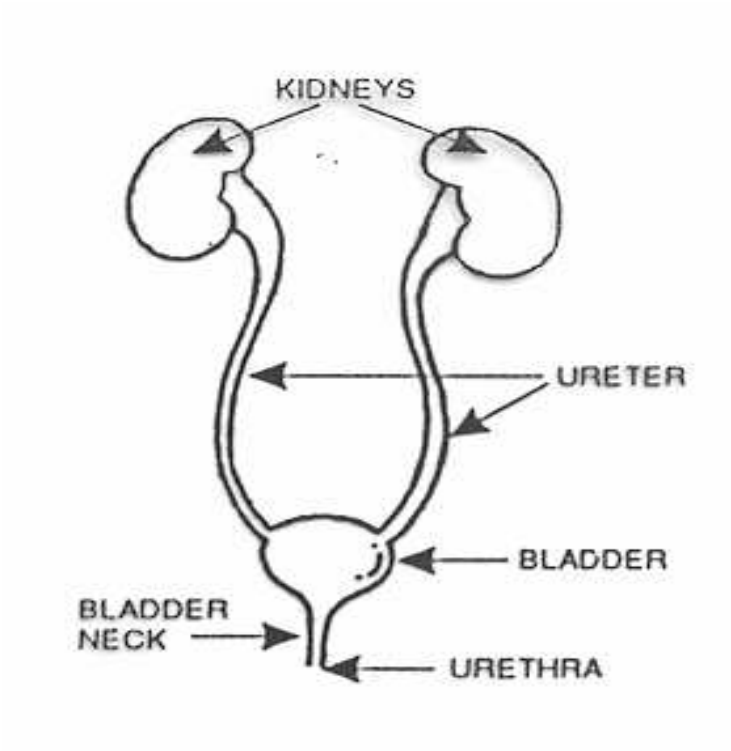
TRANSURETHRAL BULKING AGENT PATIENT INFORMATION

The information contained in this booklet is intended to assist you in understanding your proposed surgery; some of the content may or may not apply to you. Feel free to discuss any issues and questions you may have about your surgery with the medical and nursing staff looking after you. If required, your nurse will arrange for an interpreter to assist with explaining the contents of the booklet. The interpreter can also be present for doctors' consultations. Please bring this book with you to hospital as it is a useful guide.

How Does the Female Urinary System Work?

The urinary system consists of the kidneys, ureters, bladder and urethra. The structures that provide control of urine storage (continence) are the bladder neck, urethral sphincter and pelvic floor muscles.



The following is a brief outline of the role of each of these structures:

Kidneys: These organs are situated under your lower rib cage and produce urine.

Ureters: These are narrow tubes that transport urine made by the kidneys to the bladder.

Bladder: This is a muscular organ situated in the pelvis behind the pubic bone. The function of the bladder is to collect, store and expel urine.

Urethra: This is a short tube through which urine leaves the bladder and passes out of the body.

Bladder neck: This is the junction between the bladder and the urethra where muscle fibres keep the bladder outlet closed except when passing urine.

Pelvic floor muscles: The pelvic floor is the layer of muscle stretching from the pubic bone in the front to the tailbone (coccyx) at the back forming the floor of the pelvis. The pelvic floor muscles are the main support structure for the pelvic organs (bladder, uterus, bowel).

Urethral sphincter: The urethral sphincter is a valve. It consists of a muscle surrounding the urethra. The urethral sphincter is very important for continence in women.

Nerve supply: When the bladder is full of urine, nerves send a message to the brain. The brain in turn sends a signal to the bladder, pelvic floor muscles and urethral sphincter to 'hold on to the urine' until a convenient time and place is found to pass

it. At this time voluntary relaxation of the bladder neck, urethral sphincter and pelvic floor muscles occurs with a simultaneous contraction of the bladder that allows the urine to be expelled. This process is called voiding or micturition.

What is Incontinence?

Broadly defined, it is an involuntary loss of urine causing inconvenience.

There are different types of incontinence grouped according to the cause and the symptoms a person experiences. The surgery described in this booklet is performed to improve the symptoms of stress incontinence of urine. If you have incontinence of faeces, flatus, or mucous please discuss this with your doctor.

Stress Incontinence

Stress incontinence is a term used to describe the leakage of urine from the bladder related to activities such as coughing, sneezing, running and jumping, lifting etc.

Urine leakage is due to a weakness of the urethral sphincter, bladder neck or pelvic floor muscles. This can be associated with a prolapse of the bladder, vagina and/or bowel.

The pelvic floor is most commonly weakened or damaged by childbirth. Other causes include menopause (loss of oestrogen), chronic straining, chronic cough, obesity, trauma or surgery to the pelvis (as this can damage the nerves to the pelvic floor muscles).

When should I consider surgery for incontinence?

- If your incontinence is affecting your lifestyle ie. it is limiting your activities.
- If physiotherapy and bladder retraining have not improved your symptoms sufficiently.
- If your condition is likely to be improved by surgery, as recommended by your urologist.

What Surgical Procedures May Help Stress Incontinence?

There are several types of surgery for stress incontinence performed at Auckland City Hospital. This booklet provides information about one of the procedures available.

Injection of Transurethral Bulking Agent

The transurethral bulking agent procedure involves the injection of silicone gel particles (macroplastique) beneath the lining of the urethra. This is a 'bulking' substance that promotes closure of the urethra and prevents accidental leakage of urine from the bladder. The procedure is done via a telescope that is placed in the urethra.

The injection can be repeated if the best effect is not achieved or if the symptoms return after initial success. This operation takes about 30 minutes and is performed under general or spinal anaesthetic.

Transurethral bulking agents are generally reserved for women who fall into one of the following groups:

- Those who have persistent incontinence despite having good pelvic support.

- Those who have health issues that makes the risk of surgery and anaesthetic unacceptable.
- Those who have persistent incontinence despite having previous incontinence procedures.

This procedure is relatively new in terms of its use for the treatment of stress urinary incontinence. Early results from the use of transurethral bulking agents are reasonable. However you should be aware that in the long-term, symptoms could reoccur. Your surgeon will discuss if this is the most appropriate procedure with you.

Potential Complications

During your hospital stay

- Urinary retention - an inability to pass urine normally. This may require temporary drainage with a urinary catheter.
- Irritative bladder symptoms - you may pass urine frequently and experience some urgency or burning when you pass urine. These symptoms will mostly improve with time.

Ongoing

- Urinary symptoms - you may experience either incomplete emptying or urinary frequency.
- You may experience recurrent incontinence.

Length of Stay

Injection of a transurethral bulking agent is usually done as a day/overnight case.

Before Surgery

Informed consent

After consultation with the doctor you will be asked to sign a form to give written consent for the surgeon to perform the operation and for an anaesthetic to be administered. Relevant sections of the form must also be completed if you agree to a blood transfusion and/or if your particular surgery involves the removal of a body part and you wish to have this returned. Our expectation is that you feel fully informed about all aspects of your surgery before giving written consent. The following health professionals are available to help you with this process.

Medical staff

Your surgeon will explain the reason for the particular operation and the risks associated with the surgery. Your doctors will visit you while you are in hospital to provide medical care and answer questions about your surgery and progress.

Nurses

Nurses will provide your preparation for surgery and care until you are discharged from hospital.

A nurse will explain what to expect before and after surgery. Please ask questions and express your concerns; your family or people close to you are welcome to be involved in this.

When you are discharged from hospital your nurse will arrange for you to receive ongoing support, if needed.

Tests

Blood samples

Two samples of your blood will go the laboratory to check your general health before surgery

Midstream urine

A sample of your urine is sent to the laboratory to check for the presence of bacteria

ECG

An electrocardiogram of your heart may be required depending on your age and any diagnosed heart abnormalities.

Other measures

Nil by mouth

As your stomach should be empty before an anaesthetic, you must not eat anything or drink milk products six hours prior to surgery. You may, however, be able to drink clear fluids up to two hours before surgery - the Pre-Admission Clinic or ward nurse will clarify this with you.

After Surgery

You are transferred to the Recovery Room next to the operating theatre. Your condition is monitored and when you are awake and comfortable you will be transferred to either a ward or recovery room depending on your expected length of hospital stay.

A nurse will check the following regularly:

- Vital signs - your blood pressure, pulse, respiration rate and temperature
- The severity and location of any pain or discomfort
- The effectiveness of your pain relief
- The amount of urine you are producing

You may have

Intravenous fluids

A small tube is placed into a vein to give you fluids and medications. This tube can be placed in any vein, usually in the forearm.

Oxygen mask or nasal prongs

Oxygen is sometimes given after surgery to help with your recovery.

Urinary catheter
Depending on the preference of your doctor, you **may or may not** have a catheter for a few days. If a catheter is used it will be a suprapubic catheter (SPC). A supra-pubic catheter is a tube inserted into your bladder through a small hole made in the lower abdomen during surgery. The SPC may drain urine or be spigotted (blocked off).

Pain relief after your surgery

Generally pain following injection of transurethral bulking agents is minimal and easily controlled by oral pain relief like Panadol. If required, other strong forms of pain relieving medication are available in tablet form. These medications will be prescribed by the doctor in the event that you need them.

The **PAIN SCORE** is a way of your nurse establishing how much pain you are experiencing by your grading of your pain from 0 to 10 where 0 = no pain and 10 = the worst pain you can imagine. You may be asked to describe your discomfort /pain postoperatively using this scale.

Your nurse will work alongside your doctor to keep any discomfort/pain at a minimum.

Food and fluids

After you have fully woken up from your anaesthetic, you will be able to progress from sips to a full diet in a short space of time.

Mobility

You will be encouraged to walk around as soon as you able. Early mobilisation improves recovery time.

ADHB Urology Department; Reviewed FEB 2005 Ubix code UPEB23
ACH/2035/034

Removal of Drips and Drains

Intravenous (IV) fluid

This is removed when you are drinking normally. The luer (plastic tube) is removed when you no longer require intravenous medications.

Suprapubic catheter (SPC)

If you have an SPC your doctor will discuss the timing of its removal with you.

Information for passing urine post-operatively

- You will be encouraged to empty your bladder (void) when you feel the urge or every three hours, whichever comes first.
- While you are in hospital use a separate bedpan each time you pass urine as this allows your nurse to keep an accurate record of your progress.
- Tell your nurse if you have any pain or difficulty passing urine.
- Report any leakage of urine.
- Avoid straining to pass urine.
- It is important to empty the bladder as completely as possible as residual urine (urine left behind after voiding) may cause infections. A simple way of assessing if you are emptying your bladder completely is with the use of the bladder scanner. This is a painless ultrasound that measures how much urine is left behind in your bladder after you have voided.

Discharge Advice

***Pain relief*:** Some pain after surgery is normal and to be expected. Paracetamol/Panadol taken every four hours is usually sufficient to relieve any pain. **Do not take Aspirin as this increases the risk of bleeding.** If you are experiencing

severe pain or it is lasting longer than expected, it may be a sign of complications, so contact your family doctor.

Passing urine: Very occasionally you can have difficulty passing urine when you get home. If you are unable to pass urine, please contact your GP or an Emergency Department. If you require a catheter to be passed to drain urine from your bladder, please explain that you have had a transurethral-bulking agent injected. Ask the person inserting the catheter to use the smallest catheter they have to drain the bladder and then to remove it immediately. Request that they then contact the Urology Department at Auckland City Hospital for further advice.

Fluid intake: Continue to drink two litres a day. This includes your usual cups of tea, coffee etc. Avoid drinking large amounts at once as it may make you feel nauseous or bloated.

Physical activity: It is important to your recovery to have some gentle exercise every day. You can return to limited physical activity two weeks after surgery. Normally the time off work is two weeks, depending to some extent on the type of work that you do. Avoid strenuous exercise and heavy lifting for six weeks.

Sexual activity: You should avoid vaginal intercourse for approximately six weeks after surgery. Do not insert anything into your vagina until after your post operative check (use sanitary pads rather than tampons).

Hygiene: Maintain a good standard of personal hygiene.

General: Do not strain to pass urine. Sit relaxed on the toilet and rest your elbows on your knees. If you have problems passing a good urine flow, try squatting to void (lift your bottom

off the toilet seat). If you are still having to strain, discuss this with your doctor.

Keep a regular bowel habit. If you tend to become constipated, discuss this with your nurse or doctor before you are discharged from hospital.

Continue pelvic floor exercises. You will have been taught these prior to your surgery. These should be continued throughout your life.

Follow-up

Discharge letter

You and your GP will receive a copy of a letter outlining the treatment you received during your stay in hospital. This will be mailed to you if it has not been completed by the time you leave hospital.

General Practitioner

When you are discharged from hospital you will be under the care of your family doctor who will look after your general health and monitor any problems you have. Your GP will receive a letter from your hospital doctors, which describes your surgery and progress.

Contact your GP promptly if:

- You feel unwell, have vomiting
- You have fever, shivering or chills
- Your urine is cloudy or has an offensive odour
- You have pain not relieved by paracetamol
- You have increased difficulty passing urine
- You have a smelly vaginal discharge

District Nurse

If you go home with a suprapubic catheter a referral will be made to the District Nursing service for you. The District Nurse will come into your home to dress your catheter insertion site as required and support you in caring for your catheter. The hospital will give you some catheter bag supplies to go home with.

Outpatients' appointment

You will receive an appointment for Urology Outpatients approximately six weeks after discharge. This will be sent to you.

3 References: Mosby's Genitourinary Disorders, Clinical Nursing, Mikel Gray 1992
Urological Nursing 3rd Edition, Urological Nursing' 2004
Campbell's Urology 7th Edition, Urology, 1998