INSERTION of a SYNTHETIC SLING for STRESS URINARY INCONTINENCE in MEN

Information about your procedure from
The British Association of Urological Surgeons (BAUS)

This leaflet contains evidence-based information about your proposed urological procedure. We have consulted specialist surgeons during its preparation, so that it represents best practice in UK urology. You should use it in addition to any advice already given to you.

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http://rb.gy/uizht

KEY POINTS

- The male sling is used to treat urinary incontinence (leakage on activity such as exertion, movement, coughing, laughing or sneezing) after prostate removal surgery
- Approximately 70% of men are satisfied with the outcome of their surgery
- There are different types of male sling available on the market with different mechanisms of action
- Most male slings are synthetic and use "mesh". At the present time the use of "mesh" in women for stress incontinence is suspended in the UK pending certain requirements
- If removal of mesh in men becomes necessary, it is a complex procedure which may not be technically possible

What does this procedure involve?

Polypropylene mesh (male slings) are used to treat stress urinary incontinence which can develop after surgery to remove the prostate gland. A synthetic sling (made from plastic mesh) is placed under your urethra (waterpipe), near to where the prostate gland used to be.

The aim of the sling is to reduce leakage by supporting the urethra. There are different types of male slings (adjustable and fixed). Satisfaction rates are approximately 70% with this procedure, based on recent randomised

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controlled trial data from the UK.

In July 2018, a "high vigilance restriction" for vaginal mesh surgery in women, including stress incontinence surgery, was announced and, at the time of publication of this leaflet, is still in position although it does not apply to men.

We do, however, recommend that you discuss with your urologist the implications of **The Independent Medicines and Medical Devices (IMMDS) report "First do no harm"** (also known as the Cumberlege Review) regarding mesh in women. The lack of long-term outcome data for the use of mesh in men is a concern, particularly in view of the issues that have come to light in the long-term problems experienced using mesh in females.

There may be other longer-term risks with the use of mesh in men that have not yet come to light. However, the male urethra has a completely different anatomical composition to the female urethra, and the alternatives for treating stress incontinence in men may not be practical in some patients.

PLEASE NOTE: if removal of mesh in men becomes necessary, it is a complex procedure which may not be technically possible

What are the alternatives?

Stress incontinence can be treated without surgery. We recommend that all patients try non-surgical treatment before having an operation, because it avoids the risks of side-effects or complications of surgery:

- **Pelvic floor exercises** – under supervision from a continence advisor or physiotherapist can improve stress incontinence in 70% of men
- **Weight loss** and **giving up smoking** can also help
- **Incontinence pads** or a **penile sheath** – may be used if your symptoms are not a bother to you and you choose to do nothing
- **Penile clamps**

Each of the operations for stress incontinence has advantages and disadvantages, and different operations may be better for different people. You should discuss these with your surgeon before making a decision. The main alternatives to a male sling operation are:

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- **Insertion of an artificial urinary sphincter (AUS)** – a device with an inflatable cuff which squeezes the urethra to prevent incontinence, but which can be released when you need to pass urine.
- **Urethral bulking** - injection of a bulking agent into the wall of your urethra; this procedure is not currently recommended by NICE
- **Urethral** or **suprapubic catheter** - putting a catheter into your bladder to drain urine directly into a bag.
- **Urostomy** – diverting your urine straight on to the surface of your abdomen (tummy) so that it drains into a bag
- Other devices (with various trade names) e.g. non-circumferential sphincters and balloon devices but outcomes data for these devices is very limited

What happens on the day of the procedure?

Your surgeon will briefly review your history and medications, and will You will be seen by the surgeon and the anaesthetist who will go through the plans for your operation with you.

We may provide you with a pair of TED stockings to wear, and we may give you a heparin injection to thin your blood. These help to prevent blood clots from developing and passing into your lungs. Your medical team will decide whether you need to continue these after you go home.

Details of the procedure

- we normally carry out the procedure under a general anaesthetic (i.e. with you asleep)
- we usually give you an injection of antibiotics before the procedure, after you have been checked for any allergies
- we sometimes perform an internal examination of your rectum during the procedure to examine your pelvis/prostate
- we make a 5 – 10 cm (2 – 4 inch) incision in your perineum (the skin between the back of your scrotum and your anus)
- we make a small (0.5 cm) incision in each of your groins
- we put the mesh sling under your urethra to support it
- we close the skin with dissolvable stitches which normally disappear within two to three weeks
- we usually put a catheter into your bladder, through your urethra, which is kept in place throughout the procedure; this is usually removed the next day
- you can expect to go home after one days

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How effective is the procedure in curing stress incontinence?

- We do not have as much information about the male sling procedure as we do for the AUS operation
- We think that 70% of men (seven out of 10) get an improvement in their incontinence and are pleased with the result after a male sling operation. This includes those men who have improved but still need to use up to one pad per day
- A recent randomised controlled trial (study) suggested that male slings were not inferior to the AUS operation in terms of patient reported incontinence at one year. However, satisfaction rates were higher for the AUS than the male sling.
- Once a male sling has been inserted there is no need for further patient input in the day-to-day functioning of the device, unlike the AUS.
- Outcomes may be less effective, with a higher complication rate, if you have had radiotherapy

Are there any after-effects?

The possible after-effects and your risk of getting them are shown below. Some are self-limiting or reversible, but others are not. We have not listed very rare after-effects (occurring in less than 1 in 250 patients) individually. The impact of these after-effects can vary a lot from patient to patient; you should ask your surgeon's advice about the risks and their impact on you as an individual:

After-effect	Risk
Burning or stinging when you pass urine	 Between 1 in 2 & 1 in 10 patients
Discomfort and bruising in your perineum, scrotum and groins	 Between 1 in 2 & 1 in 10 patients
Failure to produce any significant improvement in your leakage	 Between 1 in 2 & 1 in 10 patients

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Complete inability to pass urine (usually, temporary retention of urine, but may be long-term in some patients with a need to insert a catheter to empty the bladder)	 Between 1 in 10 & 1 in 50 patients
Infection in your wound requiring further treatment	 Between 1 in 10 & 1 in 50 patients
Overactive bladder symptoms (passing your urine frequently and urgently)	 Between 1 in 10 & 1 in 50 patients
Damage to the urethra during the procedure – in this event, we would not proceed with mesh insertion	 Between 1 in 50 & 1 in 250 patients
Gradual migration (movement) of the sling into your urethra months or years later – this is known as extrusion or erosion & may require major reconstruction of your urethra	 Between 1 in 50 & 1 in 250 patients
Groin pain & discomfort which may last several months or be permanent	 Between 1 in 50 & 1 in 250 patients
Injury to the bladder or urethra requiring a prolonged period of catheterisation	 Between 1 in 50 & 1 in 250 patients
Anaesthetic or cardiovascular problems possibly requiring intensive care (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death)	 Between 1 in 50 & 1 in 250 patients (your anaesthetist can estimate your individual risk)

What is my risk of a hospital-acquired infection?

Your risk of getting an infection in hospital is between 4 & 6%; this includes getting *MRSA* or a *Clostridium difficile* bowel infection. This figure is higher if you are in a "high-risk" group of patients such as patients who have had:

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- long-term drainage tubes (e.g. catheters);
- long hospital stays; or
- multiple hospital admissions.

What can I expect when I get home?

- you may get some swelling and bruising of your scrotum, perineum and groins which can last several days
- you should try to keep your bowels regular, if necessary by using laxatives
- for the first 1-2 weeks, you should take it easy and rest
- you should avoid heavy lifting for 3 months
- after two weeks, you can go back to everyday activities. However, if you do very strenuous things like working out at the gym, running or you have a very physical job, you should wait for six weeks in total
- you will need at least 2-3 weeks off work (longer if you have a strenuous job)
- you will be given advice about your recovery at home
- you will be given a copy of your discharge summary and a copy will also be sent to your GP
- any antibiotics or other tablets you may need will be arranged & dispensed from the hospital pharmacy

Your data and data protection

It is important that surgeons monitor the success rates and complications of the operations they perform, to be sure that their patients get good results. This helps us to tell future patients what to expect, and ensures that the all surgeons are performing well.

General information about surgical procedures

Before your procedure

Please tell a member of the medical team if you have:

- an implanted foreign body (stent, joint replacement, pacemaker, heart valve, blood vessel graft);
- a regular prescription for a blood thinning agent (e.g. warfarin, aspirin, clopidogrel, rivaroxaban, dabigatran);
- a present or previous MRSA infection; or
- a high risk of variant-CJD (e.g. if you have had a corneal transplant, a neurosurgical dural transplant or human growth hormone

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treatment).

Questions you may wish to ask
If you wish to learn more about what will happen, you can find a list of suggested questions called "Having An Operation" on the website of the Royal College of Surgeons of England. You may also wish to ask your surgeon for his/her personal results and experience with this procedure.

Before you go home
We will tell you how the procedure went and you should:

- make sure you understand what has been done;
- ask the surgeon if everything went as planned;
- let the staff know if you have any discomfort;
- ask what you can (and cannot) do at home;
- make sure you know what happens next; and
- ask when you can return to normal activities.

We will give you advice about what to look out for when you get home. Your surgeon or nurse will also give you details of who to contact, and how to contact them, in the event of problems.

Smoking and surgery
Ideally, we would prefer you to stop smoking before any procedure. Smoking can worsen some urological conditions and makes complications more likely after surgery. For advice on stopping, you can:

- contact your GP;
- access your local NHS Smoking Help Online; or
- ring the Smoke-Free National Helpline on **0300 123 1044**.

Driving after surgery
It is your responsibility to make sure you are fit to drive after any surgical procedure. You only need to contact the DVLA if your ability to drive is likely to be affected for more than three months. If it is, you should check with your insurance company before driving again.

What should I do with this information?

Thank you for taking the trouble to read this information. Please let your urologist (or specialist nurse) know if you would like to have a copy for your own records. If you wish, they can also arrange for a copy to be kept in your hospital notes.

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What sources were used to prepare this leaflet?

This leaflet uses information from consensus panels and other evidence-based sources including:

- the Department of Health (England);
- the Cochrane Collaboration; and
- the National Institute for Health and Care Excellence (NICE).

It also follows style guidelines from:

- the Royal National Institute for Blind People (RNIB);
- the Information Standard;
- the Patient Information Forum; and
- the Plain English Campaign.

DISCLAIMER

Whilst we have made every effort to give accurate information, there may still be errors or omissions in this leaflet. BAUS cannot accept responsibility for any loss from action taken (or not taken) as a result of this information.

PLEASE NOTE: the staff at BAUS are not medically trained, and are unable to answer questions about the information provided in this leaflet. If you have any questions, you should contact your Urologist, Specialist Nurse or GP in the first instance.

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