MINIMAL INVASIVE TECHNIQUE FOR THE SURGICAL TREATMENT OF STRESS URINARY INCONTINENCE: CONTASURE NEEDLELESS® PLACEMENT

Ramon Usandizaga MD
University Hospital La Paz   Madrid.(Spain)
Email: rusandizaga@sego.es
Midurethral slings are the gold standard for the surgical treatment of stress urinary incontinence. Nowadays new minimal invasive devices are becoming more and more used, using the same concept of the tension free tapes but with a minimal invasive techniques. (single incision, no needles).

Technique: With local anesthesia we infiltrate 10 cc of lidocaine, (first with a small needle and then with a longer one)

Local anaesthetic is infiltrated into the paraurethral obturator areas. The bladder is emptied.
With the patient in lithotomic position and the legs flexed, the bladder is emptied by a Foley catheter. A longitudinal incision (1 – 2 cm.) is made at the vaginal mucosa under (0.5 cm.) the urethral meatus. A submucosal blunt dissection of the paraurethral spaces to this incision are performed at both sides (at 10 and 2 o’clock) until the endopelvic fascia is reached.
Once removed from the sterile packaging the Contasure Needleless sling has two pockets at the end of the mesh.

A surgical forceps (Kocher or Bengolea) is placed inside the pocket positioning system of the Contasure Needleless mesh and opening and closing the forceps the mesh is folded into the forceps. The forceps with the folded mesh is introduced into the paraurethral space and the internal obturator muscle is penetrated by controlled pushing force.
The forceps is then opened to extend the T pocket on the tip of the Contsure Needleless sling and then closed and pulled off the vagina.

Once the sling is introduced, it can be repositioned up to give more support to the urethra, by introducing again the tip of the forceps in the pocket positioning system and pushing the sling further up.
The sling has a suture in the middle of the sling just as a landmark to know that this part should be in the midline of the urethra, after the procedure is finish we will cut the blue suture and close the vaginal incision with an absorbable suture 2/0.

Comments

It’s a minimal invasive technique compare with the TOT /TVT technique.

Potential complications: bleeding, voiding dysfunction, failure to control SUI symptoms, urgency and vaginal erosion.

Evidence: Last clinical trials are at this moment 1 year follow up. There is no long-term evidence.