Mesh perforation into viscus following pelvic mesh surgery: Experiences and recommendations for diagnosis and management

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Introduction Pelvic mesh has been used for the treatment of pelvic organ prolapse (POP) and stress urinary incontinence (SUI). Between 3-20% of women suffer from complications with debilitating long-term outcomes.

Aims Provide recommendations regarding diagnosis and management of pelvic mesh perforation into viscus.

Methods A retrospective observational study of patients who had diagnosis and management of mesh in viscus at three tertiary urogynaecology units was performed.

Results Fifty-eight patients were diagnosed with mesh in viscus following cystoscopy and examination under anaesthesia (EUA). Mesh involved included mid-urethral slings - retropubic (36.9%), transobturator (18.5%) and single-incision slings (10.8%), transvaginal POP mesh (15.4%), abdominal sacrocolpopexy (13.8%), and uncertain type (4.6%). Viscus involved included bladder (39.7%), urethra (50%), bladder and urethra (3.4%), and rectum (6.9%). Presenting symptoms included mixed urinary incontinence [75.9%], recurrent UTIs (48.3%), voiding dysfunction (19%), and pain (56.9%). Fifty patients underwent mesh excision and viscus repair (with or without concomitant labial fat flap), with successful repair in all patients (100%). 48% had complete mesh excision. Mean follow up was 9.5 months (range 0.5 – 96 months). Post-operatively, thirty-three patients (63.5%) had recurrent urinary incontinence, seven (13.5%) had persistent pain and seven (13.5%) had recurrent UTIs. None had lower genitourinary tract fistula or wound breakdown.

Discussion All patients required EUA and cystourethroscopy for diagnosis. Excision of mesh in viscus appears to reduce risk of recurrent mesh erosion or fistula. Consideration should be given to performing a labial fat flap during urethral repair to prevent injury from future treatment for persistent pelvic floor dysfunction.