Tension-free Vaginal Tape (TVT)
Introduction
This leaflet will provide you with basic information about the Tension-free Vaginal Tape (TVT) procedure.

What is a TVT?
TVT is an operation to help women with stress incontinence (which is the leakage of urine when coughing, sneezing, moving or exercising). The TVT procedure is usually carried out under local anaesthetic and sedation. Two small cuts (0.5 cm) are made just above the pubic bone and a small cut in the vagina. Through these cuts a piece of non-dissolvable mesh tape is placed below the urethra (the tube through which you pass urine) using a needle. The mesh attaches itself to the surrounding tissues and supports the urethra. This mimics the ligaments that have been weakened by age and childbirth.

Success rates of a TVT
In the short term this operation is as successful as any major procedure used for controlling bladder leakage, but with a quicker recovery. About 80 to 90% of women are happy with their operation and feel that their incontinence is a lot better. However there is a small group of women (about 5 to 10%) for whom the operation does not seem to work. The operation is less likely to be a success if you have had previous surgery to your bladder (such as a repair or a previous continence procedure). Following this procedure you may still have symptoms of urinary urgency or leakage.

British Society of Urogynaecology
27 Sussex Place,
Regent’s Park,
London, NW1 4RG
Email: bsug@rcog.org.uk
Website: www.bsug.org.uk/patient-information.php

Royal College of Obstetricians & Gynaecologists
27 Sussex Place
Regent’s Park
London NW1 4RG
Website: www.rcog.org.uk/en/patients/patient-leaflets

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If you have any concerns, please discuss with the nurse practitioner or doctor.

Risks

With any operation there is a risk of complications. The following complications could occur with a TVT:

- **Anaesthetic** - Very small risk unless you have specific medical problems
- **Bladder perforation** - During the operation, a needle is used to insert the mesh. This needle may accidentally pass through the bladder. The bladder is always checked to make sure that this hasn’t happened and if it has, the needle will be removed and re-sited. If the bladder has been pierced then the catheter is left in overnight (so you will need to stay in hospital an extra day), but this does not affect the success of the operation
- **Haematoma** - Occasionally a small blood vessel is punctured where the needle goes through the skin. This causes a small lump (haematoma) that will get better by itself. This occurs in less than 1 in 100 cases
- **Bleeding** - Very occasionally (less than 1 in 500) there can be severe bleeding. If this happens it would be necessary to give you a general anaesthetic so that the appropriate surgery could be performed to stop the bleeding and repair the urinary leakage
- **Bladder infection** - Sometimes you can experience a burning sensation on passing urine. This may occur while you are in hospital or after discharge.
To reduce the risk of a bladder infection you will be given a single dose of antibiotics whilst in theatre.

- **Voiding difficulty** - A lot of women who have TVT find that their bladder is much slower to empty afterwards. This normally improves over time, but women often find that they cannot go for ‘a quick pee’ after a TVT. Very rarely the bladder does not work properly after the operation, in which case you will be taught to put a catheter into your bladder to empty it yourself (Intermittent Self-Catheterisation - ISC). You would not need to wear a urine bag, as you can drain the bladder, if necessary, several times a day. This happens to approximately 1 in 100 women. If you would like more information about this please ask your doctor.

- **Urinary urgency** - The operation is designed to cure stress incontinence. Urgency (the need to rush to the toilet) and urge incontinence (leakage when you cannot make it to the toilet in time) can sometimes be made better by the operation but occasionally can be worse.

- **Mesh exposure and extrusion (1 to 5 in 100 risk)** - The vaginal area over the tape may not heal properly or wear through into the vagina. When this happens it can cause a vaginal discharge. The problem can be helped by trimming the mesh and re-stitching the vagina over it. This may result in a return to theatre. Very rarely the tape might erode into the urethra (urine pipe) or the bladder. This would also require a further operation. The risk of exposure is increased by smoking and certain medical conditions.

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**Getting back to normal**

**Recovery**

Because major incisions are avoided, recovery is much quicker than after other surgery for stress incontinence such as colposuspension. Recovery after a TVT operation usually takes 1 to 4 weeks. Most patients take 1 to 2 weeks off work. There is no need to wait for a follow up appointment before returning to work.

**Driving and other activities**

You should be able to drive and be fit enough for your usual activities within 1 to 2 weeks of the surgery. We advise that you to avoid heavy lifting and sport for 6 weeks to allow the wounds to heal and the mesh to settle into place.

**Sexual intercourse**

We usually advise you to wait for 4 weeks after the operation before having sexual intercourse. In the long term there is no evidence that the operation will make any difference to your sex life. If you previously leaked urine during intercourse, the operation often makes this better, but unfortunately this is not always the case.

**Contact information**

If you have any problems or concerns after going home, please contact your GP who will be able to give you advice. If your GP is not available contact the Urogynaecology Nurse Practitioner.
A catheter (a small tube) is passed into the bladder to keep it empty throughout the operation.

The anaesthetist may give you some medication through the drip to make you very sleepy (but not a full general anaesthetic). Towards the end of the operation, the anaesthetist will allow this to wear off. You will be asked to cough again in order to check the amount of leakage. The tape will be adjusted accordingly until it stops the leakage when you cough.

**After the operation**

After the operation, you will be asked to measure how much urine you pass when you empty your bladder whilst on the ward. An ultrasound scan is normally used to check that your bladder is emptying properly, if it is you will be able to go home the same day.

If you are unable to empty your bladder fully we will empty it with a catheter which will mean that you will stay in hospital overnight. The amount of urine that you leave behind in the bladder usually decreases the next day as the swelling around the bladder reduces. However, occasionally the bladder takes longer to return to normal, in which case, although rare you may need to be taught how to insert a catheter into your bladder to empty it yourself. This is usually a short-term problem and you can generally stop using the catheter after a week or so. If the problem continues the doctor will discuss other options with you.

**Alternative treatments**

- **Pain during intercourse** – This is due to scar tissues in the vagina as a result of the incision
- **Damage to bowel or nerves** - This rarely occurs (less than 1 in 1000) and may not be discovered until after the operation.

**Do nothing** - If leakage is minimal and not distressing then treatment is not necessarily needed

**Pelvic floor exercise** - You may be referred to a physiotherapist, even if you are already practicing pelvic floor exercises, for techniques and advice.

**Manage persistent coughing** - Trying to avoid things that may put too much stress on the bladder can help to stop the cough from getting worse and might improve your symptoms

**Weight loss** - Studies show that losing a modest amount of weight can improve urinary incontinence in overweight and obese women. Even 5 to 10% weight loss can help reduce symptoms. Please discuss with your GP

**Manage constipation** - You should try to make sure that your bowels are opened regularly, as straining to open your bowels increases pressure on your bladder

**Stop smoking** - If you are a smoker you should try to stop, as it can make you prone to chest infections, which puts stress on the bladder when you cough. Please seek advice from your GP
• **Vaginal devices** – Although not a cure, there are numerous devices available to purchase over the counter. These devices are inserted into the vagina with the aim to block the urethra and to keep you dry.

• **Medication** - There is a drug (duloxetine) which has been shown to improve stress incontinence in some women, although this treatment has not been determined. It should be used with pelvic floor exercises. You may discuss this further with your GP.

### Before the operation

Prior to your admission you may be asked to attend a Pre-admission Clinic to ensure that you are fit and well for your forthcoming surgery. If you are below 60 years old and fit and well, you will be admitted directly on the day of your operation.

You will be asked about your general health, past medical history and any medication that you are taking by a nurse practitioner or doctor. Any necessary investigations for example, blood tests, ECG, chest X-ray will be organised.

You will receive information about your admission, hospital stay, operation and pre-operative and post-operative care. You will also be given the opportunity to ask any further questions that you may have.

Prior to your operation you will be given a questionnaire which will help us understand your symptoms and how they affect you on a daily basis. We will send you a further questionnaire 6 months following the surgery. The result of this will be compared with the pre-operative questionnaire to allow us to check if the operation has improved your symptoms.

Ensure that you take a bath or shower before you come in the hospital. Shaving the vulva is not necessary; however, it is advisable that you trim the pubic hair.

### About your operation

You will be asked to come in for surgery on either the day before or the same day as your operation. You will be seen by an anaesthetist and the surgeon (or a senior member of the team) who will explain what will happen during the operation. You will receive an explanation about the purpose of the operation and the risks associated with it and you will be asked to sign a consent form if you have not already done so.

An opportunity will be given for you to ask any further questions not covered during the Pre-admission Clinic.

Sometimes a TVT procedure is combined with another operation, for example prolapse surgery. This will be discussed with you by your surgeon.

When you go to theatre the anaesthetist will insert a needle into a vein on the back of your hand. You will then be positioned on the operating table. Some green towels will be placed over your legs which will act as a screen, so that you cannot see the operation. The surgeon will ask you to cough to check for any leakage from your bladder. The local anaesthetic will be given to the areas where the cuts will be made.