Surgery for stress urinary incontinence — transobturator tape

01 What is it?

The operation offered to you treats urine leakage on exertion, by the vaginal route.

This sheet supplements the explanations given by your gynaecologist at the consultation; it does not replace that discussion.

Stress urinary incontinence means leaking urine during exertion: sport, coughing, laughing, sneezing, walking, changing position. The urethra (the tube that carries urine out of the body) is less well supported and no longer closes perfectly at the moment of exertion; less often, it is the sphincter that does not work properly.

This sheet is based on the patient information sheet of the CNGOF and the SCGP "Bandelette sous urétrale pour le traitement de l'incontinence urinaire à l'effort chez la femme" (2025), adapted to the practice of the clinic.

02 Why this procedure?

The operation consists of placing under the urethra a synthetic, non-dissolvable tape made of polypropylene, which replaces the weakened supporting structures of the bladder and urethra and supports the urethra during exertion, without tension, like a hammock.

In the transobturator route, the tape is placed under the urethra, passes through the obturator foramen of the pelvis and comes out near the thigh creases.

03 How does the procedure take place?

The operation is done under general anaesthetic. It lasts about 30 minutes.

You are placed in the gynaecological position. A short incision is made in the vagina, just below the urethra; depending on the tape chosen, two short skin incisions allow it to be passed through.

The tape is passed using a needle on each side of the urethra, then placed tension-free under the urethra.

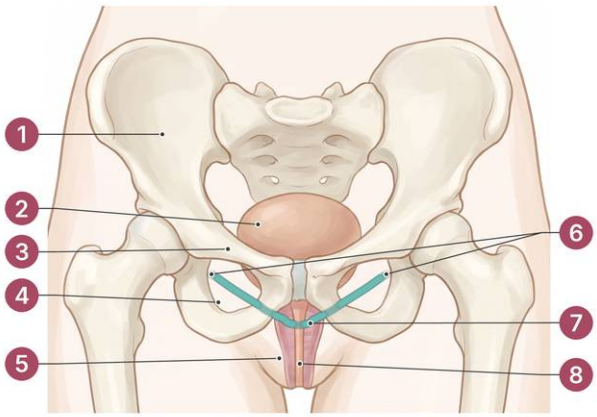


FIGURE 1 — The transobturator tape: placed under the urethra, it passes through the obturator foramen of the pelvis and comes out near the thigh creases (diagram, front view).

1. Pelvis
2. Bladder
3. Pubis
4. Obturator foramen
5. Vagina
6. Passes through the obturator foramen, comes out near the thigh creases
7. Tape: under the urethra, tension-free, like a hammock
8. Urethra

In blue-green: the tape that is placed. Paler: where it runs behind the bone or behind the urethra.

Front view: the right of the image is the patient's left side.

Diagram Wagram Clinic, 2026.

Depending on the tape chosen, an examination of the bladder by endoscopy (cystoscopy) may be carried out to check that it has not been injured.

At the end of the operation, the surgeon may leave a urinary catheter in place temporarily to rest your bladder.

During the operation, the surgeon may come across a finding or an unexpected event that calls for doing something other than what was planned, or even for stopping the operation.

04 What the procedure does not guarantee

The result on incontinence is usually very good in the long term (85 to 90%), but it cannot be guaranteed.

Leaks may persist after the operation, or come back after a much longer time; they are then managed specifically.

05 Risks and complications

In the majority of cases, the operation goes ahead without complications. However, any operation carries risks, including life-threatening ones, which are due to individual variations that are not always foreseeable. Anaesthesia has its own risks, which are explained to you by the anaesthetist.

The complications common to all surgery are infection, local or general; bleeding with haematoma and sometimes transfusion; phlebitis and pulmonary embolism; and allergy.

During the operation:

- Injury to the bladder as the tape is passed, in which case the tape is simply repositioned; more frequent if you have had previous surgery, it may interrupt the operation and mean the catheter is kept in longer.
- Injury to the urethra: it is then preferable not to place the tape.
- Injury to the bowel or a blood vessel: exceptional, it calls for specific treatment, with the risk of having to open the abdomen.

Afterwards:

- Urinary infection, treated with antibiotics.
- Difficulty passing urine: this may require a few more days with the catheter; the surgeon decides whether to loosen the tape or to wait. If significant difficulties persist, repeated catheterisation or drainage of the bladder may be needed, or even a further operation to cut or remove the tape.
- Urgent need to pass urine, most often moderate and easing with time, possibly with treatment.
- Haematoma, which most often clears up on its own; exceptionally, it requires a further operation or a transfusion.
- Exposure of the tape in the vagina, due to poor healing, early on or later: it can cause pain, during intercourse or at other times, bleeding or foul discharge; how it is managed is discussed with your surgeon.
- Some pain, such as cramps at the top of the thighs, is sometimes felt.

Exceptional complications: pain that lasts and may, in rare cases, lead to removal of the tape, or pain on penetration; an abnormal connection between the urethra or bladder and the vagina (fistula), with leakage of urine; passage of the tape into the urethra or bladder, which requires its removal in a specialist referral centre; bowel obstruction; infection of the tape, extremely rare.

06 Alternatives

- No treatment: only patients who are bothered and who ask for treatment are treated.
- Pelvic floor rehabilitation: it is recommended first, over several sessions. Its results are variable and may require maintenance sessions. Surgery is offered if rehabilitation fails, is contraindicated or is declined.
- Medication: none is currently effective for stress urinary incontinence.
- Other operations exist (injections around the urethra, balloons around the urethra, artificial sphincter, colposuspension); they may be offered if the tape fails or in very particular situations.

07 Contraindications

A urine test is done before the operation: if there is a urinary infection, the operation may be postponed.

Do not have the operation if you still have doubts or questions.

Smoking increases the risk of complications of any surgery: it multiplies the risk of infection by 3 and healing difficulties by 5. Stopping smoking 6 to 8 weeks before the operation clearly reduces these risks; it is recommended not to start again during convalescence. For help, talk to your doctors or call Tabac Info Service on 3989.

08 Before the procedure

Before the operation is scheduled, an assessment of how you pass urine (measurement of the urine flow and of the urine remaining in the bladder) and sometimes a urodynamic assessment may be carried out. Your file is presented at a multidisciplinary team meeting to confirm the indication.

An anaesthetic consultation is necessary a few days before the operation.

Follow the preparation recommendations given by your surgeon and your anaesthetist: if they are not followed, the operation may be postponed.

You will be asked to take a shower before the operation. The operation can take place during your period.

09 After the procedure and your instructions

The surgeon decides when any catheter is removed. Some burning and a weaker stream are possible in the first few days; pain is rarely severe and pain relief is prescribed for you.

You go home the same day (day surgery), once your surgeon has checked that you can pass urine.

- Healing: it takes several weeks; slight vaginal bleeding may occur. Take care with hygiene; in the shower, wash the small incisions with your usual soap; no vaginal douching. The stitches are dissolvable: feeling them when you wash is normal, they come away on their own within 6 to 8 weeks at most.
- Activities: convalescence lasts about two weeks; during this period you can resume normal activity, while avoiding strenuous effort, carrying loads of more than 5 kg and baths. Sport is stopped for 1 to 2 months depending on the sport and its intensity; cycling and motorcycling are not advised for 1 month.
- For the following month: no sexual intercourse with penetration, no tampons, so that the vaginal incision heals perfectly.
- Be sure to avoid constipation so that you do not strain on the toilet: a diet rich in fruit and vegetables, good hydration, and if needed a treatment for bowel movements. Drink plenty and pass urine regularly.
- Time off work may be prescribed for you, for a length suited to your job.

A follow-up consultation generally takes place within three to four weeks. At this consultation your surgeon decides when you can resume all your activities, in particular sport and sex, and reassesses any persistent leaks.

After that, regular monitoring is necessary: see your doctor once a year.

10 When to seek medical advice without delay

- Sweating, palpitations or paleness: this may be bleeding. Contact your GP immediately or call 15 (SAMU, the French emergency medical service).
- No passing of wind, nausea or vomiting: seek urgent medical advice. Also contact your doctor if you have not passed wind or stools for several days.
- Unexplained fever.
- Burning when passing urine that gets worse or persists, or cloudy urine: a urine test is needed.
- Blood in the urine that persists or increases.
- Difficulty passing urine that gets worse (needing to push, urine coming out drop by drop): this may be a blockage.
- Scar that is red, hot or swollen, discharge or haematoma, severe or lasting pain, or a vaginal scar that opens.
- Foul or abnormal vaginal discharge, frequent urges to pass urine that persist, repeated urinary infections.

11 Your questions for Dr Gatri

This information sheet probably cannot answer all your questions. In any case, do not hesitate to ask your doctor any question that comes to mind, either orally or in writing.