

**AN INTERNATIONAL UROGYNECOLOGICAL ASSOCIATION
(IUGA) / INTERNATIONAL CONTINENCE SOCIETY (ICS)
JOINT TERMINOLOGY AND CLASSIFICATION OF THE
COMPLICATIONS RELATED TO NATIVE TISSUE FEMALE
PELVIC FLOOR SURGERY**

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JOINT TERMINOLOGY AND CLASSIFICATION OF THE
COMPLICATIONS RELATED TO NATIVE TISSUE
FEMALE PELVIC FLOOR SURGERY

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ABSTRACT

Introduction and Hypothesis: A terminology and standardized classification has yet to be developed for those complications related to native tissue female pelvic floor surgery.

Methods: This report on the terminology and classification combines the input of members of the Standardization and Terminology Committees of two International Organizations, the International Urogynecological Association (IUGA) and the International Continence Society (ICS) and a Joint IUGA/ICS Working Group on Complications Terminology, assisted at intervals by many external referees. A process of rounds of internal and external review took place with decision-making by collective opinion (consensus).

Results: A terminology and classification of complications related to native tissue female pelvic floor surgery has been developed, with the classification based on category (C), time (T) and site (S) classes and divisions, that should encompass all conceivable scenarios for describing operative complications and healing abnormalities. The CTS code for each complication, involving three (or four) letters and three numerals, is likely to be very suitable for any surgical audit or registry, particularly one that is

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2
3 procedure-specific. Users of the classification should be assisted by case
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6 examples, and colour charts.
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9 *Conclusions:* A consensus-based terminology and classification report for
10
11 complications in native tissue female pelvic floor surgery has been
12
13 produced. It is aimed at being a significant aid to clinical practice and
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15 particularly to research.
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19 20 21 22 **KEYWORDS**

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25 Classification, Complication, Native Tissue, Female Pelvic Floor Surgery.
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32 33 **SUMMARY**

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35 A standardized terminology and classification is presented for those
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37 complications arising from native tissue female pelvic floor surgery.
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44 **WORDCOUNT** 3027
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PREFACE

The Standardization and Terminology Committee of the International Urogynecological Association (IUGA), the Standardization Steering Committee of the International Continence Society (ICS) and the Joint IUGA/ICS Working Group on Complications Terminology seek to provide a terminology and a standardized classification for those complications arising from native tissue female pelvic floor surgery. This document follows a similar document (1) for those complications related directly to the insertion of prostheses (meshes, implants, tapes) and grafts, also in female pelvic floor surgery. It would then be, amongst its various other possible applications such as medical records and surgical audits (often procedure-specific), the basis for scientific clinical studies comparing complications from the different types of female pelvic floor surgery. As the first aim is to standardize the terminology used in this classification, the terms used in the title need to be initially defined.

. **Classification:** A systematic arrangement into classes or groups based on perceived common characteristics (2). N.B. **Division:** A separation into two or more parts.

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4 . **Complication:** A morbid process or event that occurs during the course of a
5
6 surgery that is not an essential part of that surgery (“surgery” replacing
7
8 “disease” in the definition; “course” includes postoperative of whatever
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10 duration) (2).
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14 . **Related:** Connected (3).
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17 . **Tissue:** A collection of similar cells and the intercellular substances
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19 surrounding them (2).
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22 . **Native:** Pertaining to birth (2). autologous (2).
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28 INTRODUCTION

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32 In January 2011, the IUGA / ICS Joint Terminology and Classification of
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34 Complications related directly to the insertion of Prostheses (meshes,
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36 implants, tapes) and Grafts in Female Pelvic Floor Surgery was
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38 simultaneously published in the International Urogynecology Journal and
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40 Neurourology and Urodynamics (1). As usage of this classification was then
41
42 proposed for large randomized clinical trials of pelvic floor surgeries
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44 involving both (i) the insertion of prostheses or grafts and (ii) the use of
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46 native tissues alone, it became more evident that an equivalent classification
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48 for the latter indication was not available.
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3 The need and request for an equivalent native tissue surgical classification
4 (by clinical researchers) was deemed a separate challenge in itself after the
5 efforts in producing the first document. Desirably, if one was trying to
6 compare surgical complications, it would be easiest if the classifications of
7 the complications of the two different sets of surgeries were of a similar
8 style. Essentially, they were being performed in the same anatomical setting,
9 involving similar healing processes and a similar timeframe for healing. The
10 main difference was whether a surgical prosthesis or graft was additionally
11 being introduced. An attempt was then made to apply the Category (C),
12 Time (T) and Site (S) Classification for the prostheses and grafts (1) to
13 native tissue surgery. It became clear that this style of classification might
14 also be suitable for the latter indication.
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39 The analysis of synthetic meshes by Amid (4) may not have been performed
40 for suture materials in native tissue surgery, particularly around the vagina,
41 although many of Amid's (4) and others' (5, 6) findings and subsequent
42 conclusions in relation to an "ideal" mesh material (1) might still apply.
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3 ligament colpopexies. Braided sutures, if left exposed to the vaginal cavity
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5 rather than buried beneath vaginal skin, appear particularly prone to the
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7 formation of surrounding inflammation e.g. granulation.
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14 Historically, discontinuation of a surgical procedure, or the use of a
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16 particular material in that procedure, occurs generally due to either (i) a lack
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18 of efficacy or (ii) the nature or frequency of complications. Native tissue
19
20 repairs are not without complications. It was noted (1) that prostheses or
21
22 grafts potentially add to the complication profile the aspects of (i) trauma of
23
24 insertion; (ii) reaction of the body to the prosthesis in terms of inflammation
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26 or infection; (iii) the stability of the prosthesis over time; (iv) morbidity at
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28 the donor site from harvesting an autologous graft. On reflection, points (i)
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30 to (iii) might still apply to certain permanent suture materials in native tissue
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32 surgery.
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45 The classification of complications based on category (C), time (T) and site
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47 (S) is consistent with the previous report for prostheses and grafts (1) and
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49 might appear familiar and again initially complex. It is hoped that the
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51 following outline and explanatory notes, as well as user-friendly tables and
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53 case examples might alleviate any residual concerns in regards to
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complexity. It would be of greater concern if the classification did not cover all the different complication scenarios, such that previously undefined additional terminology might be needed.

PROPOSED NEW DEFINITIONS

Complications involving native tissue female pelvic floor surgery need to involve the following viewpoints of (i) local complications; (ii) complications to surrounding organs; (iii) systemic complications. As in the earlier document (1), the generic term of “*erosion*” (medically defined as the “state of being worn away, as by friction or pressure (2), does not necessarily suit the clinical scenarios encountered. Its use is best avoided, to be replaced by terms with greater physical specificity and clarity.

The additional terms to be used are:

- . ***Prominence:*** Parts that protrude beyond the surface with no epithelial separation (2).
- . ***Separation:*** Physically disconnected (3) e.g. vaginal epithelium.
- . ***Exposure:*** A condition of displaying, revealing, exhibiting or making accessible (3) (e.g. a permanent suture visualized through separated vaginal epithelium).

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3 . **Extrusion:** Passage gradually out of a body structure or tissue (2). (e.g. a
4 permanent suture protruding into the vaginal cavity – see patient 555 (Table
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9 3) and case example 8.

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11 . **Compromise:** Bring into danger (3).

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13 . **Perforation:** Abnormal opening into a hollow organ or viscus (2).

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15 . **Dehiscence:** A bursting open, splitting or gaping along natural or sutured
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20 lines (2).

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22 . **Sinus tract formation:** (Localized) formation of a fistulous tract towards
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vagina or skin, where there is no visible suture material in the vaginal lumen
or overlying skin.

31 . **Granulation:** Fleishy connective tissue projections on the surface of a
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wound, ulcer or inflamed tissue surface (2).

36 . **Ulcer:** A lesion through the skin or a mucous membrane resulting from loss
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of tissue, usually with inflammation.

42 . **Invagination:** Vaginal mucosa folded and entrapped on itself,
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characterized by a fixed and tight area on examination (7).

50 CATEGORY, TIME AND SITE (CTS) CLASSIFICATION

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The overall aim of the classification is to summarize any of a large range of
possible clinical scenarios into a code (“a numeric system for ordering and

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3 classifying information” – [2]) using as few as three numerals and three (or
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6 four) letters. No additional verbal description, possibly involving undefined
7
8 terminology, should be necessary.
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11 12 13 14 **SELECTION OF CATEGORIES** 15

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17 The selection of category (C) has used the principal that the least severe
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19 complication would occur within the anatomical site of the procedure. More
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21 severe complications would involve (i) increasing involvement of
22
23 surrounding anatomical structures; (ii) involvement of surrounding organs;
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25 and (iii) systemic compromise. The following seven categories (by number)
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31 have been formed:
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34 1. **Vaginal complication – no epithelial separation:** This incorporates
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36 the terms prominence or excessive degrees of scarring or tethering.
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40 2. **Vaginal complication – smaller epithelial separation or ulcer:** A
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42 smaller (1cm or less) degree of vaginal epithelial separation or ulcer
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44 formation is involved.
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48 3. **Vaginal complication – larger epithelial separation or ulcer or**
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50 **suture extrusion:** A larger degree (more than 1cm) of vaginal
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52 epithelial separation or ulcer formation or suture extrusion is
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56 involved.
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Categories 1-3 have been separated into the following divisions:

1A - 3A: Asymptomatic - Abnormal finding These are generally physician-diagnosed at any episode of clinical care. It can be argued that the “abnormal finding” aspects of category *1A*, in particular, are not really complications as the patient is not bothered by the potential problem. It may be, however, that the woman may not have engaged in an activity that is likely to provoke symptoms for herself, e.g. pain or bleeding during sexual intercourse (or for her partner), which would convert these complications to category *1B*.

1Aa - 3Aa: Asymptomatic - Abnormal finding The addition of an “a” specifies that the patient experiences no pain in association with the abnormal finding.

1B - 3B: Symptomatic – Unusual discomfort or pain; dyspareunia (for either partner). Bleeding or discharge may be possible symptoms.

1Bb - 3Bb: Symptomatic – Provoked pain only (during vaginal examination) The addition of a “b” to the category code specifies that pain, provoked only during vaginal examination, is associated with the abnormal finding.

1Bc - 3Bc: Symptomatic – Pain during sexual intercourse The addition of a “c” to the category code specifies that pain, provoked

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3 during sexual intercourse (patient only), is associated with the
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6 abnormal finding.
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9 **1Bd - 3Bd: Symptomatic – Pain during physical activities** The
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11 addition of a “d” to the category code specifies that pain, provoked
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13 during physical activities, is associated with the abnormal finding.
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17 **1Be - 3Be: Symptomatic – Spontaneous pain** The addition of an “e”
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19 to the category code specifies that pain, spontaneously present (i.e.
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21 without physical activity), is associated with the abnormal finding.
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25 **1C – 3C: Clinical Infection / Inflammation:** Signs of local tenderness
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27 are suggestive with the combination of redness and a purulent
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29 discharge being more conclusive. The presence of **granulation** should
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31 be accepted as representing ongoing inflammation.
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36 **1C – 3C (b-e): Infection- Pain.** The addition of the letters “b” through
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38 to “e” specifies that pain (as defined in Table 4) is part or all of the
39
40 infected abnormal finding.
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45 **1D – 3D: Abscess formation:** This is a more serious possibility.
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48 **1D – 3D (b-e): Infection –Pain** The addition of the letters “b” through
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50 to “e” specifies that pain (as defined in Table 4) is part of the
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52 abnormal finding associated with abscess formation.
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Category 4: Urinary tract compromise or perforation:

This category class has been subdivided into:

4A: *Small intraoperative defect:* e.g. bladder perforation. Such a complication does not generally create longer-term compromise for the bladder if the defect is recognised and oversewn (if necessary), and some minor precautions are taken, e.g. short term bladder drainage, with suitable antibiotics commenced.

4B: *Other lower urinary tract (bladder or urethral) complication or compromise:* This division would incorporate injuries causing longer term bladder issues, e.g. ongoing suture perforation, fistula, calculus around the suture. This category also incorporates urinary retention directly related to the procedure requiring subsequent surgical intervention (apart from any form of bladder drainage). The time and site divisions relates to those for the surgical intervention.

4C: *Ureteric or upper tract complication or compromise:*

This division is self-explanatory.

Category 5: Rectal or Bowel compromise or perforation:

This category class has been subdivided into:

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5A: *Small intraoperative defect:* Such a complication may not generally be expected to cause compromise if the defect is recognised and oversewn (as necessary) with appropriate precautions taken, e.g. short term bowel rest is instituted with suitable antibiotics commenced.

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5B: *Rectal injury or compromise:* This division would incorporate injuries causing longer term rectal issues, e.g. ongoing suture perforation, fistula.

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5C: *Small or large bowel injury or compromise:* This division would incorporate injuries causing longer term bowel issues, e.g. ongoing suture perforation, fistula, obstruction.

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5D: *Abscess formation from bowel injury/compromise:*

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Category 6: Skin and/or Musculoskeletal Complications;

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6A: *Asymptomatic:* Physician-diagnosed complication at any episode of care.

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6B: *Symptomatic: e.g.* discharge, pain, lump

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6C: *Infection from skin or musculoskeletal complication:* including sinus tract formation

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6D: *Abscess formation from skin or musculoskeletal complication:*

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Category 7: Patient compromise:

This category recognises that the patient might be brought into systemic danger with some of the complications in addition to any localized complication.

7A: Bleeding complication including haematoma: This division refers to any clinically diagnosed haematoma as well as those where blood transfusion or surgical intervention is a consideration.

7B: Major degree of resuscitation or intensive care: This division refers to significant hemodynamic or cardiopulmonary resuscitation directly related to the procedure, and/or patient transfer for management in intensive care facilities. Included in this division is hematoma *associated with sepsis*, thus increasing patient compromise.

7C: Mortality: The native tissue surgery, whilst not necessarily fatal at the time, has set in train further morbid events leading to mortality.

N.B. Because of their systemic nature, **7B** and **7C** will generally not have a specific site division. They will then be denoted **S 0**.

SELECTION OF TIME (T) DIVISIONS

The time (T) for the complication is when it is *clinically diagnosed*. This section incorporates four time periods, all of the possible episodes where clinical care might be given by the physician or sought by the patient. It might not always be possible to predict with any particular surgery when particular complications might be more frequently diagnosed. This would depend on the results of a procedure-specific surgical audit using the classification. The earliest time division (*T1*) might involve more perioperative issues, whilst later divisions (*T2-T4*) might be biased towards healing abnormality issues.

T1: Intraoperative - 48 Hours: Perioperative complications clearly more likely.

T2: 48 hours - 2 months: Bleeding, infection or healing complications more likely.

T3: 2 months - 12 months: Later healing abnormalities more likely.

T4: Over 12 months: Late healing abnormalities and other suture complications more likely.

SELECTION OF SITE (S) DIVISIONS

The selection of these divisions incorporates the current sites where complications have been noted:

S0: Systemic complications (no specific site): As mentioned earlier, category divisions ***7B*** (*septic hematoma a possible exception*) and ***7C*** which are generally systemic complications will be denoted ***S 0***.

S1: Vaginal: area of suture line: Perhaps the commonest site for complications from native tissue vaginal surgery is close to the vaginal suture line.

S2: Vaginal: away from the vaginal suture line: As most suture lines would be midline, this would generally be lateral in the vagina.

S3: Adjoining viscus: This division incorporates any extraperitoneal, bladder or rectal complication, but not intra-abdominal complications which are ***S5***.

S4: Skin or musculoskeletal site: This division is relevant to any skin or musculoskeletal complications away from the sites of the primary wound. Included might be cutaneous sinus or fistula formation and deep muscle pain from suture fixation.

S5: Intra-abdominal: Included in this section would be bowel perforation or obstruction.

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CTS Classification: (Complete code):

. Example of complete CTS code: ***3B/T2/S3*** (for simplicity, there is no “C” in front of the category class and division). The letters *a* to *e* may be added to the category code e.g. ***3Bc/T2/S3*** to indicate that pain is part of the abnormality ("*c*" - pain with intercourse).

CLASSIFICATION GUIDELINES

The following should be noted:

. Multiple complications may occur in the same patient: These should be reported separately as noted in Table 3.

. There may be early and late complications in the same patient: Again, these should be reported separately.

. All complications should be listed

. If there is progression of a particular complication over time, the highest final category is to be used: Progression of an exposure or vaginal ulcer from asymptomatic to symptomatic; an exposure progresses from smaller to larger; hematoma progresses from aseptic to septic.

CLASSIFICATION LIMITATIONS

. The classification does not note the specific type of material (suture) used:

Use of permanent sutures other than those with the least morbidity (as described in the introduction) might be further reflected in an increased rate of the healing abnormalities.

. Functional issues (e.g. voiding and defecatory dysfunction) are not included: Voiding dysfunction can be defined as abnormally slow (assessed by urine flow rate data) and/or incomplete (assessed by postvoid residual) micturition (8). Surgical intervention for severe voiding dysfunction, namely urinary retention is included in section **4B**.

. Urinary tract infections have not been included.

. Recurrences: Permanent sutures, like meshes and grafts, are often used to prevent recurrence of pelvic organ prolapse. However the addition of permanent sutures might still fail to achieve a successful outcome (over whatever period) and a recurrence occurs. However, it should be emphasized that recurrence is not a complication.

TABLES AND CASE EXAMPLES

Table 1: The definitions of terms used in the classification.

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4 **Table 2:** A classification by category (C), time (T), and site (S) of
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6 complications directly related to native tissue female pelvic floor surgery.
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9 **Table 3:** An example of a *non-procedure specific* table of complications
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11 directly related to native tissue female pelvic floor surgery using the
12
13 category (C), Time (T) and Site (S) system. The CTS Classification Code is
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15 placed adjacent to a description of the complication.
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20 **Table 4:** Subclassification of categories *1* to *3* to specify that pain is part of
21
22 the abnormal finding and the impact of that finding on patient's symptoms.
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26 **Case Examples 1 - 8:** Eight clinical scenarios, the complications and the
27
28 respective classification codes.
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31 32 **DISCUSSION**

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36 The present classification has been developed to be sensitive to all possible
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38 physical complications related to native tissue female pelvic floor surgery.
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41 Both perioperative complications and healing abnormalities are covered.
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44 Whilst this creates a large number of possible scenarios, appropriate
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46 organization has still been possible by category (C), time (T) and site (S).
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49 The end-point is a code of 3 letters (4 if "a" to "e" are used) and 3 numerals.
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52 The addition of the pain subclassification reflects the recognition of the
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54 authors that chronic pain, especially if in the higher subclasses ("c" to "e"),
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3 can be amongst the most disabling surgical outcomes from any female pelvic
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6 floor surgery.
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11 A key advantage of a standardized classification is that all parties involved
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13 in female pelvic floor surgery including surgeons, physicians, nurses, allied
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15 health professionals and industry will be referring to the same clinical issue.
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17 It is anticipated that a (CTS) codified table of complications will be a
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19 necessary part of reports of surgical procedures relevant to this document.
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21 The addition the current classification of complications to the previous one
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23 (1) allows comparison studies of surgeries without and with prostheses and
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25 grafts.
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36 It is acknowledged that to optimize the coverage of complications, the
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38 classification (1) might still appear complex and not immediately mastered.
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40 However, as noted in the introduction (page 2), we anticipate that the
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42 patient cases (Table 3) and case examples (1 to 8) provided below, the
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44 colour charts and the experience with the earlier classification (1) will
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46 ameliorate any initial concerns.
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3 As with the earlier document (1), it has been a consensus view of the authors
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5 that a formal academic terminology and classification should be completed
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7 prior to attempts at further simplification. The latter might run the risk of
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9 compromising coverage of complications.
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14 15 16 17 **ACKNOWLEDGEMENTS**

18
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20
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23 from the Joint Reports on (i) Terminology for Female Pelvic Floor
24
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26
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28
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30
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32
33 from the British Society of Urogynaecology has also assisted in the progress
34
35 towards an ICS-IUGA Registry of Mesh Complications.
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29 **JOURNAL NOTES**

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40 of John Wiley & Sons, Inc., and the International Urogynecological
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43 Association.
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51
52 Urodynamics (NAU) and the International Urogynecology Journal (IUJ), the
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55 respective journals of the sponsoring organizations, the International
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58 Continenence Society (ICS) and the International Urogynecological
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3 Association (IUGA) in the closest issue of each journal to the end of April,
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11 Standardization and Terminology Committee (IUGA) - Bernard T. Haylen,
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13 Robert M. Freeman, Joseph Lee, Steven E. Swift, Peter L. Dwyer, Eckhard
14
15 Petri, Diaa E. Rizk, Gabriel N. Schaer
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33 T. Haylen, Robert M. Freeman, Steven E. Swift, Michel Cosson, Chris
34
35 Maher, Jan Deprest, Peter L. Dwyer, Brigitte Fatton, Ralph J. Webb
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39 40 41 **REFERENCES**

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(ICS) joint report on the terminology for pelvic floor dysfunction. Int Urogynecol J 21:5-26 and Neurourol Urodyn 29:4-20.

Case Examples

Case 1: Anterior midline 1.5cm vaginal ulcer following removal of an ethibond suture and granulation and after diathermy. Presentation with vaginal bleeding was 3 years after an anterior compartment repair including the insertion of the permanent suture for uterosacral ligament plication.

Classification: **3C T4 S1**

Case 2: Rectovaginal fistula presenting 4 weeks (photo taken at 3 months) after a posterior vaginal repair concomitant with a vaginal hysterectomy and anterior vaginal repair. Presenting symptom was vaginal passage of feces.

Classification **5B T2 S3**

Case 3: Ethibond suture in the bladder of a women presenting with recurrent urinary tract infections 7 years after a Burch colopsuspension.

Classification: **4B T4 S3**

Case 4: Abnormal scarring with "tethering" presenting 3 years after a Burch colposuspension and causing dyspareunia.

Classification: **1Bc T4 S1**

Case 5: Urethrovaginal fistula presenting 9 weeks after an anterior vaginal repair

Classification: **4B T3 S1**

Case 6: Pelvic pain, dropping hemoglobin consistent with hemorrhage in first 24 hours after a vaginal hysterectomy and CT evidence of a vaginal vault hematoma. Managed conservatively for 4 days, evidence of sepsis (fever, increasing white cell count) prompted vaginal drainage and intravenous antibiotics.

Classification: **7B T2 S3** (initially **7A T1 S3**)

Case 7: Clinical evidence of vaginal urine loss 36 hours after an anterior colporrhaphy (2 previous anterior repairs). Deeper insertion of lateral fascial suture ligates the distal urethra near the vesico-ureteric junction. CT evidence of discontinuity to distal urethra and extravasation. Managed by interval stenting until extravasation proved to have ceased

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Classification: *4C T1 S3*

Case 8: Extruded goretex suture at posterior vaginal vault (behind cervix) 4 years after a sacrospinous hysteropexy. Only symptom was intermittent PV bleeding.

Classification: *3C T4 S1*

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BT Haylen: Assistance from Boston Scientific to attend London June 2008 Meeting of Authors of IUGA-ICS Report on Terminology for Female Pelvic Floor Dysfunction.

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IUGA/ICS Joint Terminology and Classification of Complications Related to Native Tissue Female Pelvic Floor Surgery

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Standardization and Terminology Committee, International Urogynecological Association (IUGA)^{*} & International Continence Society (ICS)[^]; Joint IUGA/ICS Working Group on Complications Terminology⁰

Table 1: Terminology involved in the Classification

TERMS USED	DEFINITION
COMPLICATION	A morbid process or event that occurs during the course of a surgery that is not an essential part of that surgery
NATIVE	Pertaining to birth, autologous
TISSUE	Collection of similar cells and intercellular substances surrounding them
INVAGINATION	Vaginal mucosa folded and entrapped on itself, characterized by a fixed and tight area on examination
PROMINENCE	Parts that protrude beyond the surface with no epithelial separation
SEPARATION	Physically disconnected (e.g. vaginal epithelium)
EXPOSURE	A condition of displaying, revealing, exhibiting or making accessible e.g. a permanent suture visualized through separated vaginal epithelium
EXTRUSION	Passage gradually out of a body structure or tissue e.g. a loop of suture protruding into the vaginal cavity.
COMPROMISE	Bring into danger
PERFORATION	Abnormal opening into a hollow organ or viscus
DEHISCENCE	A bursting open or gaping along natural or sutured line
GRANULATION	Fleshy connective tissue projections on the surface of a wound, ulcer or inflamed tissue surface
ULCER	A lesion through the skin or a mucous membrane resulting from loss of tissue, usually with inflammation

Table 3: An example of a *non – procedure – specific* table of complications directly related to native tissue female pelvic floor surgery using the category (C), time (T) and site (S) system. One might expect these tables to be often procedure – specific.

Patient Number	Description of complications	Code	Code
000	Retropubic haematoma following Burch colposuspension (first 24 hours)	7A /T1/ S3	
111	Persistent buttock pain at presentation six weeks after a sacrospinous colpopexy	6B /T2/ S4	
222	Bowel obstruction and 2cm vaginal vault exposure with bleeding 6 months after a (permanent) suture sacrocolpopexy	5C /T3/ S5	3B /T3/ S1
333	Permanent suture felt in a woman at a 6 week postop review (lateral vaginal-no separation) whose partner described discomfort with vaginal intercourse	1B /T2/ S2	
444	A midline vaginal ulceration (< 1cm) with redness, dyspareunia, discharge 15 months after an anterior colporrhaphy	2Cc/T4/S1	
555	Lateral vaginal extrusion with malodorous discharge and a midline rectovaginal fistula 8 months after a posterior colporrhaphy	3C /T3/ S2	5B /T3/ S1
666	Intraoperative vessel injury during a vaginal vault suspension procedure requiring major resuscitation	7B /T1/ S3	
777	Persistent intravesical suture / calculus formation / haematuria 2 years after a retropubic urethropexy	4B /T4/ S3	
888	Pelvic abscess presenting 8 days after a uterosacral vault suspension complicated by an intraoperative bowel defect (final category) Initial code was 5A/T1/S5	5D /T2/ S5	
999	Tender prominent vaginal scarring noted 9 months after a sacrospinous colpopexy (no symptoms, husband unwell)	1Bb/T3/S1	
XXX	Persistent postvoid residual of 150mls with recurrent UTI requiring suture release 4 months after Burch colposuspension	4B /T3/S1	

Table 4: Grades of Pain: Subclassification of Complication Category

To specify the presence of pain (by patient only, not the partner) as part or all of the abnormal finding and the grade in terms of the presence and severity of symptoms

- a** asymptomatic or no pain
- b** provoked pain only (during vaginal examination)
- c** pain during sexual intercourse
- d** pain during physical activities
- e** spontaneous pain

Table 2: A CLASSIFICATION OF COMPLICATIONS RELATED TO NATIVE TISSUE FEMALE PELVIC FLOOR SURGERY

		CATEGORY			
General Description	A (Asymptomatic)	B (Symptomatic)	C (Infection)	D (Abscess)	
1 Vaginal: no epithelial separation Include prominence or excessive scarring. Vaginal invagination. Grades of pain from table 4 incorporated	1A: Abnormal finding on clinical examination	1B: Symptomatic e.g. unusual discomfort / pain; dyspareunia (either partner); bleeding	1C: Infection (suspected or actual)	1D = Abscess	
2 Vaginal: smaller epithelial separation or ulcer ≤ 1cm	2A: Asymptomatic	2B: Symptomatic	2C: Infection	2D = Abscess	
3 Vaginal: larger >1cm epithelial separation or ulcer or suture extrusion	3A: Asymptomatic 1-3Aa if no surgery related pain	3B: Symptomatic 1-3B (b-e) if surgery related pain	3C: Infection 1-3C /1-3D (b-e) if surgery related pain	3D = Abscess	
4 Urinary Tract: compromise or perforation Include fistula and calculus	4A: Small intraoperative defect e.g. bladder perforation	4B: Other lower urinary tract complication or urinary retention	4C: Ureteric or upper urinary tract complication		
5 Rectal or Bowel: compromise or perforation include perforation and fistula	5A: Small intraoperative defect (rectal or bowel)	5B: Rectal injury or compromise	5C: Small or Large bowel injury or compromise	5D = Abscess	
6 Skin and / or musculoskeletal: complications including discharge, pain, lump or sinus tract formation	6A: Asymptomatic, abnormal finding on clinical examination	6B: Symptomatic e.g. discharge, pain or lump	6C: Infection e.g. sinus tract formation	6D = Abscess	
7 Patient: compromise including hematoma or systemic compromise	7A: Bleeding complication including hematoma	7B: Major degree of resuscitation or intensive care* including septic hematoma	7C: Mortality * *(additional complication - if no site is applicable - S 0)		

TIME (clinically diagnosed)

T1: Intraoperative to 48 hours	T2: 48 hours to 2 months	T3: 2 months to 12 months	T4: over 12 months
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SITE

S1: Vaginal: area of suture line	S2: Vaginal: away from area of suture line	S3: Adjoining viscus e.g. bladder or bowel	S4: other skin or musculoskeletal site	S5: Intra-abdominal
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- N.B.**
- Multiple complications may occur in the same patient. There may be early and late complications in the same patient. i.e. All complications to be listed. Tables of complications may often be procedure specific.
 - The highest final category for any single complication should be used if there is a change over time. (patient 888)
 - Urinary tract infections and functional issues (apart from 4B) have not been included



CODE - T - S

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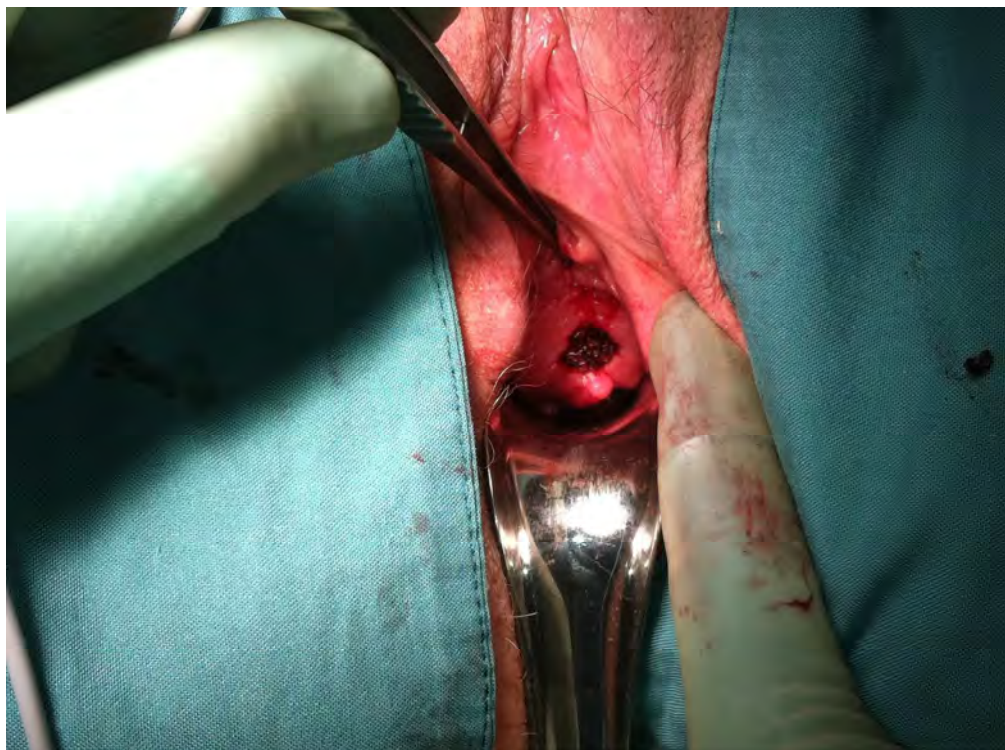


Figure 1
609x455mm (72 x 72 DPI)

Review

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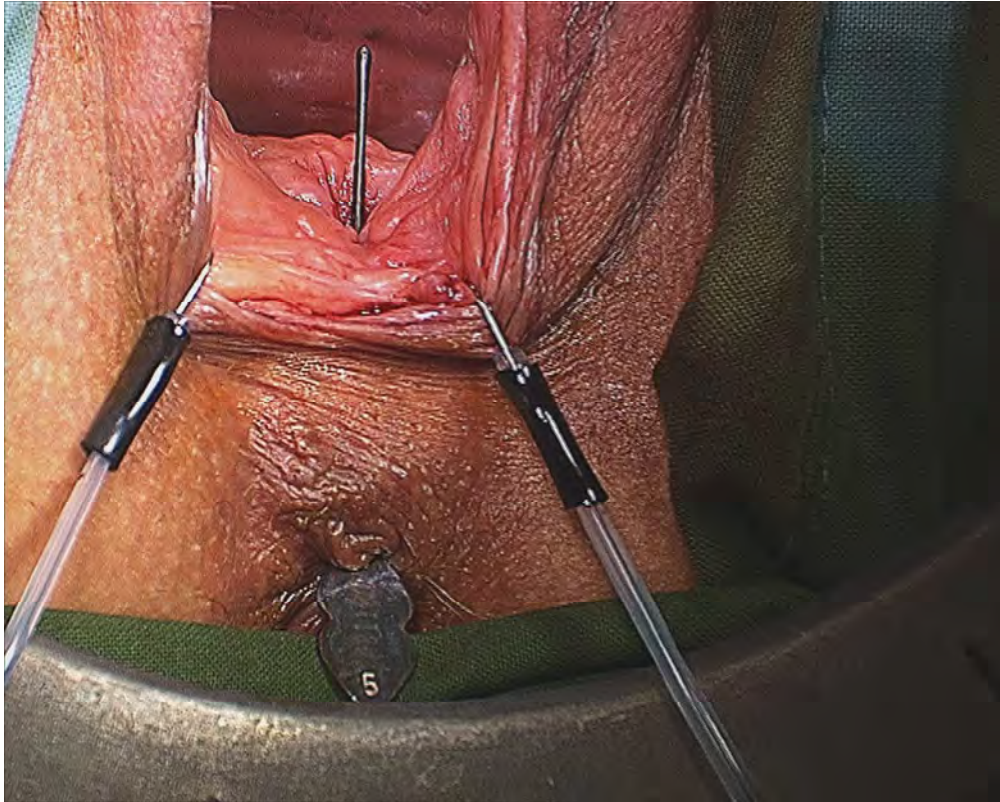


Figure 2

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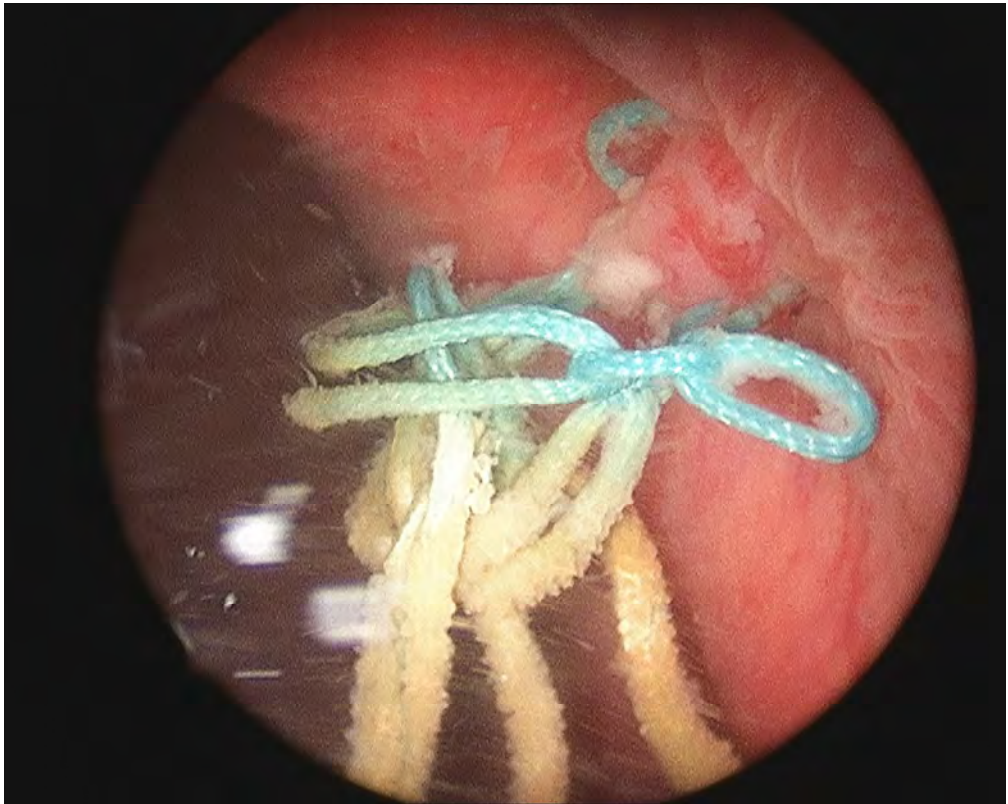


Figure 3

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Figure 4
227x212mm (96 x 96 DPI)

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Figure 5
25x17mm (300 x 300 DPI)

Peer Review

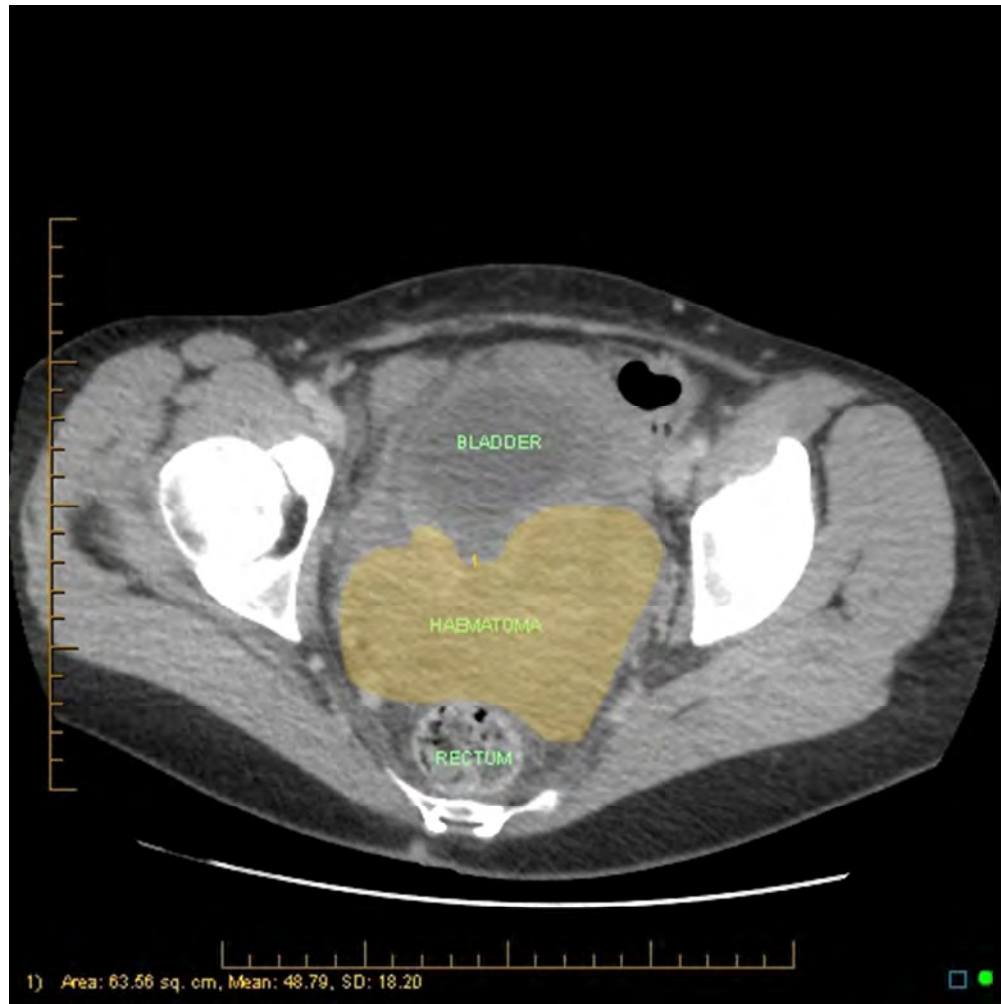


Figure 6



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Figure 7
135x135mm (96 x 96 DPI)



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Figure 8
84x112mm (72 x 72 DPI)