
COMMENTARY

Placement of prophylactic midurethral sling at time of hysterectomy...are the potential associated problems worth the additional cost and risk?

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Dillon and colleagues provide a review of their experience with complications of prophylactic midurethral sling (MUS) who underwent transvaginal tape excision. At a median of 36 month follow up post MUS excision, improvement in pain, dyspareunia and QoL scores were noted.¹ However, this “prophylactic” MUS created significant problems including: incontinence (stress, urge and mixed), fistula, urgency, recurrent urinary tract infections, pelvic and urethral pain as well as dyspareunia.² Unfortunately, procedures to alleviate the abovementioned problems required additional surgical repair in 70% of patients and persistent lower urinary tract symptoms requiring continuous pharmacotherapy in the authors’ series.

Certainly, the authors’ paper raises important questions about the efficacy and cost of performing a “prophylactic” MUS. While the MUS procedure is certainly quick to perform, minimally invasive, usually well tolerated and may spare the patient of the need for another procedure in the future, I believe that several points must be brought up in discussion with patients, referring physicians and colleagues who may help with the procedure such as gynecologists. First, preoperative urodynamics should be considered as this may unmask or reveal stress urinary incontinence that was not known to the patient and physician beforehand.³ Second, careful discussion of possible complications of voiding dysfunction should be discussed with the patient.⁴ If the patient voided normally beforehand, it is possible

that MUS placement may alter voiding physiology with development of denovo urgency, frequency, urge incontinence and obstructive symptoms. Third, a careful discussion of the possibility of development of pelvic and sexual pain must be carried out with patients. If they did not have pain prior to surgery but develop it postoperatively, they will certainly be unhappy. Finally, a discussion of mesh-based complications must be undertaken with patients. Discussion of the possibility of mesh erosion and extrusion must be disclosed to patients preoperatively.⁵ As we all know, there is an increase in public awareness of the complications of mesh-based surgery.

In light of the above discussion points and the authors’ well-written manuscript, “prophylactic” MUS should only be undertaken after a comprehensive discussion of the risks and benefits of the procedure with the patient. Preoperative urodynamic studies should be considered. As we are all aware, there is no perfect anti-incontinence procedure and all have associated complications. Further, no anti-incontinence procedure will be durable for the patient’s entire lifespan. □

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