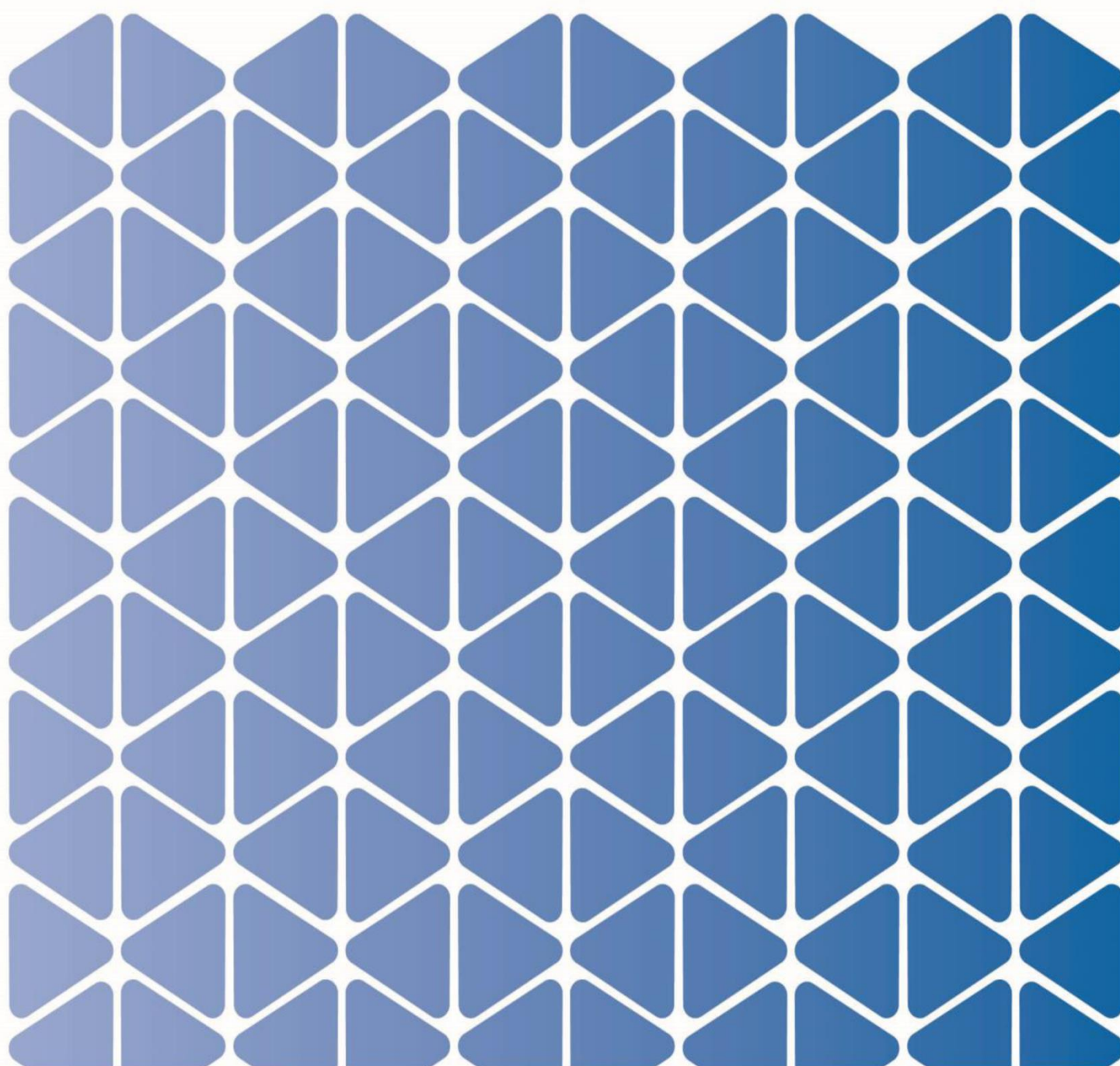


PATIENT INFORMATION SURGICAL PROCEDURE

MID-URETHRAL VAGINAL TAPE (MUT)



You have chosen to have a mid-urethral vaginal tape (MUT) to improve your urinary incontinence.

This leaflet explains some of the benefits, risks and alternatives to the MUT operation. We want you to have all the information you need to make the right decision. Please ask your Surgeon or Specialist Nurse about anything you do not fully understand or would like explained in more detail.

We recommend that you read this leaflet carefully. You and your doctor (or other appropriate health professional) will also need to record that you agree to have the procedure by signing a consent form, which they will give you.

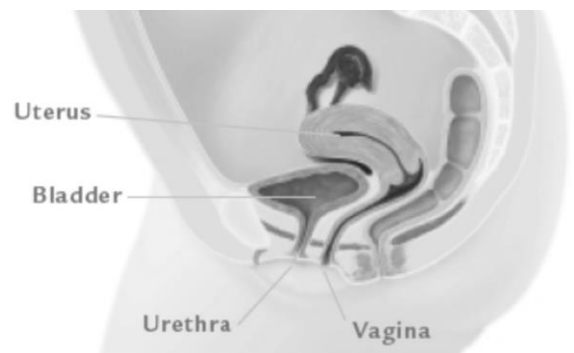
In our unit currently, most patients are offered a procedure called Tension Free vaginal tape or TVT. Other types of MUT are also sometimes used such as TVT-O or more recently the 'Adjust' procedure. Your surgeon will clarify the exact type of procedure being offered to you in clinic.

TVT has been developed as a treatment for stress urinary incontinence (SUI), which is the sudden, unintentional release of urine during normal, everyday activities. This unintentional release or leakage of urine can happen during sudden movements such as coughing, sneezing, laughing, getting up from a seated or lying position, walking and exercising. You may also go to the bathroom frequently during the day to avoid accidents. If you are experiencing sudden urine loss with activity, it means your urethra (the tube from the bladder through which urine exits the body) is opening when it is not supposed to.

TVT may also be used to treat cases of mixed incontinence. This is when women have symptoms of both stress and urge incontinence. Urge Incontinence is the sudden, intense urge to urinate and fear of leaking, followed by actual loss of urine. You may feel that you never get to the bathroom fast enough. You may wake several times a night with the strong urge to urinate.

Why do I have stress incontinence?

There are two primary reasons why the urethral tube fails to maintain its seal during stress activity. The most common is poor support of the urethra, which is normally provided by the underlying muscle and connective tissue of the vagina. Less commonly, the urethral sphincter itself could be deficient.



One of the myths about SUI is that it is a natural part of the aging process. In reality, it can affect women at any age. Although common, SUI is not a normal part of aging and affects about 30 – 40 out of 100 women.

The weakening of the pelvic floor, connective tissues and muscle can happen as a result of:

- Pregnancy and childbirth
- Chronic heavy lifting, straining or coughing
- Menopause or lack of oestrogen hormone
- Obesity

Why do I need the MUT procedure?

Following the urodynamics tests on your bladder, you have been diagnosed with stress incontinence. We call this Urodynamic Stress Incontinence (USI). The cause is a weakness of the pelvic floor muscles and ligaments, which support the bladder neck. Because of this weakness, leakage of urine may occur when pressure is exerted on the bladder, for example, when you cough, sneeze or exercise.

You have been offered surgery in the form of a MUT, most commonly a Tension-free Vaginal Tape (TVT), in an attempt to strengthen the supports of the urethra and bladder neck. This procedure should cure, or greatly improve, stress incontinence in eight out of every 10 women having this surgery.

How is the procedure performed?

The TVT procedure has been developed to help treat women with stress incontinence. TVT stops urine leakage the way your body was designed to – by supporting your urethra at times of activity.

Normally, the urethra is supported by the pelvic floor muscles to maintain a tight seal and prevent involuntary urine loss. In women with SUI, the weakened pelvic floor muscle and connecting tissue fail to keep the urethra in its normal position.

To correct this your doctor will insert a ribbon-like strip of mesh under the urethra to provide support whenever you stress this area (such as during a cough or sneeze). This allows the urethra to remain closed, when appropriate, preventing involuntary urine loss.

The ribbon-like mesh is made from a permanent material that will be well tolerated by your body. It will remain in place forever to help support your urethra. The rate of complications with TVT is low.

When the TVT is the only operation, it takes less than 30 minutes to perform. It is carried out through a small cut in the vagina and two small cuts in the tummy wall, usually under the bikini line. The procedure is often performed with local anaesthetic to the tummy wall and vagina as well as other drugs given to sedate you (to make you sleepy, throughout the procedure).

The tape is passed around the bladder outlet (urethra) lifting it up and forming a support like the body's own ligaments.

We always look inside the bladder (cystoscopy) to check that the TVT is in the correct position. You will be asked to cough to demonstrate leakage. The tape can now be adjusted until you stop leaking. You will be a little sleepy and may, or may not, remember any of this.

TVT is usually performed under general anaesthetic (where you are numbed from the waist down by an injection in your back) or under a local and sedation anaesthetic (where you are completely asleep). This additional anaesthetic is usually used if other procedures are taking place – such as hysterectomy or repair of prolapse.

There is also a variation on the TVT procedure where the incisions are at the top of the thighs rather than on the tummy wall. This is called a 'Trans-obturator' approach or 'TVT-O'. This is used in special circumstances as advised by your Surgeon.

The nurses will monitor your ability to pass urine before you go home. This could be on the day of surgery, or in the first couple of days after your operation.

Benefits of the procedure

The aim of your surgery is to improve, and hopefully cure, your stress incontinence.

MUT's are safe, effective and minimally invasive procedures that can help you control this condition. This procedure often delivers reliable, permanent results. The procedure is simpler and much less invasive than traditional surgical procedures that require large incisions and several days in the hospital.

Serious or frequent risks

Everything we do in life has risks. The general risks of surgery include problems with:

- the wound (for example, infection);
- breathing (for example, a chest infection);
- the heart (for example, abnormal rhythm or, rarely, a heart attack); and
- blood clots (for example, in the legs or occasionally in the lung).

Most people will not experience any serious complications from their surgery. The risks increase for elderly people, those who are overweight and people who already have heart, chest or other medical conditions such as diabetes or kidney failure. As with all surgery, there is a very small risk that you may die (less than 1 in 100,000).

You will be cared for by a skilled team of doctors, nurses and other health-care workers who are involved in this type of surgery every day. If problems arise, we will be able to assess them and deal with them appropriately.

The risks specifically related to tension-free vaginal tape include occasional problems with:

- Failure of procedure to improve symptoms of incontinence (2 out of 10 women).
- The new development of urinary frequency or urgency and leaking with a strong desire to urinate (one woman in 20) – see overactive bladder below.
- In women who already have urgency (with or without urge incontinence) before TVT surgery, we would expect six out of 10 to see an improvement in symptoms (but it is important to note that 1 out of 10 women may experience a worsening of urgency and leakage).
- Slow urinary stream.
- Worsening back problems due to your position on the operating table.
- Excessive bleeding due to injury to blood vessels of the pelvic sidewall and abdominal wall.
- Blood clot behind the pelvic bone (haematoma).
- Perforation of the bladder (less than 1 in 50 cases). This is a relatively minor complication but will require a catheter to be left in place in the bladder for a few days and you will need a course of antibiotics. Very rarely (<1 in 500) this can be a more serious complication resulting in a persistent bladder defect called a fistula.
- Urinary tract infection
- Retention of urine, i.e. you are unable to pass urine (this is uncommon). If this happens, a catheter is placed in the bladder and left in place for 24 hours. If the problem recurs after this has been removed you will be taught how to pass a smaller catheter yourself which allows you to empty your bladder at home for a while until you are able to pass water again naturally. These are disposable catheters, which you use as and when you need to pass water. They are thrown away and do not stay in all the time.
- Second operation to stretch or cut the tape (less than 1 every 50 cases)

The long-term risks specifically related to tension-free vaginal tape include occasional problems with:

- Groin pain is uncommon (less than 1 in 20). Chronic pain and pain on sexual intercourse have been described in 2-3 per 100 women undergoing a tape procedure. This can be difficult to treat.
- 100% cure rate is not guaranteed but results so far are most encouraging with 9 out of 10 women being satisfied with the procedure.
- Overactive bladder is when the bladder becomes over sensitive and you need to go to the toilet more frequently. This occurs in 1 in 20 women as a new problem, but usually responds to tablets, which calm the bladder down again.
- Mesh erosion is where the position of the TVT tape can be felt through the vaginal wall and causes discomfort. This happens in 1 out of 100 women having this operation. This may require one or more procedures to bury or excise the extruding/eroding tape.
- Sometimes, more surgery is needed to put right these types of complications.

Other treatments that are available

Stress urinary incontinence is very treatable at any age. However, not all approaches work for every person or for every type of incontinence. For stress urinary incontinence, your Surgeon may suggest one or more of the following:

Physiotherapy for pelvic floor muscle exercises

For women with stress urinary incontinence, the first line of therapy is usually pelvic floor muscle exercises to help strengthen the pelvic floor muscles. However, depending on the severity of your condition, pelvic floor exercises may not bring sufficient relief. Other therapies that may be used alone, or in combination with pelvic floor exercises, include:

Biofeedback – a process that helps you gain control over bodily functions by making you more aware of them.

Electrical stimulation – which aids pelvic floor exercises by isolating the muscles involved.

Medication:

Some types of urinary incontinence can be treated with medications or hormone therapy (if incontinence is associated with oestrogen deficiency, for example).

Other surgery that is available

Other operations are available for stress incontinence. These are either bigger operations with longer hospital stay and recovery time, or smaller operations, which do not appear to be as effective or long-term as MUT.

Your pre-surgery assessment visit

You may be asked to attend a pre-surgery assessment clinic on the ward about a week before admission. This allows you, the nurse and doctor to go through all the paperwork and discuss any queries. The nurse will explain the ward routine and what to expect before and after the operation. For example, when you will be allowed to eat and drink before and after the operation, when you can expect to be out of bed and what observations the nurses need to do.

At this appointment, we will also record your current symptoms and past medical history, including any medication you are taking. Your heart and lungs will be examined to check that you are well enough for surgery. Blood tests and x-rays will usually be taken or arranged during this clinic.

The members of the team will check that you agree to have the planned surgery. If you have been given a consent form please bring it with you, alternatively you may be given a consent form in clinic. Make sure that you have read and understood this information before your clinic visit. If you have not understood any part of the information, you will be able to ask any questions you may have about your planned surgery.

You will also be asked to complete a small questionnaire relating to the severity of your urinary incontinence symptoms.

Before you come into hospital

There are some things you can do to prepare yourself for your operation and reduce the chance of difficulties with the anaesthetic.

- If you smoke, consider giving up for several weeks before the operation. Smoking reduces the amount of oxygen in your blood and increases the risks of breathing problems during and after an operation.
- If you are overweight, many of the risks of anaesthesia are increased. Reducing your weight will help.
- If you have loose or broken teeth or crowns that are not secure, you may want to visit your dentist for treatment. If you require a general anaesthetic, the anaesthetist will want to put a tube in your throat to help you breathe. If your teeth are not secure, they may be damaged.
- If you have long-standing medical problems, such as diabetes, hypertension (high blood pressure), asthma or epilepsy, you should consider asking your GP to give you a check-up.

There is a risk that your procedure will be cancelled if there is a chance of very early pregnancy. In order to be sure you are not pregnant at the time of the procedure you must not have sex or you must use reliable contraception between the first day of the last NORMAL period to the date of procedure.

Being admitted to the ward

You will usually be admitted on the day of your surgery so you and we can prepare for the operation. We will welcome you to the ward and check your details. We will fasten an armband containing your hospital information to your wrist.

Your pre-surgery visit by the anaesthetist

After you go into hospital, the anaesthetist will come to see you and ask you questions about:

- your general health and fitness;
- any serious illnesses you have had;
- any problems with previous anaesthetics;
- medicines you are taking;
- allergies you have;
- chest pain;
- shortness of breath;
- heartburn;
- problems with moving your neck or opening your mouth; and
- any loose teeth, caps, crowns or bridges.

Your anaesthetist will discuss with you the different methods of anaesthesia they can use. After talking about the benefits, risks and your preferences, you can then decide together what is best for you.

On the day of your operation

Nothing to eat and drink (nil by mouth)

It is important that you follow the instructions we give you about eating and drinking. We will ask you not to eat or drink anything (including chewing gum or sucking sweets) for six hours before your operation even if your MUT is performed under local anaesthetic. This is because any food or liquid in your stomach could come up into the back of your throat and go into your lungs if you have, or need general anaesthetic. You may take a few sips of plain water up to two hours before your operation so you can take any medication tablets.

Your normal medicines

Continue to take your normal medicines up to and including the day of your surgery. If we do not want you to take your normal medication, your surgeon or anaesthetist will explain what you should do. It is important to let us know, before you are admitted, if you are taking anticoagulant drugs (for example, warfarin, aspirin or clopidogrel).

We will need to know if you do not feel well and have a cough, a cold or any other illness when you are due to come into hospital for your operation. Depending on your illness and how urgent your surgery is, we may need to delay your operation, as it may be better for you to recover from this illness before your surgery.

Your anaesthetic

When it is time for your operation, a member of staff will take you from the ward to the operating theatre. They will take you into the anaesthetic room and the anaesthetist will make you ready for your anaesthetic.

The procedure is normally performed under general anaesthetic (ie you are asleep). Occasionally, the procedure is performed under local anaesthetic to the tummy wall and vagina, as well as other drugs to sedate you (make you sleepy throughout the procedure).

Sometimes the MUT procedure may be performed under a spinal anaesthetic (where you are numbed from the waist down by an injection in your back) or under a general anaesthetic (where you are completely asleep). This additional anaesthetic is usually used if other procedures are taking place – such as hysterectomy or repair of prolapse.

To monitor you during your operation, your anaesthetist will attach you to a machine to watch your heart, your blood pressure and the oxygen level in your blood. A fine tube (venflon) will be placed in a vein in your arm or hand and the medicines will be injected through the tube. Sometimes you will be asked to breathe a mixture of gases and oxygen through a mask to give the same effect.

Pain relief after surgery

Pain relief is important as it stops suffering and helps you recover more quickly. Your anaesthetist may suggest appropriate pain relief.

Please ask for more painkillers if you are in pain.

What are the risks of anaesthetic?

Your anaesthetist will care for all aspects of your health and safety over the period of your operation and immediately afterwards. Risks depend on your overall health, the nature of your operation and how serious it is. Anaesthesia is safer than it has ever

been. If you are normally fit and well, your risk of dying from any cause while under anaesthetic is less than one in 250,000. This is 25 times less likely than dying in a car accident. Side effects of having an anaesthetic include drowsiness, nausea (feeling sick), muscle pain, sore throat and headache. We will discuss with you the risks of your anaesthetic.

After your surgery

- Once the medical team are happy with your progress, we will usually take you from the recovery room to the general ward. You will need to rest until the effects of the anaesthetic have passed. You will have a drip in your arm to keep you well hydrated.
- You may have a tube (catheter) to drain urine from your bladder into a bag next to your bed. Catheters are usually only used for women having their MUT under spinal or general anaesthetic, or when the MUT is combined with other operations such as prolapse or hysterectomy. This will usually be removed when you are ready to get out of bed and walk around . or the following day if the operation is combined with other surgeries.
- After the procedure, the amounts of urine you pass will be measured on at least two occasions and a scan of your bladder performed to check that it is emptying properly.
- Your anaesthetist will arrange for you to have painkillers for the first few days after the operation, as we mentioned earlier.
- We will encourage you to get out of bed and move around as soon as possible, as this helps prevent chest infections and blood clots.

Leaving hospital

Length of stay

How long you will be in hospital varies from patient to patient and depends on how quickly you recover from the operation and the anaesthetic. Most patients having this type of surgery will be discharged home the same day. Some will stay in hospital overnight or longer if other surgeries are performed as well.

Medication when you leave hospital

Before you leave hospital, the pharmacy will give you any extra medication that you need to take when you are at home.

Convalescence

The small cuts in your vagina and tummy will heal within five to 10 days. The stitches will dissolve gradually and should not need removing.

How long it takes you to recover from your surgery varies from person to person. On average we recommend not driving for 1 week and probably taking 2 weeks off work or for convalescence. Some patients can take longer to recover. You should consider who is going to look after you during the early part of this time. You may have family or close friends nearby who are able to support you or care for you in your home during the early part of your recovery period. You might consider going to stay with relatives or you may want to make your own arrangements to stay in a convalescent home while you recover. After you return home, you will need to take it easy and should expect to get tired to begin with for the first week.

Stitches

If your stitches have not dissolved after 10 – 14 days, visit your Practice Nurse and she will remove them for you. Your skin may itch a little but should not become redder, appear inflamed or develop any discharge. If any of these symptoms occur, ask the Practice Nurse to check them.

Personal hygiene

You can shower from the first day after the operation but non-perfumed soap should be used until all wounds are completely healed. We would suggest showering rather than bathing for the first week after surgery, but if you need to have a bath it should be a quick, shallow bath.

Diet

You do not usually need to follow a special diet. If you need to change what you eat, we will give you advice before you go home.

Exercise

We recommend that you avoid strenuous exercise and heavy lifting for up to four weeks. You should do lighter exercise, such as walking and light housework, as soon as you feel well enough. It may be appropriate for you to make other lifestyle adjustments to try and avoid heavy lifting for the long term.

Sex

You should avoid sexual intercourse for four weeks. This is to allow the internal stitches to heal.

Driving

You should not drive until you feel confident that you could perform an emergency stop without discomfort – probably at least one week after your operation (this may be longer if other surgery is performed at the same time). It is your responsibility to check with your insurance company.

Work

How long you will need to be away from work varies depending on:

- how serious the surgery is;
- how quickly you recover;
- whether or not your work is physical; and
- whether you need any extra treatment after surgery.

We advise you to take two weeks off work after this procedure. Some patients may need another 1-2 weeks in addition. Please ask us if you need a medical sick note for the time you are in hospital and for the first three to four weeks after you leave.

Outpatient appointment

Before you leave hospital we may give you a follow-up appointment to come to the outpatient department, or we will send it to you in the post. Follow up appointments are usually six months after your operation and may be with the Specialist Nurse or Surgeon.

Additional Information:

- You may experience slight spotting as the stitches dissolve in the vagina. This is normal but if you develop heavy bleeding (not a period) or an unpleasant vaginal discharge please arrange to see your family doctor.
- You may find that you need to pass water more often at first because the bladder and urethra are more sensitive. Try to drink plenty of fluids, especially water, about one and a half to two litres a day (cutting down in the evening so you are less likely to need to get up in the night).
- Caffeine drinks and alcohol may make your bladder more sensitive so are best avoided at this time.
- Until the tissues heal inside you may find passing water does sting. You may also find your stream has altered (you may pass water slower or even at an angle). This is normal and should settle with time. However, if you experience burning, stinging or pain when you pass water and feel you are going more often than you need to, please ask your family doctor to send a urine sample to the hospital in case you have a urine infection.

Contact details

If you have any specific concerns that you feel have not been answered and need explaining, please contact the following.

Worcester Royal Hospital

- Specialist Urogynaecology Nurse (phone 01905 733254)
- Gynaecology Ward Nursing Staff (phone 01905 760586)
- Hospital Switchboard (phone 01905 763333)

Alexandra Hospital

- Gynaecology Nursing Staff (phone 01527 512100)
- Surgery Nursing Staff (phone 01527 512106)
- Specialist Urology Nurse (phone 01527 503030 ext 42016)
- Hospital Switchboard (phone 01527 503030)

Kidderminster Treatment Centre

- Specialist Urogynaecology Nurse (phone 01905 733254)
- Ward 1 Nursing Staff (phone 01562 512356)
- Hospital Switchboard (phone 01562 823424)

Other information

The following internet websites contain information that you may find useful.

- www.patient.co.uk
Information fact sheets on health and disease
- www.rcoa.ac.uk
Information leaflets by the Royal College of Anaesthetists about 'Having an anaesthetic'
- www.nhsdirect.nhs.uk
On-line health encyclopaedia
- www.gynecare.com
Manufacturers of TVT tape
- www.worcestershirehealth.nhs.uk/acute_trust
Worcestershire Acute Hospitals NHS Trust

If your symptoms or condition worsens, or if you are concerned about anything, please call your GP, 111, or 999.

Patient Experience

We know that being admitted to hospital can be a difficult and unsettling time for you and your loved ones. If you have any questions or concerns, please do speak with a member of staff on the ward or in the relevant department who will do their best to answer your questions and reassure you.

Feedback

Feedback is really important and useful to us – it can tell us where we are working well and where improvements can be made. There are lots of ways you can share your experience with us including completing our Friends and Family Test – cards are available and can be posted on all wards, departments and clinics at our hospitals. We value your comments and feedback and thank you for taking the time to share this with us.

Patient Advice and Liaison Service (PALS)

If you have any concerns or questions about your care, we advise you to talk with the nurse in charge or the department manager in the first instance as they are best placed to answer any questions or resolve concerns quickly. If the relevant member of staff is unable to help resolve your concern, you can contact the PALS Team. We offer informal help, advice or support about any aspect of hospital services & experiences.

Our PALS team will liaise with the various departments in our hospitals on your behalf, if you feel unable to do so, to resolve your problems and where appropriate refer to outside help.

If you are still unhappy you can contact the Complaints Department, who can investigate your concerns. You can make a complaint orally, electronically or in writing and we can advise and guide you through the complaints procedure.

How to contact PALS:

Telephone Patient Services: 0300 123 1732 or via email at: wah-tr.PALS@nhs.net

Opening times:

The PALS telephone lines are open Monday to Friday from 8.30am to 4.00pm. Please be aware that you may need to leave a voicemail message, but we aim to return your call within one working day.

If you are unable to understand this leaflet, please communicate with a member of staff.