



A^{Q1} Basis for Long-Term Midurethral Tape Complications

The complications reported¹ may be but a prelude to many such reports in the future, a conclusion reached on revisiting the original studies which led to the creation of this operation.

Immunological reaction—a fundamental problem of all implants. Individuals react differently to implanted tapes. In the first animal experiments conducted at Royal Perth Hospital in 1987 and 1989,² we were surprised at the range of host reaction to the implanted tapes. In some animals, there was rapid and total integration of tape into the tissues. In others, there was a chronic foreign body reaction characterized by granulation tissue. However, even with discharge and sinuses, the animals remained well, with normal temperatures, and low inflammatory changes on testing with radioactive gallium studies.² Bacteriological testing rarely revealed any growth. The first group of patients had similar histological, bacteriological, and clinical patterns.^{2,3} As all the factors in the operations were identical, it can be deduced from this data, that the *incidence* of a foreign body reaction is largely immunologically determined.

Tape slippage as a cause of tape erosion. In the first 24 hr, the tape becomes surrounded by fluid containing polymorphonuclear leucocytes and macrophages. A heavier implant causes a larger wound reaction, and so is more likely to slip and erode. In an RCT, Sivaslioglu demonstrated a 13.7% erosion rate with an unbuttressed IVS tape, and a 1.8% erosion rate when the tape was buttressed by approximating the underlying vaginal fascia.⁴ He concluded that it was important to buttress a “tension-free” tape so as to prevent slippage, and therefore, erosion.

Stretching and narrowing of the tape as a cause of transfection. The origin of the term “tension-free” was first used in 1994, and signified placement of a non-stretch Mersilene tape against the posterior wall of urethra without indentation (“tension-free”). An elastic tape such as the TVT easily narrows on stretching, a major factor in urethral erosion and transfection. However, this does not explain why the constriction occurred years afterwards.

*A collagenous neoligament contracts with time.*⁵ The origin of the midurethral sling can be traced to a simple clinical test, a “simulated operation.” Pressing a hemostat upwards on the vagina exactly at the midurethra, controlled urine loss on coughing, and restored urethrovesical geometry,⁶ emphasizing the importance of a competent pubourethral ligament. We reasoned that it was impossible to repair a structure composed largely of smooth muscle by suturing it. This fact caused us to use the collagenous tissue reaction to foreign body implantation to a positive effect, to create a collagenous pubourethral neoligament.²

The relative proportion of the various glycosaminoglycans influences the mechanical properties of the tissue.⁷ During pregnancy, there is a marked change in the ratio of hyaluronic acid to dermatan sulfate, resulting in marked distensibility of collagen.⁷ Conversely, the increased content of dermatan

sulfate with age, Thonar and Kuettner⁸ renders the tissue less distensible.

This shrinkage in collagen with age confirms Jones et al.’s advice,¹ that setting the tape more tightly in patients with intrinsic sphincter defect is not only inadvisable, but potentially hazardous in the longer term.

The type of mesh. The TVT tape is cut from a large diamond patterned mesh. Following implantation, the polypropylene fibrils forming each diamond become surrounded by type 1 collagen which shrinks with age, causing the relatively thick, 150 μm fibrils to gradually cut into the substance of the urethra, much like a wire cheese knife. A tape already tight immediately after operation¹ would predispose to this complication. Nor is a fascial sling immune from longer term collagen constriction. I have seen a patient presenting with acute retention 25 years after an Aldridge sling operation. Excision of a 1 cm segment per vaginam restored micturition without loss of continence.

Conclusions and future directions. In a general sense, we need to examine all implants from the viewpoint of mechanical properties of the mesh, and the immunological reaction of a particular patient.

- (1) Any suburethral tape should be non-stretch and preferably, knitted from lighter weight threads.
- (2) If the tape is non-stretch, it should touch, but not indent the urethra.
- (3) If the tape is elastic, it is mandatory to leave a space, so as to allow for post-operative elastic retraction.
- (4) In patients who cannot pass any urine for some days, post-operative loosening of the tape is preferable to self-catheterization.
- (5) Suburethral plication of the underlying vaginal fascia reduces slippage and erosion, and it requires only one extra suture.
- (6) Patients have different immunology, and foreign body reactions will inevitably occur in some patients, sometimes many years after implantation. This has to be explained in detail during the consent process.

Re Risk of tape-related complications after TVT is at least 4%, Jones R. et al. *Neurourol. and Urodynamics* 29:40–41 (2010).

Christopher Chapple led the review process.

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