Urogynaecological Society of Australasia

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Position statement on midurethral slings

This statement has been developed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the Urogynaecological Society of Australasia (UGSA).

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This position statement by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the Urogynaecological Society of Australasia (UGSA) supports the use of mid-urethral slings (MUS) in the surgical management of female stress urinary incontinence (SUI). This is the type of urinary leakage associated with physical exertion, such as coughing, laughing and sneezing.

Stress urinary incontinence is an extremely common[1], burdensome and costly condition for women in Australasia, with a negative impact on a women's quality of life. Non-surgical measures such as pelvic floor muscle training and behavioural modifications are useful treatment options in alleviating symptoms in some women, although many proceed with surgery, which is a more effective treatment.[2]

Mid-urethral slings are minimally invasive procedures developed in the early 1990s to treat female stress urinary incontinence. These slings are narrow, synthetic polypropylene tapes that are surgically placed beneath the middle part of the urethra (water pipe) to provide dynamic support to stop leakage from the bladder. They have been shown to be as effective as more invasive traditional surgery with major advantages of shorter operating and admission times, and a quicker return to normal activities, together with lower rates of complications.[3] This has resulted in MUS becoming the operation of choice in Europe, the United Kingdom, Australasia[4] and the USA[5] for treatment of SUI.

The USA Food and Drug Administration (FDA) released a white paper[6] and safety communications[7] regarding safety and effectiveness of transvaginal placement of surgical mesh specifically for pelvic organ prolapse. A prolapse is where some of the pelvic organs bulge downwards giving rise to symptoms of an uncomfortable vaginal lump. Media attention[8] on this totally distinct and separate issue of mesh use in women has the potential to cause unnecessary confusion and fear in women considering MUS for treatment of stress urinary incontinence. Both RANZCOG and UGSA wish to strongly emphasise that the US FDA publications clearly state that MUS were not the subject of their safety communication.

There is robust evidence[9-11] to support the use of MUS from over 2,000 publications making this treatment the most extensively reviewed and evaluated procedure for female stress urinary incontinence now in use. These scientific publications studied all types of patients, including those with co-morbidities such as prolapse, obesity and other types of bladder dysfunction. It is, however, acknowledged that any operation can cause complications and for MUS, these include bleeding, damage to the bladder and voiding difficulties[12]. Nevertheless, the results of a recent large multi-centre trial[13] have again confirmed the excellent outcomes and low risks of complications to be expected after treatment with MUS. Additionally, long term effectiveness has been demonstrated in studies following patients for up to 17 years.[14-15]
In Australia, it has been the operation of choice to treat for female SUI since 2004. RANZCOG and UGSA support the use of monofilament polypropylene mid-urethral sling for surgical treatment of female stress urinary incontinence.

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Appendices

Appendix A Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

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