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Mesh implantations after pelvic floor damage caused by vaginal birth are hardly justifiable

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Short report

Publications report more on this than on the benefits for the indications of pelvic floor prolapse and severe urinary incontinence. Plastic meshes have been in use for almost 20 years. A follow-up study of Perigee implantations was carried out in 2015 by the Charité/Berlin in a dissertation (Annett Buchheim-Zieb). The period covered was 5 years (2004-2009) with 195 test subjects. The last sentence in the abstract: "Despite good long-term results, the use of foreign materials should be critically reconsidered". Before that, the statement "Perigee mesh implants are a safe method for treating genital descent. 97% of patients were satisfied with the surgical outcome". This is in contrast to the results of a study by the University of Oxford. Women after stress incontinence surgery and pelvic organ prolapse surgery were evaluated from primary care databases. Women who had surgery with and without mesh were compared. A total of 220,000 test subjects were diagnosed with stress incontinence in 74% (n=163,000) and prolapse in 37% (n=82,000). Both diagnoses were given in 11% of women (n=24,000). Of those with stress incontinence, 4% (n=6,500) and those with prolapse 9% (n=2,100) underwent surgery. Over a period of an average of 4 years, the group with mesh implantation required more diagnostics than those without mesh. Those who had mesh surgery for incontinence had more frequent MRI scans of the pelvis (RR 1.23). Those with a prolapse indication and mesh implantation were sent for pain therapy more often (RR 1.28). More CRP measurements (RR 1.13) and urine tests (RR 1.13) were necessary for those who had mesh surgery. Risk factors such as age, BMI and socioeconomic status were taken into account in the evaluation. The study author concluded: women who had mesh implantation in the small pelvis had a large burden of illness over a long period of time and needed more intensive care in the long term than women who had surgery without mesh implantation. A careful individual benefit-risk analysis was called for. A mesh device register should be called for in which data from all primary care providers is recorded. The reason why women with stress incontinence and mesh implantation were sent to a psychologist less often was probably because the symptoms were attributed to the mesh implant, thus making it unnecessary to psychologize the symptoms [1].

Comment

The results of mesh implantations are even more problematic in the long term than described in the Oxford study with observation periods of only 4 years. This is because the symptoms increase continuously, as do recurrences of incontinence

and prolapse. Long-term, close follow-up checks are of little use, since recurrences rarely result in a repeat operation. This is the author's outpatient experience with all incontinence interventions, including abdominal sacropexy for vaginal prolapse, sacrospinal vaginal fixation according to Amreich-Richter, etc. Due to chronic inflammation problems, mesh implantations as foreign bodies are a questionable method. The Oxford study reports more frequent referrals for pain therapy after mesh surgery compared to those with surgery without mesh (RR 1.28). Only the "tip of the iceberg" of pain after mesh surgery was recorded. This is because painkillers after such operations are in the majority prescribed by GPs or self-medication occurs. This was not recorded in the Oxford study. More frequent urine tests and CRP measurements after mesh surgery (RR 1.13 each) are only a small part of the common clinically relevant inflammatory consequences that rarely trigger diagnostics. This raises the critical question: why not generally educate people about the 1-to-1 risk of pelvic floor damage as a result of vaginal birth if the reconstruction options are still so disappointing. In the general population, a 1-to-1 risk is hardly accepted in any other area of life, but alternatives are sought. Prevention of pelvic floor damage through the alternative of abdominal birth is now justifiable and can be improved, such as carrying out the birth close to the due date with a short-term induction of labor beforehand in the interests of the newborn. Thrombotic events after Caesarean section can be avoided with the use of low molecular weight heparin. When choosing the mode of birth, later performance and quality of life must be considered, as confirmed by the Oxford study.

References

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