WHTA Gynaecological Surgery Table – Quick Summary Guide for Physiotherapists

The purpose of this document is to provide women's health physiotherapists with a quick, simple-language document explaining the common incontinence and prolapse procedures used in the gynaecology / urogynaecology field.

LISTING OF MESH / TAPE INCLUSION

At present we have no research to indicate whether vaginal e-stimulation, manual release or insertion of pelvic organ prolapse pessaries are safe in women who have had placement of mesh or vaginal tape as part of their surgery. Therefore, listing of which surgeries involve placement of mesh / tape is therefore provided to assist physiotherapists in identifying patients who should be counselled appropriately before considering any of these physiotherapy treatment options.

<u>The WHTA Position on Vaginal E-Stimulation, Pessary Insertion and Manual Release after Mesh / Tape Procedures: as at 20th August 2014</u>

- Vaginal E-stimulation is not recommended in women who have had a mesh / tape placement until further research is conducted to determine safety.

- Insertion of a Pelvic Organ Prolapse Support Pessary may have the potential to increase the risk of mesh erosion / pain after surgery. Insertion of pelvic organ support pessaries are therefore not recommended as first line management of recurrent prolapse / urinary incontinence until further research is conducted to determine safety.
    - If use of a pelvic organ support pessaries is to be considered after a mesh/ tape procedure, this <u>must</u> be made in consultation with a specialist gynaecologist/urogynaecologist.

- Manual therapy must be used with caution after mesh / tape procedures. The physiotherapist must feel confident in their ability to consider the location of the mesh / tape for each specific procedure and avoid manual release work over the relevant areas.

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Surgery Name	Common Abbreviation	Primary Purpose	Brief Description	Mesh / Tape
Anterior Repair	AR	Anterior Vaginal Wall Prolapse (cystocele)	Midline Vertical Incision along anterior vaginal wall, and suture repair of fascial defect	No
- Anterior Colporrhaphy	This is simply an alternate name for anterior repair			
Botox – Intravesical		Overactive Bladder – UUI	Injection of Botulinum Toxin in to the bladder wall to paralyse the bladder and reduced detrusor overactivity associated urge incontinence. Usually lasts 6-12months. Repeat injections can then be performed. May result in high post-void residuals / recurrent UTI.	No
Burch Colposuspension		Stress Urinary Incontinence +/- anterior vaginal wall prolapse	Low transverse suprapubic incision, bladder neck drawn upwards using sutures	No
Colpocleisis also called Le Fort's Procedure		Recurrent Stage III/IV Pelvic Organ Prolapse (all compartments)	Only used in women with severe, recurrent POP who are happy to no longer retain coital function. Vagina procedure that ultimately adheres the anterior and posterior vaginal wall together.	No
Cystoscopy		Assessment of inside of bladder for pathology (eg trigonitis, bladder cancer, interstitial cystitis)	Micro-camera inserted up through urethra into bladder to visualise inside of bladder wall	No
Fenton's Procedure		Removal of scar tissue at posterior forchette (entrance to vagina)	Minor procedure can be performed under local or general anaesthesia: surgical removal of scar tissue at entrance to vagina.	No
Hydro-distension		Low Compliance Bladder / Urinary Frequency	Bladder is artificially filled with fluid under general anaesthesia in attempt to increase bladder capacity (rarely used today due to low success rates)	No

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Hysterectomy		Many Purposes: Uterine Prolapse Uterine Fibroids Uterine / Cervical Cancer etc	Removal of the Uterus (including fundus, body and cervix), either abdominally, vaginally or laparoscopically. Unless specifically stated as having an oophorectomy this does not including removal of the ovaries.	No
Hysteropexy		Uterine Prolapse	General term for the upward suspension of the uterus. See sacrohysteropexy	Variable (see specific procedure)
Le Fort's Procedure (also called LeFort's Colpocleisis)		Recurrent Stage III/IV Pelvic Organ Prolapse	Only used in women with severe, recurrent POP who are happy to no longer retain coital function. Vagina procedure that ultimately adheres the anterior and posterior vaginal wall together.	No
Macroplastique		Stress Incontinence with Intrinsic Sphincter Deficiency	Injection of gel substance into urethral walls (under local anaesthetic) to bulk the urethral wall and reduced urethral lumen size. Technique designed to increased urethral closure and reduce incontinence	No
Mid-Urethral Sling	MUS	Stress Urinary Incontinence	Placement of mesh sling behind mid-urethra that extends forward to provide a u-shape support to prevent the posterior rotation of the urethra associated with stress urinary incontinence. Many types (TVT, Monarc, Single Incision Mini-Sling / Miniarc etc)	Yes - Tape
Mini-Arc		Stress Urinary Incontinence	Short length mid-urethral sling procedure. Single vertical incision along anterior vaginal wall. The short length of the tape means that unlike the TVT or the Monarc, the sling does not leave the body over the pubis or out through the obturator foramen.	Yes - Tape
Monarc Tape	Monarc	Stress Urinary Incontinence	Monarc simply refers to the specific Transobturator Tape product made by the company American Medical Systems to perform a transobturator tape (similar to the name "Panadol" being used for "Paracetamol") For explanation see Trans-Obturator Tape.	Yes - tape
Paravaginal Repair		Anterior Vaginal Wall Prolapse	Vaginal, Laparoscopic or Abdominal: suture repair of lateral defects in pubocervical fascia near its insertion into arcus tendineus fascia pelvis.	No
Posterior Repair	PR	Posterior Vaginal Wall Prolapse (rectocele)	Midline Vertical Incision along posterior vaginal wall, and suture repair of fascial defect	No

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- Posterior Colporrhaphy		Simply an alternate name for posterior repair		
Retropubic Tape		Stress Urinary Incontinence	This is a general term for any surgery involving a piece of mesh tape placed as a u-shape sling from behind urethra, extending forward and exiting body over the pubic bone to prevent the posterior urethral rotation associated with stress incontinence. The most common version of the procedure is the TVT, there is also a procedure called the SPARC (rarely used in Australia).	Yes - tape
Sacral Nerve Stimulation	SNS	Overactive Bladder / UUI Voiding Dysfunction Faecal Incontinence	Electrical lead attached to battery (like a pacemaker). Lead placed through S3 foramen, battery pack implanted under skin just below posterior iliac crest (just medial to PSIS)	No
Sacrocolpopexy		Vaginal Vault Prolapse - Also assists with anterior and posterior wall prolapse	Abdominal or Laparoscopic Procedure. Upside down y-shaped mesh placed over / attached to vaginal vault. Mesh pulled upwards and attached to fascia on inside of sacral base.	Yes – abdominally placed y-shape mesh.
Sacrohysteropexy		Uterine Prolapse	Abdominal or laparoscopic procedure. Piece of mesh attached to uterus then drawn upwards and attached to fascia on inside surface of sacrum to suspend uterus.	Yes – abdominally placed mesh, but not necessarily attached to vaginal walls
Sacrospinous Colpopepexy		Vaginal Vault Prolapse	Vaginal procedure: attachment of vaginal vault to sacro-spinous ligament (usually unilateral) using sutures. Often results in deviation of vaginal canal toward one side	No
Sacrospinous Ligament Fixation	SSLF	Vaginal Vault Prolapse	Same procedure as sacrospinous colpopexy	No
Sub-Total Hysterectomy	STH	Various	Removal of fundus and body of uterus, cervix remains.	No
Tension-Free Vaginal Tape	TVT	Stress Urinary Incontinence	Piece of mesh tape placed as a u-shape sling from behind urethra, extending forward and exiting body over the pubic bone	Yes - Tape
Trans-Obturator Tape	TOT	Stress Urinary Incontinence	Piece of mesh tape place in the body to create a sling from behind the urethra and extending forward to exit the body through the obturator foramen. Goal is to	Yes - Tape

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			prevent the posterior urethral rotation associated with stress urinary incontinence	
Tension-Free Vaginal Tape – Obturator Route	TVT-O	Stress Urinary Incontinence	Piece of mesh tape placed as a u-shaped sling from behind urethra extending forward and exiting body through obturator foramen. Goal is to prevent the posterior urethral rotation associated with stress urinary incontinence.	Yes - Tape
Trans-Obturator Tape	TOT	Stress Urinary Incontinence	Piece of mesh tape placed as a u-shaped sling from behind mid urethra extending forward and exiting body through obturator foramen. Only difference to TVT-O is that the surgeon starts by entering through the obturator foramen, whereas the TVT-O starts by entering through the vagina.	Yes - tape

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