Bard Align midurethral mesh sling and cystourethroscopy

PREOPERATIVE DIAGNOSIS:
Stress urinary incontinence.
POSTOPERATIVE DIAGNOSIS:
Same.
PROCEDURE:
Bard Align midurethral mesh sling and cystourethroscopy
SURGEON:
ASSISTANT:
ANESTHESIA:
ESTIMATED BLOOD LOSS:
URINE OUTPUT:
FLUIDS:
SPECIMENS:
DRAINS:
COMPLICATIONS:
CONDITION:
INDICATIONS:
This is a 58-year-old female who recently underwent Uphold mesh and cystoscopy on 08/14/2012, who developed postoperative stress urinary incontinence. We discussed the various options for management with the patient preoperatively and she elects to undergo midurethral mesh sling surgery. The risks, benefits, and alternatives of surgery were discussed with the patient and all her questions were answered. We specifically discussed the risks of mesh placement such as erosion, pain, need for further procedures as well as the FDA advisory on mesh products. She verbalized understanding. All her questions were answered written consent was obtained.

FINDINGS:
Cystourethroscopy performed at the end of the procedure revealed no evidence of cystotomy with no bladder masses or lesions with bilateral ureteral orifices appeared patent. Urethra was without injury.

PROCEDURE:
The patient was taken to OR where anesthesia was administered. She was prepped and draped in normal sterile fashion in the dorsal lithotomy position in Allen stirrups. Care was taken upon positioning to avoid any areas of extreme flexion or extension. A transurethral Foley catheter was placed in the bladder and the bladder was drained.

The level of the midurethra was palpated. Allis clamps were used to grasp the overlying vaginal epithelium. The vaginal epithelium was infiltrated with 0.25% bupivacaine with epinephrine and a 1-cm vertical midline incision was made with a 15-blade scalpel. The underlying fibrovascular tissue was dissected away from the vaginal epithelium. Using metzenbaum scissors on the right side a tunnel was made to the level of the endopelvic fascia and a tunnel was made in a similar fashion on the left side. The Bard Align trocar was passed through the right hand tunnel traveling through the retropubic space and exiting through a skin incision 1-1/2 fingerbreadths from the midline at the level of the pubic symphysis. In a similar fashion the Bard Align trocar was placed on the left side.
The catheter was removed and a 70-degree 17-French cystoscope was inserted through the urethra into the bladder with the above-noted findings. The cystoscope was then removed. The Foley was replaced and the bladder was drained. The vaginal epithelial edges were inspected with no evidence of vaginotomy. The mesh was brought through the incision and noted to lie flatly against the urethra with no undue tension. The mesh was trimmed at the level of the abdomen and the abdominal incisions were closed with Indermil. The vaginal epithelium was reapproximated with 3-0 Vicryl in interrupted stitches.

The patient tolerated procedure well. Sponge, lap and needle counts were correct times 2. All remaining instruments were removed from the vagina. The patient was taken out of dorsolithotomy position and awakened from anesthesia. She was transferred to the Recovery Room awake, alert and breathing independently in stable condition.

Dr. _____ was scrubbed, present and participated throughout the entire procedure.