all the alternatives to this surgery and their main advantages and disadvantages.
- ☐ I understand all the possible risks.
- ☐ All of my questions were answered to my satisfaction.

OR

- ☐ I have been informed but don't really understand.
- ☐ I feel as if I need more information and would like to talk this through again.
- ☐ I am still unsure which option to choose.

Form

The form on the next page is not a legal consent form, nor does it need to be signed today if you have not decided which option you prefer. If you go ahead with surgery, there will be a different form for you to sign on the day, where you give your consent for the procedure.

The form on the next page is designed to show that you and your surgeon have discussed and agreed on your preferred surgical option.

Making the right decision is important, so take your time before choosing which surgical option you prefer.

It is absolutely fine to change your mind about what surgery you would like, or the timing of it. There will be plenty of time for your surgeon to go through all the information in this guide with you again before you decide and sign the form.

Your health care team recognises that what matters to you may change during the decision-making process and you may have new concerns you would like to discuss. For example, you may have concerns about recovery after a particular type of surgery, but as you f ind out more about it, you may not have concerns anymore.

You can change the information after completing the form at any time. Note: a copy of this form will be put in your clinical record.

Patient to sign:

I, _____

[insert name of patient], confirm that all the surgical options have been discussed to my satisfaction together with my surgeon,

_____

[insert name of surgeon], and I confirm I have chosen to proceed with the following surgery:

_____

[insert name of surgery].

Patient signature: _____

Patient name: _____

Date: _____

Please write any other comments here:

Surgeon to sign:

I, _____

[insert name of surgeon], confirm that all relevant surgical options have been discussed together with my patient,

_____

[insert name of patient], and I confirm they have chosen to proceed with the following surgery:

_____

[insert name of surgery].

Surgeon signature: _____

Surgeon name: _____

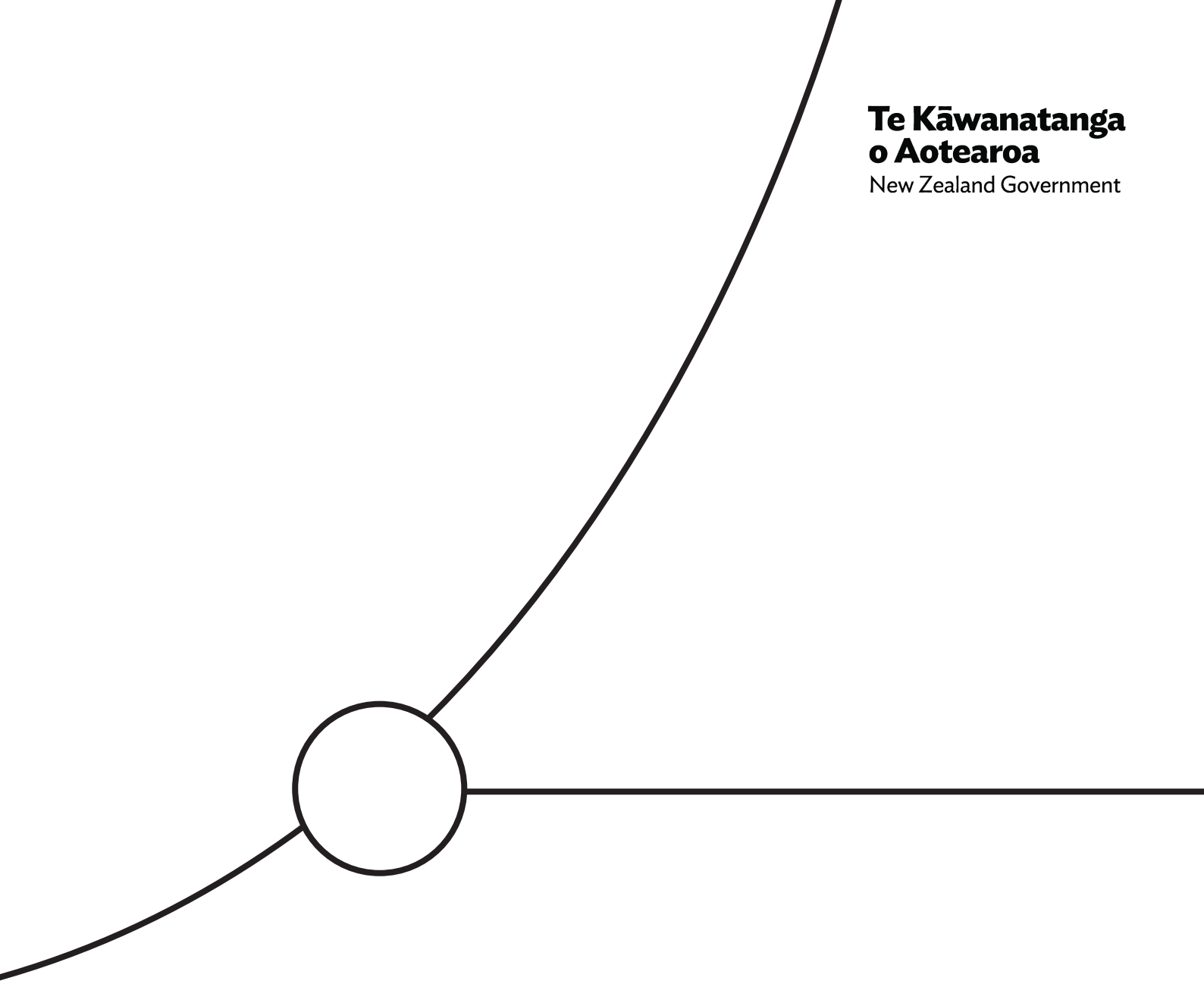
Date: _____

Please write any other comments here:

Explanations of terms used in this guide

Auto-immune condition	When the immune system attacks the healthy cells of the body by mistake.
Catheter	A tube that is placed to drain urine from the bladder.
Catheterise	To insert a catheter to drain urine from the bladder, for example, after surgery.
Credentialling	Credentialling is the process used to verify a surgeon's qualifications, experience, professional standing and other relevant professional attributes for the purpose of forming a view about their ability to deliver surgical services in a particular health service.
Exposure	When mesh or a permanent suture is visible inside an organ, such as the vagina or bladder.
Fascia	A naturally occurring sheet of supporting fibrous tissue that holds body organs in their correct positions.
Fascia lata	The thin but very tough layer that covers muscles in the thigh like an elastic stocking.
Fascia rectus	The thin but very tough layer that covers the abdominal muscles.
Foreign body response	When your immune system has an inflammatory reaction to a foreign body (or material) that has been implanted into you. This is a normal response in the first 3 months after surgery.
Hysterectomy	Surgery to remove the uterus.
Keyhole surgery	Surgery involving only small cuts to get through the skin and other tissues. Also known as laparoscopy.
Laparoscopy	See definition for keyhole surgery.

Mesh	A medical implant that is intended to be permanent. It resembles a net-like fabric with open spaces between the strands of the net. It is usually made from a polypropylene (plastic) material that the body can't absorb.
Mesh contraction	When mesh shrinks after being implanted. This can cause an increase in inflammation, tension on the surrounding tissues and an increase in the likelihood of excessive scar tissue (fibrosis), pain and ongoing contractions.
Mesh exposure	Where mesh is exposed and pushes against and comes through into the vagina, bladder or urethra, surrounding tissue or nerves and organs.
Open surgery	Surgery involving a large cut to the skin.
Pessary	A removable device placed inside the vagina to support the pelvic organs.
Perforation	When an organ such as the urethra, bladder or bowel is accidentally punctured.
Prolapse	When the organs in the pelvis (such as the uterus, bladder or rectum) move out of their normal position and press against the walls of the vagina.
Rectocele	When the back wall of the vagina collapses/falls into the vagina.
Retropubic	This describes the space behind the pubic bone and in front of the bladder (the retropubic space); this is the route of tape passage in the most common form of mesh tape surgery.
Self-catheterisation	When the patient rather than a health professional inserts their own catheter to drain urine from the bladder.
Seroma formation	When uninfected and clear (serous) fluid collects under the skin.
Sutures	Stitches; these may be dissolvable or permanent.
Tape	A flat strip of mesh tape and a permanent implant. See also mesh.
Urethra	The pipe through which the bladder empties urine to the outside of the body.
Urge incontinence	When you have a sudden, strong desire to urinate, followed by accidentally leaking urine.



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