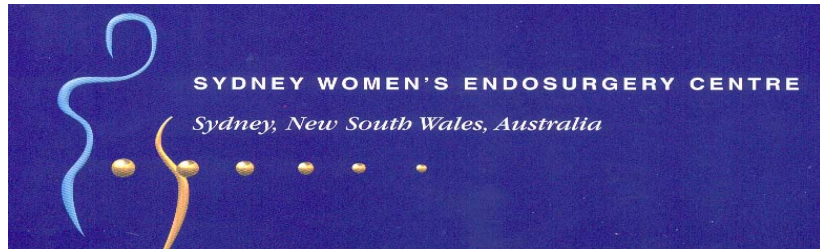


LAPAROSCOPIC INCONTINENCE SURGERY

Information Sheet for patients having a Laparoscopic Incontinence Operation



Dr Greg Cario
FRCOG FRANZCOG



Director of the Sydney Women's Endosurgery Centre (SWEC), Australia's leading Centre for the development and training in Advanced Laparoscopic Surgery for Women and Director of the St George Urodynamic Centre for Pelvic Floor Disorders

What is Stress Incontinence?

There is a lifetime risk of **25-50%** of women complaining of urinary stress incontinence which is leakage of urine during times of exertion. When this results in a significant affect on lifestyle, patients will seek treatment that may include surgery.

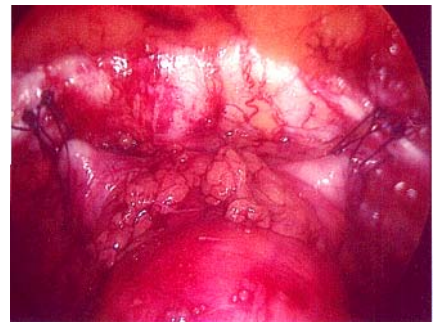
How can it be treated?

When conservative measures such as Pelvic Floor Physiotherapy and intravaginal appliances as well as lifestyle changes and weight loss have failed patients will usually present for a surgical option. The Gold Standard for the treatment of Genuine Stress Incontinence due to weakness of the bladder neck has become the **Burch Colposuspension** since it was first reported in 1961. There are long term studies up to 10 years following surgery that support this. This bladder neck weakness is caused by childbirth, congenital factors and the tissue softening associated with the menopause. It usually causes the symptoms of stress, cough or sneeze induced leakage. Our surgeons at SWEC have performed over 1000 of these procedures with a success rate of around 90% using the open technique with a transverse "caesarean" type scar. Since 1991 we have been performing this procedure using the new techniques of **advanced laparoscopic or keyhole surgery** with exactly the same results (Aust. N.Z.J Obs and Gyn. 1996 36:1:44)



The operation involves the stitching of the **bladder neck** to the ligaments at the back of the pubic bone. This prevents the bladder valve from dropping during a cough, which would cause it to open up and lose urine. The traditional operation involves a 10-15 cm **“bikini cut”** incision, a considerable amount of **postoperative pain** requiring intramuscular or intravenous narcotic analgesia, prolonged postoperative **catheter drainage**, and worst of all, a **7-10 day hospital stay** and **4-6 weeks off work**. This meant that many women had to persevere with their symptoms rather than commit to this major abdominal surgery and prolonged convalescence.

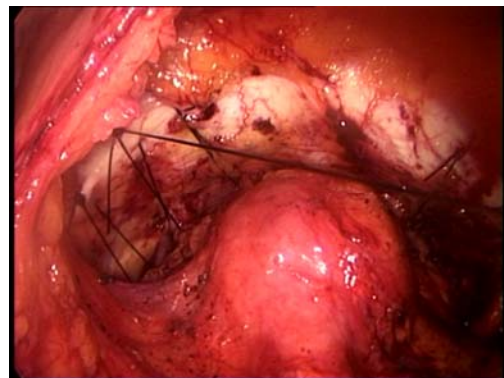
In our initial report of 113 **Laparoscopic Burch Colposuspensions** published, we found that the same operation could be performed exactly without incisions using the keyhole approach. In 2003 we reported the long term results of over 500 cases with results available **5-10 years after surgery** with a subjective success rate of **85%**. Laparoscopy uses a **TV camera** on the end of a telescope introduced through a 1cm puncture in the navel. This projects the operation site onto a monitor screen. Newly developed instruments are introduced through 3 other tiny nicks in the skin to dissect down to the area around the bladder neck so that it can be stitched to the pubic bone ligaments. This technique allows us to better visualise all the anatomy, the various areas of weakness and repair these site specific defects in a more anatomical way, often repairing multiple defects at the same surgery.



We also found that because there was **no large incisions** there was **very little postoperative pain** and therefore **little need for postoperative catheter drainage** with a bag to establish early normal voiding. The average patient **went home on the 2-3rd postoperative day** without a catheter and was **back to normal activities around the house and work in 1-2 weeks respectively**. Ten percent of patients required catheterisation for longer than 48 hours. Most of these still went home very early with the very modern forms of simple bladder drainage using an indwelling urethral catheter or a simple suprapubic catheter which is usually removed in the ward or the office at one week following a successful trial of void. **You can read all about this in detail by reading the postoperative instruction leaflet that will be given to you.**

[Is this operation safe?](#)

Complications are similar to those of the open operation except that the incidence of wound infection is drastically reduced. These complications include those of any general anaesthesia and major pelvic operation including haemorrhage, infection, thrombosis and inadvertent injury to the bladder, major vessels. This rate is approximately 5 cases per 1000. There is also a failure rate of 10-15% in the first 5 years after surgery. If for any reason we felt that the operation could not be completed perfectly for reasons or because of complications then it would be **completed by open operation or laparotomy** and this assumed in your **consent**.



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POSTOPERATIVE INSTRUCTIONS

for patients after Laparoscopic Incontinence or Pelvic Floor Reconstruction

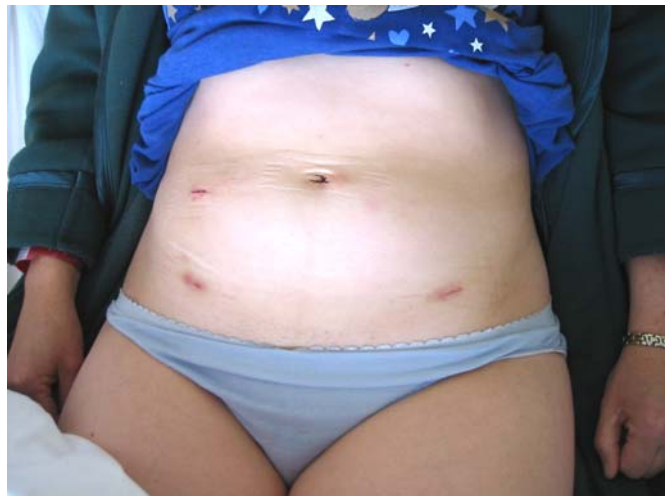
Following your operation you will return to the ward with an **indwelling urethral catheter** or suprapubic catheter or no catheter at all. You will also have a dressing over the 3-5 small puncture incisions at the umbilicus and on the right and left side above the hip. This may be simple little bandaids or a large Elastoplast sheet with little pads underneath to put pressure on the cuts to reduce bruising. You may also be experiencing **post laparoscopy pain** which is usually minimal but may be enough to require an injection to settle you early on. It can be felt as a generalised abdominal pain or a colicky wind like pain with bloating and pressure under your ribs or shoulder tip pain. It usually lasts from 4-24 hours and I stress it is usually minor. You will **not** need any injections after 6 am the following morning. The nursing staff will give you **tablets** or **suppositories** which give excellent pain relief without sedation from then on. You may also experience postoperative **nausea** within the first 12 hours and therefore you will have an IV infusion to give you fluids. This drip is usually removed the following morning and you are encouraged **to eat and drink freely**.

The next day you will be mobilized very early to help accelerate your recovery and your bladder and bowel function. If there is a catheter in place it will be removed and then you will be encouraged to void. **Here are some rules to help you:-**

1. Go to the toilet whenever you feel the normal sensation to go, but never leave it longer than **4 hours** without emptying your bladder. You may need to try on a number of occasions. Following this, your residual urine will be assessed by using a simple **bladder scan** performed by your nurse.
2. If you are going very frequently and passing small amounts only, then is it likely that you have some **retention** of urine. Don't worry as the nurse will pass a small in and out catheter from time to time until your voiding well with **residuals** (what is left in your bladder after you void) less than 100 mls on at least two occasions.
3. If you have burning or scalding or bladder pain you may have an **infection**. Tell the nurse or let me know as a sample must be taken and usually an antibiotic prescribed. When passing your urine it is best to **relax and not force your urine**. You must remember that the operation is supposed to hitch up your bladder valve and obstruct your flow. Before your operation when your bladder was weak, you usually emptied your bladder by just dropping your pelvic floor and the urine fell out. If the operation is a success it means that when you drop your pelvic floor muscles, nothing will happen, and you will have to expel the urine using your bladder detrusor muscle. With long term weak bladders **the muscle may be lazy** and take some time to regain it's power. It doesn't matter and merely is a short-term nuisance.
4. The bladder empties best by sitting on the toilet with your weight forward on your toes, not on your heels, even if this means lifting your bottom off the seat. This is called the **"double voiding"** technique.
5. If you are one of a group of about 10% who still have voiding problems then we can insert a simple **indwelling urethral catheter** which is left on free drainage for your discharge, or a **suprapubic catheter** inserted in the ward or at the time of your operation to allow you to void normally and then test your residual at home just by sliding a valve on the tubing and not by inserting anything. You will still go home early.
6. **Only 10% of patients need any form of catheter after 48 hours.**



7. It is very unusual to require any form of catheterisation after 2 weeks
8. **15%** of patients develop an **irritable or unstable bladder** after this type of incontinence operation and this can cause unwanted bladder contractions that give you **frequency, urgency and even urgency leakage** with the loss of even large amounts of urine immediately after the operation. With normal operations you have a catheter for up to 5 days with a bag draining freely before you even try to pass urine so you don't notice it so much because your bladder is empty. Because you use your bladder straight away these symptoms are more evident. **Don't worry** as this is normal and doesn't have anything to do with the success of your operation. It is usually gone within a few days but may last in a minor fashion for up to 6 weeks.
10. If you have any problems after leaving hospital particularly with unusually severe **pain, nausea and vomiting, hot and cold chills or fevers or voiding problems**, then ring my rooms or contact the nurse at the ward of your hospital for advice.
11. Return for your postoperative visit at 4-6 weeks as organized by my secretary.
12. The dressings on your port sites are taken off usually after one day and almost always **the stitches are dissolvable, usually invisible below the skin and do not need to be removed by your Doctor.**



Remember that as soon as you go home **you can** drive a car, carry out light household duties, and begin low impact exercise such as walking. **You can't** have intercourse or indulge in strenuous exertion until you see me for your postoperative check up at 4-6 weeks. This is because the suture slings that hold the bladder neck in place need to scar securely to **weld** the structure in place for a permanent cure. Don't worry about coughing or sneezing by accident, as this will do no harm at all and you should be dry.

[What is the cost of this procedure?](#)

This practice charges the fees set by the **AMA** in most cases. The Medicare schedule does not reflect the difficulty or complexity of ground breaking operations like this and in fact have not even gone to the trouble of providing an item number for this operation despite the fact that we have been doing them for over 10 years. Advanced laparoscopic surgery requires many years to master and is only performed by a small group of surgeons in Australia who are certified to perform this operation in particular. It may take up to 2 times longer than the open operation yet only attracts the same Medicare rebate. The Medicare system considers operations like this in a similar fashion to plastic surgery where there is a very poor rebate. They feel that the great cosmetic advantage and early release from hospital as well as early return to work are a **luxury** that people should pay for. There is therefore a considerable gap to pay despite our attempts to lobby the government for a review.

The exact fees and gaps can be easily obtained from my secretary prior to the operation and from the anaesthetist and hospital in a similar fashion. Obviously the big decrease in hospital bed days and the early return to family and work do offset the gap considerably. Please discuss this with me if you have a problem.