In-Office Excision Often Resolves Vaginal Mesh Erosion

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EXPERT ANALYSIS FROM AN INTERNATIONAL PELVIC RECONSTRUCTIVE AND VAGINAL SURGERY CONFERENCE

ST. LOUIS – Complaints of vaginal discharge, bleeding, and/or general vaginal discomfort in a patient who has undergone sling placement may signal vaginal mesh erosion.

Patients with vaginal mesh erosion might also note that their partner "feels something" in the vagina during intercourse, Dr. Ginger Cathey said at the conference, which was sponsored by the Society of Pelvic Reconstructive Surgeons.

Separation of the mesh from the bladder can be challenging, but it can be accomplished using laparoscopic or cystoscopic equipment, or by mini-laparotomy.

Vaginal mesh erosion occurs in about 0.5% of synthetic sling patients, according to the most recent reports in the literature, and in most cases, the mesh erosion will be quite apparent although, in some cases, the mesh fibers can be felt, but not visualized, said Dr. Cathey, a practicing urogynecologist at Baylor College of Medicine, Houston.

Bladder and urethral mesh erosions are far less common, with only case reports appearing in the literature. Patients with bladder or urethral erosions might present with complaints of recurrent urinary tract infections, irritative voiding symptoms such as frequency and urgency, and hematuria. Consider these types of erosions if you have a sling-placement patient who complains of greater frequency and urgency than before the procedure and who has normal post void residuals, Dr. Cathey advised.

Management of vaginal mesh erosion – which usually occurs in the midurethral area, can include local estrogen, especially in cases where a few fibers can be palpated, but not seen, or when the patient is hesitant about excision. However, Dr. Cathey has doubts about the ability of local estrogen to promote re-epithelialization. Excision, she said, is her preferred approach to management of vaginal mesh erosion, and it can generally be performed in the office. "It's very rare that I would take a sling erosion back to the operating room to excise it," she said. Even if a patient has undergone excision and comes back saying they still feel something, you may be able to remove the remaining fibers in the office by using a colposcope and a suture removal kit to tweeze out the fibers and snip them at that time.

Treatment of larger areas involving exposed tissues or recurrent erosion is best treated by advancing the vaginal epithelium to cover the defect, Dr. Cathey said, noting that use of a Martius graft in such cases would be overkill, but that such a graft would be reasonable in cases of urethral erosion in which the patient has developed a urethral-vaginal fistula.

For bladder or urethral erosion, avoid urethral dilation, which can loosen the sling, but which also places the sling closer to the urethra thereby increasing the potential for more erosion, Dr. Cathey explained.

Try to manage these patients "as minimally invasively as possible," she said.

Separation of the mesh from the bladder can be challenging, but it can be accomplished using laparoscopic or cystoscopic equipment, or by mini-laparotomy, she noted.

"If you want to resect all the mesh fibers, it's really important that you put counter-traction on the mesh before cutting it," she said, noting that the simplest approach is to distend the bladder and to place a 5-mm suprapubic trocar through the bladder, using it to apply traction while you take the endoscopic endoshears and trim the mesh as closely as possible.

If a patient treated for bladder or urethral erosion presents with recurrent irritating voiding symptoms, be sure to evaluate the contralateral side for a second erosion, she said.

Dr. Cathey disclosed that she is a consultant for Bard Medical. ■

Bulking Agents Buy Time For Incontinence Patients

EXPERT ANALYSIS FROM AN INTERNATIONAL PELVIC RECONSTRUCTIVE AND VAGINAL SURGERY CONFERENCE

ST. LOUIS – It's bulking-agent season.

This is the time of year when many women will present with stress urinary incontinence, looking for a no-downtime solution for their symptoms. For these women, bulking agents may be the answer, Dr. Peter M. Lotze said at the conference, which was sponsored by the Society of Pelvic Reconstructive Surgeons.

In August and September, teachers will often come to the office saying that they need treatment because they are leaking urine, but adding that they need to be ready for work in a week, said Dr. Lotze of the department of ob.gyn. at the University of Texas, Houston, who is a practicing urogynecologist.

The upcoming winter holiday season presents another occasion for which women desire a solution that doesn't involve the downtime and restrictions associated with a more involved surgical procedure, he said.

Granted, most patients will do better in the long term with a midurethral sling, as long as they have some mobility of the urethra, but some patients simply need (or prefer) a quick fix, said Dr. Ginger Cathey of the department of ob.gyn. at Baylor College of Medicine, Houston, who is also a practicing urogynecologist.

Although most of her patients choose the sling once they've been counseled about the higher cure rates compared with bulking agents, Dr. Cathey does sometimes use C.R. Bard Inc.'s Contigen, an injectable collagen implant, in those who do not choose sling surgery.

BioForm Medical Inc.'s Coaptite injectable implant is another option.

"If I do [use bulking agents], I use Coaptite," Dr. Lotze said, noting that just one or two injections of the gel-like implant can temper incontinence in some patients, with no restrictions, and two to five injections can "get you where you want to be" in terms of alleviating symptoms and buying the patient time.

Injection of Coaptite is not layer dependent; you don't have to be in a specific muscle layer right underneath the epithelium of the urethra, which makes for a simpler procedure, he said.

"You can get it in the tissue of the urethra, and it doesn't matter – you're in the right spot," he said.

Do you have patients who are miserable due to their leakage, but who don't have time for surgery?

"Really think about this as part of what to do this time of year," he said.

Dr. Lotze disclosed that he is a speaker and researcher for Boston Scientific Corp., which is the distributor of Coaptite. Dr. Cathey is a consultant for C.R. Bard Inc. ■

Fever Plus Tachycardia Suggest Infection After Surgery

EXPERT ANALYSIS FROM AN INTERNATIONAL PELVIC RECONSTRUCTIVE AND VAGINAL SURGERY CONFERENCE

ST. LOUIS – Postoperative fever in a patient who has undergone gynecologic surgery doesn't necessarily indicate infection.

In fact, fever without tachycardia – even if the fever is high – is most likely "drug fever," which is commonly associated with antibiotics. A single dose of antibiotics that is given prophylactically could cause this, Dr. Sebastian Faro said at the conference, which was sponsored by the Society of Pelvic Reconstructive Surgeons.

"I do a physical exam on all these patients, and if I don't find anything on my exam, I stop her drugs. This patient should become afebrile within 24-36 hours" if it's drug fever, said Dr. Faro, professor and vice chairman of the department of obstetrics, gynecology, and reproductive sciences at the University of Texas Health Science Center at Houston.

He said residents will often ask, "What if she's really infected?"

If the antibiotics are discontinued and the patient is indeed infected, then the signs and symptoms of the infection will manifest themselves and different antibiotics can be instituted. Localization of the infection may be realized with further evaluation.

"I have never had a patient's condition deteriorate and [the patient] become critically ill or die from stopping antibiotic therapy" when she has a fever plus a normal pulse rate, normal blood pressure, and good urine output, Dr. Faro said.

Conversely, spiking temperatures with a parallel pulse rate is an indication of infection. "This is the hallmark for me, which makes me come in and evaluate that patient," he said.

This isn't tachycardia associated with anemia, he added, noting that tachycardia with anemia doesn't follow the temperature curve.

When both fever and tachycardia are present, you need to examine the patient, said Dr. Faro, who is also chief of obstetrics and gynecology and clinical medical director at Lyndon B. Johnson Hospital, Houston.

Consider it a fever if the oral body temperature is 101° F or greater, or if it's 100.4°-101° F as measured on two occasions at least 6 hours apart. Do expect infection if fever is present and the pulse rate is 100 beats per minute or greater, he said.

A white blood count is also important for identifying infection, he said.

White cell counts go up in the first 24 hours, so Dr. Faro suggests obtaining a count 6 or more hours after surgery, and obtaining another early the next morning.

If the count is high the night before but has decreased in the morning, that's good. If it hasn't declined, the patient needs to be evaluated. Check blood pressure and urine output, he said.

"One of the most subtle signs [of infection] is oliguria," he said, explaining that oliguria can be secondary to dehydration.

If a patient with oliguria is febrile and doesn't respond to fluids in an hour – Dr. Faro recommends a 550-cc bolus in a patient with healthy kidneys – the patient may have sepsis, he said.

Dr. Faro disclosed that he is a consultant for American Medical Systems Inc. ■