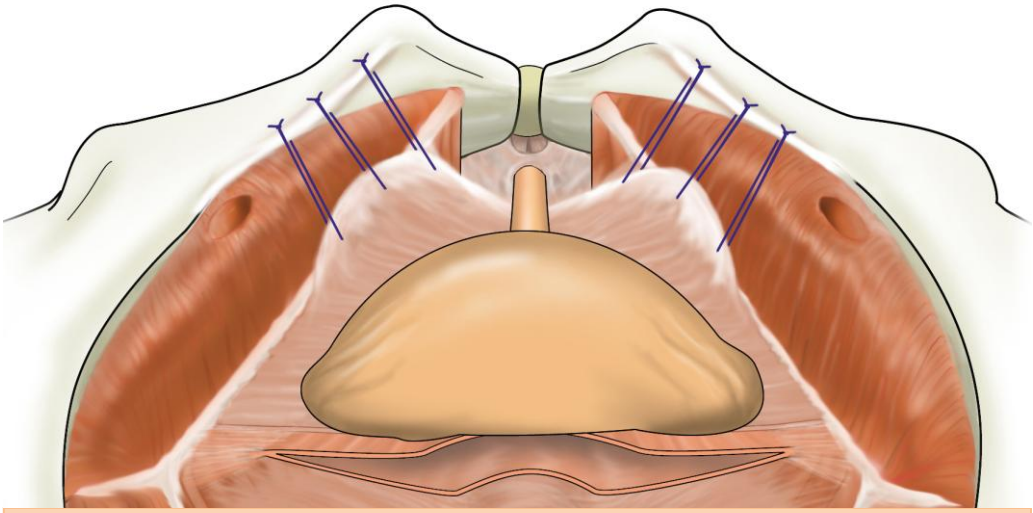
Burch Colposuspension

Aim: To correct urinary stress incontinence (urinary leakage with coughing, sneezing or with exercise). Colposuspension has been performed for many years for the management of urinary stress incontinence with a long-term success rate of 85%. During the last decade, colposuspension has been replaced by the mid-urethral sling as the standard surgery for the treatment of urinary stress incontinence. The procedure is still performed in those who wish to avoid permanent mesh and in some undergoing abdominal surgery for prolapse. The surgery can be performed via a laparotomy (low open cut in the abdomen) or laparoscopically (keyhole). The long-term success of both the laparoscopic and open colposuspension procedures is equal to that of the mid-urethral sling; however, colposuspension has a longer operating time, in-patient stay and recovery than the mid-urethral sling.

Surgical technique: Both the open and laparoscopic surgeries are performed under general anaesthesia (fully asleep) and are identical except for the incisions in the abdomen. In the open surgery, a low horizontal incision (Pfannenstiel) is made in the abdomen approximately 10–15cm in size, compared to three incisions totalling 3cm in the laparoscopic technique. At surgery, the bladder outlet is re-supported by 4–6 permanent sutures (stitches), suspending the vagina from the ligaments on the pubic bone. A cystoscopy (look inside the bladder with a telescope) is performed at the end of the surgery to ensure no damage has occurred to the lower urinary tract. The skin incisions are closed with an absorbable suture that does not require removal.



Surgery will be covered with antibiotics to decrease the risk of infection and blood-thinning agents will be used to decrease the risk of clots forming in the postoperative phase. A catheter will drain your bladder for the first day following surgery.

Serious complications are rare with this type of surgery. However, no surgery is without risk and the main potential complications are listed below.

- Failure rate of 10–15%
- Developing urgency, or urge, urinary incontinence after the operation in 5%
- Urinary tract infection and wound infection in 5%
- Difficulty emptying the bladder that necessitates prolonged self-catheterisation in 1–2%
- Damage to the bowel, bladder or lower urinary tract requiring further surgery in 1%
- Blood loss requiring transfusion or re-operation in less than 1%
- Clotting in the legs or lungs in 1%
- The development of new vaginal prolapse after the operation in 10%
- Long-term pubic pain in <1%.

IN HOSPITAL: You can expect a 2–3 day hospitalisation that maybe shorter with the laparoscopic approach. After the operation, you will have an intravenous drip in your arm and a small catheter will drain your bladder initially. Once the catheter is removed, the nurses will check that you are emptying your bladder appropriately. Skin sutures are absorbable and do not need to be removed.

RECOVERY: In the early postoperative period, you should avoid situations where excessive pressure is placed on the repair (lifting, straining, coughing, constipation), this is especially so in the first 2 weeks. During this time, you should not drive but it is important to mobilise slowly around the home. Regular Panadol (up to eight a day) is the mainstay of your pain relief at home and further pain relief options will be available from your doctor if required. After 2-3 weeks, you can generally return to driving and start mobilising further including gentle walking. You can return to work between 3-6 weeks depending upon the amount of strain placed upon your repair at work and this should be discussed with your doctor. If you develop urinary burning, frequency or urgency or redness or inflammation of the wound you should see your local doctor.

Maximal fibrosis (scarring) around the repair occurs at 3 months and care needs to be taken during this time period to ensure straining and lifting do not negatively affect the repair sutures and your continence status. You will see your doctor at 6 weeks for a review and sexual activity can usually be safely resumed at this time. You will be able return to most daily activities and sport at 6 weeks. All aerobic activities such as walking, running, gardening, Pilates, swimming, tennis and cycling can be resumed at this time; however, weight-bearing exercises at the gym, crunches and sit-ups create high intra-abdominal pressure on the repair and are best avoided.

Avoiding heavy lifting (more than 15kg), weight gain, constipation and weight-bearing exercises can minimise failure of the procedure in the long term. If you have any questions about this information, you should speak to your doctor at the six-week visit.

This statement has been developed by the Urogynaecological Society of Australasia (UGSA).