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## WAIT AND SEE: IS IT A POSSIBLE OPTION IN ASYMPTOMATIC PATIENTS WITH MESH EXPOSURE?

### Hypothesis / aims of study

The vaginal mesh exposure is associated with vaginal secretions, pain, dyspareunia, vaginal infections, and abscesses rarely cellulitis (1) The choice of treatment depends on the type of mesh implanted, the location and extent of exposure, and the symptoms at visit. A possible treatment is represented by the local medical therapy (estrogen, or local antiseptics). However the effectiveness of the treatment is around 23.5% (2,3). After the failure of the local medical therapy, the patient is generally underwent to surgical repair. Until 2014 we treated symptomatic and asymptomatic vaginal mesh exposure after prolapse or anti incontinence surgery by vaginal surgical treatment. The aim of this study was to evaluate the effectiveness of "wait and see" for vaginal mesh exposure after anti incontinence and prolapse surgery.

### Study design, materials and methods

This is a multicentre prospective study conducted from April 2014 to January 2016 in four Italian centres, approved by local ethical committee. All women with vaginal mesh exposure, without infection signs, pain, vaginal discharge, dyspareunia or other sexual dysfunctions, after failure of vaginal oestrogen therapy for 1 months, were underwent to "wait and see". The exposure was diagnosed during check ups after anti incontinence surgery, abdominal and vaginal surgery with use of mesh. All patients signed an informed consent after counselling on the possible surgical treatment in case of worsening of clinical picture or enlargement of the exposure. Patients were followed up every 3 months after mesh exposure diagnosis for the first year and then every 6 months. At each visit all the patients underwent a clinical examination with measurement of the size of the exposure and the evaluation of vaginal discharge. In sexually active patients, sexual activity, discomfort, bleeding or partner's disturbances were evaluated. Patients completed self-administered Female Sexual Function Index questionnaire (FSFI), and Patient Global Impression of Improvement (PGI-I) questionnaire at 6 and 12 months after surgery.

### Results

Thirty-six women (mean age 62.4± 8.2) were diagnosed for mesh exposure after surgery. The meshes used were polypropylene for anti-incontinence surgery and vaginal prolapse surgery, and polyvinylidene fluoride for abdominal prolapse surgery. Three mesh exposure were after trans-obturator-tape (2 and 1 in left and right lateral vaginal wall respectively), 27 after vaginal correction of prolapse (19 in anterior vaginal wall and 7 in vaginal vault, 1 lateral fornix), 6 after laparoscopic Hysterectomy plus Sacrocolpopexy (1 and 2 in posterior and anterior vaginal wall respectively, 3 vaginal vault). Time to mesh exposure ranged from 1 to 12 months (mean 6.8), with 30 erosions (83%) within 6 months after surgery. Median follow up was 12.36 (range 6.1- 40.93 months), 27 patients had a follow up >1 years, 1 six months, 8 from seven to ten months. All the exposures were < 1.5 cm (mean 6.3 mm±1.6, range 5-10mm). During follow up, the size of exposure was stable and women remain asymptomatic independently of the type of previous surgery. Five women were widows and no sexually active. Eleven women were no sexually active also before surgery. Twenty women were sexually active before surgery and continue to be even after surgery. They and their partners did not refer any sexual discomfort, only 5 patients referred sporadic bleeding after sexual intercourse. Median FSFI was 22,4 (range 17,1-38), PGI-I was 1 or 2 in 70% and 30% of the cases respectively, they were stable during follow up.

### Interpretation of results

Our numbers of meshes exposure are confirmed by literature, in fact after hysterectomy plus sacrocolpopexy there are more meshes exposure compared to sacrocolpopexy. In 80% of women the time mesh exposure is about six months, also this result is confirmed by literature, however probably our strict follow up allows early detection. Twenty women were sexually active and their partners did not refer any sexual discomfort, the most plausible hypothesis is that the position and size of mesh exposure are not a problem during sexual intercourse. This result is confirmed by FSFI score and PGI-I.

### Concluding message

Overall results demonstrated that wait and see option is a good available option in asymptomatic patients with mesh exposure.

### References

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### Disclosures

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