University College Hospital

Transobturator midurethral sling
An operation for stress urinary incontinence

Urogynaecology and Pelvic Floor Unit
Women’s Health
If you require the services of an interpreter, contact us on 020 3447 9411. We will do our best to meet your needs.

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1 Introduction

Stress urinary incontinence means leakage of urine when you are coughing, sneezing, exercising or lifting. It might also happen during other activities such as walking, changing position, or even just standing up.

This leaflet provides information about an operation called a transobturator midurethral sling. It is one of the operations that we offer to treat stress urinary incontinence. This leaflet has been made to help you understand why this operation has been recommended and what surgery might involve.

This leaflet contains information from medical research studies and guidance from independent organisations that specialise in this type of surgery. We have tried to simplify this information and make it easy to understand for patients. We hope that this leaflet will help you decide if you want to go ahead with surgery.

We will review this information every two years. This is to make sure that any information from new research studies is included. We may do this sooner if we think important new information becomes available that you need to be aware of.

2 What does transobturator midurethral sling mean?

Transobturator midurethral sling surgery is an operation to help with stress urinary incontinence. The sling is a thin strip of soft, plastic mesh that is implanted in the pelvis. The mesh is inserted through a small cut just inside the vagina and two tiny cuts at the top of the thighs.

The mesh acts like a ‘hammock’ under the urethra, providing extra support. The urethra is the tube that you pass urine out of. This additional support helps to prevent leakage during coughing, sneezing, or activities such as exercise.
3 How can a transobturator midurethral sling help?

If you have symptoms of stress urinary incontinence, this operation is likely to help you. Although the operation is effective, no operation will work for everybody. Some women will find that their stress urinary incontinence is not helped by the surgery. Occasionally, the operation works well initially but the problems start again some time later.

The most reliable medical research studies (called randomised trials) have shown that at five years, most women are satisfied:

- Around 80 out of 100 women will be cured of their stress urinary incontinence or very much improved.

Whilst this surgery is performed to help with stress urinary incontinence, it may also help with urinary urgency. Urgency means having to suddenly rush to the toilet to pass urine without warning. Most of the research would suggest that:

- Around 60-70 out of 100 women will find that their urinary urgency improves after surgery.

4 What are the risks of a transobturator midurethral sling?

All treatments and procedures have risks and we will talk to you about the risks of a transobturator midurethral sling. Problems that occur during or after surgery are called complications. These are undesirable or unwanted effects that happen as a result of surgery. If a complication affects you, it does not mean that something must have gone wrong during the surgery. If you have a complication, you can expect us to explain what has happened, and whether any further treatment is required. We always provide additional care and support for patients who experience problems after an operation.

We will use numbers to explain how often we might expect problems to happen after transobturator midurethral sling
surgery. For example, a ‘10 in 100’ chance of a problem means that if we performed 100 operations, the problem would happen 10 times. This is the same as a 10 per cent chance.

Problems that may happen straight away

Bleeding during surgery

- Bleeding that might need a blood transfusion: 1 in 100.

Infections after surgery

- Urine infection immediately after surgery: 10 in 100.
- Urine infections that might be a recurrent problem: 5 in 100.
- Infection of the wounds in the vagina or abdomen: 1 in 100.
- Infection inside the pelvis or infection of the mesh: This has been described in medical reports but it is rare. The risk of this happening is unknown.

How are infections treated? Most infections are easily treated with antibiotics. Recurrent urine infections can require repeated courses of antibiotics. Some patients need a small dose of antibiotic everyday to keep the infection away. If the mesh became infected, or there was a serious pelvic infection, you might need a second operation. The mesh might have to be removed. Life-threatening infections after stress urinary incontinence surgery are extremely rare.

Damage to other organs during surgery

- Damage to bladder: 1 in 100.
- Damage to the urethra: 1 in 100.
Any damage is usually fixed during the operation. If the urethra is damaged we would not be able to put the mesh in safely. If this happened, you will need to heal, then come back for a second operation to fix your incontinence. We might even recommend a different operation. If you have had previous pelvic surgery the risk of damage may be higher.

Rarely, damage might occur that is not recognised during the operation. If this happened, you might experience no symptoms, or you could become ill after your surgery. You would need extra tests to find out if this was the case. You might need another operation to repair the damage.

**How is bladder or urethral damage repaired?** We use stitches to repair the bladder. A catheter tube is left in the bladder for around two weeks afterwards whilst the bladder heals. If the urethra is damaged, it is also repaired with stitches. Sometimes we might have to take some fatty tissue from the vulval skin to complete the repair. This is known as a ‘Martius’ fat pad. Sometimes a catheter tube has to be left in place for longer if the damage is severe.

**Bladder symptoms after surgery**

Even if your stress urinary incontinence improves after surgery, there is small chance that you could develop other problems.

These problems might include:

- New or worsening urinary urgency: 5-10 in 100.
- Difficulty emptying your bladder:
  - Short term catheter use for a few days: 10 in 100.
  - Catheter use for six weeks or more: 1 in 100.
• Being unable to pass urine at all after surgery: 1-10 in 1000

**How is urinary urgency treated?** Problems with urinary urgency after surgery often settle down on their own. If treatment is needed, medication or other non-surgical treatments are usually effective.

**How are problems with bladder emptying dealt with?** Sometimes women can pass urine after surgery but the bladder does not empty very well. If this happens you might have to go home with a catheter tube in the bladder. It is removed after a few days and things usually go back to normal. If the bladder is still not emptying fully, you may have to use intermittent self-catheterisation up to four times a day. This means that you would pass a small catheter tube through the urethra yourself to empty the bladder. You would still pass urine normally and self-catheterisation would drain off any urine left behind. We would teach you how to do this. Things usually settle down in a few weeks although it can take longer. Permanent problems are uncommon.

**What if I cannot pass urine at all?** If this happens we will initially leave a catheter in place and send you home. We usually try to remove the catheter after a week. If you still cannot pass any urine we may allow a further week with a catheter tube in place. If there is no improvement at this point we may advise that the sling is cut. This requires a further small operation. Things usually go back to normal after the cutting the sling but not always. If the sling is cut your stress incontinence will come back.

**Pelvic pain or problems with sexual intercourse**

Pain after surgery is common but usually settles down quite quickly. Sometimes, pain can be a long-term problem. In some cases the pain can be severe and very difficult to treat.
If you have no problems with sex before surgery you are unlikely to have develop problems afterwards. Some women can experience painful sex after surgery. Others may have sexual difficulties other reasons. Problems with arousal or reaching orgasm have been reported. Urinary leakage during sex that did not happen before has also been described.

- Pain in the pelvis, vagina, groin or thighs lasting weeks or months: 6 in 100.
- Pain lasting more than six months: 1 in 100.
- Worsening sexual function: 5-10 in 100.

Painful sexual intercourse might be caused by scarring, the mesh irritating the tissues in the pelvis, or nerve damage. These problems can often be treated but things do not always get better. Other problems with sex, such as difficulties become aroused or reaching orgasm, are more complex. Nerve damage might be contributing to this but it might not be the only problem.

If you already experience chronic pain in other areas of the body, the risk of pain after surgery might be higher.

What if I have persistent pain in the pelvis? You will be checked to see if there is a problem with the operation, or another cause. If no problem is found the pain could be coming from nerves that have been damaged by surgery. If this happens, you will be referred to a specialist in pain medicine and you may be prescribed medication.
Can the sling be removed if I have problems?
We think that in some women, the sling causes irritation and the area can become inflamed. The formation of scar tissue around the sling might also cause pain. If other treatments do not help, we may offer you removal of the sling. This can sometimes help to improve pain but in some cases the pain carries on. Once the transobturator midurethral sling has been in place for more than a few weeks, it cannot usually be removed fully. The part of the sling implanted in the vagina can be removed. The ends of the sling are in the groin and upper thigh. They cannot normally be removed. Occasionally, further surgery can make things worse rather than better. Removing a sling is associated with a higher risk of complications than when it is inserted. The decision to offer sling removal would be made by a team of specialists. When a sling is removed, incontinence often comes back. This might need further treatment.

What if I have problems with sex? Painful sex is treated in a similar way to pelvic pain after surgery. The two problems can sometimes happen together. Physiotherapists can sometimes help with pelvic pain and painful intercourse. Occasionally, a lack of hormones in the vagina can cause pain. This can be treated with a hormone cream. Other problems are more complex and may be difficult to make better. In some circumstances, we may suggest that you see a psychosexual counsellor.

Can persistent pain be serious? Rarely, chronic pain can be severe and difficult to treat. Some women have even found difficulty walking or moving around. Such cases are very uncommon but have a serious impact on quality of life.
Symptoms caused by nerve damage

When the sling is inserted, it might cause nerve damage in the pelvis. As previously discussed, this can cause pain, but it can also cause other symptoms. These problems include pins and needles around the pelvis, groins and inner thighs, loss of sensation, and even muscle weakness. These problems usually settle down in time. Long-term problems are rare.

- Nerve symptoms lasting weeks or months: 10 in 100.
- Permanent nerve symptoms: 1-10 in 1000.

Problems that may happen later

Your stress urinary incontinence might come back

Whilst the operation is usually successful, it will not work in some cases. Sometimes the operation does not work right from the start. This can occur even if the operation went well. Sometimes surgery works initially but then the leakage comes back after a few months or years. Overall, around 20 in 100 women will find that the surgery will not work long term.

Mesh exposure and erosion

The mesh used in transobturator midurethral sling is called polypropylene, which is a type of plastic. This mesh has been used in hernia surgery for many years. Recently there have been concerns raised about the use of mesh in surgery for incontinence and prolapse. These problems relate particularly to chronic pain but also other complications. These include problems with mesh exposure in the vagina and mesh erosion into the bladder and urethra.

Vaginal exposure means that the mesh becomes visible in the vagina where it was inserted. Normally, this does not happen as the vaginal skin is stitched closed and heals over the mesh. Mesh erosion means that the mesh ‘cuts through’ into the
urethra or the bladder. This can sometimes happen many years after the sling is inserted.

- These complications can cause long-term pain, painful sexual intercourse, vaginal discharge, urinary infections, and other bladder problems.

- Mesh exposure in the vagina: 2 in 100.

- Mesh erosion into bladder or urethra: 1 in 1000.

We do not know exactly why problems with exposure or erosion happen. There may be some form of ‘foreign body reaction’. This means that your body is reacting to the presence of the mesh. The area then becomes inflamed. At the time of writing, there is no evidence that implanting mesh in the body can cause problems with your general health.

How is mesh exposure in the vagina treated? Mesh exposure in the vagina soon after surgery often heals on its own. We may recommend a vaginal hormone cream to help with the healing process. If things do not get better, some women need a small operation. This is to trim the mesh and stitch the skin back over the area. If this is a recurrent problem, a larger piece of mesh may need to be removed to fix things. This might mean that your incontinence comes back.

How is erosion into the bladder or urethra treated? Erosion of the sling into the urethra or bladder requires more major surgery. Sometimes a cut on the abdomen is needed to remove mesh from the bladder. If a large piece of mesh needs removing, you incontinence is likely to come back.
A recent study found that 5 in 100 women need surgery to treat mesh complications in the first five years after their operation.

**Problems that are rare, but serious**

- Damage to major blood vessels and life-threatening bleeding: 1 in 1000.
- Blood clots in the legs that can travel to the lungs: 5 in 1000.

**How is serious bleeding dealt with during surgery?**

Damage to major blood vessels is rare but can cause life-threatening bleeding. If this happens, a large cut on the abdomen is needed to repair the damage. You would require a major blood transfusion that would be life saving. Please ensure to tell you doctor if you would not accept a blood transfusion on religious or other grounds. This is extremely important.

**What happens if I develop a blood clot?** After surgery, blood becomes stickier, and clots more easily. Blood clots can form in the legs, break off, and travel through the bloodstream to the lungs. These blood clots stop the lungs working properly, causing breathing difficulties. This condition is known as ‘venous thromboembolism’. If this happens, your hospital stay will be prolonged, and you will be given blood-thinning medication for a few months. Thankfully, the condition is only life-threatening for a very small number of affected patients. To reduce the risk of this problem, you will wear special stockings on your legs, and receive a small, daily injection of blood thinning medication in hospital.

**Problems with the anaesthetic**

You will be given a general anaesthetic for your operation. This means that you will be unconscious and will not feel anything
during your surgery. Anaesthetists are doctors who specialise in anaesthetics. Your anaesthetist will give you your anaesthetic medication and gently place a tube through your mouth into your throat. This is to keep your windpipe open so oxygen can get to your lungs.

Some problems are very common after an anaesthetic. They normally settle down very quickly after surgery or are easy to treat. Sore throat or throat pain, feeling sick and vomiting, or shivering after surgery, can affect up to half of patients.

Some problems are more likely to affect certain groups of patients. If you are older, overweight, a smoker, or have other medical problems, you are more likely to be affected:

- Chest infection after surgery: 1-10 in 100.
- Permanent nerve damage: 1 in 1000.
- Permanent loss of sight: 1 in 100,000.
- Death as a result of anaesthesia: 1 in 100,000.

Older patients, especially those with dementia, poor eyesight or hearing, can become confused after an operation. It is not known how often this happens.

Damage to the lips and tongue may occur but this is usually minor. Tooth damage is more likely to happen if you have diseased teeth and gums, or have had extensive dental work:

- Damage to the lips and tongue: 5 in 100.
- Damage to teeth: 5 in 10,000.

Some problems can happen to anyone as a result of an anaesthetic:

- The eyeball getting grazed or damaged: 4 in 10,000.
• Being aware of what is happening during surgery despite the anaesthetic: 5 in 100,000.

• Life-threatening allergic reaction: 1 in 10,000.

5 What will happen if I choose not to have transobturator midurethral sling?

If you decide not to have this operation you could simply carry on as you are. You will continue to have symptoms of stress urinary incontinence. Whilst these symptoms can be distressing, you are unlikely to come to any harm.

6 What alternatives are available?

After reading this leaflet, you may decide that you want to look at other options. We provide a separate leaflet on the available treatments for stress urinary incontinence and we should have given you this to read. Please ask for this leaflet if you do not already have it.

The non-surgical alternatives to transobturator midurethral sling surgery include:

• Pelvic floor physiotherapy.

• Weight loss.

• A continence pessary.

Other surgical options include:

• Colposuspension.

• Autologous sling.

• Urethral bulking agents

• Artificial urinary sphincter.
Sometimes your doctor may suggest that one treatment might be better than another in your particular case. They will let you know the reasons for this if it is the case.

**Will physiotherapy work?** You will be taught how to strengthen your pelvic floor muscles with an expert physiotherapist. If you keep doing the exercises, they seem to keep working. If you stop, your problems will come back. Around 60 in 100 women will improve and not request any more treatment.

**Can weight loss help?** If you are overweight, weight loss can reduce urinary leakage. In research studies, women who lost just 5-10 per cent of their body weight saw big improvements. This is the same as weighing 15 stones and losing a stone and a half. In these studies, women only leaked half as often after losing weight. Some women became completely dry. If you need advice or guidance to help you lose weight, please speak to your GP.

**What is a continence pessary?** These are flexible plastic or silicone rings that are inserted into the vagina. They gently press on the urethra to help with leakage. If you use a pessary, you will need a check-up every six months so that your vagina can be examined. Pessaries can sometimes rub on the vaginal walls, or cause a little bleeding or discharge. This affects around 5 in 100 women. Rarely a minor infection can develop. Pessaries can be safely used long term. You can learn to remove and replace the pessary yourself. This is helpful if you only use it at certain times when your symptoms are worse. Some women use continence pessaries only when they are exercising. This can be useful if they only leak when they are active. Some women remove their pessary overnight. Continence pessaries can make sex difficult as they might get in the way. If you learn to remove the pessary yourself, you can take it out before sex.
What is a colposuspension? This is an operation that we perform using keyhole surgery through the abdomen. It uses permanent stitches instead of the mesh used in the retropubic midurethral sling. It seems to be as effective as the retropubic midurethral sling. The risks of colposuspension and retropubic midurethral sling surgery are similar. Your recovery may take slightly longer after colposuspension.

What is an autologous sling? This is a similar procedure to the retropubic midurethral sling but does not use mesh. A thin strip of your own body tissue is used instead of the mesh. This tissue, called ‘fascia’, is normally taken from the lower abdomen. This needs a larger cut on the abdomen and will make your recovery a little longer. The autologous sling is just as effective as the retropubic midurethral sling. Problems with urinary urgency and difficulty passing urine are more common after an autologous sling. There is a higher risk of needing to use self-catheterisation than after other surgeries.

What are urethral bulking agents? A soft gel is injected into the urethra. This makes it more difficult for urine to escape. The gel is injected using a cystoscope, which is a camera passed down the urethra. No cuts are needed and you go home the same day. There is a much lower risk of complications compared with other procedures but it is not as effective. We are also unsure how well the procedure works long term.

What is an artificial urinary sphincter? This is a mechanical valve that controls urine flow through the urethra. The valve is inserted through a cut on your lower abdomen. A small pump is then placed under the labial skin. By pressing the pump, you can control when you want urine to flow. Although very effective, the device may need to be repaired because it breaks down or removed because of infection. Because of these problems, it is usually reserved for patients in whom other treatments have failed.
7 How should I prepare for transobturator midurethral sling?

The Preoperative Assessment Clinic (PAC)

Before your operation, you will be seen in the PAC to make sure that you are fit for your surgery. Specialist nurses and anaesthetists run the clinic. This normally happens a few weeks before your operation. When you come to your appointment, you should bring the following:

- A list of your medical conditions and previous operations.
- A list of your current medications and allergies.

Sometimes, certain types of medication need to be stopped before your operation. The team in PAC will tell you if any of your medication needs to be stopped and which ones you should take on the day of your operation. **Please do not stop any medication before your operation unless you are asked to do so. Stopping important medication before your surgery may mean that your operation is cancelled or you come to harm.**

What if the PAC finds a problem? Occasionally, a new health problem is found. Sometimes, an existing problem may need further treatment before surgery. If this happens, your surgery will need to be delayed. Your GP will be asked to arrange any extra tests, treatment, or consultations with other specialists. Whilst we understand how disappointing this might be, the PAC team are there to make sure your surgery is conducted safely. If your operation is delayed, we will arrange another date for you as quickly as possible when you are cleared for surgery. Unfortunately, we are unable to speed up any tests or extra appointments requested by PAC.
The day of your surgery

On the day of surgery, you will come to the Surgical Reception on the First Floor of University College Hospital at 07:00 in the morning. You will receive a letter confirming these details. Your operating surgeon will see you for final checks. Please note that your operating surgeon may not be the same specialist as you saw in clinic. The nurses will then prepare you for your surgery.

On the day of surgery, you should follow the instructions given to you at the PAC appointment about the following:

- Which medications to take on the morning of surgery.
- When to stop eating and drinking before your surgery.

If you are confused about any of the instructions, you must contact them before your surgery. Their details are at the end of this leaflet.

- Bring your regular medications along with you.
- Pack a bag with clothes and toiletries for your stay.
- Bring the copy of your consent form that we gave you.

Please be aware that your surgeons will be operating through the day until 19:00. They are often unable to leave the operating theatre between patients. For this reason, they see all patients in the morning, even if surgery is planned for later in the day.

Your surgery will usually be in the morning but if there are delays, you may be allowed to drink some water. You might also be able to leave the Surgical Reception for a little while until you are due for surgery. Please do not drink, or leave the Surgical Reception, until instructed to do so. Drinking at the wrong time may mean that your operation is cancelled.
There is a very small chance that your surgery may be cancelled on the day you come in to hospital. This might happen because the hospital is full and there is no bed for you. This is uncommon but obviously very distressing if it occurs.

Whilst beds often become available as the day passes, this is not always the case. If it looks like your surgery will have to be cancelled, we will let you know as early as we can. We will then work with our management team to rearrange your surgery as soon as possible.

Making plans for after your surgery

Please make plans well in advance:

- You will usually go home the same day. Up to two people can visit you in hospital between 09:00 and 20:00 every day.

- Please ensure that your travel plans are flexible. Remember that your stay might also be extended on medical grounds.

- You will need an escort to help you get home and you will not be able to use public transport to get home alone.

- You will need at least two weeks off work. If you have a strenuous job you may need slightly longer to recover.

- You should avoid carrying anything heavier than 5kg for the first four weeks after surgery.

- You will need friends and family to help with groceries and household chores, particularly in the first week.

Unfortunately, we will be unable to extend your hospital stay if you have not made transport arrangements. If you already use hospital transport because of a medical illness, we will be able to help arrange this. Unfortunately, hospital transport is not available for other patients.
8 Asking for your consent

We want to involve you in all the decisions about your care and treatment. If you decide to go ahead with treatment, by law we must ask for your consent and will ask you to sign a consent form. This confirms that you agree to have the procedure and understand what it involves. Staff will explain all the risks, benefits and alternatives before they ask you to sign a consent form. If you are unsure about any aspect of your proposed treatment, please ask to speak with a senior member of staff again. Our contact details are at the end of this leaflet.

9 What happens during a transobturator midurethral sling?

The operation usually takes one hour.

- A small 2 cm cut is made inside the vagina under the urethra.

- Two other tiny cuts are made at the top of the thighs, in the groins at both sides.

- The mesh, which is around 15cm in length, is inserted and forms a ‘hammock’ under the urethra.

- The mesh is pulled into position using a trocar, which is a strong needle. Each end of the mesh is attached to the trocar and passed through the cut in the vagina.

- The trocar is passed through natural ‘windows’ in the pelvic bones on both sides and comes out through the tiny cuts at the top of the thighs. The trocar is then disconnected from the mesh and removed.

- We then check that the mesh has not accidentally pierced the urethra or bladder. We use a camera in the bladder called a cystoscope to do this. If this happened, we would reposition the mesh whilst you were asleep.
Once the mesh is in the correct position, the cut in the vagina and the tiny cuts at the top of the thighs are stitched up.

You will have a drip in your hand and a catheter tube in the bladder for a few hours after surgery.

10 What should I expect after transobturator midurethral sling?

The first two weeks after surgery

- You will need to rest and take regular painkillers.
- You should take regular medicine, known as a laxative, to keep your bowels opening every day.
- You will spend much of your time at home but you may take short walks. You should avoid anything strenuous and lifting anything heavier than 5kg.
- You can expect some vaginal bleeding and discharge.
- You will wear a sanitary pad and change it regularly.
- You can shower as often as you like. You can gently wash around the vaginal opening in the shower. You can direct the shower spray around the vaginal entrance to clear away any discharge or blood. You can use soap or shower gel on the outside of the vagina but not on the inside.
- If you do take a bath, do so in shallow water for a maximum of ten minutes.
- You can remove the plasters from the cuts on the lower abdomen after a day or two then keep the area clean and dry.
- You will receive a telephone clinic appointment through the post. This is normally scheduled for two to three weeks after
surgery. The urogynaecology nurses will call you by phone on this day to check on your progress.

We will give you a two-week supply of painkillers, laxative medication, and any other drugs you will need at home. If you need further supplies after you have gone home, you will need to contact your GP.

**Weeks two to four after surgery**

- You will be able to reduce your regular painkillers, start taking them only if needed, and eventually stop using them.

- You will continue to use your laxatives to keep your bowels opening daily. If you can do this by eating plenty of fruit and fibre, and drinking enough water, you can stop the laxatives.

- You will increase your activity and go back to work. Exactly when you return to work depends on your job.

- You will continue to avoid lifting anything heavier than 5kg.

- You can start driving again but you should inform your insurance company that you have had surgery. They must be happy for you to drive again. You should only start driving again if you feel safe to do so. You must be able to perform an emergency stop if needed.

- If you have a period, please use pads rather than tampons.

**Six weeks onwards**

- You can get back into your normal routine.

- If you exercised regularly before your surgery, you should be able to continue as usual. Please discuss this with us before you go home. We might suggest some changes to your usual exercise programme.
• You can start having sexual intercourse.
• We will send you a clinic appointment through the post for three months after your surgery. At the appointment, we will ask you how things are and examine you. This is to make sure that the operation has worked and that you do not have any problems.

What serious problems should I look out for? Serious problems after surgery are rare but they need to be checked urgently. If you develop the following symptoms, you should go to your nearest Accident and Emergency department.

- High fever.
- Repeated vomiting.
- Pain in the abdomen that is getting worse.
- You are unable to pass urine or pass very little.
- Swelling, redness, or tenderness in the lower legs.
- Difficulty breathing, or chest pain.

If you have to go to hospital, please contact the urogynaecology nursing team afterwards to let them know. Their contact details are below.
**What I have other less urgent problems?** You should discuss these problems with the urogynaecology nursing team or your GP within 24 hours. Such problems might include:

- Burning when you are passing urine.
- Difficulty passing urine.
- Not opening your bowels for three days.
- Redness around your abdominal wounds.
- A smelly vaginal discharge.

The urogynaecology team will usually return telephone calls and messages the same day, or the next working day. You should ring them first if you have problems. If you call them on Friday and do not hear back the same day, you should see a GP. At the weekend, you should see a GP or go to Accident and Emergency if there is no other help available.

**11 Where can I get more information?**

**The British Society of Urogynaecology**

Website: http://bsug.org.uk/pages/information-for-patients/111
Email: bsug@rcog.org.uk
Telephone: 020 7772 6211
Fax: 020 7772 6410

**The National Institute for Health and Care Excellence**

Website:
Email at: https://www.baus.org.uk/about/contact.aspx
Telephone: 0207 869 6950
The International Urogynecological Association

Website:
http://www.iuga.org/general/custom.asp?page=patientinfo
Email at: www.iuga.org/general/?type=CONTACT

UCLH cannot accept responsibility for information provided by other organisations.

12 References


13 Contact details

Urogynaecology nursing team
(For medical problems and questions only)
Direct line: 020 3447 6547
Mobile: 07951 674140
Fax: 020 3447 6590
Email: urogynaecology@uclh.nhs.uk

Gynaecology outpatient appointments
(Contact for outpatient clinic appointments only)
Direct line: 020 3447 9411
Fax: 020 3447 6590

Preoperative Assessment Clinic (PAC)
(Contact for questions about PAC only)
Direct line: 020 3447 3167
Fax: 020 3383 3415

Gynaecology Admissions
(Contact for surgery dates and scheduling only)
Direct line: 020 3447 2504

Urogynaecology secretary
Direct line: 020 3447 2516
Fax: 020 3447 9775

University College Hospital
Switchboard: 020 3456 7890
Website: www.uclh.nhs.uk
14 How to find us

The Urogynaecology and Pelvic Floor Unit
Clinic 2, Lower Ground Floor
Elizabeth Garrett Anderson (EGA) Wing
University College Hospital
25 Grafton Way
London
WC1E 6DB
Space for notes and questions