



AUTOLOGOUS SLING PROCEDURE for STRESS URINARY INCONTINENCE (SUI)

Information about your procedure from
The British Association of Urological Surgeons (BAUS)

This leaflet contains evidence-based information about your proposed urological procedure. We have consulted specialist surgeons during its preparation, so that it represents best practice in UK urology. You should use it in addition to any advice already given to you.



<http://rb.gy/sz807>

To view this leaflet online, scan the QR code (right) or type the short URL below it into your web browser:

KEY POINTS

- Autologous slings are used to treat stress urinary incontinence (SUI)
- The sling is made from your own body tissues (i.e. there is no mesh)
- Two thirds (66%) of women are completely dry after this operation
- 80 to 90% of women are happy with the result of their surgery even though some still have some leakage
- 10% of women develop urgency (needing to rush to the toilet)
- Up to 10% of women may experience chronic (long-term) pelvic pain following this type of surgery
- Some women have difficulty emptying their bladder and will need to pass a disposable catheter to empty completely

What does this procedure involve?

This is a procedure to treat stress incontinence (leakage of urine when you exercise, cough, sneeze or strain). We place a sling, harvested from your own body tissue (abdominal wall or outside of your thigh), under your urethra (waterpipe) through a cut in your vagina and then brought out to the pubic area under your skin.

When you exercise or cough, there is normally downward pressure on your bladder. The sling acts as a support underneath your urethra, and holds it closed when the bladder is pushed downwards; this prevents urine leakage.

The procedure works in a similar way to [mid-urethral tape operations](#) (TOT or TVT; see below). The main difference is that this procedure does not use a synthetic mesh material. Recovery time tends to be a little longer than for mid-urethral tape operations.

What are the alternatives?

Stress incontinence can usually be treated without surgery. We recommend that all patients try non-surgical treatment before having an operation, because it avoids the risks of side-effects or complications of surgery.

- **Incontinence pads** – if your symptoms are not a bother to you
- [Pelvic floor exercises](#) – with a continence adviser or physiotherapist can improve stress urinary incontinence in approximately 50% of women
- **Weight loss and stopping smoking** - can also help stress incontinence
- **Continence pessaries** – placed temporarily inside your vagina can help leakage that occurs only during exercise

There are several operations used to treat stress incontinence. Each one has advantages and disadvantages, and different operations may be better for different people. You should discuss these with your surgeon before coming to a decision:

- [Urethral bulking](#) – an injection around your urethra
- [Mid-urethral tape operations](#) ^{see footnote 1} (e.g. TVT or TOT) - using a synthetic mesh tape to support your urethra from below
- [Colposuspension](#) – an open operation which lifts the tissues around your bladder neck on to the back of your pelvis
- [Artificial urinary sphincter insertion](#) – an implant that squeezes the urethra

¹ *Mid-urethral tape operations are currently “paused” on the recommendation of the July 2020 Cumberlege report*

For further information about the options available to treat stress incontinence, see the [BAUS leaflet on the comparison of treatment options for stress urinary incontinence](#) and the [NICE guideline NG123](#).

What happens on the day of the procedure?

You will be seen by the surgeon and the anaesthetist who will go through the plans for your operation with you.

We may provide you with a pair of TED stockings to wear, and give you an injection to thin your blood. These help to prevent blood clots from developing and passing into your lungs. Your medical team will decide whether you need to continue these after you go home.

Details of the procedure

- we make a cut in your lower abdomen (tummy) or the outside of your thigh
- we remove a strong piece of fascia (muscle lining) and trim it into a ribbon-like sling
- through a small cut in your vagina, we put the sling under your urethra (waterpipe) and bring it out just above your pubic bone, in your lower abdomen, underneath the skin
- we may put a catheter into your bladder through your urethra and a small pack in your vagina; we usually remove these on the first day after the procedure
- the autologous sling operation works in a similar way to mid-urethral synthetic tape operations like TOT or TVT; the main difference is that this operation does not involve using a synthetic mesh material

What happens immediately after the procedure?

Most people stay in hospital overnight, after the operation. When you wake up, you may have a catheter in your bladder and, possibly, a gauze dressing in your vagina. There may be some bleeding from your vagina at the start. This is normal and will settle within 2 days. The nurse will check to make sure the bleeding is not excessive.

When you first pass urine, it may be uncomfortable and the urine flow may be slower than usual. The nurses will measure the amount of urine you pass and then check a scan of the bladder afterwards to make sure you are emptying well.

If your bladder does not empty well, we may replace the bladder catheter for a few days or teach you how to perform [intermittent self-catheterisation](#). This happens in 10% of patients (1 in 10) but is sometimes needed in the longer term.

The cut in your abdomen (tummy) can be sore for one or two weeks. The recovery time is longer than for mid-urethral tape operations like TVT or TOT and there tends to be more discomfort.

Your catheter

A catheter is a small tube made out of latex or silicone that is put into the bladder through the water pipe to let the urine drain out. If your bladder is not emptying properly after the operation, the nurse will empty the bladder using a catheter. Sometimes a catheter is left in for a few days (an indwelling catheter) and sometimes you will be taught how to drain the bladder yourself using a disposable “in-and-out” catheter (self-catheterisation). This problem affects 10% of patients in the immediate post-operative period, but it is less common for this to be needed for more than a few days or weeks.

If you go home with an indwelling catheter, you will come back to have the catheter removed at a convenient time. The team will then measure your bladder emptying with a scanner again.

How effective is the procedure in curing stress urinary incontinence?










About two thirds of women will be completely dry after the operation and one third will have some degree of leakage. Most people are much better after surgery, even if they still have some leakage. To put it another way, 80 to 90% (eight or nine out of 10) of women are satisfied with the result after an autologous sling operation.






These results are similar to those seen after colposuspension or mesh tape operations, both in the short and long term. Outcomes for surgery in women with recurrent stress urinary incontinence after previous surgery, however, are not as good.

Are there any after-effects?

The possible after-effects and your risk of getting them are shown below. Some are self-limiting or reversible, but others are not. We have not listed very rare after-effects (occurring in less than 1 in 250 patients) individually.

The impact of these after-effects can vary a lot from patient to patient; you should ask your surgeon's advice about the risks and their impact on you as an individual:

After-effect	Risk
Mild vaginal bleeding for the first 48 hours	 Almost all patients
Short-lived pain in the incision requiring simple painkillers	 Almost all patients
Failure to produce a significant improvement in your incontinence	 Between 1 in 5 & 1 in 10 patients (10 - 20%)
Recurrence of your stress incontinence even if it was cured straight after the procedure	 Between 1 in 5 & 1 in 10 patients (10 - 20%)
Worsening frequency & urgency with urge incontinence (leakage) especially if already present to a minor degree before the procedure	 1 in 10 patients (10%)
Chronic (long-term) pain in your vagina or abdomen (tummy)	 1 in 10 patients (10%)
Injury to your bladder during the procedure requiring a catheter for slightly longer than usual	 Between 1 in 10 to 1 in 20 patients (5 - 10%)
Infection in the wound requiring antibiotics	 Around 1 in 20 patients (5%)
Urinary infection requiring antibiotics	 Around 1 in 20 patients (5%)

<p>Temporary inability to empty your bladder completely requiring a catheter or intermittent self-catheterisation</p>	 <p>Between 1 in 10 & 1 in 20 patients (5 - 10%)</p>
<p>Inability to empty your bladder completely, which does not get better on its own, requiring a catheter or intermittent self-catheterisation</p>	 <p>Between 1 in 20 & 1 in 50 patients (2 - 5%)</p>
<p>Inadvertent injury to surrounding structures (e.g. urethra, rectum, blood vessels) requiring further surgery</p>	 <p>Between 1 in 50 & 1 in 250 patients</p>
<p>Severe bleeding requiring a further procedure</p>	 <p>Between 1 in 50 & 1 in 250 patients</p>
<p>Anaesthetic or cardiovascular problems possibly requiring intensive care (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death)</p>	 <p>Between 1 in 50 & 1 in 250 patients (your anaesthetist can estimate your individual risk)</p>

What is my risk of a hospital-acquired infection?

Your risk of getting an infection in hospital is between 4 & 6%; this includes getting *MRSA* or a *Clostridium difficile* bowel infection. Individual hospitals may have different rates, and the medical staff can tell you the risk for your hospital. This figure is higher if you are in a “high-risk” group of patients such as patients who have had:

- long-term drainage tubes (e.g. catheters);
- long hospital stays; or
- multiple hospital admissions.

What can I expect when I get home?

- you may have some vaginal bleeding but this usually settles within 48 hours
- you may find passing urine uncomfortable once your catheter has been removed
- you may be discharged with a catheter in your bladder

- if you do have a catheter, we will show you how to manage it at home and will arrange for it to be removed at a suitable time
- the incision (cut) on your tummy may be sore for up to two weeks
- for the first four weeks, you should avoid any strenuous activity or heavy lifting (e.g. no more than two four-pint milk cartons)
- after four weeks, you can go back to everyday activities but if you do undertake strenuous activity (e.g. running, gymnasium exercises or you have a very physical job), you should wait a total of six weeks before gradually introducing exercise
- you should avoid sexual intercourse for six weeks after the procedure
- you will be given a copy of your discharge summary and a copy will also be sent to your GP
- any antibiotics or other tablets you may need will be arranged & dispensed from the hospital pharmacy

Your data and data protection

It is important that surgeons monitor the success rates and complications of the operations they perform, to be sure that their patients get good results. This helps us to tell future patients what to expect and makes sure that all surgeons are performing well. All stress incontinence operations were previously recorded on a BAUS database but, following the publication of the [Cumberlege report and its recommendations](#), an independent National Pelvic Floor Registry has been set up.

BAUS will support full participation in this national audit that aims to mandate collection of data on all pelvic floor operations, including all surgery carried out for stress urinary incontinence. This will allow surgeons to see how well the surgery is being done under their care and, secondly, will help us to examine national trends for all these procedures.

Some basic patient data (e.g. name, NHS number and date of birth) are entered and securely stored. This is required so that members of the clinical team providing your care can go back to the record and add follow-up data, such as length of stay or post-operative complications. This helps your surgeon to understand and fully document the various outcomes of the procedure.

General information about surgical procedures

Before your procedure

Please tell a member of the medical team if you have:

- an implanted foreign body (stent, joint replacement, pacemaker, heart valve, blood vessel graft);
- a regular prescription for a blood thinning agent (e.g. warfarin, aspirin, clopidogrel, rivaroxaban, dabigatran);
- a present or previous MRSA infection; or
- a high risk of variant-CJD (e.g. if you have had a corneal transplant, a neurosurgical dural transplant or human growth hormone treatment).

Questions you may wish to ask

If you wish to learn more about what will happen, you can find a list of suggested questions called "[Having An Operation](#)" on the website of the Royal College of Surgeons of England. You may also wish to ask your surgeon for his/her personal results and experience with this procedure.

Before you go home

We will tell you how the procedure went and you should:

- make sure you understand what has been done;
- ask the surgeon if everything went as planned;
- let the staff know if you have any discomfort;
- ask what you can (and cannot) do at home;
- make sure you know what happens next; and
- ask when you can return to normal activities.

We will give you advice about what to look out for when you get home. Your surgeon or nurse will also give you details of who to contact, and how to contact them, in the event of problems.

Smoking and surgery

Ideally, we would prefer you to stop smoking before any procedure. Smoking can worsen some urological conditions and makes complications more likely after surgery. For advice on stopping, you can:

- contact your GP;
- access your local [NHS Smoking Help Online](#); or
- ring the Smoke-Free National Helpline on **0300 123 1044**.

Driving after surgery

It is your responsibility to make sure you are fit to drive after any surgical procedure. You must not drive for 24 hours after a general anaesthetic. If you experience pain while moving around your vehicle or during braking,

you should not drive until it has settled completely. You only need to [contact the DVLA](#) if your ability to drive is likely to be affected for more than three months. If it is, you should check with your insurance company before driving again.

What should I do with this information?

Thank you for taking the trouble to read this information. Please let your urologist (or specialist nurse) know if you would like to have a copy for your own records. If you wish, the medical or nursing staff can also arrange to file a copy in your hospital notes.

What sources have we used to prepare this leaflet?

This leaflet uses information from consensus panels and other evidence-based sources including:

- the [Department of Health \(England\)](#);
- the [Cochrane Collaboration](#); and
- the [National Institute for Health and Care Excellence \(NICE\)](#).

It also follows style guidelines from:

- the [Royal National Institute for Blind People \(RNIB\)](#);
- the [Information Standard](#);
- the [Patient Information Forum](#); and
- the [Plain English Campaign](#).

DISCLAIMER

Whilst we have made every effort to give accurate information, there may still be errors or omissions in this leaflet. BAUS cannot accept responsibility for any loss from action taken (or not taken) as a result of this information.

PLEASE NOTE: the staff at BAUS are not medically trained, and are unable to answer questions about the information provided in this leaflet. If you have any questions, you should contact your Urologist, Specialist Nurse or GP in the first instance.